Assessment of Patient / client

⇒ Definition:

→ Health is state of well being.

WHO defines it as, "state of complete physical, mental, & social well being & not merely the absence of disease & infirmity.

→ Assessment: (ANA)

"a systematic, dynamic process by which the nurse through interaction with client, significant others & health care providers, collects & analyses data about client."

⇒ Purpose of health assessment:

1.) To collect data about physical, mental & social well beings of client
2) To identify the problem in early stage
3) To determine the cause & extend of disease
4) To evaluate/monitor the changes in client's health status
5) To determine the nature of treatment required for client
6) To allivate the complications
7.) To certify whether client is medically fit to resume duties
8.) To collect data
9.) To contribute medical research
10.) To identify client's strength, weakness.

→ Health Assessment has 2 purposes

- Health History
- Physical examination

a) Health History:

- It is a collection of subjective data regarding client's health in a chronological order

→ purpose of Health history:

1) To gather subjective data from client
2) To develop nursing diagnosis
3) To plan action of promoting health, preventing disease
4) To compare client's health status with optimum health

→ Format of health history:

1) Biographic data
2) chief complaints
3) History of present illness
4) Past health history
5) Family history
6) Occupational & environmental history
7) Psychosocial history
8) Reviews of systems.

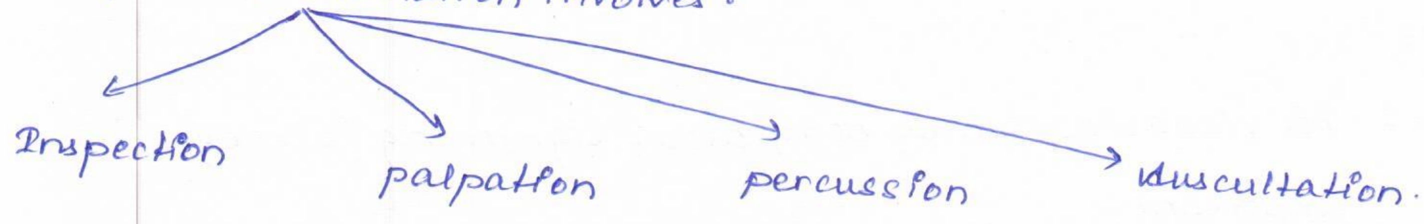
b) Physical Examination:

- It is an important part of health assessment. It provides objective data for identifying problems & making diagnosis.

→ purpose of physical examination:

- To identify problem in early stage
- To compare the client's state of health with ideal state. Considering his age, gender, culture, physical, psychologic & socio-economic status.

→ Physical examination involves:



1) Inspection:

- It is visual examination of body
- It involves careful & keen observation of client's general appearance, body size, shape, stature, gait, posture.
- It involves to correlate the client's expressions are in accordance with body language.

2) Palpation:

- It is use to tactile sensation (use of touch) to feel texture size, shape, consistency & placement / location of organs.

3) Percussion:

- It is tapping
- It involves striking fingers against client's body to get sound quality.

- It is used to reflect the density of internal organs.
- with percussions, sound resonance, pitch, vibrations, & resistance are produced with different density & from organ to organ

4.) Auscultation:
- It involves listening the sounds within body either by ears or by ~~sthe~~ stethoscope.

→ Preparation of client:

1) Time of examining must be convinient to both client as well as nurse
2) Light: - For visualization of body area, lightening is very important
   - Make sure of adequate light.
3) Equipment: - All equipment should be on reach & in working condition
4) Privacy
5) Temperature
6) Positions
7) Draping

→ General Assessment :

1) Skin :

a.) Inspection of skin : - colour
- pigmentation
- Moles
- lesions
- Dry/oily skin
- change in colour

b.) Palpation of skin :
- Temperature
- Texture
- Mobility
- Turger

2) Nails :

a.) Inspection & palpation of nails :
- shape
- Texture
- colour

3) Head :

a) Inspection & palpation of head includes :
- size, shape, symmetry of head
- Inspect scalp for noting texture, skin lesions, mass
- Skull symmetry & size

4) Hair :

- colour
- texture
- distribution
- Quantity

5) Face :

a) Inspection :

- facial expression
- Facial movement
- Facial symmetry
- colour of skin & temperature
- Texture
- lesions

6) Neck :

a) Let the client look staight ahead, then inspect :

- size & symmetry
- Range of motion
- Position of trachea
- Thyroid gland

b) Palpation :

- pulsation of neck region
- Jugular veins distention
- Tracheal rings, cricoid
- cartilage & thyroid cartilage

7.) Nose & paranasal sinuses:

a) Inspection & palpation includes:-

- General appearance
- Discharge if any
- Olfactory nerve
- Internal nasal cavity
- Paranasal sinuses
- Nostrils.

8) Mouth:

a.) palpation:

- temporomandibular joint
- breath of odour

9.) Lips:

- colour
- symmetry
- Moisture & texture.

10.) Teeth:

- alignment.
- colour
- surface
- Palpate teeth for checking symmetric

11.) Buccal Mucosa:

- colour
- symmetry

12) Tongue Inspection:

- Movement
- colour
- ulceration
- surface

13.) Pharynx:

a.) Inspection of posterior wall of pharnyx

color.

14.) Ear:

a.) Inspection of both ears:

- Alignment
- symmetry
- skin colour: - uniformity
  - skull intactness
  - Discharge or lesion
  - clear, purulent, bloody
  - injury

15.) Chest:

a.) Inspection:

- Breathing
- chest wall symmetry

- Breathing rate
- Breathing pattern
- chest expansion
- pulsation

b) palpation:

- chest wall
- Symmetry
- Thoracic expansion: - curvature
  - Abnormal finding
  - pleural friction

c) Percussion of thorax:

- Tone
- intensity
- Pitch

d) Auscultation

- Heart sound
- Rate, Rythm, pitch, splitting of sound checked

16) Breast & Axilla in females:

a) Inspection:

- Breast size, shape, symmetry
- skin of breast
- Areola: - colour
  - surface characteristics
- Nipples

- Axillae

c) palpation:

- Breast & Axillae :- surface characteristics
  - Nodules
  - tenderness

- Nipples :- surface characteristics
  - discharge

17) Abdomen:

a) ~~Skin colour~~ Inspection:

- Skin colour
- surface characteristics :- smooth
  - contour
  - surface movements
  - Any bulges or masses

b) Palpation:

- tenderness
- Muscle tone
- Surface characteristics.
- Umbilicus

c) ~~Percuss~~ Auscultation:

- Bowel sound increases or decrease
- vascular sound
-

d) Percussion:

- Tone
- Liver & spleen

18) Lower limbs & Hips:

a) Inspection:

- client's feet, legs for muscle strength
- vascular sufficiency
- pulses symetry

b) palpation:

- Temperature
- tenderness
- Deformities

18) Genitalia:

a) Inspection:

- Lesions/scar
- Discharge /Infection
- voiding

⇒ Neurologic Assessment:

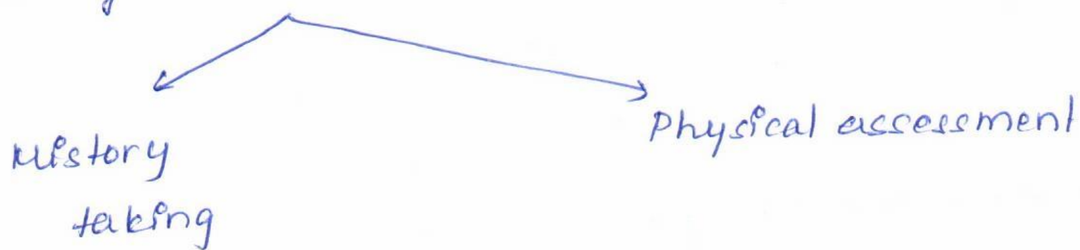
Assessment done to collect subjective as well as objective data related to neurologic functioning of body

Purpose:

collect base line data

- compare base line data with ongoing assessment
- Diagnose / identify client's health problems.

• Neurologic assessment include



1) History taking :

a) Biographic & demographic data

b) source of information

c) client's mental status

d) chief complaints

e) History of present illness

f) past history

g) family history

h) occupation / Environmental history

i) Psychosocial history

2) Physical examination :

a) vital signs

b) Mental status

c) Head, neck & back

d) cranial nerves

e) Motor function

f) Reflexes.

a.) vital signs:- Temperature
- pulse
- respiration
- BP

b.) Mental status:

→ Assess level of consciousness
- orientation
- Language
- Mood & affect
- Attention
- Memory
- Thought process
- perception

c.) Head, Neck & Back:

→ Inspection:
- size, shape, symmetry
- Any skull fracture, lesion etc
- Hydrocephalus

→ Palpation:
- Skull for nodules, masses
- Areas of bogginess or depression
- Neck muscles for masses or tenderness

→ Percussion: spine

→ Auscultation: of neck & major vessels to detect abnormal sounds.

d) cranial nerves :

I - olfactory nerve : smell

II - optic nerve : visual activity, visual field

III - oculomotor : pupillary reaction

IV - Trochlear : Eye movement

V) - Trigeminal : Facial sensation, motor function

VI - Abducen : Motor function

VII - Facial : Motor function, sensory

VIII - Acoustic : Hearing, balance

IX - Glossopharyngeal : swallowing & voice

X - Vagus : Gag reflex

XI - spinal : Neck motion

XII - Hypoglossal : Tongue movement & strength.

e) Motor functions :

→ observations : - Involuntary movements
- Muscle symmetry
- Gait

→ Muscle tone :

→ Muscle strength

→ coordination & Gait : - Rapid alternating movement
- Point-to-point movement

f) Reflexes

- Deep tendon reflexes
- Bisceps (C5, C6)
- Triceps (C6, C7)
- Brachioradialis (C5, C6)
- Abdominal (T8, T9, T10, T11, T12)
- knee (L2-L4)
- Ankle
- clonus
- Plantar response

g) Sensory:

→ General
→ Vibration:- use of low pitched turning fork
→ subjective light touch
→ Position sense
→ Pain
→ Temperature
→ Discrimination: