Physical Assessment

Goal of Holistic Health

objective data: anything that you can measure
subjective data: whatever the client tells you

the health history

-always address 3 generations when asking a medical history (2 parents and 4 grandparents)

-maternal and paternal

-review of systems: going through each system

health history questions:

1. alcohol use
2. drug use
3. cocaine use
4. caffeine

-nutrition

-sleep

-stress (scale of 1-10 or medium, moderate, high)

health practices: do you follow western medicine, do you pray, do you take herbal supplements for pain?

focused assessment

-focus interview on one specific body part as indicated by pain

-always interview first before you notify doctor or start assessing patient physically—> subjective data comes first

nursing order of assessment

-inspection, auscultate, palpate, percuss (can be different for every system though!!)

oldcart and ice

O= Onset

L= Location

D= Duration

C= Characteristics

A= Aggravating Factors

R= Relieving Factors

T= Treatment

&

I= Impact on ADL's

C= Coping Strategies

E= Emotional Response

inspection

the nurse assesses each body system or region, inspects for color, size, shape, contour, symmetry, movement or drainage.

-make sure to look at the patient

auscultation

-the skill of listening to the sounds produced by the body

palpation

-anytime you touch or feel the patient

-dorsal hand or fingers is how you feel the clients temperature

-to palpate for vibration, use palm of hand and put over vocal cords to feel vibration when speaking

-LIGHT (1 cm depth), MODERATE (2 cm depth), AND DEEP (two hands on top of each other- 2-4 cm depth)

LIGHT= assess surface characteristics (skin texture, pulse, or tender inflamed area near the surface of the skin)

MODERATE= helps the nurse determine the depth, size, shape, consistency and mobility of organs as well as any pain, tenderness, or pulsations

DEEP= used to palpate the organs that lie deep within a body cavity such as the kidneys, liver, or spleen

-this is when two hands are used

percussion

-the nurse strikes through a body part with an object, fingers, or reflex hammer, ultimately producing a measurable sound.

-the more dense the tissue is, the softer and shorter the tone

-the less dense the tissue is, the louder and longer the tone

-direct percussion: on the lymph nodes by the nose and forehead to feel tenderness or pain

-indirect percussion: produces a sound

1. tympani (loud, high pitched, and drum like for over the *belly*)
2. resonance (hollow, low pitched sound and normal finding for *healthy lungs*)
3. hyperresonance (air trapped in the lungs- COPD/ emphysema- very loud)
4. dullness (high pitched, over solid body organs like *heart and liver*)
5. flat (high pitched, over solid tissue like *muscle and bone*)

stethoscope

diaphragm= high pitched sounds

-abdomen, lungs, heart

bell= low pitched sounds

-heart for murmurs, thyroid for bruit (swishing sound)