NUR 181

PHYSICAL ASSESSMENT

PREPARATION FOR UNIT 1 MODULE

This Module is intended to give you a head start as you begin the Physical Assessment course in the Bergen Community College Nursing Program. The first unit will cover a lot of material in a very short time, and it is important that you review the main concepts, definitions and techniques that are introduced in this Module.

All of the material covered can be found in the Physical Examination and Health Assessment, 7th edition, by Carolyn Jarvis, which is required for NUR 181. This text is an excellent source for a wealth of information, and you are strongly urged you to read the chapters that refer to the assessments that are going to be covered each week. There will be Class Preparation Exercises for each unit, and you are urged to complete them before coming to class. This Module and the Class Preparation Exercises are available on Moodle.

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NUR 181

Self-Directed Learning Exercise for Unit 1

1. Unit 1 of this course covers multiple chapters. To avoid becoming overwhelmed and to be prepared for class start reading them ahead of the beginning of the course. After this unit, each week will only refer to one chapter. As you read the chapters, keep in mind that the focus of this course is assessment of the adult patient and expected changes related to aging. You do not need to concentrate on the infant, baby, child and adolescent, although these will be covered in later courses.

2. For this unit you need to read Chapters 1, 2, 3, 4, 8, and 9 in the Jarvis text.

3. Refer to Chapters 1, 3 and 4 for the following definitions and concepts:

    a. What is holistic health?

    b. Why are health promotion and disease prevention important to nursing?

    c. Distinguish between objective and subjective data. Complete the **Subjective and Objective Data Exercise** included at the end of this Module.

    d. Describe the types of information that are collected for these data bases:
        i. Complete data base

        ii. Episodic or Problem-centered data base

        iii. Follow-up data base

        iv. Emergency data base

4. Which type of data does the Health History obtain? How can the nurse approach the patient in order to enhance the patient's comfort and willingness to share information during the Health History interview?

5. Give some examples of open-ended and closed-ended questions.

6. Refer to pp. 50 and 51 in Jarvis to review the questions the nurse needs to ask to help a patient fully describe a symptom that he/she is experiencing. Review the meaning of "O, P, Q, R, S, T, U", and complete the **Describing Symptoms** exercise included in this module.

7. What are the components of Functional Assessment? Why would this data be important to the nurse?

8. Refer to chapter 8, and describe these techniques of physical assessment and the type of data. that they help to reveal:

    a. Inspection

    b. Palpation

    c. Percussion

        i. What is the significance of the different sounds that are elicited by percussion?

    d. Auscultation

        i. Describe the correct technique for using a stethoscope and distinguish between the use of the diaphragm and the bell of the stethoscope.

9. What is the correct order for performing these techniques?

10. Complete the **Assessment Techniques Review Exercise** that is included in this Module.

11. Refer to chapter 9, and describe each of the components of a **General Survey** of a patient. Use the General Survey form that is included in this Module to perform the General Survey on your patient when you are in the clinical area.

NUR 181 PHYSICAL ASSESSMENT

HEALTH HISTORY EXERCISES

SUBJECTIVE AND OBJECTIVE DATA

Read the following client description and identify which facts are objective and which are subjective. With your partner, list all of the objective and subjective data under the correct heading below.

Client description:

During the nursing history, Mr. B. tells you he has been unusually tired lately and that he has lost 10 pounds since last month. He is pale, and is sitting somewhat slumped over in his chair. He speaks slowly and doesn't look directly at you during the interaction. He states that it is too much bother to get out of the house, even to do shopping. His clothing is clean, but very wrinkled and he shirt is only half tucked into his trousers.

Objective data	**Subjective data**

Nurse's note excerpt from the ER:

9/2/01, 9:15 am. Pt. reported crushing chest pain under the sternum that started ½ hour ago. Pt. was lying in bed, sweating profusely, grabbing at her chest. VS: Heart rate 120 and irregular, BP 95/60, respirations 30 and shallow. Pt. stated she took three nitroglycerine tablets with no relief. She reports that she has angina, but this is much worse than ever before. Blood was drawn stat, and results revealed elevated cardiac enzymes, and an EKG showed premature ventricular beats and ventricular tachycardia.

Objective data	**Subjective data**

NUR 181 PHYSICAL ASSESSMENT
DESCRIBING SYMPTOMS

OPQRSTU:

O: **O**nset

P: **P**rovoking, palliating, perception

Q: **Q**uality/quantity

R: **R**egion/radiation

S: **S**everity

T: **T**iming

U: **U**nderstanding

The above tool can help to encourage a client to fully describe a symptom or problem in order to get a full picture of the problem being reported. Using this tool, label each statement below with the letter corresponding to the correct aspect of symptom description.

___ "The pain is a '7' on a scale of 1 –10."

___ "I noticed redness on my right calf."

___ "I think this means I have cancer."

___ "I feel very tired every morning, even after sleeping all night."

___ " I got short of breath after I walked half a block."

___ "My migraines get better if I lie down in a dark room."

___ " I feel burning in my stomach before I eat."

___ "The nausea is constant."

___ "The first time this happened was one month ago."

___ "I have a very annoying dry cough."

___ "I noticed that my urine was pink and had a bad odor."

___ "I can't get to sleep at night if I eat too much for dinner."

___ " My fingers and toes feel like they are all on pins and needles."

___ " This headache goes all the way from my forehead right down the back of my neck."

___ " Ever since my husband died I haven't even wanted to be around my friends or family.

___ "It's a good sign that this lump I found in my breast doesn't hurt."

NUR 181 PHYSICAL ASSESSMENT
ASSESSMENT TECHNIQUES REVIEW EXERCISE

Four Techniques of assessment: These techniques are used to collect objective data.

Inspection: Gathering of data by observation and use of the senses.

Palpation: Using the sense of touch to obtain data.

Percussion: Tapping the skin directly or indirectly.

Auscultation: Listening, usually with a stethoscope, to sounds produced within the body.

State which technique(s) is (are) used to assess each of the following:

_____ Abdomen flat in contour.

_____ Skin is blue and cold.

_____Full range of motion in all joints.

_____ Respirations labored, wheezing on expiration.

_____ Radial pulse weak, thready.

_____ Tympany heard throughout the abdomen.

_____ _Bowel sounds active in all 4 quadrants.

_____ Relaxed posture, sitting upright, smiling expression.

_____ _Hard, immovable lump in right upper quadrant of left breast.

_____ Serosanguinous drainage on abdominal dressing, 4cm. in diameter.

_____ Reports pain when lower left quadrant is touched.

_____ Dullness heard over right upper lobe of lung.

_____ Heart rate 76 and irregular.

_____ Fine tremor noted in left hand.

_____ Rigid abdomen.

_____ Knee joint feels boggy.

Assessment Techniques Exercise (con't.)

Techniques of assessment must be performed correctly and equipment used appropriately in order to obtain accurate data. Review your notes and text regarding how to use the stethoscope and how to inspect, palpate, and percuss and describe the correct way to carry out the technique to assess each of the following:

Temperature of the skin _____

Listening to heart sounds _____

Percuss the chest _____

Consistency of a mass _____

Assessing vibrations in the chest _____

Checking reflexes at the knee _____

Assessing for pain and tenderness _____

Percussing the abdomen _____

Listening to heart sounds _____

Listening to breath sounds _____

Name:_____ Patient initials: ___

GENERAL SURVEY:

1. Physical appearance:

Age: ____ Skin color: _____

Sex: ____

Level of consciousness: _____

Facial features: _____

Obvious distress: _____

2. Body structure:

Stature: _____

Nutrition: _____

Posture: _____

Position: _____

Symmetry: _____

Contour: _____

3. Mobility:

Gait: _____

ROM (range of motion): _____

Quality of movement: _____

4. Behavior:

Facial expression: _____

Mood and affect: _____

Speech: _____

Dress: _____

Hygiene and grooming: _____

General Survey (con't.)

5. Measurements:

Height: _____

Weight: _____

Vital signs:

Temperature: _____

Pulse: _____

Respirations: _____

BP: _____