Group 23

Basic physical assessment

Under The Supervision

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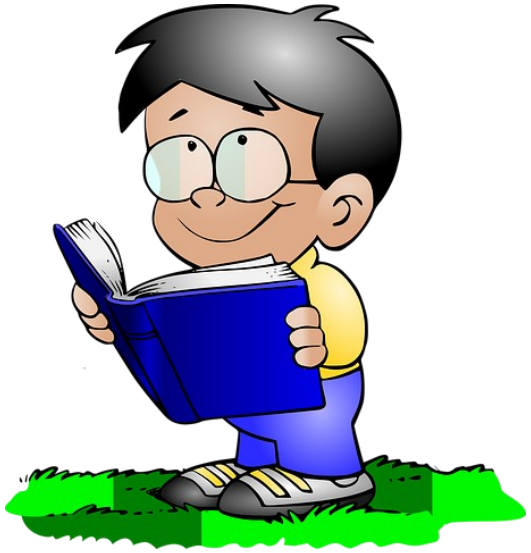
Basic Principles of Physical Examination



Objective of physical examination (PE) is Obtaining valid information about health status of the patient

This is achieved by Identifying ‘’normal’’ state & Identifying any variations from ‘’normal’’

Validation of patient's complaints & symptoms

Screening of the patient general well being

Monitoring of the patient's current health problems

Methods of Physical Examination

In Proper Physical Assessment

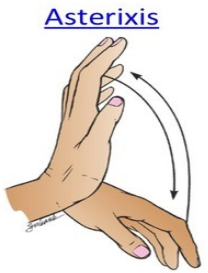
I - Inspection

P - Palpation

P - Percussion

A - Auscultation

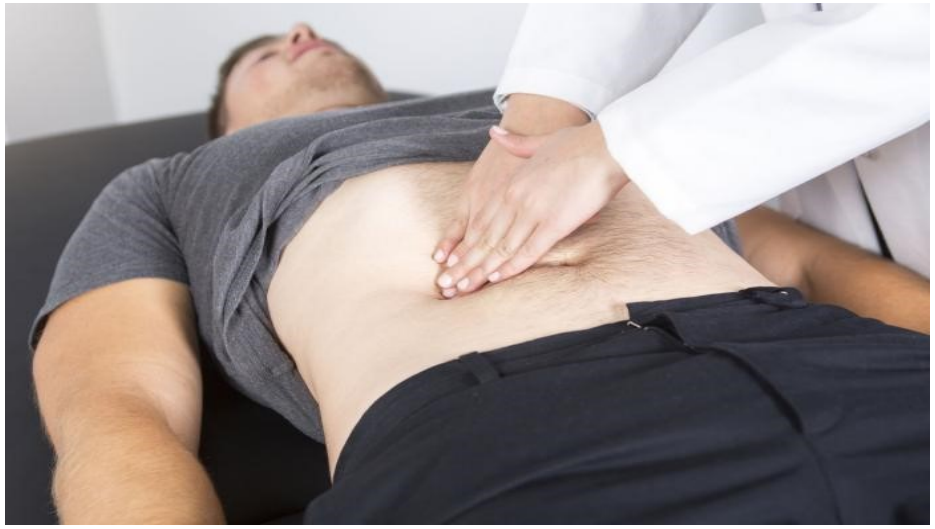
what is inspection?



Inspect each body system using **vision, smell, and hearing** to assess normal conditions and deviations.

Assess for color, size, location, movement, texture, symmetry, odors, and sounds as you assess each body system.

Palpation



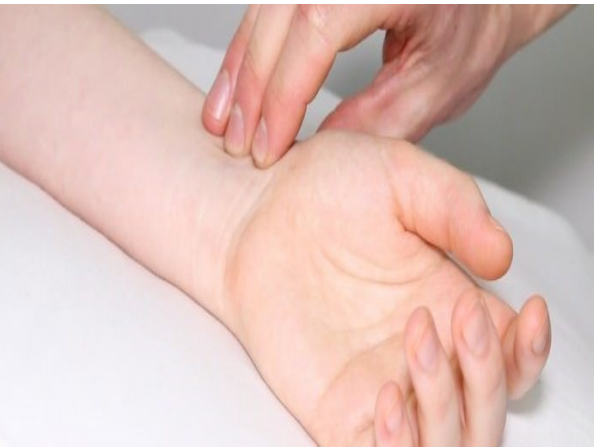
- Palpation requires touching the patient with different parts of hands, using varying degrees of pressure

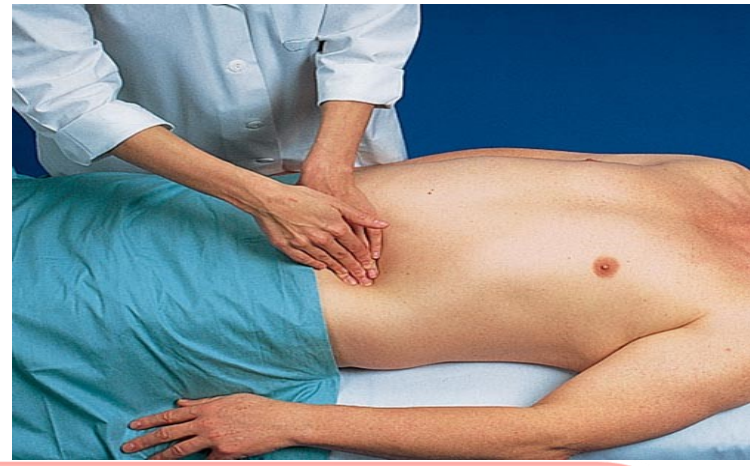
Because hands are the tools, keep your fingernails short and your hands warm.
Wear gloves when palpating mucous membranes or areas in contact with body fluids

Types of palpation

Light palpation

Use this technique to feel for surface abnormalities.
Depress the skin ½ to ¾ inch (about 1 to 2 cm) with
your finger
Assess for texture, tenderness, temperature, moisture, elasticity, pulsations, and masses.
pads, using the lightest touch possible.

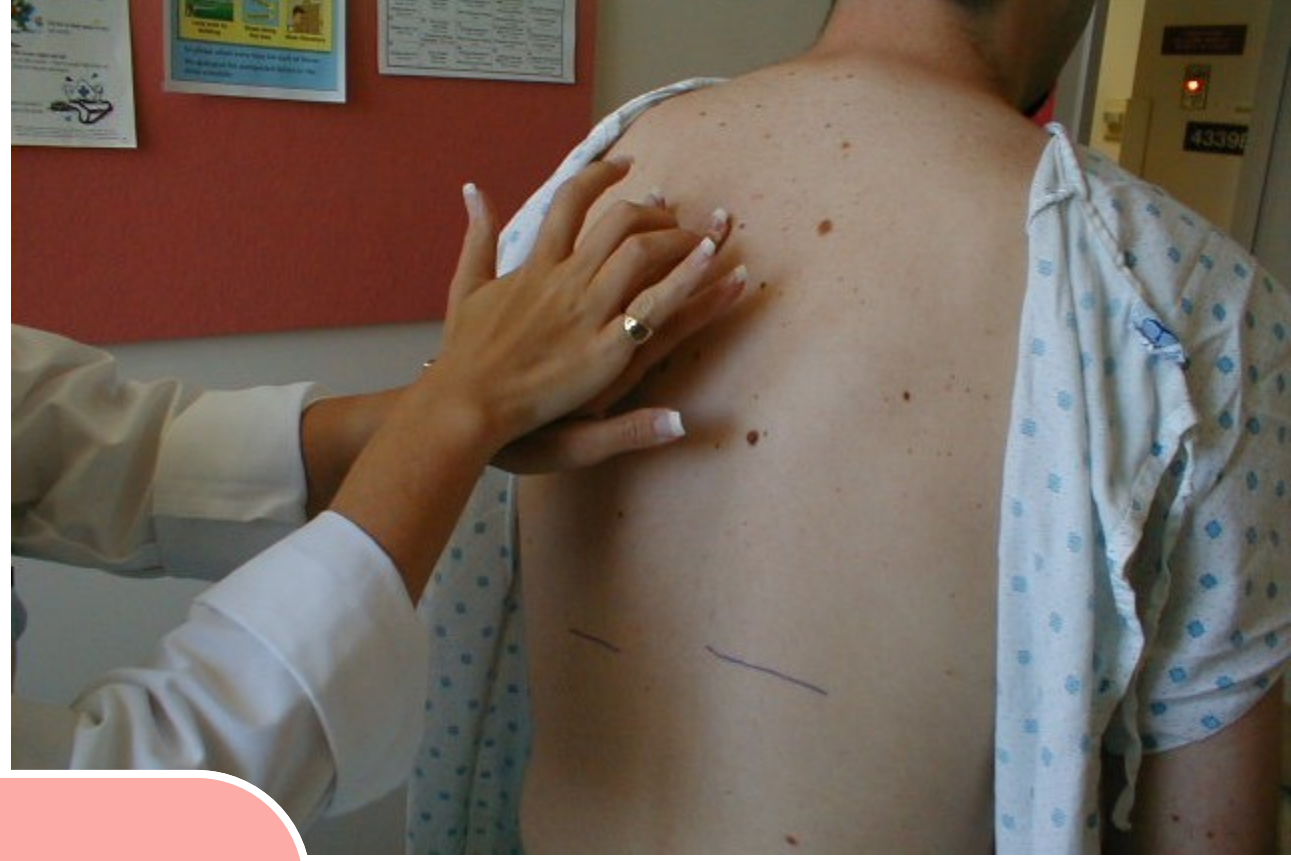




Deep palpation

Use this technique to feel internal organs and masses for size, shape, tenderness, symmetry, and mobility.
Depress the skin 1½ to 2 inches (about 4 to 5 cm) with firm, deep pressure.
Use one hand on top of the other to exert firmer pressure, if needed.

Percussion



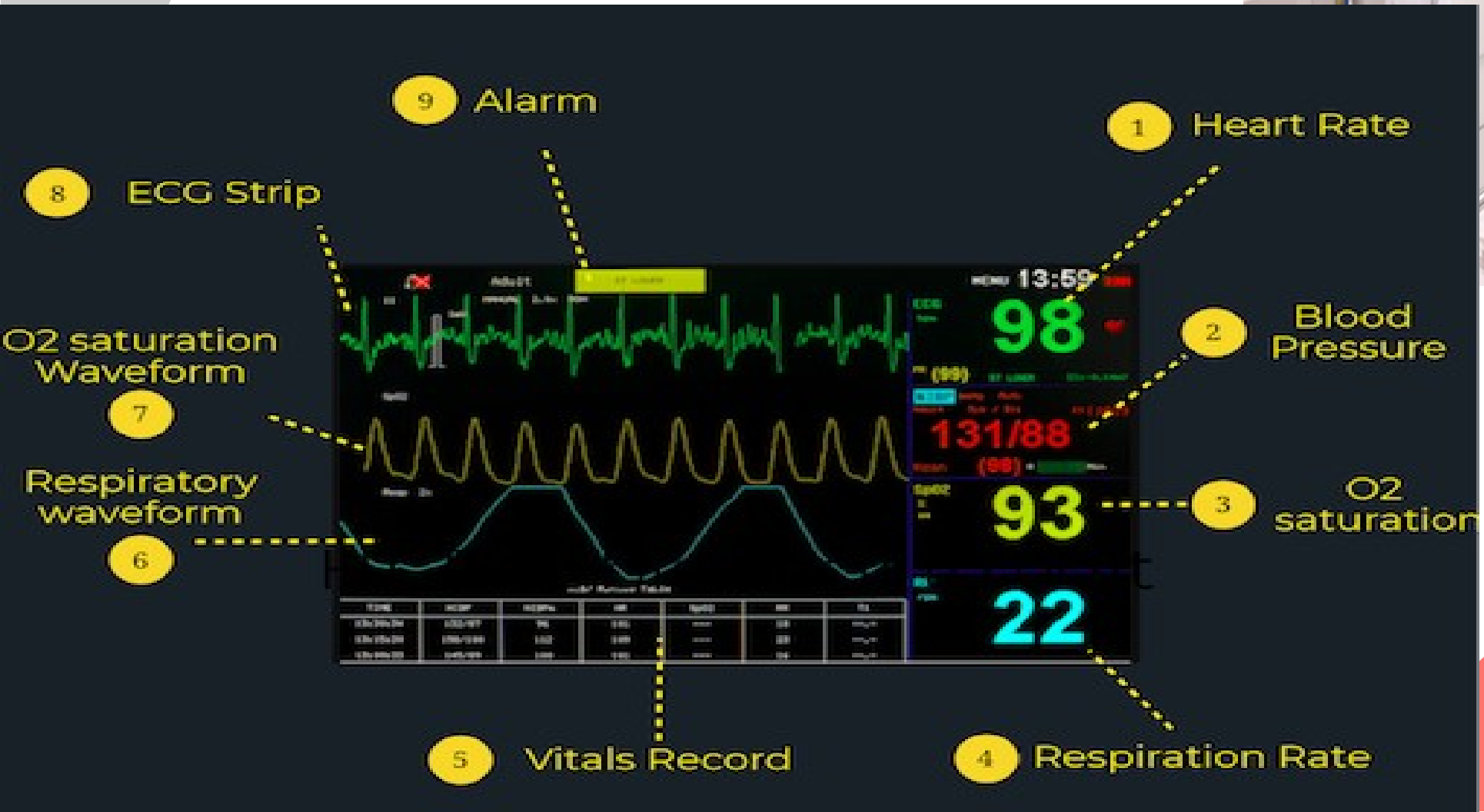
Percussion involves tapping your fingers or hands quickly and sharply against parts of the patient's body to help you locate organ borders, identify organ shape and position, and determine if an organ is solid or filled with fluid or gas.

auscultation

Auscultation is a method your healthcare provider may use to listen to the sounds of your heart, lungs, arteries and abdomen. They'll place a stethoscope directly onto your chest, back and/or abdomen. Your healthcare provider uses auscultation during physical examinations to check your circulatory system, respiratory system and gastrointestinal system.

Vital signs


122/82 (95)


9 Alarm
1 Heart Rate
8 ECG Strip
2 Blood Pressure
O2 saturation Waveform
7
Respiratory waveform
6
3 O2 saturation
5 Vitals Record
4 Respiration Rate
13:59
98
131/88
93
22

VITAL SIGNS

1 RESPIRATORY RATE (RR)

- Normal range (Adut) : 12 to 16
- Normal range (Newborn): 30 to 60

2 HEART RATE (BR)

- Normal range (Adut) : 60 to 100
- Normal range (Newborn): 90 to 180

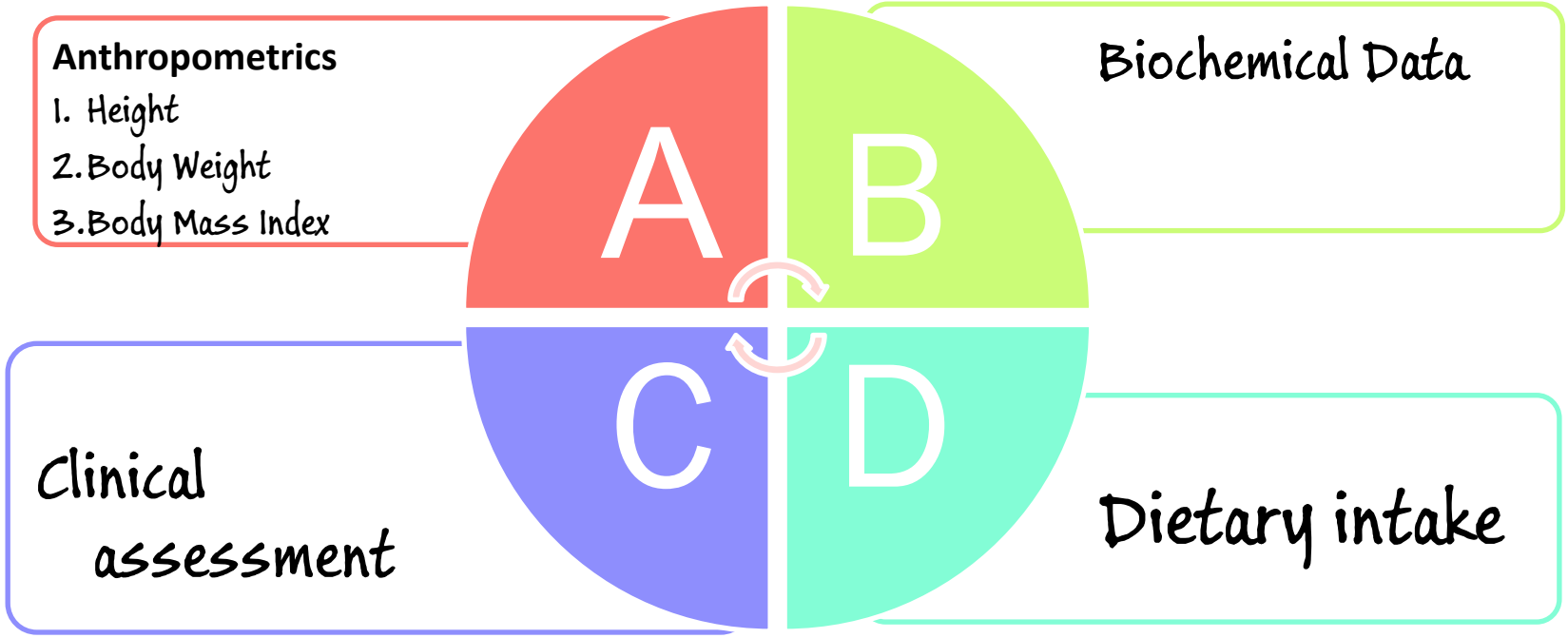
3 BLOO PRESSURE (BP)

- Normal range (Adut) : 110-120 / 70-80
- Normal range (Newborn): 75 / 40

4 TEMPERATURE

- Normal range (core) : 36.5 - 5.25 C
- Normal range (oral*) : 36.5 - 37.5 C
- Normal range (axillary) : 35.9 - 36.9 C
- Normal range (obtic) : 37.1-38.1 C

nutrition Assessment



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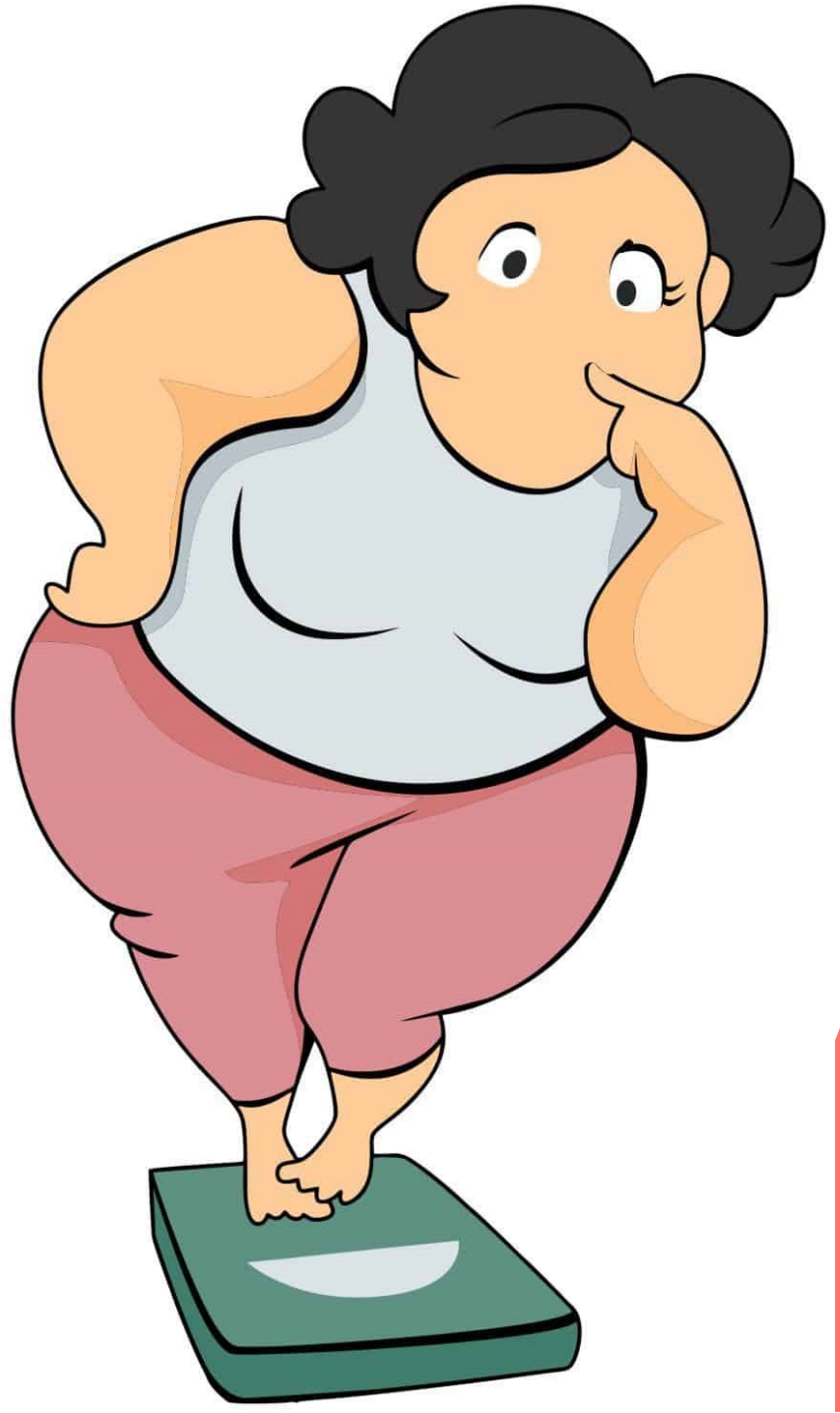
A-Height

able to stand without assistance, **height should be measured in a standing position, without shoes, using a wall-mounted stadiometer.**

For adults who are unable to stand, **height can be estimated by doubling the arm span measurement (from the patient's sternal notch to the end of the longest finger).**

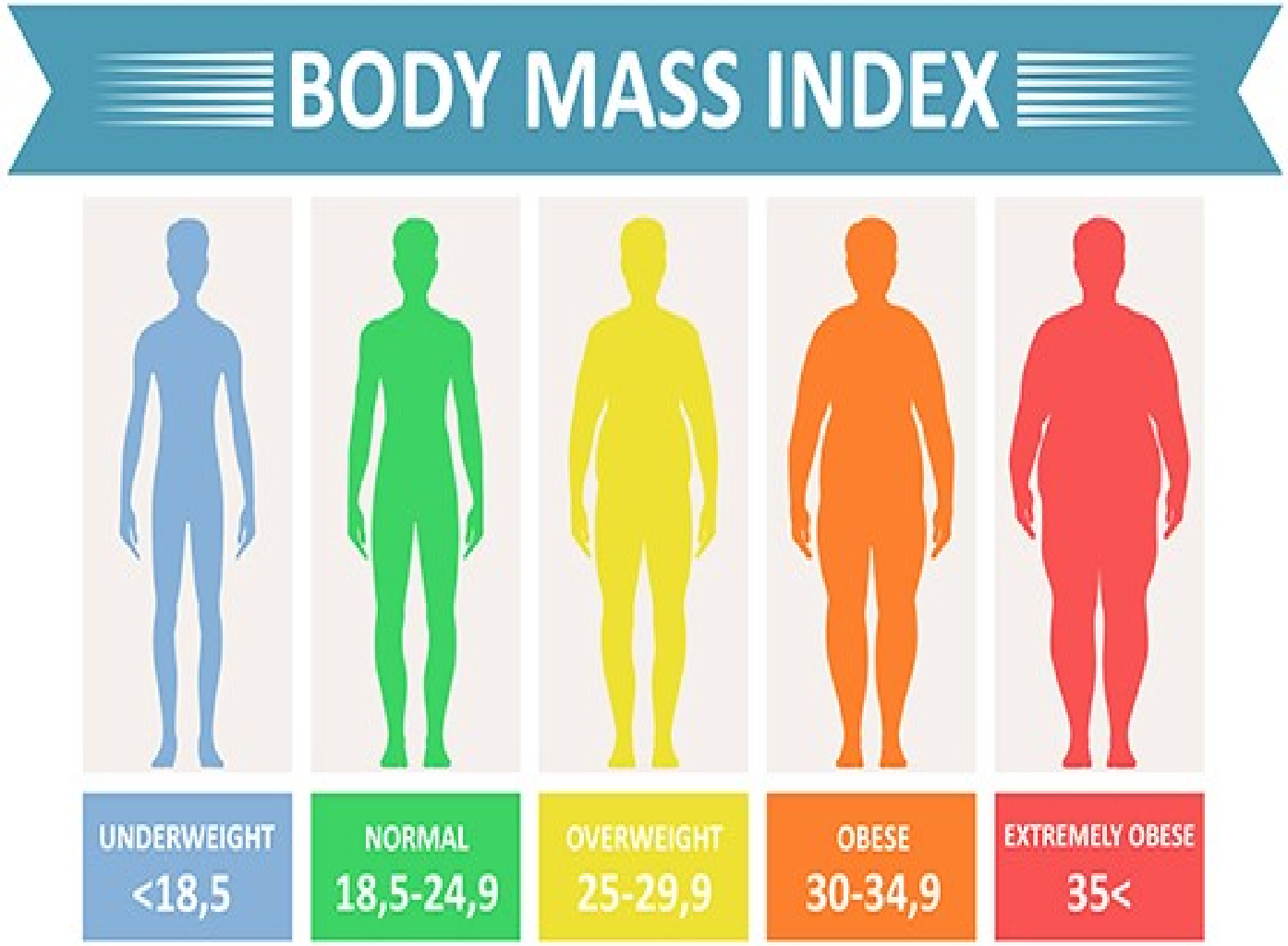
B-Body Weight

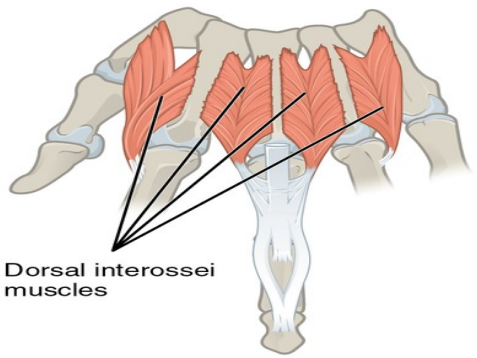
Chair and bed scales are available for those who cannot stand. These instruments should be used according to manufacturers' guidelines for the most accurate results



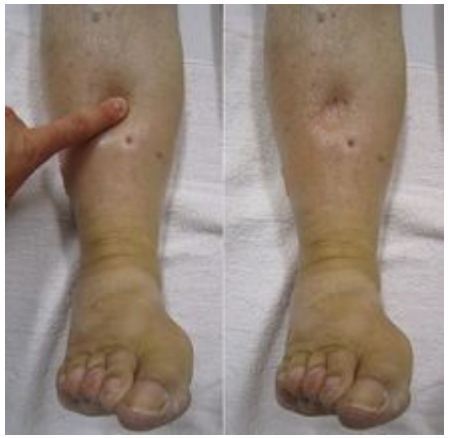
Body Mass Index

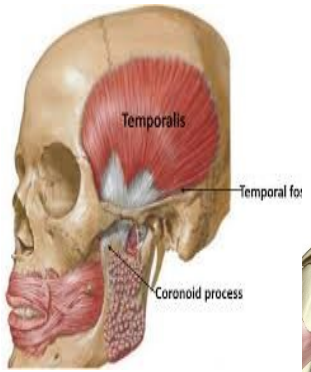
BMI = Weight (kg)/Height (m)2

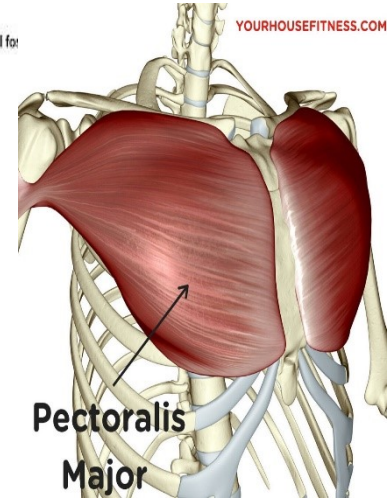


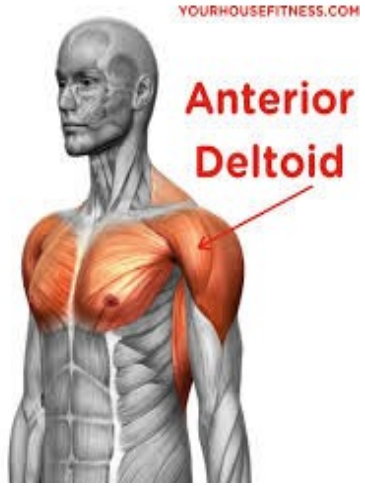


Clinical assessment









subjective global assessment

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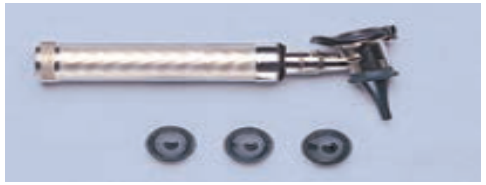
Medical history	SGA rating		
	A	B	C
1. Weight change			
Clothing size: No change _____ Change _____ Overall loss: In past month _____ 6 months _____ 1 year _____			
% Loss of usual weight: <5% _____ 5-10% _____ >10% _____			
Change in past 2 weeks: Increase (gain) _____ No change (stabilization) _____ Decrease (continued loss) _____			
2. Dietary intake			
Reduction: Unintentional _____ Intentional _____ Overall change: No change _____ Change _____ Increase or Decrease			
Duration: Weeks _____ Months _____			
Diet change: Suboptimal solids (ie, 75%, 50%, 25% intake) _____ Full liquid diet _____ Hypocaloric fluids _____ NPO (starvation) _____			
3. Gastrointestinal symptoms (persisting daily for >2 weeks)			
None _____ Diarrhea _____ Dysphagia/odynaphagia _____ Nausea _____ Vomiting _____ Anorexia _____			
4. Functional impairment			
Overall impairment: None _____ Mild _____ Severe _____			
Duration: Days _____ Weeks_____ Months _____			
Type: Ambulatory (walking or wheelchair) _____ Bedridden _____			

Physical examination	SGA rating		
	Well (A)	Mild/mod (B)	Severe (C)
5. Muscle wasting			
Bicep _____ Tricep _____ Quadricep _____ Deltoid _____ Temple _____			
6. Subcutaneous fat loss			
Tricep _____ Chest _____ Eyes _____ Perioral _____ Interosseous _____ Palmar _____			
7. Edema			
Hands _____ Sacral _____ Lower extremity _____			

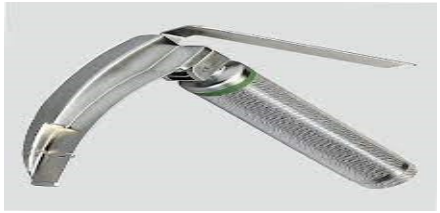
Equipment of physical assessment

Equipment		purpose
Flash light		To assist viewing of the pharynx or to determine the reactions of the pupils of the eye
Ophthalmoscope		A lighted instrument to visualize the interior of the eye Otoscope
Otoscope		A lighted instrument to visualize the eardrum and external auditory canal (a nasal speculum may be attached to the otoscope to inspect the nasal cavities)
Tongue Depressor		To depress the tongue during assessment of the mouth and pharynx

Equipment of physical assessment

Equipment		purpose
Thermometer		Measuring body temperature
Stethoscope		To Hear heart sound
Sphygmomanometer		Measuring blood pressure
Gloves		To protect physician & nurse

Equipment of physical assessment

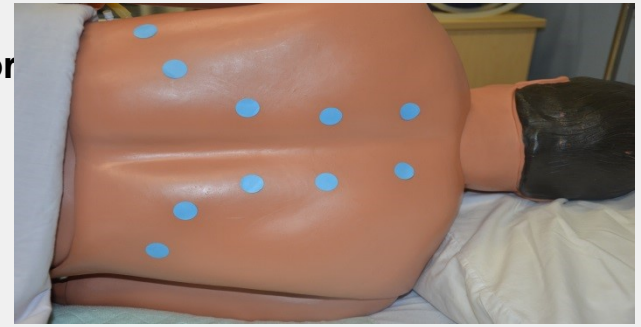
Equipment		purpose
Reflex hummer		An instrument with a rubber head to test reflexes
Tuning fork		A two-pronged metal instrument used to test hearing acuity and vibratory sense
Laryngoscope		To examine the larynges
Watch		Facilitate measuring of pulse per unit of time

Performing of Examination

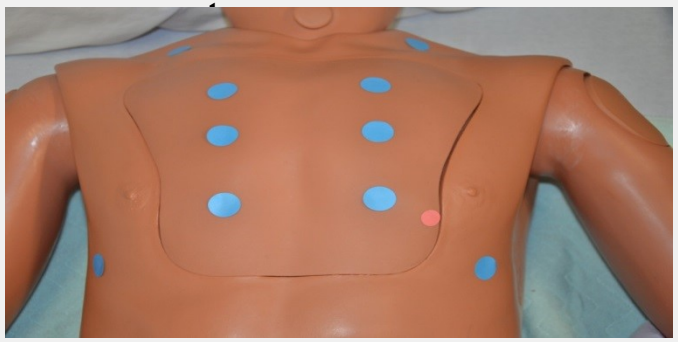
Steps	Additional information
1. General appearance: ✓ Affect/behaviour/anxiety ✓ Level of hygiene ✓ Body position ✓ Patient mobility ✓ Speech pattern and articulation	Alterations may reflect neurologic impairment, oral injury or impairment, improperly fitting dentures, differences in dialect or language, or potential mental illness. Unusual findings should be followed up with a focused neurological system assessment.
2. Head and neck: ✓ Inspect eyes for drainage. ✓ Inspect eyes for pupillary reaction to light. ✓ Inspect mouth, tongue, and teeth for moisture, colour, dentures. ✓ Inspect for facial symmetry.	❑ Check eyes for drainage, pupil size, and reaction to light. Drainage may indicate infection, allergy, or injury. ❑ Slow pupillary reaction to light or unequal reactions bilaterally may indicate neurological impairment. ❑ Dry mucous membranes indicate decreased hydration. ❑ Facial asymmetry may indicate neurological impairment or injury. Unusual findings should be followed up with a focused neurological system assessment.

Performing of Examination

Steps	Additional information
3. Chest: ➢ **Inspect:** ✓ **Expansion/retraction of chest wall/work of breathing and/or accessory muscle use** ✓ **Jugular distension** ➢ **Auscultate:** ✓ **For breath sounds anteriorly and posteriorly** ✓ **Apices and bases for any adventitious sounds** ✓ **Apical heart rate** ➢ **For**	❑ **Chest expansion may be asymmetrical with conditions such as atelectasis, pneumonia, fractured ribs, or pneumothorax.** ❑ **Use of accessory muscles may indicate acute airway obstruction or massive atelectasis.** ❑ **Jugular distension of more than 3 cm above the sternal angle while the patient is at 45º may indicate cardiac failure.** ❑ **The presence of crackles or wheezing must be further assessed, documented, and reported. Unusual findings should be followed up with a <u>focused respiratory</u>**



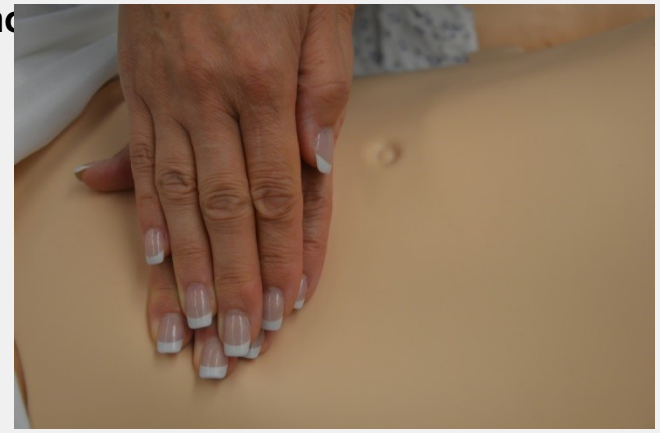
Auscultate posterior chest; blue dots indicate stethoscope placement for auscultation



Auscultate anterior chest; blue dots indicate stethoscope placement for auscultation

Performing of Examination

Steps	Additional information
4. Abdomen: ➢ **Inspect:** ✓ **Abdomen for distension, asymmetry** ➢ **Auscultate:** ✓ **Bowel sounds (RLQ)** ➢ **Palpate:** ✓ **Four quadrants for pain and bladder/bowel distension (light palpation only)** ➢ **Check urine output for frequency, color, odor.** ➢ **Determine frequency and type of bowel mo**	❑ **Abdominal distension may indicate ascites associated with conditions such as heart failure, cirrhosis, and pancreatitis. Markedly visible peristalsis with abdominal distension may indicate intestinal obstruction.** ❑ **Hyperactive bowel sounds may indicate bowel obstruction, gastroenteritis, or subsiding paralytic ileum.** ❑ **Hypoactive or absent bowel sounds may be present after abdominal surgery, or with peritonitis or paralytic ileus.** ❑ **Pain and tenderness may indicate underlying inflammatory conditions such as peritonitis. Unusual findings in urine output may indicate compromised urinary function. Follow up with a focused gastrointestinal and genitourinary assessment** ❑ **Unusual findings with bowel movements should be followed up with a focused gastrointestinal and genitourinary assessment.**



Performing of Examination

Steps	Additional information
5. Back area **(turn patient to side or ask to sit up or lean forward):** ✓ Inspect back and spine. ✓ Inspect coccyx/buttocks.	❑ Check for curvature or abnormalities in the spine. ❑ Check skin integrity and pressure areas, and ensure follow-up and in-depth assessment of patient mobility and need for regular changes in position.
6. Mobility: ✓ Check if full or partial weight-bearing. ✓ Determine gait/balance. ✓ Determine need for and use of assistive devices.	❑ Assess patient's risk for falls. Document and follow up any indication of falls risk. Note use of mobility aids and ensure they are available to the patient on ambulation.
7. Skin, hair, and nails: ✓ Inspect for lesions, bruising, and rashes. ✓ Palpate skin for temperature, moisture, and texture. ✓ Inspect for pressure areas. ✓ Inspect skin for edema. ✓ Inspect scalp for lesions and hair and scalp for presence of lice and/or nits. ✓ Inspect nails for consistency, color, and capillary refill.	❑ Check for and follow up on the presence of lesions, bruising, and rashes. Variations in skin temperature, texture, and perspiration or dehydration may indicate underlying conditions. ❑ Redness of the skin at pressure areas such as indicates the need to reassess patient's need for position changes. ❑ Unilateral edema may indicate a local or peripheral cause, whereas bilateral-pitting edema usually indicates cardiac or kidney failure. ❑ Check hair for the presence of lice and/or nits (eggs)