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ICON

UNIT VIII - HEALTH ASSESSMENT

IMPORTANT QUESTIONS AND ANSWER KEY

1. Define health assessment and its purposes (2marks) (3 TIMES REPEATED)

Defintion:-

It is a collecting of data about client health status. It is the detailed study of the entre body in order to determine general or mental condition of the body.

Purpose:-

- To identify the problem in the early stage
- To collect the data about physical, mental and social well being of the client
- To identify the causes and extent of the disease
- To evaluate or monitor the changes in the cleint health status
- To certitfy whether the client is medically fit to resume duty
- To contribute in the medical research
- To identify the patients weakness, strength, knowledge and coping abilities
- To collect the data systematically

2. Describe about components of history collection /health history

Definition:

It is the collection of subjective data regarding clients health in a chronological order.

Components of health history:

1) Biographical data
2) Chief complaints
3) Present health history
4) Past health history

5) Family history
6) Socio economic status
7) Personal history
8) Psychosocial history
9) Obstetrical history

1) Biographical data:

   It includes: name, address, phone number, age, palce of birth, gender, nationality, religion, marital status, educational level, health insurance, occupation, source of history

2) Chief complaints :

   It includes symptom analysis and chief complaints are document in clients own words.

3) Present heath history:

- Medical history
  - Onset of illness
  - Duration
  - Management done before admission
  - Treatment given in the hospital and present status
- Surgical history
  - Name of the surgery
  - Management
  - Post operative day

4) Past health history:

   It includes chiidlhood illness, surgeries, hospitalization, serious injuries, medical problem, medication, allergies, immunization, blood transfusion.

5) Family history:

   It includes patient spouse, children, sibling, parents & grandparents health status or if deceased, collect age and cause of death. Family hsitory of hereditory disease or illness such as diabetes mellitus, cancer, heart diseases etc.

   Family tree:

6) Socio economic status:

   it includes monthly family income, bread winner of the family, source of income, financial status, types of house (own/rented), facilities like electricity, ventilation, drainage, lighting, water, waste disposal & latrine facility, availability of hospital, clinics, health centres, market, temple, school and transport.

7) Personal history :

It includes sleep pattern(hours of sleep during day & night), exercise pattern, dietary pattern(veg, non-veg, mixed, solid, liquid diet), bowel elimination (passing of stool/defecates), bladder elimination (passing of urine/voiding pattern)

8) Psychosocial history :

   It includes mood stability, communicating with others

9) Obstetrical history :

   It includes menstrual history/menstrual cycle(regular or irregular, no.of days in cycle, problem), history of pregnancy, abortion, labour, delivery

   G-Gravida , P-Para , L-Live children , A-Abortion, D-Dead

3. Techniques or methods of physical examnation/health assessment (5 MARKS) (6 TIMES REPEATED)

Introduction:

Physical examination is a complete assessment of a patients physical and mental status.

Definition:

It is thr systematic collection of objective information that is directly observed or elicited through examination techniques.

Techniques of physical examination:

1) Inspection
2) Palpation
3) Percussion
4) Auscultation
5) Olfaction

1)Inspection:

- It is the systematic visual examination of the client
- It involves observation of the patients colour, size, shape, symmetry, position & movements

General inspection of a client focuses on:

- Overall appearance of health or illness
- Signs of distress
- Facial expression & mood
- Body size

- Grooming & personal hygiene

2)Palpation:

- It is the use of hands & fingers to gather the information through touch
- It is the assessment technique by the use of sense of touch
- It is the feeling of the body or parts to determine the size and position of the organ.
- The hands & fingers are the sensitive tools to assess such as
  - Temperature
  - Skin Turgor (check elasticity of the skin)
  - Texture (rough/smooth/soft/thick skin)
  - Moisture (eg. Oil/dry skin)
  - Size
  - Position
  - Consistency
  - Masses (swollen area)
  - Fluids

Surfaces of the hands and fingers:

- Dorsum surface is used to measure the temperature
- Palmer surface of fingers & fingers pads are used to assess skin turgor, texture, moisture, size , vibrations, position
- Fingertips are used to palpate the breast, lymph nodes & pulses
- Thumb and index finger are used to palpate the tissue firmness

Types of palpation:

i) Light palpation
ii) Deep palpation

i)Light palpation:

- It is used to detect the characteristics of the skin & the superficial tissues
- It is attained by pressing 1cm in depth to assess the skin pulses & tenderness(touch to pain)

ii)Deep palpation:

- It is attained by pressing of 2 to 4 cm in depth to determine the organ size & contour(boundary of organ)

Special consideration/principles of palpation:

- You should have short the finger nails
- Warm the hands & fingers prior to placing them on the patient skin surface.
- Encourage the patient to continue to breathe normally throughout the palpation.
- If pain is experienced during the palpation, discontinue the palpation immediately.
- Inform the patient where, when and how the touch will occur, especially when the patient cannot see what you are doing.
- Before palpation explanation is very important for the client because touch has the great significant in the culture.
- Always proceeds from light palpation to deep palpation because palpation may cause tenderness.

3) Percussion:-

- It is used by physician & advanced nursing practitioners
- It is used to determine the consistency of the underlying tissues.
- It is a examination by tapping the fingers on the patient's body surface to assess the condition of the internal organs by the sound that may produce.
- It is the striking the body surface on the skin with the sharp strokes in order to determine or produce palpable vibration & characteristics of the sound.
- It is used to detect the presence of air or fluid in the body surface.

Characteristics of the sound:

- Tympany – it is a drum like sound heard over the air such as gas in the stomach/abdomen.
- Resonance – it is a hallow sound heard over the air filled lung tissues
- Hyper resonance – it is the over inflated lungs.
- Dull sounds – it is heard over fluid filled area such as liver or urinary bladder
- Flat sounds – it is heard over the muscles.

Types of percussion:

i) Direct percussion
ii) Indirect percussion
iii) Direct fist percussion
iv) Indirect fist percussion

i)Direct percussion:

- it is accompanied by tapping the areas directly with the fingertips of the middle finger.

ii)Indirect percussion:

- Place the non dominant hand on the patients surface of the skin & make gentle pressure of the fingertips & give a stroke on the inter phalangeal joint of the middle finger by the dominant hand on the finger tips of the middle finger .

iii)Direct fist percussion:

- It is used to detect the presence of tenderness or pain in the internal organs such as liver or kidney with the ulnar aspect of the closed fist that directly hit the area where the organ is located.

iv)Indirect fist percussion:

- Place the non dominant hand on the patient's surface of the skin where the organ is examined.
- With the ulnar aspect of the closed fist used moderate intensity to hit the outstretched non-dominant hand on the dorsal aspect.

4) Auscultation:

- It is the process of listening the sounds that are generated within the body
- It is performed by placing the stethoscope(diaphragm or bell) against the body part being assessed.
- When auscultating , expose the part listened to, use the proper part of the stethoscope (diaphragm or bell) for specific sounds & listen in a quiet environment.
- Heart and blood vessel are auscultated for the circulation of blood.
- Lungs are auscultated for moving of air/breath sound.
- Abdomen is auscultated for the movements of gastro intestinal content sound/bowel souns

Characteristics of sound:

i) Pitch – ranging from higher to lower
ii) Loudness – ranging from soft to loud
iii) Quality – bubbling sounds or gurgling sounds
iv) Duration – short/medium/long sounds

5) Olfaction:

Olfaction can be assessed by sense of smell

Eg. Halitosis – foul smelling/bad odour

4. Physical examination (15m) (2 TIMES REPEATED)

DEFINITION:

It is the systematic collection of objective information that is directly observed or elicited through the examination techniques.

GENERAL ASSESSMENT:

Introduction:

- ✔ It is carried out in an orderly manner focusing upon one area at a time.
- ✔ The observation of the patient starts as the patient's walk into the examination room.

Eg : Lymph may be noted

- ❖ **General Appearance**
  - ✔ Nourishment – Undernourished / well nourished / mal nourished
  - ✔ Consciousness –Unconscious Conscious Semiconscious / Coma
  - ✔ Orientation – Orient to time, place, person
  - ✔ Signs of distress – Pain, dyspnoea
  - ✔ Body bruit – Thin, obese (or) moderate
  - ✔ Posture & Gait – Co-ordinator, Unco-ordinated, Normal
  - ✔ Body movements – Purposeful, tremors, immobile
  - ✔ Hygiene & grooming– Neat, appropriate, unhygienic
  - ✔ Mood & effect – Stable, stressed (or) depressed, swings
  - ✔ Facial expression – Smiling (or) black, sad
  - ✔ Speech – Understandable (or) paused (or) rapid (or) slow

Physiological Assessment :

- **Vital Signs :**

- Temperature
- Pulses
- Respiration
- Blood Pressure

 Measurements :

- Height
- Weight
- Circumference – mid arm in children, head & Chest.

  (Incase of abdominal distension check the abdominal birth)
- BMI

HEAD TO TOE EXAMINATION :

Skin : -

Inspection of the skin :

Pallor : It results in decreased amount of circulating flood or hemoglobin causing inadequate oxygenation of body tissues.

Colour of the skin :

- Pink
- Black
- Brown
- Flushing

Palpating the Temperature, Moisture, Texture, Turger & Edema.

 Temperature :
 (Warm, Cold, Feverish, Clammy)
 Texture :
 Smoothness, Roughness, Thickness, Dryness
 Moisture :

- (Oily skin, Dry skin, Moist skin, Excessive sweating)
- **Turger :**
- Normal, Wrinkled skin or decreased elasticity. It can be assessed in Torearm, Sternum, under the clavicle.

Inspecting skin integrity

- Intact – healthy skin in which there is no breaks, cut, abnormal openings.
- Lesions – Abnormal appearance or ulcer on the skin. It is an abnormal damage or injury.

Nail :

Inspecting the Nail :

- Cleanliness, Smoothness

Shape of the nail : Convex

Angles : Between nail & its base is 160 degrees

Colour : Pinkish nail bed with translucent white tips

Capillary refill time : Less than 2 seconds

In newborn infants, capillary refill time (CRT) can be measured by pressing on the sternum for 5 seconds with a finger or thumb, or noting the time needed for the colour to return once the pressure is released.

Texture : Smooth, nail should be non – tender

HEAD AND SCALP

Skull : Normal Shape, Contour, Size, Shape

Inspect the Scalp :

- Cleanliness, Colour, Dryness
- Lump, Lesions
- Lice (pediculus humanus capitis)
- Dandruff etc
- Lump (Compact mass with indefinite shape)

- ❖ Lice (either of two small wingless parasitic insects that live on the skin)

Assessing Hair & Scalp :

Colour, Straight, Curly Hair, Brittle hair

Texture & Distribution

Thickness & Lubrication of hair

Inspecting the face :

Symmetry, shape, disfigurement, facial expression

Eyes :

Inspecting the external eyes :

Inspecting the eyebrows :

- Shape (curved / straight / thin / thick / sparse – very thin)

Inspecting the eye lashes :

- long / short / curved / none / artificial
- It should be curl outwards

Inspecting the eyelids :

- Colour
- Edema

Conjuntiva : Pale, pinkish or any masses, inflarmation of conjunction

Corner & Iris :

- ❖ Colour
- ❖ Cloudy – Cataract
- ❖ Infact

Pupils : PERLA (Pupil equally round reacting to light accommodation & it is done by pen torch).

It of used to assess the papillary reaction.

Inspecting the pupils

- ❖ Pupils are normally black, equal in size, (3 to 7 mm in diameter), round.
- ❖ Pupils may be pale cloudy if the patients has cataracts (opacity of the lens – loss of transparency)

Assessing the eye movements :

- Normal
- Nystagmus
- Exotrophia
- Esotrophia

Assessing the visual acuity :

- The visual acuity test is used to determine the smallest letters you can read on a standardized chart (Snellen chart) or a card held 20 feet (6 meters) away. The normal visual acuity is 6/6 or 20/20.

EAR (helical shape)

Inspecting & palpating the ears :

- o Assess the external ear by inspection & palpation
- o A otoscope is used to inspect the ear cancel & tympanic membrane, which is usually performed by advanced practitioners.

Inspecting & palpating the auricles / pinna :

- Inspect the auricles for shape, size (large / small)

  redness, lesions, symmetry, smooth
- Abnormal findings includes unequal height & size, uneven colour & lesions.
- Palpate the auricles for texture, tenderness or pain, edema, or presence of lesions – pain when manipulating the pinna is a symptom of an infection of the external membrane.

Inspecting the ear cancel & tympanic membrane :

- The Otoscope is used to examine the car cancel & tympanic membrane.
- Ear cancel should be smooth & pink.

- Ear cancel is examined for clean, wax / cerumen discharge & foreign bodies.
- Tympanic membrane should be intact, translucent, gray & shiny.

Assessing hearing acuity :

- Normal (whisper test, weber test, rinne test)
- It is usually done by turning fork

Inspecting the nose :

- ❖ Size & shape (long / short / swollen)
- ❖ Assess the patency of nose by occluding one nostril at the time & asking the patient to inhale & exhale through nose (patent / obstructed)
- ❖ Inspecting the anterior nares by shining the light.
- ❖ Inspecting the nasal septum for intactness & deviation.
- ❖ Inspect the nasal mucous is moist & darker red than the oral mucosa.

Palpating the Sinuses :

- The frontal & maxillary sinuses, located in the frontal & maxillary bones, respectively are palpated for pain & edema.
- Fronted sinuses are palpated by gently pressing upward on the bony prominences located above each eye.
- The maxillary sinuses are palpated by gently pressure on the bony prominences of the upper cheek.
- Normally the sinuses are not painful when palpated pain may be find if sinuses are infected (or) obstructed.

Mouth & Pharynx :

Lips :

Pale, Pink, Cyanosis, Smooth, Dry, Crackled fissure (abnormal opening), angular stomatitis (inflammation of one or both corners of the mouth).

Teeth :

Colour, Stained dental caries, alignment & dentures.

Gums :

Pink, Swollen, Bleeding (nutritional deficits), Poor, Oral hygiene), Gingivitis (inflammation of the gum), Ulcerated, Spongy.

Angular stomatitis Infection in the corner to tongue

Buccal Mucosa :

Colour (Pink), soft, dry, moist, moist, ulcers, cleft clip, cleft palate, halitosis.

- To inspect the buccal mucosa, ask the client to open the mouth & them gently retract the cheeks with a tongue depressor.
- To palpated the buccal lesions by placing the index finger within the buccal cavity & thumb on the outer surface of the cheek.

Tongue :

- Tongue are normally pink, moist, free of swelling or lesions.
- Abnormal findings includes dry, white coated (tongue) fissures, cracked, bluish, microglossia, macroglossia, glossitis.

Tonsils :
- Uvule (mobile, midline – centrally located)
- Red tonsils (Infected) Tonsillitis
- Pink

Inspecting of the neck :

Appearance : Long

Short

Masses

Symmetrical

Non – symmetrical

Jugular vein distension

Movements :

- ❖ Assess the neck movements with sitting position & neck slightly hyper extended, if possible.
- ❖ Ask the client to tilt the head backward, forward & side to side to assess range of motion (ROM).

Inspecting the thyroid gland :

- ❖ Assess the thyroid gland with the neck slightly
- ❖ Observe the lower portion of neck overlying the thyroid gland
- ❖ Assess for symmetry & visible masses
- ❖ Ask the patient to swallow
- ❖ Offer a glass of water, if necessary to make it easier for the patient to swallow
- ❖ Observe the area while the patient swallow
- ❖ It helps to visualize an abnormally enlarged thyroid
- ❖ Normally cannot visualize the thyroid
- ❖ Abnormal findings includes asymmetry, enlargement, lumps & bulging
- ❖ These findings may indicate the presence of enlargement of the thyroid(goiter), inflammation of the thyroid (thyroiditis) or cancer of the thyroid.

Palpating the thyroid gland:

- ❖ Palpating the thyroid for size, shape, symmetry, tenderness & presence of any nodules
- ❖ If palpable, the thyroid gland should feel soft but elastic
- ❖ It should be non tender, no enlargement, masses, nodules (which may indicate thyroid gland disease, infection of thyroid or cancer)
- ❖ palpation of thyroid is an advance assessment skill.

Palpating the lymph & trachea:

Palpating the trachea:

- ❖ Palpate the trachea, normally midline at the suprasternal noch, for alignment & position
- ❖ An unequal space between the trachea & the sternocledomastoid muscel oneach side is an abnormal finding tracheal displacement

Palpating the lymph nodes:

- ❖ Palpating the lymph nodes with the using of finger pads for enlargement, tenderness, and mobility.
- ❖ Nodes are generally not palpable, if palpable, they should be small, mobile, smooth & non tender
  - If lymph modes are palpable, assess the location, size, consistency, mobility & tenderness.

- Enlarged lymph modes may indicate infection & auto immune disorders.

Chest : -

Thoracic Configuration :

- **Size & Shape**

(Symmetrical / Diameters / Pigcon / Barrel Shape)

Abnormalities :

Pigcon chest : chest projecting forward

Barrel Chest : It generally refers to a broad. It usually have a naturally large ribcage.

Respiratory Pattern :

- Respiratory Pattern
- Visible Pulsation
- Tenderness
- Fremitus (Vibration into the body)

Breast :

- Size (normally breast extend third to sixth sibs with nipple at the fourth intercoastal space)
- Shape (normally convex to pendulous, conical
- Nipple retractions (inverted nipple)
- Discharges
- Galactorrhea (Spontaneous flow of milk from the breast, unassociated with childbirth)
- Nodules / masses / lumps

Lung Sounds / Breath Sounds :

Normal Sounds : Broncho Vesicular Sounds

Abnormal sounds:

- Crackles (sound of wood burning in a fireplace)
- Wheeze (rhonchi)
- Pleural friction (move something over a surface with friction)

Heart Sounds :

- S1, S2(lub, dub normal sounds)
- S4, S4 (abnormal sounds)

- ❖ Heart rate
- ❖ Other Sounds - murmurs

Abdomen : -

Size & shape: flat/rounded/ascities/umbilical/bulging/scars/rashes/abdominal distensions

Bowel region: present/absent/hyperactive/hypoactive

Fluid collection: present/absent/dullness or tympany on percussion

Organomegally :

Palpable spleen, liver / tenderness / inguinal or femoral hernia.

Ascetic :

Accumulation of fluid in a peritoneal cavity, causing abdominal swelling.

Inguinal Hernia :

Protrusion of abdominal cavity contents through the Inguinal canal.

GENITALIA

Female Genitalia :

- Colour
- Size of labia mojora
- Vaginal opening
- Lesions
- Ecchymosis
- Heamatoma (abnormal collection of blood outside of a blood)
- Foul smelling discharges
- Cystocele (dropped or prolapsed bladder occurs when the bladder wall bulges into the vaginal space)
- Perinecum – intact
- Uterine prolapsed (uterus is only party sagging into the vargina)

Male genitalia :

- ❖ Size, Placement, Contour, Appearance of the skin, redness , edema & discharge.
- ❖ Symmetry
- ❖ Free of lesions
- ❖ Intact
- ❖ Uniform in colour
- ❖ Location of urinary meatus (normally located in the centre of the glans penis & free of discharges)

Anus & rectum :

- Haemorrhoids (Dilated veins that appear protrusions)
- Inflammation
- Tissues (break or tear in the skin of the anal canal)
- Anal skin tags (non-cancerous growth of excess skin appearing near the opening of the anus)
- Rectocele (rectum protrudes into the vagina)
- Patency

Back - Spinal Curvature

- Kyposis - Excessive outward curvature of the spine
- Lordosis - Excessive inward curvature of the spine
- Scoliosis - Abnormal lateral curvature of the spine

Vertebrae :

- Intact
- Tenderness
- Spondylosis (Painful condition of the spine resulting from the degeneration of the intervertebral discs)
- Spinal cord defects
- Lesion / rashes
- ROM : Possible / limited

Extremities :

- Normal
- Symmetrical
- Non – symmetrical
- Swollen
- Edema
- Deformities
- Rashes
- Prosthesis (an artificial body part)
- Varicose veins (enlarged & twisted veins)