

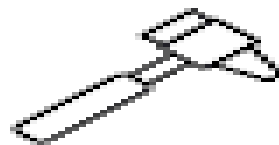
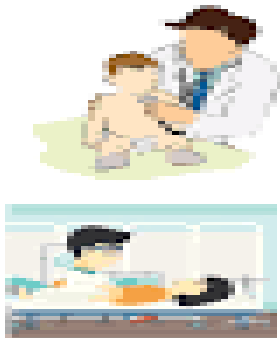


Physical Assessment

Definition

It is the techniques used to gather objective data about the body from head to toes

PHYSICAL EXAMINATION



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Preparation for physical assessment:

Provide a warm, comfortable, private environment with natural lighting, if possible.

- The room should be quiet. Eliminate distractions and disruptions (because excessive environmental noises may make detection of some physiological sounds difficult).
- Introduce yourself to the client by name and title if you have not already met the client.

- Explain the purpose of each step of the examination to the patient (to alleviate anxiety and secure the patient's cooperation).
- Ask the client to undress and wear a patient's gown if a complete physical assessment is to be performed (to facilitate the examination).
- The person is also asked to void before examination.
- Wash your hands and wear gloves if the patient has drainage wound, bleeding and/or vomiting (to prevent spread of infection).
- Warm your hands and instruments before touching the client's skin.
- Arrange the needed equipment and supplies, and check equipment for proper functioning

Positions of Physical Examination

1) Standing/ Erect position:

- Upright posture with both feet flat on the floor.
- Used to examine the musculoskeletal and neurological systems and to assess gait and cerebellar function.



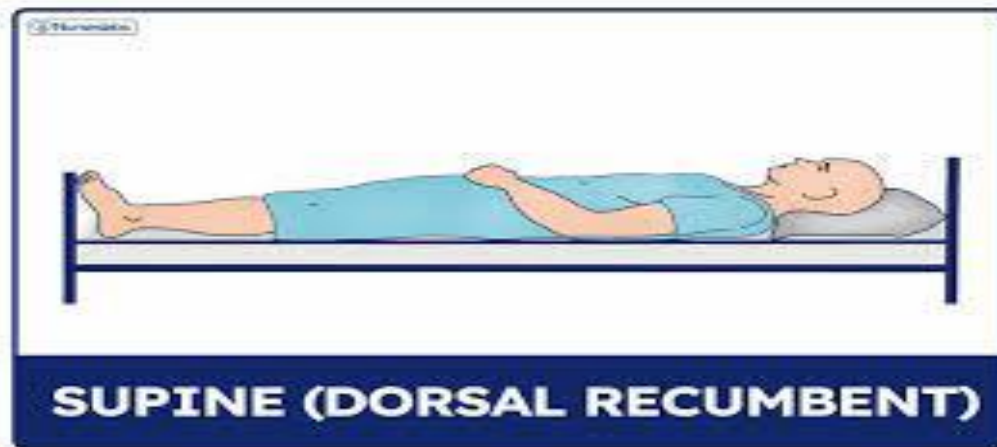
2) Sitting position:

- Sitting upright at side of bed or exam table.
- Used to assess vital signs, head and neck, chest, cardiovascular system, and breasts.



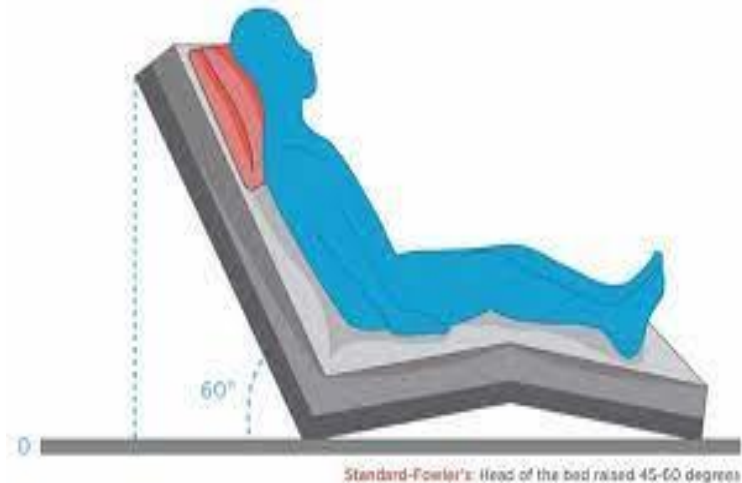
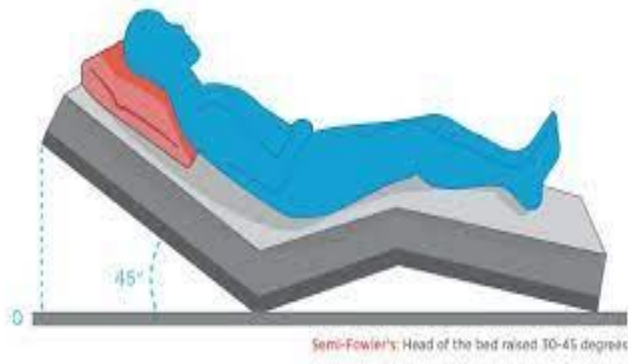
3) Supine position/ Recumbent:

- Lying flat on the back with arms and legs fully extended.
- Used to assess the abdomen, breasts, extremities, and pulses.
- If your client becomes short of breath, raise the head of the bed (HOB).



4) Fowler's position, the head is elevated 60°.

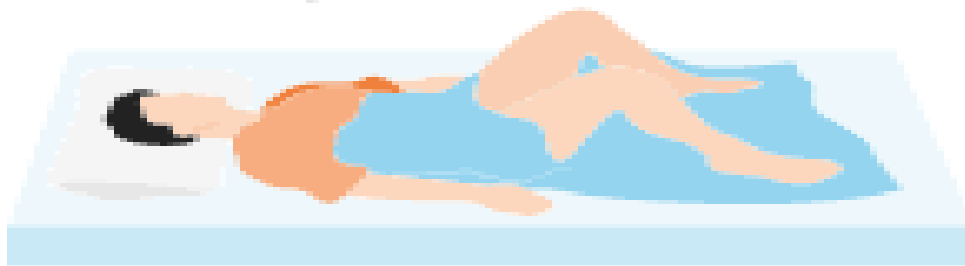
5) Semi-Fowler's position, the head is elevated only 30°–45°.



6) **Dorsal Recumbent position**

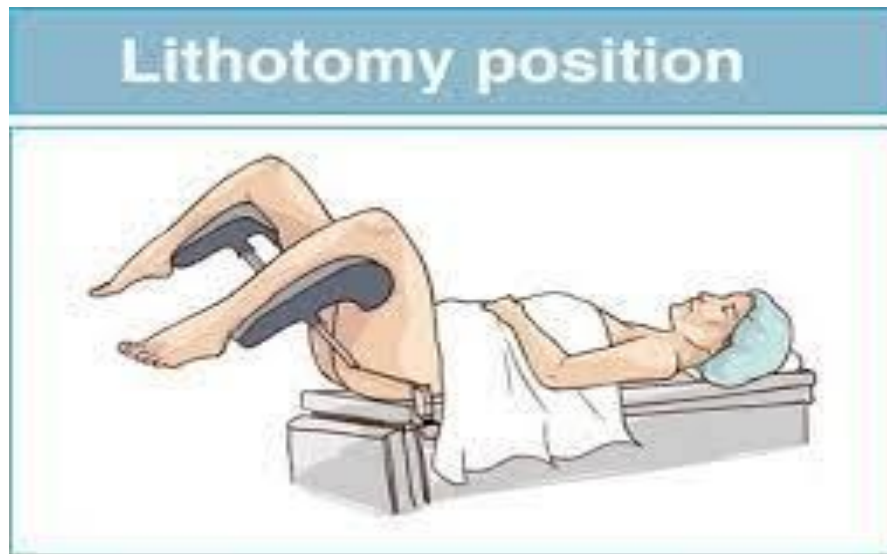
- Supine with knees flexed.
- Used for abdominal assessment if the client has abdominal or pelvic pain.
- Flexing the knees promotes relaxation of the abdominal muscles.

Dorsal recumbent
position



7) **Lithotomy position**

- Dorsal recumbent position at end of table with feet in stirrups, legs flexed, and widely open.
- Used for a female pelvic exam.



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8) Sims' position:

- Flexion of the hip and knees in a side lying position.
- Used to examine the rectal area.



9) Lateral position:

- Lying on the side in a straight line.
- Left lateral is used to evaluate heart murmur or during cardio-vascular assessment.
- This position brings the heart closer to the chest wall.



Right Lateral Recumbent



Left Lateral Recumbent

10) Prone position:

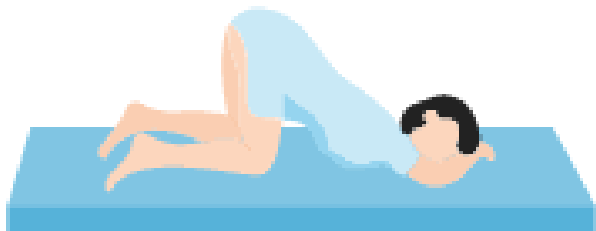
- Lying on the abdomen.
- Used to examine the musculoskeletal system, also be used to examine the back and buttocks.



11) Knee–Chest position:

- On hands and knees with head down and buttocks elevated.
- Provides good visualization for examining the rectal area

Knee and chest position



Techniques of physical assessment

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



1. INSPECTION:

is" a systematic visual examination of the patient done in a deliberate manner".

or "The use of sight to gather data".

- Through inspection we can observe patient's gait, posture, personal hygiene, grooming and mental status, a rate of breaths per minute and cyanotic nail beds.
- Describe what you see not what you think (e.g. swollen joints, not arthritis).



2. PALPATION:



Palpation is "the examination using the sense of touch by hand for determining the following characteristics:

texture (rough /smooth),

temperature (hot/warm/cold), moisture (dry/moist/wet),

mobility (fixed/ movable/ still/ vibrating),

consistency (soft/ hard /fluid filled),

strength of pulses (strong/weak/thready/bounding),

size (small/medium/large),

shape (well defined/irregular),

degree of tenderness, symmetry of body parts and presence of thrills"

Types of palpation



a. Light Palpation

Light palpation reveals information on skin texture and moisture, superficial masses; and fluid, muscle tone and superficial tenderness.

Technique:

- Place the hand with fingers together parallel to the area being palpated.
- Press down 1 to 2 cm.
- Repeat in ever-widening circles until the area to be examined is covered.

Types of palpation

b. Deep Palpation

Deep palpation can reveal information about the position of abdominal organs and masses, as well as their size, shape, mobility, consistency, and areas of discomfort.

Technique:

- ❑ One –handed deep palpation: With fingers together, approach the area to be examined and use the pads and tips of the fingers of one hand to press in 4 cm.
- ❑ Two–handed deep palpation: Place the fingers of hand on top of those of the other.

Example, deep palpation of the right upper quadrant area of the abdomen lets you estimate the size of the liver.



3. PERCUSSION:

a. Direct Percussion

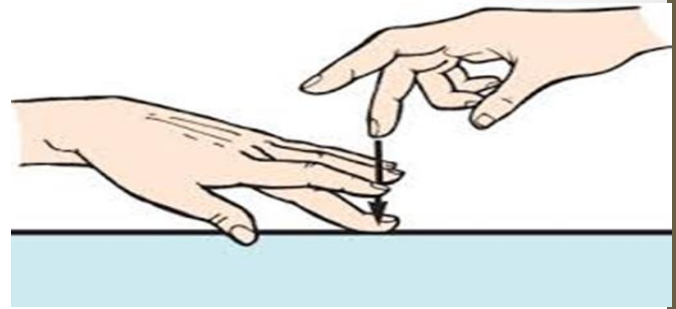
Percussion in which one or two fingers of one hand are used to strike the skin directly to elicit tenderness or pain. It is primarily used to assess sinuses in the adult.

Techniques:

☐ Using sharp rapid movements from the wrist, strike the body surface with the pads of two, three, or four fingers or with the pad of the middle finger alone.

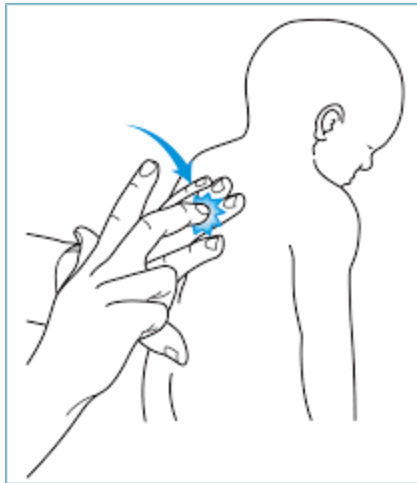
Direct Percussion





b. Indirect Percussion

Using the middle finger of the dominant hand as the striking finger, and tap the middle finger of the other hand using a quick motion from the wrist.



4. AUSCULTATION:

Auscultation is "the use of hearing sense to listen to sounds produced inside the body to determine presence and quality of heart, lung, and bowel sounds".

or "It is the use of hearing to gather data




Types of auscultation:

➤ Direct auscultation is listening without using an instrument (e.g. hearing wheezing or chest congestion without the use of a stethoscope).

Direct Auscultation

- It involve listening to the client body sound without using any assistive instrument [eg wheezing, chest congestion]



5. OLFACTION :

Olfaction is "the use of the sense of smell to gather data about patient's health".

- E.g. If the client's breath has a —fruity|| or —acetone|| odor, you would suspect ketoacidosis.
- You should assess the urine for ketones.
- You would also ask the client about dietary patterns, because a high protein, high fat, low-carbohydrate diet can cause a buildup of ketones in the blood.

