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Nursing Admission Assessment and Examination

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Definition/Introduction

The initial nursing assessment, the first step in the five steps of the nursing process, involves the systematic and continuous collection of data; sorting, analyzing, and organizing that data; and the documentation and communication of the data collected. Critical thinking skills applied during the nursing process provide a decision-making framework to develop and guide a plan of care for the patient incorporating evidence-based practice concepts. This concept of precision education to tailor care based on an individual's unique cultural, spiritual, and physical needs, rather than a trial by error, one size fits all approach results in a more favorable outcome.[1][2][3]

The nursing assessment includes gathering information concerning the patient's individual physiological, psychological, sociological, and spiritual needs. It is the first step in the successful evaluation of a patient. Subjective and objective data collection are an integral part of this process. Part of the assessment includes data collection by obtaining vital signs such as temperature, respiratory rate, heart rate, blood pressure, and pain level using an age or condition appropriate pain scale. The assessment identifies current and future care needs of the patient by allowing the formation of a nursing diagnosis. The nurse recognizes normal and abnormal patient physiology and helps prioritize interventions and care.[4][5]

Nursing Process

- Assessment (gather subjective and objective data, family history, surgical history, medical history, medication history, psychosocial history)
- Analysis or diagnosis (formulate a nursing diagnosis by using clinical judgment; what is wrong with the patient)
- Planning (develop a care plan which incorporates goals, potential outcomes, interventions)
- Implementation (perform the task or intervention)
- Evaluation (was the intervention successful or unsuccessful)

Issues of Concern

The function of the initial nursing assessment is to identify the assessment parameters and responsibilities needed to plan and deliver appropriate, individualized care to the patient.[6][7][8][9]

This includes documenting:

- Appropriate level of care to meet the client's or patient’s needs in a linguistically appropriate, culturally competent manner
- Evaluating response to care
- Community support
- Assessment and reassessment once admitted
- Safe plan of discharge

The nurse should strive to complete:

- Admission history and physical assessment as soon as the patient arrives at the unit or status is changed to an inpatient
- Data collected should be entered on the Nursing Admission Assessment Sheet and may vary slightly depending on the facility
- Additional data collected should be added
- Documentation and signature either written or electronic by the nurse performing the assessment

Summary Nursing Admission Assessment

1. Documentation: Name, medical record number, age, date, time, probable medical diagnosis, chief complaint, the source of information (two patient identifiers)
2. Past medical history: Prior hospitalizations and major illnesses and surgeries
3. Assess pain: Location, severity, and use of a pain scale
4. Allergies: Medications, foods, and environmental; nature of the reaction and seriousness; intolerances to medications; apply allergy band and confirm all prepopulated allergies in the electronic medical record (EMR) with the patient or caregiver
5. Medications: Confirm accuracy of the list, names, and dosages of medications by reconciling all medications promptly using electronic data confirmation, if available, from local pharmacies; include supplements and over-the-counter medications
6. Valuables: Record and send to appropriate safe storage or send home with family following any institutional policies on the secure management of patient belongings; provide and label denture cups
7. Rights: Orient patient, caregivers, and family to location, rights, and responsibilities; goal of admission and discharge goal
8. Activities: Check daily activity limits and need for mobility aids
9. Falls: Assess Morse Fall Risk and initiate fall precautions as dictated by institutional policy
10. Psychosocial: Evaluate need for a sitter or video monitoring, any signs of agitation, restlessness, hallucinations, depression, suicidal ideations, or substance abuse

11. Nutritional: Appetite, changes in body weight, need for nutritional consultation based on body mass index (BMI) calculated from measured height and weight on admission
12. Vital signs: Temperature recorded in Celsius, heart rate, respiratory rate, blood pressure, pain level on admission, oxygen saturation
13. Any handoff information from other departments

Physical Exam

- Cardiovascular: Heart sounds; pulse irregular, regular, weak, thready, bounding, absent; extremity coolness; capillary refill delayed or brisk; presence of swelling, edema, or cyanosis
- Respiratory: Breath sounds, breathing pattern, cough, character of sputum, shallow or labored respirations, agonal breathing, gasps, retractions present, shallow, asymmetrical chest rise, dyspnea on exertion
- Gastrointestinal: Bowel sounds, abdominal tenderness, any masses, scars, character of bowel movements, color, consistency, appetite poor or good, weight loss, weight gain, nausea, vomiting, abdominal pain, presence of feeding tube
- Genitourinary: Character of voiding, discharge, vaginal bleeding (pad count), last menstrual period or date of menopause or hysterectomy, rashes, itching, burning, painful intercourse, urinary frequency, hesitancy, presence of catheter
- Neuromuscular: Level of consciousness using AVPU (alert, voice, pain, unresponsive); Glasgow coma scale (GCS); speech clear, slurred, or difficult; pupil reactivity and appearance; extremity movement equal or unequal; steady gait; trouble swallowing
- Integument: Turgor, integrity, color, and temperature, Braden Risk Assessment, diaphoresis, cold, warm, flushed, mottled, jaundiced, cyanotic, pale, ruddy, any signs of skin breakdown, chronic wounds

Initial Assessment[10][11][12]

Steps in Evaluating a New Patient

- Record chief complaint and history
- Perform physical examination
- Complete an initial psychological evaluation; screen for intimate partner violence; CAGE questionnaire and CIWA (Clinical Institute Withdrawal Assessment for Alcohol) scoring if indicated; suicide risk assessment
- Provide a certified translator if a language barrier exists; ensure culturally competent care and privacy
- Ensure the healthcare provider has ordered the appropriate tests for the suspected diagnosis, and initiate any predetermined protocols according to the hospital or institutional policy

Which provides the diagnosis most often: history, physical, or diagnostic tests?

- History: 70%

- Physical: 15% to 20%
- Diagnostic tests: 10% to 15%

History Taking Techniques

Record chief complaint

History of the present illness, presence of pain

P-Q-R-S-T Tool to Evaluate Pain

- P: What provokes symptoms? What improves or exacerbates the condition? What were you doing when it started? Does position or activity make it worse?
- Q: Quality and Quantity of symptoms: Is it dull, sharp, constant, intermittent, throbbing, pulsating, aching, tearing or stabbing?
- R: Radiation or Region of symptoms: Does the pain travel, or is it only in one location? Has it always been in the same area, or did it start somewhere else?
- S: Severity of symptoms or rating on a pain scale. Does it affect activities of daily living such as walking, sitting, eating, or sleeping?
- T: Time or how long have they had the symptoms. Is it worse after eating, changes in weather, or time of day?

S-A-M-P-L-E

- S: Signs and symptoms
- A: Allergies
- M: Medications
- P: Past medical history
- L: Last meal or oral intake
- E: Events before the acute situation

Pain Assessment

Pain, or the fifth vital sign, is a crucial component in providing the appropriate care to the patient. Pain assessment may be subjective and difficult to measure. Pain is anything the patient or client states that it is to them. As nurses, you should be aware of the many factors that can influence the patient's pain. Systematic pain assessment, measurement, and reassessment enhance the ability to keep the patient comfortable. Pain scales that are age appropriate assist in the concise measurement and communication of pain among providers. Improvement of communication regarding pain assessment and reassessment during admission and discharge processes facilitate pain management, thus enhancing overall function and quality of life in a trickle-down fashion.

According to one performance and improvement outpatient project in 2017, areas for improvement in pain reassessment policies and procedures were identified in a clinic setting. The study concluded compliance rates for the 30-minute time requirement outlined in the clinic policy for pain reassessment were found to be low. Heavy patient load, staff memory rather than

documentation, and a lack of standardized procedures in the electronic health record (EHR) design played a role in low compliance with the reassessment of pain. Barriers to pain assessment and reassessment are important benchmarks in quality improvement projects. Key performance indicators (KPIs) to improve pain management goals and overall patient satisfaction, balanced with the challenges of an opioid crisis and oversedation risks, all play a role in future research studies and quality of care projects. Recognition of indicators of pain and comprehensive knowledge in pain assessment will guide care and pain management protocols.

Indicators of Pain

- Restlessness or pacing
- Groaning or moaning
- Crying
- Gasping or grunting
- Nausea or vomiting
- Diaphoresis
- Clenching of the teeth and facial expressions
- Tachycardia or blood pressure changes
- Panting or increased respiratory rate
- Clutching or protecting a part of the body
- Unable to speak or open eyes
- Decreased interest in activities, social gatherings, or old routines

Psychosocial Assessment

The primary consideration is the health and emotional needs of the patient. Assessment of cognitive function, checking for hallucinations and delusions, evaluating concentration levels, and inquiring into interests and level of activity constitute a mental or emotional health assessment. Asking about how the client feels and their response to those feelings is part of a psychological assessment. Are they agitated, irritable, speaking in loud vocal tones, demanding, depressed, suicidal, unable to talk, have a flat affect, crying, overwhelmed, or are there any signs of substance abuse? The psychological examination may include perceptions, whether justifiable or not, on the part of the patient or client. Religion and cultural beliefs are critical areas to consider. Screening for delirium is essential because symptoms are often subtle and easily overlooked, or explained away as fatigue or depression.

Safety Assessment

- Ambulatory aids
- Environmental concerns, home safety
- Domestic and family violence risk, human trafficking risks, elder or child abuse risk
- Fall risk

- Suicidal ideation (initiate suicide precautions as directed by institutional policy)

Therapeutic Communication Techniques Used to Take a Good History

Multiple strategies are employed that will include:

- Active, attentive listening
- Reflection, sharing observations
- Empathy
- Share hope
- Share humor
- Touch
- Therapeutic silence
- Provide information
- Clarification
- Focusing
- Paraphrasing
- Asking relevant questions
- Summarizing
- Self-disclosure
- Confrontation

What are examples?

- Active, attentive listening: Attention to the details of what the patient is saying either in a verbal or nonverbal manner
- Reflection, share observations: Repeat the patient's words to encourage discussion, state observations that will not make the patient angry or embarrassed; i.e., " You seem tired today, sad...," " You have hardly eaten anything this morning."
- Empathy: Demonstrate that you understand and feel for the patient, recognition of their current situation and perceived feelings, and communicating in a nonjudgmental, unbiased way of acceptance
- Share hope: Ensure in the patient a sense of power, hope in an often hopeless environment, and the possibility of a positive outcome
- Share humor: Fosters a relationship of emotional support, establishes rapport, acts as a positive diversion technique, and promotes physical and mental well being. Cultural considerations play a role in humor

- Touch: Touch may be a source of comfort or discomfort for a patient, wanted or unwanted; observe verbal and nonverbal cues with touch; holding a hand, conducting a physical assessment, performing a procedure
- Therapeutic silence: Fosters an environment of patience, thought and reflection on difficult decisions, and allows time to observe any nonverbal signs of discomfort (the patient typically breaks the silence first)
- Provide information: During an assessment and care, inform the patient as to what is about to happen, explain findings and the need for further testing or observation to promote trust and decrease anxiety
- Clarification: Ask questions to clear up ambiguous statements, ask the client or patient to rephrase or restate confusing remarks so wrong assumptions are clarifiable and a missed opportunity for valuable information forgone
- Focusing: Brings the focus of the conversation to an essential area of concern, eliminating vague or rambling dialogue, centers the assessment on the source of discomfort and pertinent details in the history
- Paraphrasing: Invites patient participation and understanding in a conversation
- Asking relevant questions: Questions are general at first then become more specific; asked in a logical, consecutive order; open-ended, close-ended, and focused questions may be useful during an assessment
- Summarizing: Provides a review of assessment findings, offers clarification opportunities, informs the next step in the admission and hospitalization process
- Self-disclosure: Promotes a trusting relationship, the feeling that the patient is not in this alone, or unique in their current circumstances; provides a framework for hope, support, and respect
- Confrontation: You may have to confront the patient after a trustful rapport has been established, discussing any inconsistencies in the history, thought processes, or inappropriate behavior

Cultural Assessment

The cultural competency assessment will identify factors that may impede the implementation of nursing diagnosis and care. Information obtained should include:

- Ethnic origin, languages spoken, and need for an interpreter
- Primary language preferred for written and verbal instructions
- Support system, decision makers
- Living arrangements
- Religious practices
- Emotional responses
- Special food requirements, dietary considerations

- Cultural customs or taboos such as unwanted touching or eye contact

Physical Examination Techniques

Initial evaluation or the general survey may include:

- Stature
- Overall health status
- Body habitus
- Personal hygiene, grooming
- Skin condition such as signs of breakdown or chronic wounds
- Breath and body odor
- Overall mood and psychological state
- Initial vital sign measurements: temperature recorded in Celsius in most institutions, respiratory rate, pulse rate, blood pressure with appropriate sized cuff, pulse oximetry reading and note if on room air or oxygen; accurately measured weight in kilograms with the proper scale and height measurement, so body mass index (BMI) is calculable for dosing weights and nutritional guidelines

Secondary Assessment

- Cardiovascular
- Pulmonary
- Gastrointestinal
- Musculoskeletal
- Neurological
- Genitourinary/Pelvic
- Integumentary
- Mental status and behavioral

Techniques

Inspection

- Look at all areas of the skin, including those under clothing or gowns
- Ensure patient is undressed, allowing for privacy, uncover one body part at a time if possible
- Lighting should be bright
- Be alert for any malodors from the body including the oral cavity; fecal odor, fruity-smell, odor of alcohol or tobacco on the breath
- Compare one side to the other, and ask the patient about any asymmetrical areas

- Observe for color, rashes, skin breakdown, tubes and drains, scars, bruising, burns
- Grade any edema present
- Document pertinent normal and abnormal findings

Palpation

- Texture
- Size
- Consistency
- Crepitus
- Any masses
- Turgor
- Tenderness
- Temperature and moisture (warm, moist or cool, and dry)
- Distention
- Tactile fremitus

Percussion

- Good hand and finger technique
- Good striking and listening technique
- Especially important in the pulmonary and gastrointestinal systems
- Dull, flat, resonance, hyper-resonance, or tympany sounds
- Percussion is an advanced technique requiring a specific skill set to perform. Therefore, it is a skill practiced by advanced practice nurses as opposed to a bedside nurse on a routine basis

Auscultation

- Listening to body sounds such as bowel sounds, breath sounds, and heart sounds
- Important in examination of the heart, blood pressure, and gastrointestinal system
- Listen for bruits, murmurs, friction rubs, and irregularities in pulse

What are important things to remember about the physical exam?

- Physical exam length can vary depending on complexity
- Physical exam extends from passive observation to hands-on
- Be systematic and thorough
- Ensure privacy and comfort
- Warm hands for patient comfort

- Avoid long fingernails to prevent patient injury during the exam
- Palpate areas that are tender or painful last
- Be alert for any signs of maltreatment or abuse, and follow mandatory reporting guidelines
- Abdominal assessment follows the techniques in this sequence: inspection, auscultation, percussion, and palpation
- Auscultate bowel sounds for at least 15 seconds in each quadrant using the diaphragm of the stethoscope, starting with the lower right-hand quadrant and moving clockwise
- If a fistula is present for hemodialysis, assess for a thrill or bruit, document presence or absence. Notify managing healthcare provider immediately if absent
- Steps in a comprehensive lung exam include PIPPA; Positioning of the patient, Inspection, Palpation, Percussion, Auscultation

Diagnostic Studies

Driven by findings on the history and physical examination; options include:

- Blood tests (CBC, chemistry, bedside glucose, pregnancy test, urinalysis, cardiac enzymes, coagulation studies)
- Imaging studies (X-rays, CT, MRI, ultrasound)
- Other diagnostic studies (ECG, EEG, lumbar puncture, etc.,)

Discharge Planning

- Document mode of transport
- Who is accompanying the patient?
- Transfer forms/EMTALA considerations
- Functional status
- Financial considerations
- Discharge medications and instructions
- Follow up information, referrals, hotline numbers, shelter information
- Barriers to learning
- Document verbalization that discharge instructions were understood by caregiver or surrogate
- Provide translators and language appropriate discharge instructions or paperwork

Clinical Significance

Often the initial history and physical examination lead to the identification of life- or limb-threatening conditions that can be stabilized promptly, ensuring better patient outcomes. The sooner the patient is correctly assessed, the more likely a life-altering condition is recognizable,

nursing diagnosis formulated, appropriate intervention or treatment initiated, and stabilizing care rendered. Physiological abnormalities manifested by changes in vital signs and level of consciousness often provide early warning signs that patient condition is deteriorating; thus, requiring prompt intervention to forego an adverse outcome, decreasing morbidity and mortality risk. In the fast-paced, resource-challenged healthcare environment today, thorough assessment can pose a challenge for the healthcare provider but is essential to safe, quality care. The importance of a head-to-toe assessment, critical thinking skills guided by research, and therapeutic communication are the mainstays of safe practice. [13][14][15]

Assessment findings that include current vital signs, lab values, changes in condition such as decreased urine output, cardiac rhythm, pain level, and mental status, as well as pertinent medical history with recommendations for care, are communicated to the provider by the nurse. Communicating in a concise, efficient manner in rapidly changing situations and deteriorating patient conditions can promote quick solutions during difficult circumstances. Healthcare providers communicate and share in the decision-making process. The SBAR model facilitates this communication between members of the healthcare team and bridges the gap between a narrative, descriptive approach and one armed with exact details.

Communication using the SBAR Model

- Situation
- Background
- Assessment
- Recommendation

Assessment Tools

- Activities of daily living scale
- Cough assessment
- Health questionnaires such as those that address recent travel and exposure risks
- Waterlow or Braden scale for assessing pressure ulcer risk
- Glasgow coma scale/AVPU for assessment of consciousness
- Pain scales such as the Faces Pain Scale (FPS), Numeric Rating System (NRS), Visual Analogue Scales (VAS), Wong-Baker Faces Pain Rating Scale (WBS), and the (MPQ) McGill Pain Questionnaire
- CAGE assessment/CIWA scoring
- Morse Fall Risk
- Standard vital sign flow charts for different age groups
- NIH Stroke Scale (NIHSS)
- Dysphagia Screen
- 4AT Assessment for Delirium

Equipment

- The nurse should be familiar with the otoscope, penlight, stethoscope (bell and diaphragm), thermometer, bladder scanner, speculum, eye charts, cardiac and blood pressure monitors, fetal doppler and extremity doppler, and sphygmomanometer
- Stretcher or bed for proper positioning during a physical exam
- Hand hygiene products, personal protective equipment if required
- Alcohol swabs, sanitizer, or soapy water to clean equipment after use, such as with stethoscopes, to decrease the likelihood of cross-contamination of pathogens from inanimate objects (follow any manufacturer guidelines or institutional policies)
- Computer or paper chart to document findings
- Calculation devices for BMI, conversion from pounds to kilograms, kilograms to pounds, Celsius to Farenheight

Review Questions

- Access free multiple choice questions on this topic.
- Comment on this article.

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