AL RYADA UNIVERSITY FOR SCIENCE AND TECHNOLOGY

FACULTY OF NURSING

HEALTH ASSESSMENT practical

Prepared by:

Medical Surgical Nursing Department staff

2024 - 2025

University Vision

Al-Ryada University for Science and Technology aspires to be a distinguished and highly competitive leading university at the local and international levels in line with the sustainable development goals.

University Mission

The University is committed to providing a distinguished graduate capable of innovating and competing in the labor market and meeting the challenges of the future by providing a stimulating educational environment with intelligent and sophisticated techniques and strengthening partnerships with local and international universities and institutions and employing scientific research to achieve academic and research excellence while adhering to national identity, ethical values and community responsibility.

AL RYADA UNIVERSITY FOR SCIENCE AND TECHNOLOGY

FACULTY OF NURSING

Faculty Vision

The College of Nursing at the Al-Ryada University for Science and Technology in Egypt aspires to become a leading college in embracing comprehensive, distinguished education that supports students' personal capabilities and leads to self-confidence and continuous self-development. This positively impacts fair professional competition locally, regionally, and internationally, and advances the educational, research, and societal aspects of the profession.

Faculty Mission

The College of Nursing at the Al-Ryada University for Science and Technology in Egypt is committed to utilizing a variety of modern educational methods and theories and continually developing them in line with scientific developments and educational quality standards. This will result in the graduation of distinguished cadres with a high competitiveness at the local, regional, and international levels in the practice of the nursing profession and in the field of scientific research. The College is committed to actively participating in the continuous development of various aspects of the profession, which will positively impact the profession and society, achieving sustainable development.

AL RYADA UNIVERSITY FOR SCIENCE AND TECHNOLOGY

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ADA UNIVERSITY FOR
CE AND TECHNOLOGY

FACULTY OF NURSING

Course Specification

Health Assessment

توصيف مقرر دراسى
بناء على المعايير الاكاديميه المبنيه على الكفايات
سبتمبر٢٠٢٥

جامعة : الريادة للعلوم والتكنولوجيا
كليــة : التمريض
قسم : التمريض الباطني الجراحي

بيانات المقرر : الرمز الكودي : NUR 3111	اسم المقرر : Health Assessment	١- الفرقة / المستوى الاول: 1Th semester (first year)
التخصص : B.Sc in Nursing Credit hour system	عدد الساعات المعتمدة: (٢) نظرى عملى (١)	

2- Aim of the course ٢- هدف المقرر

After completion of the course, the student will be acquire the essential knowledge and skills to conduct comprehensive health assessment.

- Course specification based on competencies **٣- توصيف المقرر المبنى على الكفايات**

Domain No: 1Professional and Ethical Practice

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
1.1 Demonstrate knowledge, understanding, responsibility and accountability of the legal obligations for ethical nursing practice	**1.1.1**Practice nursing based on policies and procedural guidelines considering patient/ client rights.	-Introduction and critical thinking in Health Assessment, Culture care and competency -Interview and History taking	Describe concepts, principles, and techniques of health assessment utilizing appropriate tools for direct and indirect health measurements.	• Modified lecture for discussion with students	❖ Power point presentation	❖ Quiz I ❖ Quiz I I ❖ (Mid-term written exam). ❖ Quiz III Re-demonstration ❖ Final exam ❖ OSCE and \ or Clinical performance ❖ -Practical exam

	1.1.2. Demonstrate responsibility and accountability for care within the scope of professional and practical level of competence.	-Physical assessment strategies and techniques	-Discuss ethical and legal aspects of health assessment -Describe health assessment approach -List the component of health history - Perform physical assessment techniques	• Modified lecture for discussion with students	❖ Power point presentation ❖ Videos	❖ Quiz I ❖ Quiz I I ❖ (Mid-term written exam). ❖ Quiz III Re-demonstration ❖ Final exam ❖ OSCE and \ or Clinical performance ❖ -Practical exam

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Domain No: 2 Holistic Patient-Centered Care

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
2.1Provide holistic and evidence-based nursing care in different practice settings.	**2.1.1**Conduct holistic and focused bio-psychosocial and environmental assessment of health and illness in diverse settings. **2.1.2**Provide holistic patient-centered care respecting people diversity.	•Physical assessment strategies and techniques •Breast and regional lymphatic	Analyze health assessment data to differentiate between normal and abnormal health status. -Discuss ethical and legal aspects of health assessment -Describe health assessment approach -List the component of health history -Perform physical assessment techniques -Demonstrate competence in performing health assessment. -Use effective communication techniques to conduct a comprehensive health assessment.	• Active learning using lecture for discussion with groups of students	• Modified lecture • Power point presentation • Videos	- Quiz I - Quiz I I (Mid-term written exam). -Quiz III Re-demonstration Final exam -OSCE and \ or Clinical performance -Practical exam

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
		-Respiratory Assessment -Cardiovascular Assessment	-Document accurate health assessment data using paper-based and electronic clinical records. - Examine thoracic landmarks - Mention health history for physical examination of thoracic cavity and lung -Perform physical assessment techniques for thoracic cavity and lung. -Describe normal heart sounds and extra heart sounds -Prepare the equipment necessary to perform an examination of the cardio and peripheral vascular system			

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
		Peripheral vascular Assessment •Abdominal Assessment	-Demonstrate the physical examination techniques used to assess the cardiac and peripheral vascular system -Discuss physical examination of heart and neck vessel -Describe techniques required for assessment of the abdomen -Identify the reason for the sequence of abdominal examination -Describe developmental variations in assessment techniques and findings of the abdomen -Mention the common findings on inspection, auscultation, percussion and palpation of the abdomen -Differentiate normal from abnormal findings in physical assessment			

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
		•Skin, hair, and nails Assessment	of the abdomen -Discuses techniques required for assessment of the skin, hair and nails - Describe developmental variations in assessment techniques and findings of skin, hair and nails - Mention the common findings on inspection, and palpation of skin, hair and nails			

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
		•Head, face, and neck; including regional lymphatics	-Describe the techniques required for assessment of the head, face and neck -Differentiate normal and abnormal findings in physical assessment of the head, face and neck and regional lymphatics - Discuss the focus areas related to the overall health of the head, face and neck and related lymphatics			
		•Nose, sinus, mouth, and throat Assessment	-Describe the techniques required for assessment of the nose, sinus, mouth and throat. -Differentiate normal and abnormal findings in physical assessment of the nose, sinus, mouth and throat.			

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
			- Mention the common findings on inspection, and palpation of nose, sinus, mouth and throat			

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
		Eyes and ears Assessment	-Describe the techniques used to assess external and internal eyes. - Differentiate between normal and abnormal findings. -Discuss developmental variations in assessment			
		•Musculoskeletal system assessment	-Describe the function of musculoskeletal system. -Enumerate the component of musculoskeletal health history -Apply the musculoskeletal assessment techniques.			

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
		•Genitourinary system Assessment	-Demonstrate assessment techniques for the evaluation of the male and female reproductive system. -Distinguish common variations and abnormal changes of the male and female reproductive system -Differentiate between normal and abnormal finding in male and female reproductive system.			
		•Neurological assessment and Mental Status Assessment	-Discuss the structure and function of neurological system. -Conduct neurological assessment.			

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
		The complete health Assessment: Putting it all together (Head-to-toe Examination including BMI, weight, height, and nutritional assessment)	-Discuss the principles of preparing the client for health assessment. - Perform the general and complete steps total health assessment techniques. - Distinguish common equipment needed for health assessment. - Differentiate between normal and abnormal finding in different systems.			

Domain No: 3Manage People, Work Environment and Quality

Competency	Key elements	Course subjects	Subject objectives	Teaching Methods	Media used	Assessment methods
3.2 Review health care outcomes in the light of quality indicators and Benchmarks to achieve the ultimate goals of improving the quality of nursing care.	**3-2-**1 Participate in quality improvement process to enhance nursing care rendered and patient/client outcomes.	Physical assessment strategies and techniques	-Exhibit ethical, legal principles, and Islamic values while performing health assessment. -Demonstrate leadership and teamwork skills throughout the course	-Active learning using lecture for discussion with students	❖ Power point presentation ❖ Modified lecture	❖ Quiz I ❖ Quiz I I ❖ (Mid-term written exam). ❖ Revision Re-demonstration ❖ Final exam ❖ OSCE and \ or Clinical performance ❖ -Practical exam

٤- محتوى المقرر

List of topics	No. of hours (theory)	No. of lecture (theory)	Practical/ tutorial (Hours No.)
• Course Specification and Course Assignments • Introduction and critical thinking in Health Assessment, Culture care and competency • Interview and History taking	٢	1	
• Physical assessment strategies and techniques	٢	1	
• Breast and regional lymphatic	٢		
• Respiratory Assessment	٢	1	
• Cardiovascular Assessment	٢	1	
• Peripheral vascular Assessment	٢	1	
• Abdominal Assessment	٢	1	
• Skin, hair, and nails Assessment • Head, face, and neck; including regional lymphatics	٢	1	

• Nose, sinus, mouth, and throat Assessment • Eyes and ears Assessment	٢	1	
• Musculoskeletal system assessment	٢	1	
• Genitourinary system Assessment	٢	١	
• Neurological assessment and Mental Status Assessment	٢	1	
• The complete health Assessment: Putting it all together (Head-to-toe • Examination including BMI, weight, height, and nutritional assessment)	٢	١	
• Revision	٢	1	-
List of Laboratory Skills Covered			
Demonstration of principles of interview and history taking			١
Demonstration of physical assessment strategies and techniques Demonstration of breast and regional lymphatic assessment			١
Demonstration of respiratory assessment			١
Demonstration of cardiovascular assessment			١
Demonstration of peripheral vascular assessment			١

Demonstration of abdominal assessment			١
Demonstration of skin, hair, and nails Assessment Demonstration of head, face, and neck; including regional lymphatic assessment			١
Demonstration of nose, sinus, mouth, and throat assessment Demonstration of eyes and ears assessment			١
Demonstration of musculoskeletal system assessment Demonstration of genitourinary system assessment			١
Demonstration of neurological assessment and mental status assessment			١
Revision			1
Total	**٣٠ hours**	**15 week**	**١٠ hours**

• Traditional classroom lectures (70%) and online Group discussion (30%) • Face to face and online lectures. • Individual and group exercises (topic presentation). • Role play and demonstration. • Simulated practice on models in the skill lab.	٥- أساليب التعليم والتعلم : **Teaching and Learning Methods.**
• لا يوجد	٦- أساليب التعليم والتعلم للطالب ذوي القدرات المحدودة **Teaching and Learning Methods of Disables.**

٧- تقويم الطلاب: Students assessment

Assessment I: To assess accumulative knowledge and ability to express himself **Assessment II (Mid-term written exam):** To assess accumulative knowledge and ability to express himself **Assessment III:** To assess accumulative knowledge and ability to express himself **OSCE** and \ or **Clinical performance** evaluation and Assignments **Final exam:** to assess accumulative knowledge in writing exam	أ- الأساليب المستخدمة: **Methods used**
Assessment I — **Week ٤** **Assessment II(Mid-term written exam).** — **Week ٧** **Assessment III** — **Week ١١**	ب- التوقيت : **Time**

OSCE and \ or **Clinical performance**	**Week 14**			
Final exam	**Week 16**			
Assessment I	10	**6.6 %**		**ج- توزيع الدرجات :** **Mark Distribution**
Assessment II (Mid-term written exam).	10	**6.6 %**		
Assessment III	١0	**٦.6 %**		
Final exam	٧0	**46.6 %**		
OSCE and \ or Clinical performance	20	**13.3%**		
Practical exam	30	**20 %**		
Total	**150**	**100 %**		
List of References				**٨- قائمة الكتب الدراسية والمراجع**
Health Assessment Course note 2024				**أ- مذكرات Course note**
Carolyn Jarvis &Ann L. Eckhardt,(2023). Physical Examination and Health Assessment **ISBN: 9780323827799. eBook ISBN: 9780323811705. 9th Edition. Elseveir** Jarvis, C. (2020). Physical Examination and Health Assessment, (8th ed). St. Louis, Missouri, Saunders Elsevier.				**ب- كتب مقترحة** **Recommended Books**
Forbes,H.,& Watt,E. (2020). Jarvis's Health Assessment and Physical Examination. ISBN: 9780729543378.3rd Edition. Elseveir.				**ج- كتب مقترحة Recommended Books**

https://www.pdfdrive.com/seidels-guide-to-physical-examination-true-pdf-e176306985.html Rn Journal http://rnjournal.com/ Bmj open Journal http://bmjopen.bmj.com/ Journal of Continuing Education in Nursing Contemporary nurse journal http://www.contemporarynurse.com/	د- دوريات علمية او نشرات Periodicals. Websites etc

منسق المادة:	أستاذ المقرر	رئيس القسم
أية فوزى	أ.د/ سماح الجارحى أ.م.د/ وفاء محمد السيد	أ.م.د/ وفاء محمد السيد

AL RYADA UNIVERSITY FOR SCIENCE AND TECHNOLOGY

FACULTY OF NURSING

COURSE Distribution hours/ semester

Topic	No. of lectures (theory)	Practical/ tutorial (Hours No.)
Introduction to the course ▪ Techniques of physical Examination ▪ How to prepare equipment ▪ General Survey	---	2
Eye, ear and nose assessment ▪ Physical examination ▪ Abnormal findings	---	1
Skin, hair and nails assessment ▪ Physical examination ▪ Abnormal findings	---	1
Cardiovascular assessment □ Physical examination □ Abnormal findings	---	2
Respiratory assessment ▪ Physical examination ▪ Abnormal findings	---	1
Gastrointestinal assessment ▪ Physical examination ▪ Abnormal findings	---	1
Midterm examination	---	1
□ intake and output for critically ill patients		
Neurological assessment ▪ Glasgow Coma Scale ▪ Examination of Cranial nerves	---	2
Musculoskeletal assessment □ Physical examination □ Abnormal findings	---	2
Breast assessment □ Physical examination	---	1

□ Abnormal findings		
□ intake and output for critically ill patients		
Final exam.		
Total	**---**	15

PHYSICAL EXAMINATION

Learning Objectives:

1. Define physical examination and identify its purposes
2. Determine the preparation before beginning with physical examination
3. Enumerate the equipment appropriate for each examination
4. Identify positions appropriate for physical examination
5. Learn and apply the physical examination techniques correctly.

Introduction

One of the major components of health assessment is physical examination. It can be performed through complete assessment, per body system or per body area.

Definition:

It is the process of examining the patient's body to determine the presence or absence of physical problems.

Purposes:

1. To obtain valid information concerning the health of the patient
2. To identify, analyze, and synthesize the accumulated information into a comprehensive assessment
3. To make direct observations of any deviations from normal and to validate subjective data gathered through the interview.

Preparation:

A. Environment

1. Adjust the environment to allow for placement of the equipment on a surface that is clean and free from movement at the bedside.
2. Check to make sure that nothing is on the floor that would place the client at risk of falling.
3. The room needs to be quiet, warm, without drafts, and adequately lit.

B. Equipment

Required	Optional
Stethoscope	Gauze pads
Tongue Blades	Lubricant gel
Penlight	Nasal speculum
Tape measure	Turning fork: 128 Hz,512Hz
Sphygmomanometer	Pocket visual acuity card
Reflex hammer	Oto-ophthalmoscope
Safety pins	
Gloves	

TABLE 28–3 Equipment and Supplies Used for a Health Examination

Guidelines		Example
Flashlight or penlight		To assist viewing of the pharynx and cervix or to determine the reactions of the pupils of the eye
Laryngeal or dental mirror		To observe the pharynx and oral cavity
Nasal speculum		To permit visualization of the lower and middle turbinates; usually, a penlight is used for illumination
Ophthalmoscope		A lighted instrument to visualize the interior of the eye
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)
Percussion (reflex) hammer		An instrument with a rubber head to test reflexes
Tuning fork		A two-pronged metal instrument used to test hearing acuity and vibratory sense
Vaginal speculum (various sizes)		To assess the cervix and the vagina
Cotton applicators		To obtain specimens
Disposable pads		To absorb liquid
Gloves (sterile and unsterile)		To protect the nurse
Lubricant		To ease insertion of instruments (e.g., vaginal speculum)
Tongue blades (depressors)		To depress the tongue during assessment of the mouth and pharynx

Note: From Fundamentals of Nursing: Concepts, Process, and Practice, *6th ed., by B. Kozier, G. Erb, A. Berman, & K. Burke, 2000, Upper Saddle River, NJ: Prentice Hall Health.*

TABLE 28–2 Client Positions and Body Areas Assessed

Position	Description	Areas Assessed	Cautions
Dorsal recumbent 	Back-lying position with knees flexed and hips externally rotated; small pillow under the head; soles of feet on the surface	Head and neck, axillae, anterior thorax, lungs, breasts, heart, extremities, peripheral pulses, vital signs, and vagina	May be contraindicated for clients who have cardio-pulmonary problems. Not used for abdominal assessment because of the increased tension of abdominal muscles.
Supine (Horizontal recumbent) 	Back-lying position with legs extended; with or without pillow under the head	Head, neck, axillae, anterior thorax, lungs, breasts, heart, abdomen, extremities, peripheral pulses	Tolerated poorly by clients with cardiovascular and respiratory problems.
Sitting 	A seated position, back unsupported and legs hanging freely	Head, neck, posterior and anterior thorax, lungs, breasts, axillae, heart, vital signs, upper and lower extremities, reflexes	Elderly and weak clients may require support.
Lithotomy 	Back-lying position with feet supported in stirrups; the hips should be in line with the edge of the table.	Female genitals, rectum, and female reproductive tract	May be uncomfortable and tiring for elderly people and often embarrassing.
Sims' 	Side-lying position with lowermost arm behind the body, uppermost leg flexed at hip and knee, upper arm flexed at shoulder and elbow	Rectum, vagina	Difficult for the elderly and people with limited joint movement.
Prone 	Lies on abdomen with head turned to the side, with or without a small pillow	Posterior thorax, hip joint movement	Often not tolerated by the elderly and people with cardiovascular and respiratory problems.

C. Positioning and Draping

Techniques

1. Inspection

-The use of senses of sight, hearing, smell and touch - The first step in assessment

Procedure:

a. Inspect skin for color, tone, and texture, as well as scars, lesions, abrasions, and rashes.

b. Inspect for client's general body appearances, such as movement, motor dexterity, contour and symmetry of the body, and deformities.

2. Palpation

- Uses the sense of touch to assess texture, temperature, moisture, organ location and size, vibrations and pulsations, swelling, masses, and tenderness.

2.1. Light Palpation

- *Temperature:* Best detected using the dorsal (back) surface of the hand
- *Texture, pulses, and swelling:* Best detected using fingertips
- *Vibration:* Best detected with the base of the fingers
- *Shape and consistency of organs or masses:* Best detected by grasping organ or mass between fingertips

Procedure:	
a. Use the flat part of the right hand or the pads of the fingers, not the fingertips	

b. With the tips of two or three fingers held close together, press gently on the skin to a depth of 1 to 2 cm. Use the lightest touch possible; too much pressure blunts your sensitivity	
Note: ✓ Sudden jabs are to be avoided ✓ The hand should be lifted from one area to area instead of sliding over the abdominal wall	

2.2. Deep Palpation

- Used to determine organ size as well as the presence of abdominal masses

Procedure:	
a. Place one hand on top of the other.	
b. Then press down about 4 to 5 cm with the fingertips of both hands.	
Note: - Pressure should be applied to the abdomen gently but steadily - The patient should be instructed to breathe quietly through the mouth and to keep arms at the sides	

2.3 Bimanual palpation

- It is employed during the processes of liver, spleen, kidney or abdominal masses examination

Procedure:	
a. Use two hands one on each side of the body part being palpated	
b. Place the left hand over the pack of organs to be examined, in order to fix or elevate the organs. It may be helpful for the right hand palpation	

3. Percussion

- Uses short, tapping strokes on the surface of the skin to create vibrations of underlying organs.

3.1 Direct percussion

- The use of one hand to strike the surface of the body.

Procedure:	
a. Strike the area to be percussed directly with the pads of two, three or four fingers or with the pad of the middle finger.	
b. Make the strikes rapid and the movement is from the wrist.	

Note: This technique is not generally used to percuss the thorax but useful in percussing the sinuses.	

3.2. Indirect percussion

- The striking of a finger held against the body area to be examined

Procedure:	
a. Hyperextend the middle (pleximeter) finger of the nondominant hand and press its distal phalanx and joint firmly on the surface to be percussed. *Note:* Only the distal phalanx and joint should be touching the surface. Having other parts of the hand in contact with the surface will damp the vibrations.	
b. Position the forearm of the dominant hand close to the surface, with the hand cocked upward, with the middle finger partially flexed, relaxed, and poised to strike.	

c. With a quick, sharp, but relaxed *wrist* motion, strike the pleximeter finger with the tip of the right plexor finger of the dominant hand. ***Note:*** Only the wrist joint is flexed, not the finger or elbow.	
d. Quickly withdraw the plexor finger to avoid damping the vibration.	
e. Strike one or two blows in one location, then move on, using the lightest percussion that will produce a clean note.	

Percussion Sounds and Tones

Sound	Quality	Pitch	Example of Location
Resonance	Hollow	Low	Normal lung
Hyperresonance	Booming	Very low	Air-filled lungs (pulmonary emphysema)
Tympany	Drumlike, Musical	High	Abdomen
Dullness	Thudlike	Medium	Liver
Flatness	Extremely dull	High	Muscle, bone

4. Auscultation

- Involves listening to sounds in the body that are created by movement of air or fluid. Areas most often auscultated include the lungs, heart, abdomen, and blood vessels with the use of stethoscope.
- It evaluates the frequency, intensity, during, number and quality of sounds

Procedure:	
a. Eliminate distracting noises	
b. Expose the body part you are going to auscultate	
c. Use the diaphragm to listen for normal heart sounds, and bowel sounds	
d. Press the diaphragm firmly	
e. Use the bell to listen for abnormal heart sounds or bruits	
f. Hold the bell lightly	

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT:----------

SKILL NAME/TOPIC: Physical Examination Techniques check list

NO	STEPS Required Frequency: 10	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	**Preparation** 1 -Explain procedure to the patient 2- Provide comfortable environment 3- Prepare equipment 4- Position patient according to examination 5- Provide privacy 4- Stand at the right side of the bed 5- Wear gloves	B						
2	**Inspection** a.Inspect skin for color, tone, and texture, as well as scars, lesions, abrasions, and rashes. b. Inspect client's general body appearances, such as movement, motor dexterity, contour and symmetry of the body, and deformities.	A						

3*	**Palpation** **Light palpation** a. Use the flat part of the right hand or the pads of the fingers, not the fingertips b. With the tips of two or three fingers held close together, press gently on the skin to a depth of 1 to 2 cm. c. Sudden jabs are to be avoided d. The hand should be lifted from one area to area instead of sliding over the abdominal wall.	B						
	Deep palpation a. Place one hand on top of the other b. Then press down about 4 to 5 cm with the fingertips of both hands.	B						
	Bimanual palpation a. Use two hands, one on each side of the body part being palpated b. Place the left hand over the pack of organs to be examined,	B						

	to fix or elevate the organs. It may be helpful for the right-hand palpation.							
4*	**Percussion** **Direct Percussion** a. Strike the area to be percussed directly with the pads of two, three or four fingers or with the pad of the middle finger. b. Make the strikes rapid and the movement is from the wrist.	B						
	Indirect Percussion a. Hyperextend the pleximeter finger and press the distal phalanx and joint firmly on the surface to be percussed b. Cock the hand upward with the middle finger partially flexed and poised to strike c. Strike the pleximeter finger with the tip of the right plexor finger.	B						

5	**Auscultation** a. Eliminate distracting noises b. Expose the body part you are going to auscultate c. Use the diaphragm to listen for normal heart sounds, and bowel sounds d. Press the diaphragm firmly e. Use the bell to listen for abnormal heart sounds or bruits f. Hold the bell lightly	B							
6	Document findings	B						Done	Repeat

Clinical instructor **Hospital Instructor**

Head of department

Name Name:

Name:

Signature: Signature:

Signature:

Level of performance

A-Ability to perform the activity without supervision

B - Ability to perform the activity under supervision

C- Ability to assist with performance of activity

Rating

D -Knowledge of the activity by observation.

5=Excellent

4=Very Good

3=Good

2=Unsatisfactory

1=Failed

GENERAL SURVEY

Learning Objectives:

1. Define general survey and identify its purposes.
2. Identify normal from abnormal findings in the assessment of appearance and mental status
3. perform accurate general survey

Introduction:

The overall appearance of a patient usually reflects the status of his/her general health. General survey primarily uses the sense of sight through inspection to assess a patient's appearance and mental status.

Definition:

General survey is the beginning of assessment that involves observation of client's appearance and mental status and measurement of vital signs, weight and height.

Purposes:

1. To provide baseline data in terms of patient's appearance and mentation.
2. To provide accurate data on patient's vital signs, weight and height.

Equipment:

Disposable Gloves

Assessing Appearance and Mental Status

Assessment	Normal Findings	Abnormal Findings
1. Observe build, height and weight in relation to the client's age, lifestyle and health.	Proportionate, varies with lifestyle	Excessively thin or obese
2. Observe client's posture and gait, standing, sitting and walking	Relaxed, erect posture, coordinated movement	Tensed, slouched, bent posture, uncoordinated movement, tremors
3. Observe client's overall hygiene and grooming	Clean, neat	Dirty, unkempt
5. Observe for signs of distress in posture or facial expression	No distress noted	Bending over because of abdominal pain, vomiting, fainting, labored breathing .
6. Note for obvious signs of health or illness	No body odor or minor body odor relative to work and exercise; no breath odor Healthy appearance	Foul body odor; fruity breath odor; foul breath Pallor, weakness, lesions
7. Assess attitude	Cooperative, able to follow instructions	Negative, hostile, withdrawn
8. Note for affect/mood; assess appropriateness of responses	Appropriate to situation	Inappropriate to situation
9. Listen to: a. quantity of speech (amount and pace) b. quality of speech (loudness, clarity) c. organization of speech (coherence of thought)	Understandable, moderate pace, clear tone, exhibits thought association	Rapid or slow pace Overly loud or soft Lacks of association

10. Listen for relevance and organization of thoughts 4. Note body and breath odor		

On Measuring Height and Weight

a. Weigh client without shoes, and without extra clothing.

b. Client should stand erect with heels together, and the heels, buttocks and back of the head against the measuring stick

c. Eyes should be looking straight ahead when taking the height

d. Note for the proportion of height and weight "Weight = height – “100” = ---- +/- 10kg".

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: General Survey

NO	STEPS Required Frequency: 3	Required Level of Performance	PERFORMANCE RATING			
			1	2	3	4
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient and provide privacy	B				
2	Observe build, height and weight in relation to the client's age, lifestyle and health	B				
3	Observe client's posture and gait, standing, sitting and walking	B				
4	Observe client's overall hygiene and grooming	B				
5	Note body and breath odor	B				
6	Observe for signs of distress in posture or facial expression	B				
7	Note for obvious signs of health or illness	B				
8	Assess attitude	B				
9	Note for affect/mood; assess appropriateness of responses	B				

10	Listen to quantity of speech, quality of speech, organization of speech	B			
11	Listen for relevance and organization of thoughts	B			
11	Take height and weight	B			
12	Take vital signs	B			
13	Document findings *Student should be able to state the abnormal findings	B			

Steps with stars are vital steps

College instructor	**Hospital Instructor**	**Head of department**
Name	Name:	Name:
Signature:	Signature:	Signature:

Level of performance: A-Ability to perform the activity without supervision
B- Ability to perform the activity under supervision
C- Ability to assist with performance of activity
D-Knowledge of the activity by observation

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

ASSESSMENT OF THE INTEGUMENTARY SYSTEM

Learning Objectives:

1. Define assessment of integumentary system and identify its purposes
2. Enumerate the equipment used for assessment of the integumentary system
3. Identify normal from abnormal findings in the integumentary system
4. Learn and perform accurate assessment of the integumentary system

Introduction:

The examination begins with generalized inspection using a good source of lighting, preferably indirect natural daylight.

Definition:

The assessment of the skin, hair and nails

Purposes:

1. Provide baseline data on patient's health status on her skin, hair and nails
2. Plan an effective care plan in management of integumentary problems

Equipment:

Millimeter Ruler

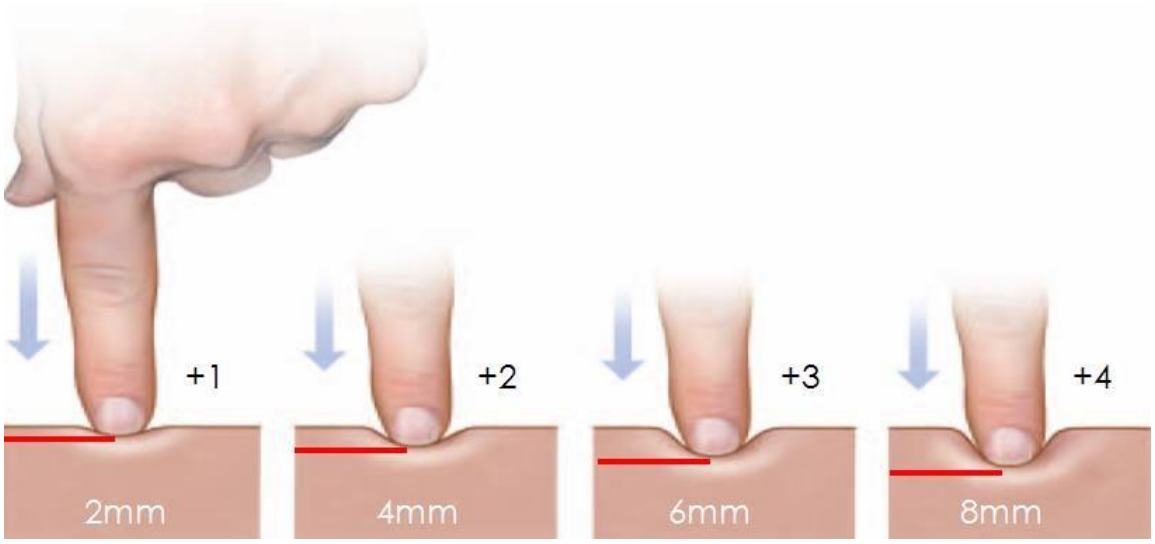
Clean gloves

Magnifying glass

ASSESSMENT OF SKIN

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
1. Inspect skin color (best assessed under natural light and on areas not exposed to the sun)	Absence of abnormal discoloration	a. Pallor – paleness due to inadequate circulating blood, haemoglobin or oxygen Ex. Hemorrhage b. Cyanosis – bluish discoloration Ex. severe asthma c. jaundice – yellow discoloration Ex. Liver problems such as Hepatitis d. Erythema – red discoloration Ex. Rashes
2. Inspect uniformity of skin color	Generally uniform except in areas exposed to the sun	Areas of hyperpigmentation or hypopigmentation
3. Assess edema if present	No edema	Presence of edema graded with the

(note for location, color, temperature, shape, and grading)		following:

		
4. Assess skin integrity. Inspect, palpate, and describe skin lesions (location, distribution, color, size, shape type). Apply gloves if lesions are open and draining.	Freckles, some birthmarks, some flat or raised nevis; No abrasions or other lesions	Presence of rashes and lesions
5. Observe and palpate skin moisture	Some moisture in skin folds and axilla	a. Excessive moisture ex. during fever, hyperhydrosis b. excessive dryness ex. dehydration

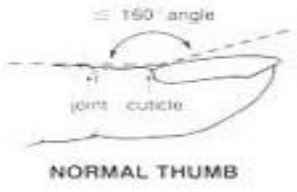
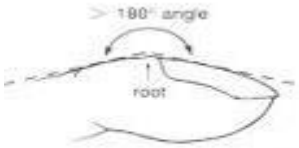
6. Palpate skin temperature (Use the back of your hand)	Uniform; within normal range	a. Generalized hyperthermia ex. in fever b. generalized hypothermia ex. in shock c. localized hyperthermia
		ex. in infection d. localized hypothermia ex. in arteriosclerosis
7. Note skin turgor (fullness or elasticity) by: Lifting and pinching the skin on an extremity	Returns back to previous state after pinching	Skin stays pinched or moves back slowly Ex. dehydration 

ASSESSMENT OF HAIR AND SCALP

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
1. Inspect hair distribution	Evenly distributed hair	Hair loss Ex. alopecia
2. inspect hair thickness and thinness	Thick hair	Very thin hair Ex. hypothyroidism
3. Inspect hair texture and oiliness	Silky, resilient hair	Brittle hair Ex. hypothyroidism Excessively oily or dry hair
4. Note presence of infestation or infections by parting the hair in several areas, checking behind the ears and along the hairline at the neck	No infection or infestation	Lesions, lice, eggs of lice, ringworm
5. Inspect amount of body hair	a. Terminal hairs (coarse and thick) Ex. in axilla, pubic areas b. Vellus hair (fine, soft, tiny) Ex. covers most part of the body except palms and soles	Abnormal hairiness Ex. hirsutism in women

ASSESSMENT OF NAILS

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
1. Inspect fingernail plate shape to determine its curvature and angle	Convex curvature; angle of nail plate about 160 degrees	Spoon nail 

	 NORMAL THUMB	Clubbing  THUMB WITH CLUBBING
2. Inspect fingernail and toenail texture	Smooth texture	Excessive thickness or thinness
		Beau's lines  
3. Inspect nail color	pink	Bluish or purplish (cyanosis) Pallor (poor circulation)
4. Inspect tissues surrounding nails	Intact skin	Presence of inflammation or infection
5. Assess capillary refill by: a. Pressing down the nails to compress capillaries b. If color goes white, release the nail	Returns to pink color within 3 seconds	Sluggish (returns to pink after more than 3 seconds)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF INTEGUMENTARY SYSTEM (SKIN, HAIR AND NAILS

NO	STEPS Required Frequency: 3	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient and provide privacy	B						
2	**Skin** a. Inspect skin color b. Inspect uniformity of skin color	A						
3	Assess edema for location, color, temperature, shape and grading	B						
4	Assess skin integrity. Inspect, palpate, and describe skin lesions (location, distribution, color, size, shape type).	B						

5	Observe and palpate skin moisture	B								
6	Palpate skin temperature	A								
7	Assess skin turgor	B								
8	**Hair and Scalp** a. Inspect hair distribution b. inspect hair thickness and thinness c. Inspect hair texture and oiliness	B								
9	Assess presence of infestation or infections	B								
10	Inspect amount of body hair	B								
11	**Nails** Inspect fingernail plate shape to determine its curvature and angle	B								
12	Inspect fingernail and toenail texture	B								
13	Inspect nail color	B								
14	Inspect tissues surrounding nails	B								
15	Assess capillary refill	B								
16	Document findings	B						Done	Repeat	

College instructor of department

Name

Signature:
Signature:

Hospital Instructor

Name:
Name:

Signature:

Head

Level of performance:
A-Ability to perform th without supervision
B- Ability to perform the under supervision
C- Ability to assist with of activity
D-Knowledge of the act observation

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

ASSESSMENT OF HEENT
(HEAD, EYES, EARS, NOSE, THROAT)

Learning Objectives:

1. Define assessment of HEENT and identify its purposes.
2. Enumerate the equipment appropriate in the assessment of HEENT
3. Identify normal from abnormal findings in HEENT
4. Learn and perform accurate assessment of HEENT

Definition:

The examination of the skull, face, eyes, ears, nose, sinuses, mouth and pharynx.

Purposes:

1. Provide comprehensive assessment data on the patient's status in relation to his/her head, eye, ears and throat.
2. Identify signs and symptoms of illness, disease or disorder of the HEENT that currently affect the patient's health.
3. To plan effective interventions to alleviate the patient's health problems.

Equipment:

Clean Gloves

Gauze square

Millimeter ruler

Penlight

Snellen or E chart

Rosembaum Chart or newspaper

Otoscope

Nasal Speculum

Tongue depressor

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ASSESSMENT OF EYES

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
External Eye		
Inspect the eyebrows for hair distribution, alignment and movement	Hair evenly distributed, eyebrows symmetrically aligned; equal movement	Loss of hair Unequal alignment and movement of eyebrows
Inspect eyelashes for evenness of distribution and direction of curl	Evenly distributed, Curled slightly outward	Turned inward
Inspect the eyelids for surface characteristics (skin quality and texture) and observe for blinking	Skin intact, no discharge, no discoloration, lids close symmetrically, bilateral blinking (Normal: 15-20 blinks per minute)	Redness, swelling, discharge, nodules, lesions Lids close asymmetrically, incompletely or painfully Rapid, absent or infrequent blinking
Inspect conjunctiva	Shiny, smooth, pink	Extremely pale (ex. anemia)

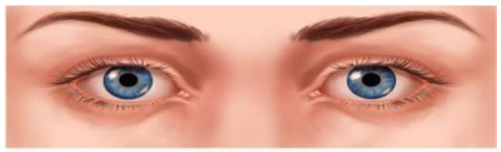
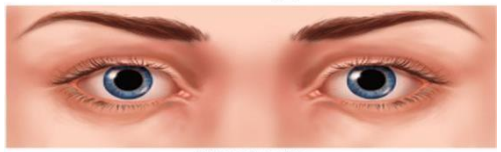
ASSESSMENT OF HEAD (SKULL AND FACE)

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
1. Inspect the skull for size, shape and symmetry	Rounded with smooth skull contour	Lack of symmetry Increased skull size (ex. hydrocephalus)
2. Palpate the skull for nodules and masses	Absence of nodules or masses	Sebaceous cyst

		Masses and nodules
3. Inspect facial features	Symmetric or slightly asymmetric facial features	Asymmetric features Exopthalmos, moon face (ex. endocrine disorder – cushing disease)
4. Inspect the eye for edema and hollowness	No edema; not sunken	Periorbital edema Sunken eyeballs
5. Note symmetry of facial movement	Symmetric facial movements	Asymmetric facial movements (ex. neurologic disorders)

		Extremely red (ex. inflammation) Nodules and lesions
5. Inspect and palpate the lacrimal glands using the tip of index finger	No edema or tenderness over lacrimal gland	Swelling or tenderness
6. Inspect and palpate the lacrimal sac and nasolacrimal duct using the tip of index finger	No edema or tearing	Evidence of increase tearing; Flow of fluid upon palpation of lacrimal sac
7. Inspect the cornea for clarity and texture	Transparent, shiny and smooth Iris are visible	Surface not smooth (ex. due to abrasion or trauma)

8. Perform corneal sensitivity test by lightly touching the cornea with a corner of gauze	Client blinks when the cornea is touched	One or both eyelids has no response
PUPILS		
1. Inspect the pupils for color, shape and symmetry of size.	Black in color, equal in size, normally 3-7 mm in diameter; found, smooth border	Cloudy (ex. cataracts) Dilated (ex. trauma, neurologic disorder, glaucoma Constricted (ex. drug use) Pinpoint (ex. opoiod intoxication)

		ABNORMAL FINDINGS AND EXAMPLES
 Normal pupils  Constricted pupils  Dilated pupils 		
2. Assess each pupil's direct and consensual reaction to light. Procedure: a. Partially darken the room. b. Ask patient to look straight ahead. c. Shine a light on the pupil using a penlight. d. Observe response to the lighted pupil.	Presence of direct response (Lighted pupils constrict) Presence of consensual response (Unlighted pupils also constricts)	No constriction of pupils Unequal responses Absent responses

		ABNORMAL FINDINGS AND EXAMPLES
e. Shine light on the pupil again and observe response on the unlighted pupil. f. Repeat procedure on the other pupil.		
3. Assess pupil's reaction to accommodation Procedure: a. Hold an object about 10 cm from the bridge of the client's nose.	Pupils constricts when looking near object Pupils dilate when looking far object	One or both pupils fails to constrict, dilate or converge
b. Ask the client to look at the object then look away from the object. c. Observe for response.	Pupils converge when object is moved towards the nose PERRLA (Pupils Equally	

		ABNORMAL FINDINGS AND EXAMPLES
d. Then move the object toward the client's nose.	Round and React to Light and Accommodation)	
VISUAL ACUITY		
1. Assess near vision either by asking a client to read a newspaper or Rosenbaum Eye Chart held at a distance of 14 inches.	Able to read	Difficulty reading
2. Assess distance vision. Procedure: a. Ask client to stand or sit at 20 feet away from a Snellen Chart. b. Cover one eye and identify the letters. c. Take three readings: Right, left and both eyes.	20/20 vision on the Snellen Chart	Denominator of 40 or more

		ABNORMAL FINDINGS AND EXAMPLES
3.Test for extraocular eye movements (To be discussed in Neurorological Assessment)		

ASSESSMENT OF EARS

ASSESSMENT	NORMAL	AND EXAMPLES
1. Inspect the auricle for color, symmetry of size and position.	Color same as the facial skin, symmetrical, aligned with outer cantus of eye	Cyanosis, pallor or excessive redness of the earlobe Asymmetry Low-set ears (ex. Down syndrome)
2. Palpate auricles for texture, elasticity and tenderness	Mobile, firm, not tender Pinna recoils after it is folded	Lesions, scaly, tenderness
3. Inspect external ear using otoscope ***Note:*** For adult, pull pinna up and back	Minimal amount of dry or slightly sticky cerumen Distal third contains hair follicles	Redness, discharge Scaling Excessive cerumen

		ABNORMAL FINDINGS AND EXAMPLES
For children below 3 years old, pull pinna down and back		
4. Inspect the tympanic membrane	Pearly gray color Semi transparent	Pink to red, yellow, white, blue
5. Test for hearing acuity: Weber Test, Rinne Test		

ASSESSMENT OF NOSE AND SINUSES

ASSESSMENT	NORMAL	
1. Inspect the external nose for shape, size, color, flaring and discharge.	Symmetric and straight No discharge or flaring Uniform color	Asymmetric Discharge from nostrils Redness or skin lesions
2. Lightly palpate the external nose	No tenderness, no lesions	Tenderness, lesions

		ABNORMAL FINDINGS AND EXAMPLES
3. Determine patency of both nasal passages. Procedure: a. Ask the client to close his mouth. b. Press one nostril and breath with the other. b. Repeat with other nostril.	Air freely moves as the client breathes through the nostrils	Air flow is restricted in one or both nostril
4. Inspect the nasal passages using a nasal speculum	Pink mucosa Clear watery discharge No lesions Nasal septum is intact and midline	Red and edematous mucosa Abnormal discharge (ex. pus) Presence of lesions (ex. polyps) Septum deviated to the right or left
5. Palpate maxillary and frontal sinuses	No tenderness	Tenderness in one or more sinuses

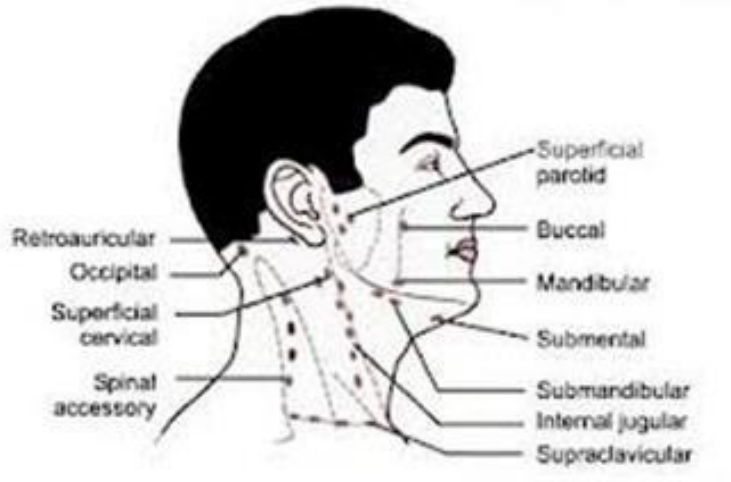
ASSESSMENT OF MOUTH AND THROAT

		ABNORMAL FINDINGS AND EXAMPLES
ASSESSMENT	**NORMAL**	
1. Inspect outer lips for symmetry, color and texture	Uniform pink color Soft, moist, smooth texture Symmetry of contour	Pallor; cyanosis Blisters, swelling, scales, lesions
2. Inspect and palpate inner lips and buccal mucosa for color, texture and lesions.	Uniform pink color Moist, smooth, soft and elastic texture	Pallor, white patches, red, bleeding Excessive dryness Cysts, ulcerations, irritations, nodules
3. Inspect teeth and gums	32 adult teeth Smooth white shiny tooth Pink gums Intact gums	Missing teeth Brown or black discoloration of tooth Excessively red gums Wounded or swelling gums
4. Inspect tongue for color, texture and position.	Pink color central position, smooth and no lesions	Smooth red tongue (ex. Vitamin B12 or B3 deficiency, iron deficiency) Not in the center (ex. neurological problem) Nodes, ulcerations, tenderness

		ABNORMAL FINDINGS AND EXAMPLES
5. Inspect tongue movement	Moves freely	Restricted movement
6. Inspect palates for color, shape and texture	Light pink for soft palate Lighter pink for hard palate	Cyanosis; pallor irritations
7. Inspect uvula	Positioned in the midline	Presence of tumor, immobility
8. Inspect oropharynx and tonsils	Pink and smooth	Red, edematous, presence of lesions, discharges Inflamed tonsils

ASSESSMENT OF NECK

ASSESSMENT	**NORMAL**	Neck swelling, mass, injury
1. Inspect neck muscles (sternocleidomastoid and trapezius)	Muscles equal in size Head at the center	
2. Observe head movement and muscle strength (To be discussed in Neurological assessment)		

		ABNORMAL FINDINGS AND EXAMPLES
3. Palpate neck for lymph nodes	Not palpable	Enlarged, palpable and tender
NECK LYMPH NODES 		
4. Palpate the trachea by placing your fingertip or thumb on the trachea in the suprasternal notch.	Midline of neck	Not midline (ex. if there is neck tumor or thyroid enlargement)
5. Inspect and palpate the thyroid gland. Procedure: a. Stand behind or in front of patient.	Not visible on inspection Smooth and painless when palpated Rise freely with swallowing	Visible enlargement Nodules

b. Place fingertips on the lower half of the neck over the trachea. c. Ask the patient to swallow and feel for the thyroid.		
		
6. If enlargement of the gland is inspected, auscultate for bruit.	Absence of bruit	Presence of bruit

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF HEAD, EYES, EARS and NECK

NO	STEPS Required Frequency: 3	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1.	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient and provide privacy	B						
2	**HEAD** Inspect skull (shape, size, symmetry)	A						
3	Palpate the skull for nodules and masses	B						
4	Inspect facial features	B						
5	Inspect the eye for edema and hollowness	B						

6	Note symmetry of facial movement	B						
7	**EYES** Inspect the eyebrows for hair distribution, alignment and movement	B						
8	Inspect eyelashes for evenness of distribution and direction of curl	B						
9	Inspect the eyelids for surface characteristics (skin quality and texture) and observe for blinking	B						
10	Inspect conjunctiva	B						
11	Inspect and palpate the lacrimal glands using the tip of index finger	B						
12	Inspect and palpate the lacrimal sac and nasolacrimal duct using the tip of index finger	B						
13	Inspect the cornea for clarity and texture	D						
14	Perform corneal sensitivity test by lightly touching the cornea with a corner of gauze	D						

15	**Pupils** Inspect the pupils for color, shape and symmetry of size.	B						
16	Assess each pupil's direct and consensual reaction to light.	B						
17	Assess pupil's reaction to accommodation	B						

18	**Visual Acuity** Assess near vision.	C						
19	Assess distance vision.	C						
20	Test for extraocular eye movements	D						
21	**EARS** Inspect the auricle for color, symmetry of size and position.	A						
22	Palpate auricles for texture, elasticity and tenderness	A						
23	Inspect external ear using otoscope	D						
24	Inspect the tympanic membrane	D						
25	Test for hearing acuity: Weber Test, Rinne Test	D						
26	**NOSE ANDS SINUSES** Inspect the external nose for shape, size, color, flaring and discharge.	A						
27	Lightly palpate the external nose	B						
28	Determine patency of both nasal passages.	B						
29	Inspect the nasal passages using a nasal speculum	D						
30	Palpate maxillary and frontal sinuses	D						

31*	**MOUTH AND OROPHARYNX** **Inspect the following:** - outer lips for symmetry, color and texture - inner lips and buccal mucosa for color, texture and lesions. - teeth and gums - color, texture and position. - tongue movement - palates for color, shape and texture - position of uvula - oropharynx and tonsils	B							
32	**NECK** Inspect neck muscles (sternocleidomastoid and trapezius)	B							
33	Observe head movement and muscle strength	B							
34	Palpate neck for lymph nodes	D							
35	Palpate the trachea by placing your fingertip or thumb on the trachea in the suprasternal notch.	D							
36	Inspect and palpate the thyroid gland.	D							
37	If enlargement of the gland is inspected, auscultate for bruit.	B							
38	Document findings ***Note:*** *Students should be able to state*	B						Done	Repeat

	abnormal findings								

Steps with stars are vital steps

College instructor

Name

Signature:

Hospital Instructor

Head of department

Name:

Name:

Signature:

Level of performance:
A
without supervision
B- Ability to perform the activity
- Ability to assist with performanc
Knowledge of the activity by obse

Signature:

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

ASSESSMENT OF THORAX AND LUNGS

Learning Objectives:

1. Define assessment of thorax and lungs and identify its purposes.
2. Enumerate the equipment appropriate in the assessment of thorax and lungs
3. Identify normal from abnormal findings in thorax and lungs
3. Learn and perform accurate assessment of thorax and lungs

Introduction

Assessing the thorax and lungs is frequently critical to assessing the client's oxygenation status. It usually involves the assessment of both posterior and anterior part of the thorax.

Definition:

It is the application of inspection, palpation, percussion and auscultation techniques in obtaining data from the structures supporting the respiratory system.

Purposes:

1. Provide a detailed assessment data on patient's respiratory system.
2. Identify signs and symptoms of illness, disease or disorder of the respiratory system.
3. To plan effective management of patient's respiratory problems.

Equipment:

Stethoscope

Skin Marker/pencil

Centimeter ruler

POSTERIOR THORAX

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
1. Inspect the shape and symmetry of the thorax from posterior and lateral view.	Anteroposterior to transverse diameter in ratio 1:2 Chest symmetric	Asymmetric Barrel chest; increased anteroposterior to transverse diameter (Ex. COPD) Funnel Chest Pegion Chest

ABNORMAL T

HORAX SHAPES

Barrel Chest

Funnel Chest

Pegion Chest

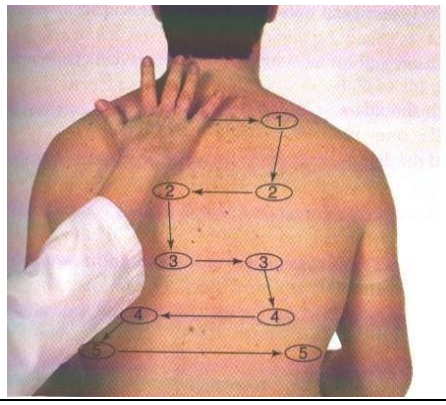
2. Inspect spinal alignment and deformities.	Spine are aligned	Exaggerated spinal curvatures Ex. Kyphosis, Scoliosis, Lordosis

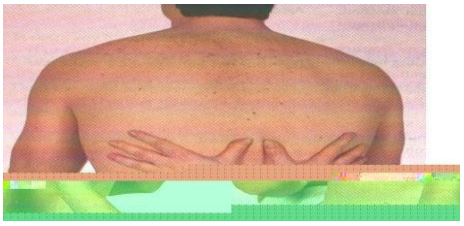
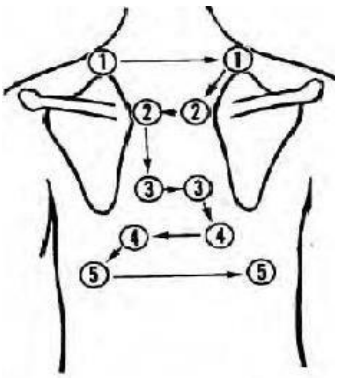
SPINAL DEFORMITIES

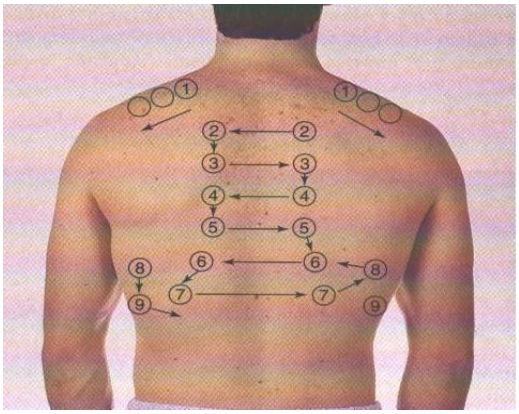
Kyphosis Scoliosis

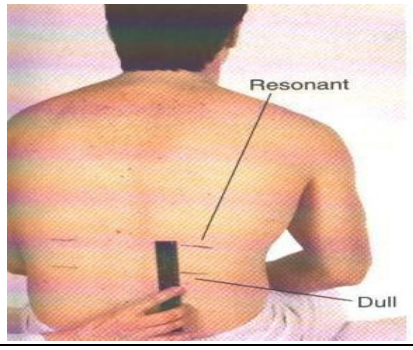
Lordosis

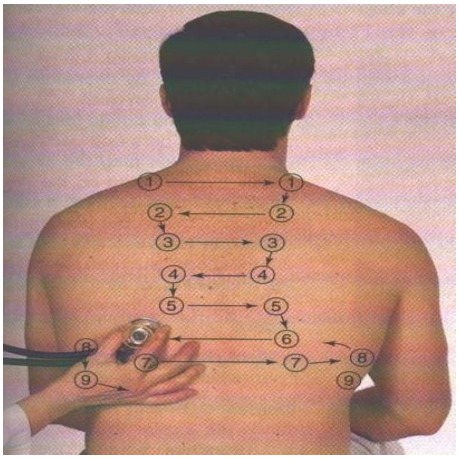
3. Inspect the posterior thorax for skin integrity	No lesion	Skin lesions

4. Palpate the posterior thorax  	Uniform skin temperature No tenderness, no masses	Lumps, tenderness, masses, depressions, displacement of bones
5. Palpate the posterior thorax for respiratory excursion Procedure: a. Place the palms of both hands over the lower thorax (T9-T10) with your thumbs adjacent to the spine and your finger stretched laterally b. Ask the client to take a deep breath while you observe the movement of your hands.	Full and equal movement of thumbs when inhaling	Unequal or/and decreased chest expansion

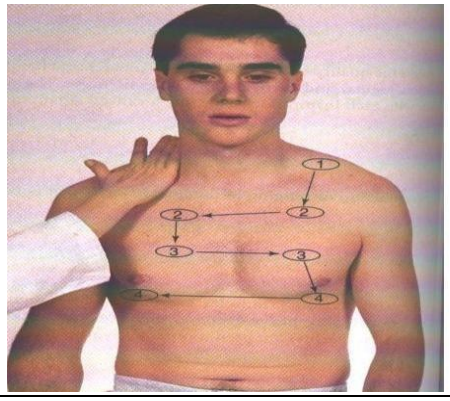
		
6. Palpate the posterior chest for tactile fremitus (vibration) Procedure: a. Place the palmar surfaces of your fingertips or the ulnar aspect of your hand on the posterior chest, starting near the apex of the lungs b. Ask the client to repeat such words as “blue moon” or “one, two, three”. c. Repeat the steps in the following sequence: 	Bilateral symmetry	Decreased or absent fremitus (ex. pneumothorax) Increased fremitus (ex. pneumonia)

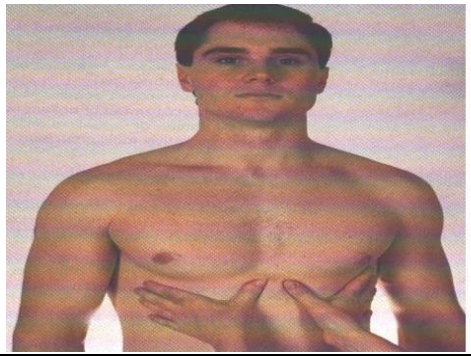
7. Percuss the thorax beginning in the apices and follow the sequence below: 	**LUNG PERCUSSION SOUNDS** ■ **<u>Resonance</u>: non-musical;** Ex. **healthy lung** ■ **<u>Hyper-resonance</u>: slightly musical; too much air, Ex. emphysema/pneumothorax** ■ **<u>Dull</u>: muffled; organ or abnormal density Ex. pneumonia** ■ **<u>Flat</u>: soft thud Ex. muscle mass, bone**

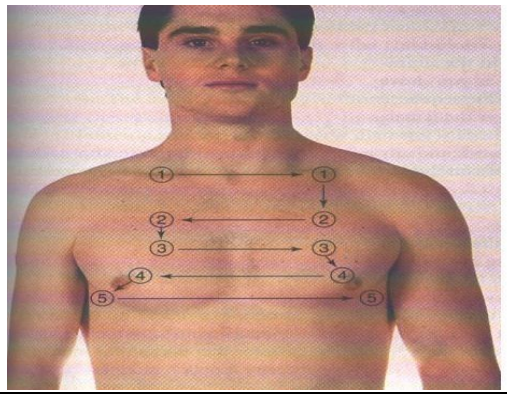
8. Percuss diaphragmatic excursion Procedure: a. Ask the client to take a deep breath and hold it while you percuss downward along the scapular line until dullness is percussed. b. Mark the point with a marking pencil. c. Repeat it on the other side of the chest d. Ask the client to exhale deeply and hold it while you percuss upward from the marked point. e. Mark the point. f. Measure the distance between the two marks. g. Repeat it on the other side.  	3-5 cm in women 5-6 cm in men Diaphragm is slightly higher on the right side	Restricted excursion (ex. lung disorder)

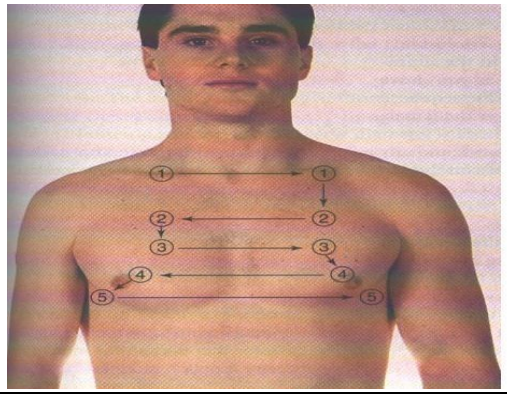
8. Auscultate the chest using the diaphragm of the stethoscope. 	■ **Bronchial** Loud, harsh sounds over trachea ■ **Bronchovesicular** Moderate, mixed sounds over bronchi ■ **Vesicular** Soft, rustling sounds over periphery	■ **Crackles** Air passing through fluid ■ **Ronchi** (Gurgles) Air passing through narrowed airways as result of secretions, tumors and swelling. ■ **Friction Rub** Rubbing together of inflamed pleural surfaces □ **Wheeze** Air passing through constricted bronchus as result of secretions, swelling, tumors

ANTERIOR THORAX

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
1. Inspect breathing patterns (e.g. respiratory rate and rhythm).	Quiet, rhythmic, and effortless respirations	Abnormal breathing patterns and sounds
2. Inspect the costal angle (angle formed by the intersection of the costal margins) and the angle at which the ribs enter the spine.	Costal angle is less than 90°, and the ribs insert into the spine at approximately a 45°angle.	Costal angle is widened (associated with chronic obstructive pulmonary disease.
2. Palpate the anterior chest 	Uniform skin temperature No tenderness, no masses	Lumps, tenderness, masses, depressions, displacement of bones
3. Palpate the anterior chest for respiratory excursion. Procedure: a. Place the palms of both of your hands on the	Full symmetric excursion, thumbs normally separate 3 to 5 cm.	Asymmetric and/ or decreased respiratory excursion.

lower thorax, with your fingers laterally along the lower rib cage and your thumbs along the costal margins. b. Ask the client to take a deep breath while you observe the movement of your hands. 		
4. Palpate tactile fremitus in the same manner as for the posterior chest and using the sequence shown. Note: If the breasts are large and cannot be retracted adequately for palpation, this part of the examination is usually omitted.	Same as posterior vocal fremitus; fremitus is normally decreased over heart and breast tissue.	Same as posterior fremitus.

5. Percuss the anterior chest systematically. Procedure: a. Begin above the clavicles in the supraclavicular space, and proceed downward to the diaphragm. b. Compare one side of the lung to the other. c. Displace female breasts for proper examination.	Percussion notes resonate down to the 6th rib at the level of the diaphragm but are flat over areas of heavy muscle and bone, dull on areas over the heart and the liver, and tympanic over the underlying stomach. .	Asymmetry in percussion notes Areas of dullness or flatness over lung tissue
		
5. Auscultate the trachea.	☐ Bronchial ☐ Tubular	☐ Ronchi
6. Auscultate the anterior chest. Use the sequence used in percussion	☐ Bronchial ☐ Bronchovesicular ☐ Vesicular	☐ Crackles ☐ Ronchi ☐ Friction Rub

		☐ Wheeze

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF THORAX AND LUNGS

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient	B						

	d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient in sitting position (for bedridden patient, elevate head of bed 45 to 90 degrees) g. Provide privacy							
2.	Ask if the client has any history of the following: a. family history of illness, including cancer, allergies, tuberculosis; b. lifestyle habits such as smoking and occupational hazards (i.e. inhalation fumes); c. medications being taken;	B						

	d. current problems (i.e. swellings, coughs, wheezing, and pain).							
3	**POSTERIOR THORAX** **Inspect:** a. shape and symmetry of the thorax from posterior and lateral view. b. spinal alignment and deformities c. skin integrity	B						

4*	**Palpate for:** a. skin temperature, tenderness, masses b. respiratory excursion - Place the palms of both hands over the lower thorax (T9-T10) with your thumbs adjacent to the spine and your finger stretched laterally - Ask the client to take a deep breath while you observe the movement of your hands. c. tactile fremitus - Place the palmar surfaces of your fingertips or the ulnar aspect of your hand on the posterior chest, starting near the apex of the lungs - Ask the client to repeat such words as “blue moon” or “one, two, three”. - Repeat the steps until the whole chest area is assessed	B						

5*	**Percuss for:** a. lung sounds b. diaphragmatic excursion - Ask the client to take a deep breath and hold it while you percuss downward along the scapular line until dullness is percussed. - Mark the point with a marking pencil. - Repeat it on the other side of the chest - Ask the client to exhale deeply and hold it while you percuss upward from the marked point. - Mark the point - Measure the distance between the two marks. g. Repeat it on the other side	D						
6*	**Auscultate** for breath sounds using the diaphragm of the stethoscope	B						
7	**<u>ANTERIOR THORAX</u>** **Inspect:** a. breathing pattern b. respiratory rate c. respiratory rhythm d. costal angle	A						

8*	**Palpate for**: a. skin temperature, tenderness, masses b. respiratory excursion - Place the palms of both of your hands on the lower thorax, with your fingers laterally along the lower rib cage and your thumbs along the costal margins. - Ask the client to take a deep breath while you observe the movement of your hands. c. tactile fremitus - Palpate tactile fremitus in the same manner as for the posterior chest	B							
9*	**Percuss** anterior thorax - Begin above the clavicles in the supraclavicular space, and proceed downward to the diaphragm. - Compare one side of the lung to the other. - Displace female breasts for proper examination.	D							
10	**Auscultate** trachea	B							
11*	**Auscultate** anterior chest for breath sounds using the same pattern with percussion.	D							
12	Document findings.	B						Done	Repeat

Steps with stars are vital steps

College instructor **Hospital Instructor**

Head of department

Name Name:

Name:

Signature: Signature:

Signature:

Level of performance:
A -Ability to perform the supervision
B- Ability to perform tl supervision
C - Ability to assist activity
D -Knowledge of tl observation

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

ASSESSMENT OF THE CARDIOVASCULAR AND PERIPHERAL VASCULAR

SYTEMS

Learning Objectives:

1. Define assessment of cardiovascular and peripheral vascular system and identify its purposes.
2. Enumerate the equipment appropriate in the assessment of cardiovascular and peripheral vascular system.
3. Identify normal from abnormal findings in heart and blood vessels
4. Learn and perform accurate assessment of cardiovascular and peripheral vascular system.

Introduction

The circulatory system comprises both the cardiovascular (heart and central vessels) and peripheral system which is primarily responsible for the distribution of blood and oxygen throughout the body.

Definition:

The process of examining the heart and assessment of central and peripheral blood vessels to determine signs of disease or disorders.

Purposes:

1. Provide baseline data about patient's health
2. Develop nursing diagnosis and care plan
3. Make clinical judgments about patient's changing health status and management

Equipment

Stethoscope

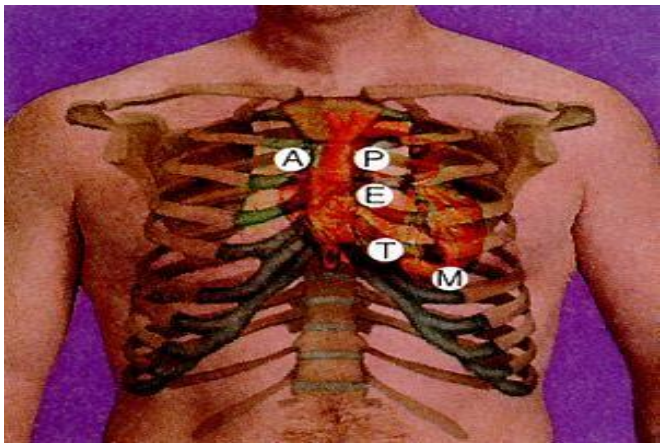
Centimeter Ruler

ASSESSMENT OF HEART AND CENTRAL VESSELS

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
HEART		
1. Simultaneously inspect and palpate the precordium for the presence of abnormal pulsation, lifts or heaves. Locate the valve areas of the heart for inspection and palpation. Procedure: a. Locate the angle of Louis, It is felt as a prominence in the sternum. b. Slip your finger down each side of angle Louis to find the aortic area in the2nd intercostals space on right side of sternum board. c. The pulmonic area in the 2nd intercostals space on the left side of sternum board. d. The second pulmonic area is found by moving down left side of sternum to the third intercostals space also referred to erb' s point. e. The tricuspid area is located at the fourth left intercostals space along the sternum.	No pulsations, lifts or heave Pulsations visible in 50% of adults and palpable in most PMI in 5th LICS at or medial midclavicular line	Presence of pulsations, lifts, heaves

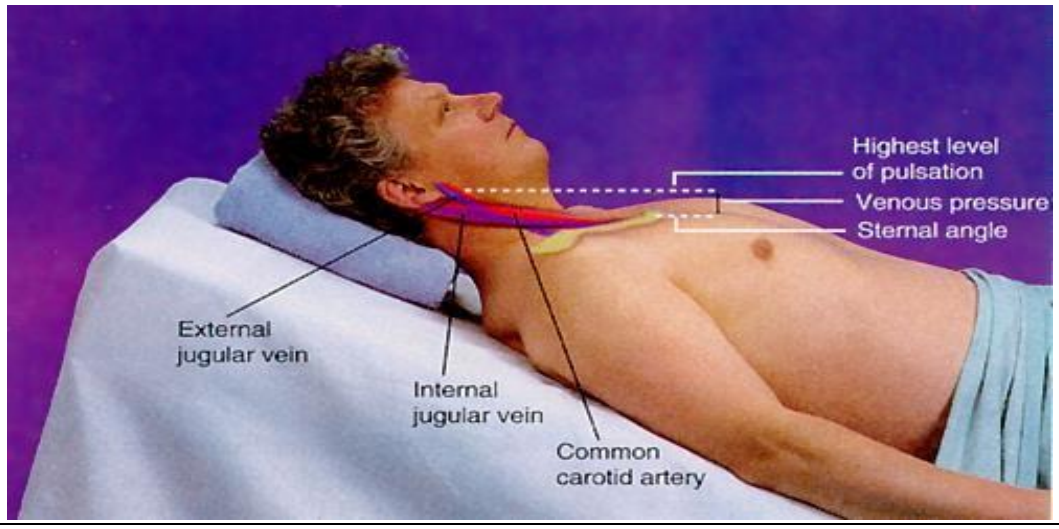
f. The mitral area is found by moving fingers laterally to client left to locate fifth intercostals space at left midclavicular line. g. The epigastria area is the inferior tip of the sternum. Note: Mitral area is also known as apical area or Point of maximal Impulse (PMI)	Aortic pulsations in the epigastric area	Bounding abdominal pulsations (ex. abdominal aneurysm)

HEART VALVE AREAS



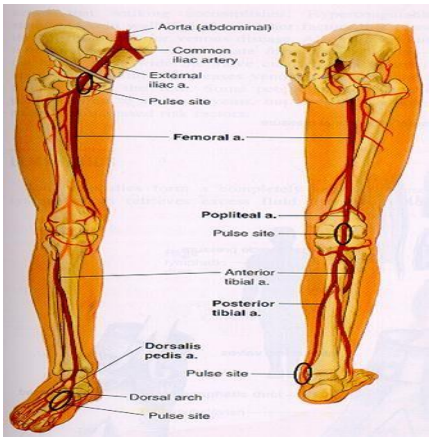
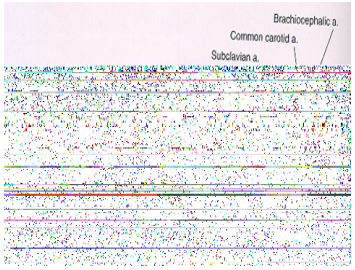
2. Auscultate the heart in all four anatomic sites: aortic, pulmonic, tricuspid and mitral. Procedure: a. Eliminate all sources of room noise. b. Keep the client in supine position with head elevated to 30 to 45 degrees c. Use both diaphragm to listen to all areas d. In every area of auscultation, distinguish both s1 and s2 sounds e. Later, re-examine the heart while client is in the upright sitting position.	S1 usually heard at all sites and louder in apical area S2 usually heard at all sites and louder at the base of the heart S3 in children and young adults S4 in many older adults	Increased or decreased intensity Varying intensity with different beats S3 in older adults S4 maybe a sign of hypertension

CAROTID ARTERIES		
3. Palpate the carotid artery using extreme caution. Procedure: a. Palpate one carotid artery at a time. b. Ask the client to turn the head slightly toward the side being examined for more access.	Symmetric pulse volumes Full pulsations, thrusting quality Quality of pulse remains even when client shifts head and position	Asymmetric volumes (possible thrombosis) Decreased pulsation (may indicate impaired left cardiac output) Increased pulsations
4. Auscultate the carotid artery.	No sound heard on auscultation	Presence of bruit on one or both arteries
Procedure: a. Turn the client's head slightly away from the side being examined for proper placement of stethoscope. b. Ausculate the carotid artery on one side and then the other using the bell of the stethoscope. c. Listen for the presence of bruit. If you hear a bruit, gently palpate the artery to determine the presence of a thrill.		(possibly due to occlusive artery disease.
JUGULAR VEINS		
5. Inspect the jugular veins for distension while the patient is placed in semi-fowler's position with a head supported in a pillow.	Veins not visible	Veins visibly distended (ex. may indicate advance cardiopulmonary disease)

6. If jugular distension is present, assess the jugular vein pressure (JVP). Procedure: a. Locate the highest visible point of distension of the internal jugular vein. b. Measure the vertical height of this point in centimetres from the sterna angle. c. Repeat the steps on the other side.		Bilateral measurements above 3 to4 cm are considered elevated (ex. may indicate right-sided heart failure) Unilateral distension (ex. in local obstruction)
		

ASSESSMENT OF PERIPHERAL VASCULAR SYSTEM

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
Peripheral Pulses		

1. Palpate peripheral pulses on both sides of client's body individually and simultaneously (except for the carotid pulse) for symmetry of pulse volume.	Symmetric pulse volumes Full pulsations	Unequal pulse volumes (ex. poor circulation) Absence of pulsation (ex. in arterial spasm or occlusion) Increased, weak, thread pulse
PULSE SITES   		
Peripheral Veins		
2. Inspect peripheral veins in the arms and legs for appearance of superficial veins when limbs are dependent and when elevated.	In dependent position, presence of destention and nodular bulges at calves When limbs elevated, veins collapse	Distended veins in the thigh or lower leg Ex. Varicose veins

3. Assess peripheral leg veins for signs of phlebitis Procedure: a. Inspect the calves for redness or swelling over vein sites. b. Palpate calves for firmness or tension of the muscles and presence of edema over the dosrsum of foot, and areas of localized warmth c. Push the calves from side to side to test for tenderness d. Test for Homan's Sign. Firmly dorsiflex the client's foot while supporting the leg in extension	Limbs not tender Symmetric in size	Tenderness on palpation Positive Homan's Sign (pain in calf muscles with forceful dorsiflexion of the foot Warmth or redness over vein Swelling of one calf or leg Ex. Deep Vein Thrombosis
Peripheral Perfusion		

4. Inspect the skin of the hands, and feet for color, temperature, edema and skin changes	Skin color pink Skin not excessively warm or cold No edema Skin texture resilient and moist	Cyanotic Pallor that increases with limb elevation Redness when limb is lowered Brown pigmentation around ankles mild edema Severe edema Skin thin, shiny, cool with reduced hair Ulcerations Ex. Reynaud's Disease, Burger's disease
5. Asses adequacy of arterial flow if arterial problem is suspected. **Buerger's Test**	Original color returns in	Delayed color return

Procedure: 1. Assist the client to a supine position. Ask the client to raise one leg or one arm about 30 cm (1 foot above the heart level). 2. Move the foot or hand briskly for up and down for about 1 minute. 3. Sit up and dangle the leg or arm. 4. Observe the time of return of original color and vein filling. **Capillary Refill Test**	10 seconds (arms/leags) 15 seconds (hands/feet) Returns to pink color within 3 seconds	Delayed color return

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF CARDIOVASCULAR SYSTEM (HEART AND CENTRAL VESSELS)

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient g. Provide privacy	A						

2	Inquire if the client has any history of the following: -family history of heart disease, high cholesterol level, hypertension, obesity, congenital heart failure -past history of heart diseases or any signs and symptoms fatigue, edema, cough, chest pain palpitation, high blood pressure -lifestyle habits such as smoking, alcohol intake, cause of severe stress, exercise and eating patterns	B						

3*	**HEART** a. Simultaneously inspect and palpate the precordium for the presence of abnormal pulsation, lifts or heaves. Locate the valve areas of the heart for inspection and palpation - Locate the angle of Louis, It is felt as a prominence in the sternum. - Slip your finger down each side of angle Louis to find the aortic area in the 2nd intercostals space on right side of sternum board - The pulmonic area in the 2nd intercostals space on the left side of sternum board - The second pulmonic area is found by moving down left side of sternum to the 3rd intercostals space also referred to erb, s point	D						

	- The tricuspid area is located at the 4th left intercostals space along the sternum - The mitral area is found by moving fingers laterally to client left to locate 5th intercostals space at left midclavicular line. - The epigastria area is the inferior tip of the sternum							

4*	**Auscultate** the heart in all four anatomic sites: aortic, pulmonic, tricuspid and mitral. - Eliminate all sources of room noise. - Keep the client in supine position with head elevated to 30 to 45 degrees - Use both diaphragm to listen to all areas - In every area of auscultation, distinguish both s1 and s2 sounds -Later, re-examine the heart while client is in the upright sitting position,	D						
5	**<u>CAROTID ARTERIES</u>** **Palpate** the carotid artery using extreme caution. - Palpate one carotid artery at a time. - Ask the client to turn the head slightly toward the side being examined for more access.	C						

6*	**Auscultate** the carotid artery. -Turn the client's head slightly away from the side being examined for proper placement of stethoscope. - Ausculate the carotid artery on one side and then the other using the bell of the stethoscope. -Listen for the presence of bruit. If you hear a bruit, gently palpate the artery to determine the presence of a thrill.	C						
7	**JUGULAR VEIN DISTENTION** **Inspect** the jugular veins for distention while the patient is placed in semifowler's position with a head supported in a pillow.	B						

Steps with stars are vital steps

College instructor **Hospital Instructor**

Head of department

Name Name:

Name:

Signature: Signature:

Signature:

Level of performance:
A perform the activity witl B- Ability to perform th supervision

Rating
5=Excellent 4=Very Good 3=Good 2=Unsatisfactory

8	If jugular distension is present, assess the jugular vein pressure (JVP). - Locate the highest visible point of distension of the internal jugular vein. - Measure the vertical height of this point in centimetres from the sterna angle. - Repeat the steps on the other side.	C							
9	Document findings	B						Done	Repeat

C - Ability to assist with performance of activity

D -Knowledge of the activity by observation

I-Failed

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF PERIPHERAL VASCULAR SYSTEM

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient in sitting position (for bedridden patient, elevate head of bed 45 to 90 degrees) g. Provide privacy	A						

2	Inquire if the client has any history of the following: - Past history of heart disorder, varicosities, arterial disease, hypertension - lifestyle habits such as exercise, patterns, activity patterns and tolerance, smoking, use of alcohol	B						
3	**PERIPHERAL PULSES** Palpate peripheral pulses on both sides of client's body individually and simultaneously (except for the carotid pulse) for symmetry of pulse volume.	B						
4	**PERIPHERAL VEINS** Inspect peripheral veins in the arms and legs for appearance of superficial veins when limbs are dependent and when elevated.	B						

5*	Assess peripheral leg veins for signs of phlebitis - Inspect the calves for redness or swelling over vein sites. - Palpate calves for firmness or tension of the muscles and presence of edema over the dosrsum of foot, and areas of localized warmth - Push the calves from side to side to test for tenderness - Test for Homan's Sign. Firmly dorsiflex the client's foot while supporting the leg in extension	B						
6	**PERIPHERAL PERFUSION** **Inspect** the skin of the hands, and feet for color, temperature, edema and skin changes	A						

7*	Assess adequacy of arterial flow if arterial problem is suspected. **Buerger's Test** - Assist the client to a supine position. Ask the client to raise one leg or one arm about 30 cm (1 foot above the heart level). -Move the foot or hand briskly for up and down for about 1 minute. - Sit up and dangle the leag or arm. - Observe the time of return of original color and vein filling. **Capillary Refill Test**	C							
8	Document findings	B						Done	Repeat

Steps with stars are vital steps

College instructor of department
Name
Name: Signature:
Signature:

Hospital Instructor
Name:
Signature:

Head

Level of performance:	Rating
A-Ability to perform the activity without supervision B - Ability to perform the activity under supervision C - Ability to assist with performance of activity D-Knowledge of the activity by observation	5=Excellent 4=Very Good 3=Good 2=Unsatisfactory 1=Failed

ASSESSMENT OF THE ABDOMEN

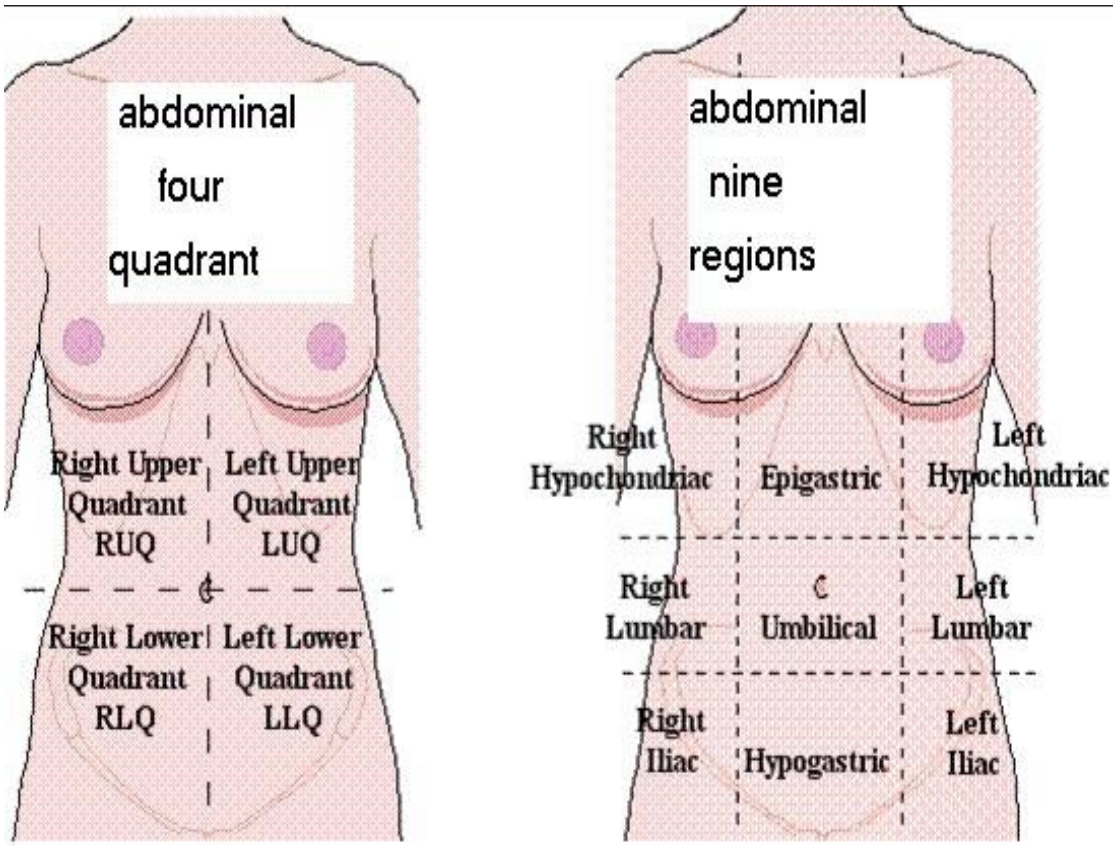
Learning Objectives:

1. Define assessment of abdomen and identify its purposes.
2. Enumerate the equipment appropriate in the assessment of Abdomen
3. Identify normal from abnormal findings in abdomen

3. Learn and perform accurate assessment of abdomen

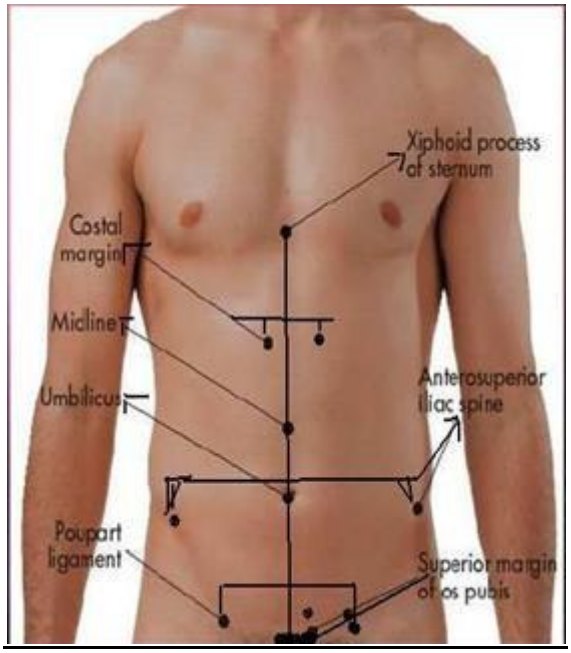
Introduction

Prior to the assessment, one should be able to identify the **abdominal landmarks.**



The **Landmarks** are commonly used to identify abdominal areas :

1. Xiphoid process
2. Costal margin
3. Midline
4. Anterior-superior iliac spine
5. Inguinal (poupart's) ligaments
6. Superior margin of pubic bone



Definition:

The clinical evaluation of the abdominal cavity and its organs to identify abnormalities.

Purposes:

1. To locate and describe abdominal findings 2. To develop nursing diagnosis and care plan.
3. To detect any abnormalities.

Equipment:

Stethoscope
Examining Light
Tape measure
Water-soluble skin marking pen
Gloves
Gauze pad
Lubricant ge

ASSESSMENT OF THE ABDOMEN

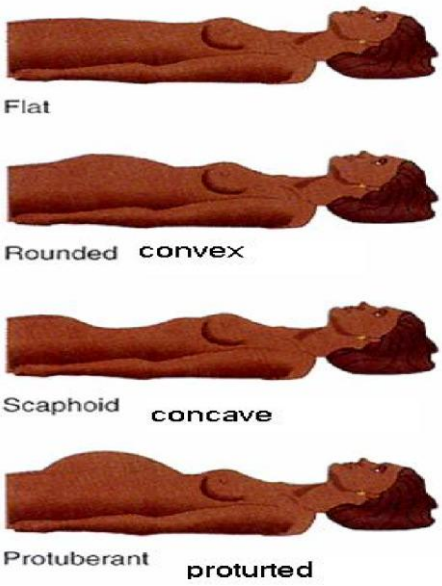
1. Inspection
2. Auscultation
3. Percussion
4. Palpation

Preparation:

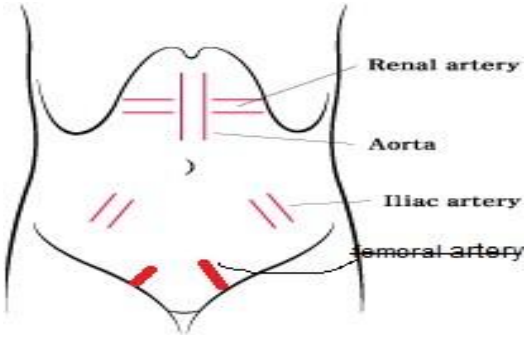
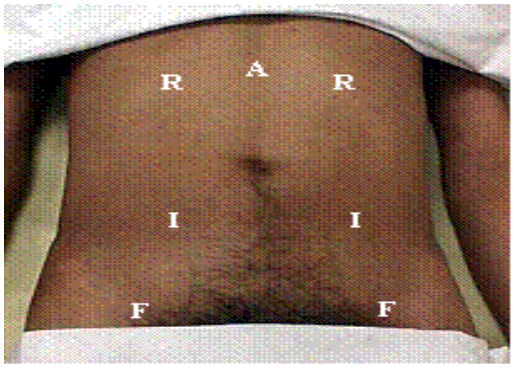
A. Have patient empty bladder
B. Have patient lie supine with hips and knees flexed
C. Drape for privacy
D. Tell patient what you will do before you do it
E. Have warm room and warm hands.
F. Have good light source
G. Examine identified painful areas last.

ASSESSMENT	**NORMAL**	**ABNORMAL FINDINGS AND EXAMPLES**
1. Inspect the abdomen for: a. Color, scars, rashes, lesions, silvery white striate and artificial opening	Unblemished skin Flat, rounded (convex) or scaphoid(concave)	Rash or lesion or surgical scares, striae, distended, or enlargement.

b. Contour of abdomen, symmetry, shape c. Location and shape of umbilicus	

	
2. If the abdomen appears distended, note if distension is generalized. Look at the flanks on each side. If distension is suspected, measure size of abdominal girth by placing tape measure around abdomen at level of umbilicus. Use the marking pen to indicate where the tap measure	

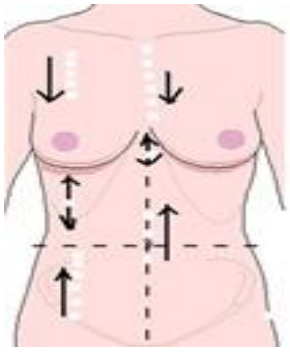
2. Auscultate for normal bowel sounds, vascular sounds and peritoneal friction rubs. **Note:** Auscultation is performed before percussion or palpation (**Rationale:** palpation and percussion cause movement or stimulation of the bowel , which can increase bowel motility and bowel sound and creating false results) **Bowel sounds** : Normal sounds are due to peristaltic activity. (Use the diaphragm of stethoscope in each of the four quadrants over all of the auscultatory sites of the abdomen) **Vascular sounds (bruits)** **Bruits**: an abnormal blowing sound or murmur resulting from blood flowing through narrow or	Normal bowel sound of 5-30 p/m	Bowel sound: Absent: **no BS for 5 min**

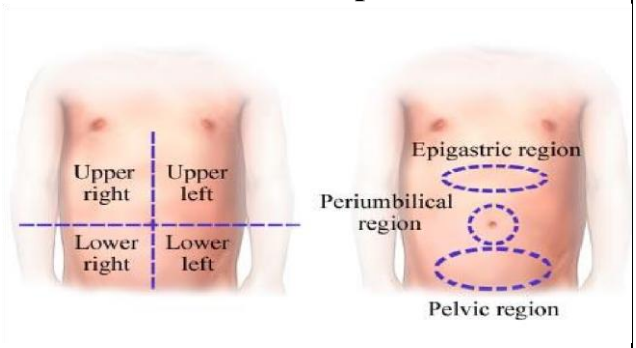
partial obstructed artery (Use the bell of stethoscope over the aorta, renal arteries, iliac arteries and femoral arteries and listen for bruits) Areas of auscultation of bruits   A--- Aorta R--- Renal artery (right & left) I---Iliac artery F--- Femoral artery **Peritoneal Friction Rubs:** Rough, grating (harsh) sounds like two pieces of leather rubbing together) *Liver—place bell of stethoscope over lower right rib cage	Absence of arterial bruits Absence friction rub	-Hypoactive: **less than 5/min** - Hyperactive:> **30 /min** Loud bruit over aortic area Bruit over renal or iliac arteries

		Present in peritoneal inflammation

3. Percuss several areas in each of the four quadrants. **Note:** Use a systemic pattern: Begin in LRQ, URQ, ULQ, then LLQ. 	**Resonance:** heard over lung tissue **Tympany**: heard over most portions of the abdominal cavity **Dullness:** heard over solid organs (liver) and muscles	Large dull areas (associated to presence of fluid and tumor)
4. Percuss the liver to determine its size. Procedure: 1. Begin in the right midclavicular line below the level of umbilicus. 2. Percuss upward over the tympanic areas until dull sound indicates the lower border of liver. 3. Mark with skin marker 4. Then percuss downward at right midclavicular line. 5. Begin from lung resonance area until dullness is heard over the upper	6 to 12 cm in the midclavicular line 4-8 cm at the midsternal line	Enlarged size (associated with liver disease)

border of the liver at 4th or 7th ICS. Mark this site. 6. Measure the distance between the two marks. 7. Repeat steps 1 to 3 at midsternal line.		



4. Palpate four quadrants superficially from LLQ counter clockwise. **Areas of Palpation**  A. Perform **Light Palpation**: a. First warm your hands by rubbing them together before placing them on the patient. b. Abdominal wall depressed approximately 1 cm c. Use pads of three fingers of one hand and a light, gentle, dipping maneuver to examine abdomen **B. Perform Deep Palpation:** a. Use palmar surface of fingers of one hand (greatest number of fingers) and a deep, firm, gentle maneuver to examine abdomen b. Depress the abdominal wall about 4-5cm	No tenderness, relaxed abdomen with smooth, consistent tension	Tenderness and hypersensitivity Superficial masses Localized areas of increased tension For rebound tenderness: Pain at the release of pressure (Can indicate

 c. Or use the bimanual palpation for liver and other organs. d. Check for rebound tenderness in areas where client complains of pain. With one hand, press slowly and deeply over the area indicated and lift the hand quickly.		peritoneal inflammation)
5. Palpate the bladder by palpating the area above the symphysis pubis Procedure: a. Palpate for a smooth, rounded mass, while applying light pressure, ask if the client has sensation of need to void	Not palpable	Distended and palpable as smooth, round, tense mass (indicates urinary retention).

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF ABDOMEN

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: A. Have patient empty bladder B. Have patient lie supine with hips and knees flexed C. Drape for privacy D. Tell patient what you will do before you do it E Have warm room and warm hands. F. Have good light source G. Examine identified painful areas last.	A						
2	Inspect the abdomen for: a. Color, scars, rashes, lesions, silvery white striate and artificial opening	B						

	b. Contour of abdomen, symmetry, shape c. Location and shape of umbilicus							
3	If the abdomen appears distended, note if distension is generalized. Look at the flanks on each side. If distension is suspected, measure size of abdominal girth by placing tape measure around abdomen at level of umbilicus. Use the marking pen to indicate where the tap measure	B						

4*	Auscultate for normal bowel sounds, vascular sounds and peritoneal friction rubs. a. Use the diaphragm of stethoscope in each of the four quadrants over all of the auscultatory sites of the abdomen to hear bowel sounds b. Use the bell of stethoscope over the aorta,	B						

	renal arteries, iliac arteries and femoral arteries and listen for bruits							
5*	Percuss several areas in each of the four quadrants. **Note:** Use a systemic pattern: Begin in LRQ, URQ, ULQ, then LLQ.	B						
6*	Percuss the liver to determine its size. Procedure: 1. Begin in the right midclavicular line below the level of umbilicus. 2. Percuss upward over the tympanic areas until dull sound indicates the lower border of liver. 3. Mark with skin marker 4. Then percuss downward at right midclavicular line. 5. Begin from lung resonance area until dullness is heard over the upper border of	B						

	the liver at 4th or 7th ICS. Mark this site. 6. Measure the distance between the two marks. 7. Repeat steps 1 to 3 at midsternal line.							

7*	Palpate four quadrants superficially from LLQ counter clockwise. A. Perform **Light Palpation**: a. First warm your hands by rubbing them together before placing them on the patient. b. Abdominal wall depressed approximately 1 cm c. Use pads of three fingers of one hand and a light, gentle, dipping maneuver to examine abdomen B. Perform **Deep Palpation**: a. Use palmar surface of fingers of one hand (greatest number of fingers) and a deep, firm, gentle maneuver to examine abdomen b. Depress the abdominal wall about 4- 5cm c. Or use the bimanual palpation for liver and other organs. d. Check for rebound tenderness in areas where client complains of pain. With one hand, press slowly and	B						

	deeply over the area indicated and lift the hand quickly.								
8	Palpate the bladder by palpating the area above the symphysis pubis -Palpate for a smooth, rounded mass, while applying light pressure, ask if the client has sensation of need to void.	B							
9	Document findings.	B						Done	Repeat

Steps with stars are vital steps

College instructor **Hospital Instructor** **Head of department**

Name Name: Name:

Level of performance:

A-Ability to perform the activity without supervision

B- Ability to perform the activity under supervision

C - Ability to assist with performance of activity

D-Knowledge of the activity by observation

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

Signature: Signature:

Signature:

ASSESSMENT OF MUSCULO-SKELETAL

Learning Objectives:

1. Define assessment of musculo-skeletal and identify its purposes.
2. Enumerate the equipment appropriate in the assessment of bones, muscles, joint and tendons.
3. Identify normal from abnormal findings in the musculo-skeletal

3. Learn and perform accurate assessment of the musculo-skeletal

Introduction

The musculoskeletal encompasses the muscles, bones, and joints. The completeness of an assessment of this system depends on the needs and problems of the individual client. The nurse usually assesses the musculoskeletal system for muscle strength, tone, size, and symmetry of muscle development, and for tremors.

Bones are assessed for normal form. Joints are assessed for tenderness, swelling, thickening, crepitation, presence of nodules, and range of motion.

Definition:

The assessment of extremities for bones, muscles, tendon and joint. It is the process by which a health care provider examine the extremities and peripheral circulation for signs of disease.

Purposes:

1. To collect objective data from the client
2. To early detect the abnormalities using systematic technique
3. To diagnose diseases
4. To determine the status of present health in health check-up and refer the client for consultation if needed

Equipment:

Goniometer

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
MUSCLES		
1. Inspect the muscles for size. Compare the muscles on one side of the body (i.e. of the arm, thigh, and calf) to the same muscle on the other side. For any discrepancies, measure the muscle with a tape measure.	Equal size on both sides of body	Atrophy (a decrease in size), or hypertrophy (an increase in size), asymmetry
2. Inspect the muscles and tendons for contractures (shortening).	No contractures	Malposition of body part, e.g. foot drop (foot flexed downward)
3. Inspect the muscles for tremors, for example by having the client hold the arms in front of the body.	No tremors	Presence of tremor
4. Palpate muscles at rest to determine muscle tonicity (the normal condition of tension, or tone, of a muscle at rest).	Normally firm	Atonic (Lacking tone)
5. Palpate muscles while the client is active and passive for flaccidity, spasticity, and smoothness of movement.	Smooth coordinated movements	Flaccidity (weakness or laxness) or spaticity (sudden involuntary

		muscle contraction)
6. Test muscles strength. Compare the right side with the left side **Sternocleidomastoid:** Client turns the head to one side against the resistance of your hand. Repeat with the other side. **Trapezius:** Client shrugs the shoulders against the resistance of your hands. **Deltoid:** Client holds arm up and resist while	Equal strength on each body side.	25% or less of normal strength Grading Muscle Strength 0: 0% of normal strength; complete paralysis 1: 10% of normal strength; no movement,

you try to push it down. **Biceps:** Client fully extends each arm and then tries to extend it against your attempt to keep arm in flexion. **Triceps:** Client flexes each arm and then tries to extend it against your attempt to keep arm in flexion. **Wrist and finger muscles:** Client spreads the fingers and resist as you attempt to push the finger together. **Grip Strength:** Client grasps your index and middle fingers while you try to pull the fingers out. **Hip muscles:** Client is supine, both legs extended; client raises one leg at a time while you attempt to hold it down. **Hip abduction:** Client is supine, both legs extended. Place your hands on the lateral surface of each knee; client spreads the legs apart against your resistance.		contraction of muscle is palpable or visible 2: 25% of normal strength; full muscle movement against gravity, with support 3: 50% of normal strength, normal movement against gravity 4: 75% of normal strength; normal full movement against gravity and against minimal resistance 5: 100% of normal strength; normal full movement against gravity and against full resistance

Hip adduction: Client is in same position as for hip abduction. Place your hands between the knees; client brings the legs together against your resistance. **Hamstrings:** Client is supine, both knees bent. Client resists while you attempt to straighten the legs.		

Quadriceps: Clients is supine; knee partially extended; client resists while you attempt to flex the knee. **Muscle of the ankles and feet:** Client resists while you attempt to dorsiflex the foot and again resist while you attempt to flex the foot.		
BONES		
11. Inspect the skeleton for structure.	No deformities	Bones misaligned
12. Palpate the bones to locate any areas of edema or tenderness.	No tenderness or swelling	Presence of tenderness or swelling (may indicate fracture, neoplasms, or osteoporosis)
JOINTS		
13. Inspect the joint for swelling. Palpate each joint for tenderness, smoothness of movement, swelling, crepitation, and presence of nodules.	No swelling No tenderness, swelling, crepitation, or nodules Joints move smoothly	One or more swollen joints Presence of tenderness, swelling, crepitation, or nodules
14. Assess joint range of motion. Ask the client to move selected body parts. The amount of joint movement can be measured by a goniometer, a device that measures the angle of the joint in degrees.	Varies to some degree in accordance with person's genetic makeup and degree of physical activiity	Limited range of motqion in one or more joints

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF MUSCULO-SKELETAL

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient g. Provide privacy	A						

2.	Inquire if the client has any history of the following: - presence of muscle pain: onset; location; character, redness and swelling of joints - limitations to movement or inability to perform activities of daily living, previous sports injuries, loss of function without pain.	A						
3	**<u>MUSCLES</u>** **Inspect:** a. muscles for size. Compare the muscles on one side of the body to the same muscle on the other side. -For any discrepancies, measure the muscle with a tape measure.	B						

	b. muscles and tendons for contractures (shortening). c. muscles for tremors by having the client hold the arms in front of the body							

4	**Palpate:** a. muscles at rest to determine muscle tonicity (the normal condition of tension, or tone, of a muscle at rest). b. muscles while the client is active and passive for flaccidity, spasticity, and smoothness of movement.	C						
8	Test muscles strength. Compare the right side with the left side **Sternocleidomastoid:** Client turns the head to one side against the resistance of your	B						

	hand. Repeat with the other side.							
9	**Trapezius:** Client shrugs the shoulders against the resistance of your hands.	B						
10	**Deltoid:** Client holds arm up and resist while you try to push it down.	B						
11	**Biceps:** Client fully extends each arm and then tries to extend it against your attempt to keep arm in flexion.	B						
12	**Triceps:** Client flexes each arm and then tries to extend it against your attempt to keep arm in flexion.	B						
13	**Wrist and finger muscles:** Client spreads the fingers and resist as you attempt to push the finger together.	B						
14	**Grip Strength:** Client grasps your index and middle fingers while you try to pull the fingers out.	B						
15	**Hip muscles:** Client is supine, both legs extended; client raises one leg at a time while you attempt to hold it down.	B						
16	**Hip abduction:** Client is supine, both legs extended. Place your hands on the lateral surface of each knee; client spreads the legs apart against your resistance.	B						

17	**Hip adduction:** Client is in same position as for hip abduction. Place your hands between the knees; client brings the legs together against your resistance.	B						
18	**Hamstrings:** Client is supine, both knees bent. Client resists while you attempt to straighten the legs.	B						
19	**Quadriceps:** Clients is supine; knee partially extended; client resists while you attempt to flex the knee.	B						
20	**Muscle of the ankles and feet:** Client resists while you attempt to dorsiflex the foot and again resist while you attempt to flex the foot.	B						
21	**BONES** **Inspect** the skeleton for structure.	A						
22	**Palpate** the bones to locate any areas of edema or tenderness.	B						
23	**JOINTS** -**Inspect** the joint for swelling. -**Palpate** each joint for tenderness, smoothness of movement, swelling, crepitation, and presence of nodules.	B						
24	Assess joint range of motion. Ask the client to move selected body parts.	C						

25	Document findings.	B						Done	Repeat

Step with stars are vital steps

College instructor **Hospital Instructor**

Head of department

Name Name:

Name:

Signature: Signature:

Signature:

Level of performance:
A
-Ability to perform the supervision
B- Ability to perform tl supervision
C - Ability to assist activity
D -Knowledge of tl observation

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

ASSESSMENT OF THE NEUROLOGICAL SYSTEM

Learning Objectives:

1. To learn a basics of Nervous System Examination
2. To differentiate between “normal” and “abnormal” findings on Nervous System
3. To apply findings to common clinical presentations
4. To document findings in a structured, systematic way

Definition:

Neurological assessment is the examination of the function of neurological system. A neurological examination is an essential component of a comprehensive physical examination. It is a systematic examination that surveys the functioning of nerves delivering sensory information to the brain and caring motor commands (Peripheral nervous system) and impulses back to the brain for processing and coordinating (Central nervous system).

Purposes:

1. Detect any neurological abnormalities
2. Identify common causes of cranial nerve palsies
3. Determine the cause of impairment

Equipment

Sugar, salt, lemon juice

Reflex hammer

Tongue depressors (one broken diagonally for testing pain sensation)

Wisps of cotton

Pins or needles

Penlight

Vision Screeners

MENTAL STATUS

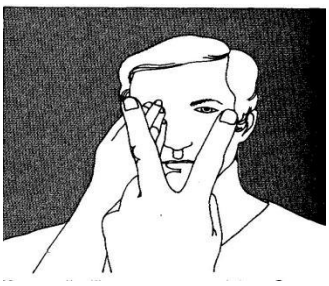
ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
Level of Consciousness		
1. Assess orientation by asking about: a) name, location, day of week and year, b) note behavior and appearance	Able to state correct information Appropriate behaviour and appearance	Unable to state correct information
2. Apply the Glasgow Coma Scale through assessing the eye response, motor response and verbal response	15 points – indicates that patient is alert and completely oriented	7 or less – comatose

GLASGOW COMA SCALE

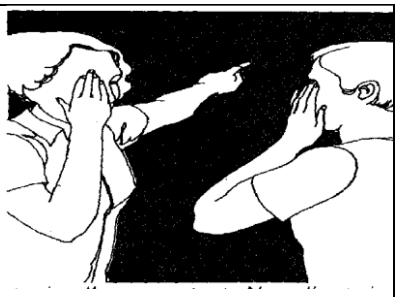
Eye Opening Response	Spontaneous	4 points
	to verbal command	3 points
	to pain	2 points
	None	1 point
Verbal Response	Oriented	5 points
	Disoriented	4 points
	Uses Inappropriate words,	3 points
	Incomprehensible speech	2 points
	None	1 point

Motor Response	To verbal command	6 points
	To localized pain	5 points
	Flexes and Withdraws	4 points
	Flexes Abnormal	3 points
	Extends abnormalities	2 points
	None	1 point

CRANIAL NERVES

ASSESSMENT	
First Cranial Nerve (Olfactory) a) Ask the patient to close eyes, block nostril of one side to test each nostril separately. b) Ask the patient to identify the smell, e.g. coffee, lemon or an apple . c) Make sure to use different smell object for each nostril.	
Second Cranial Nerve (Optic): A) <u>Tests of visual acuity.</u> a) Ask patient to cover right eye and tell you how many fingers you are holding up (hold up any number of fingers, perhaps two). b) Uncover patient right eye and cover left eye. c) Again ask patient to tell you how many fingers you are holding up. (hold up a different number of fingers, perhaps	

B) Test of visual field:



a) Be sure you are at eye level with your patient and facing him directly .

b) Cover your own eye opposite the eye your patient is covering – for example cover your left eye when the patient is covering his right.

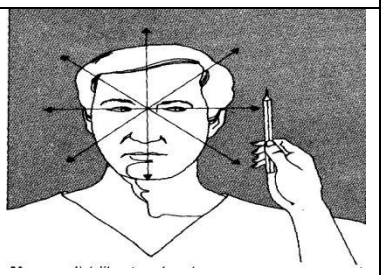
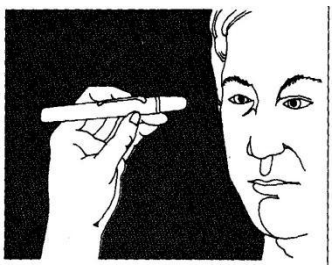
c) Instruct patient to look straight at you.

d) Hold your finger out to the side at arm's length, then slowly bring it toward you and have your patient say when he sees it. e) To test the whole visual field, imagine it's a clock face and test it from the six even numbered positions.

f) Make sure that your pointed finger is equidistant between you and the patient.

g) Repeat the test for the other eye, then for both eyes – Note that a normal person, even when looking straight a head, can detect a moving object almost 90 degrees to the side.

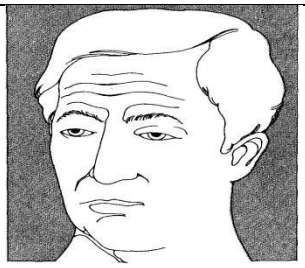
h) If you find a defect in either of the patient's visual fields, for

example, hemianopia (loss of half of visual field) do more than just record it in your assessment notes. Alert the other nurses as well. Special measures should be taken to ensure patient's safety	
CN III (oculomotor), IV (Trochlear), VI (Abducens) <u>A. Extraocular movement (EOM) functioning.</u> a) While the patient watches with both eyes, b) Hold a small object in front of him. c) Now move it as far as you can up, down, sideways and diagonally, always returning to the central point after each movement. d) Be sure your patient keeps his head still and follows the movement with his eyes only e) As he does so check that both eyes move together and follow the pencil in all directions.	
<u>B. Test for pupil's direct and consensual reaction to light (CNIII)</u> a) Partially darken the room. b) Ask patient to look straight ahead. c) Shine a light on the pupil using a penlight. d) Observe response to the lighted pupil. e) Shine light on the pupil again and observe response on the unlighted pupil. f) Repeat procedure on the other pupil.	

C. Test for pupil's reaction to accommodation (CNIII) a) Hold an object about 10 cm from the bridge of the client's nose. b) Ask the client to look at the object then look away from the object. c) Observe for response. d) Then move the object toward the client's nose.	
CN V (trigeminal) **A. Motor function test:** The trigeminal nerve controls the muscles of mastication and the opening and closing of the	
jaws a) Feel the masseter muscles during jaw clench. b) Test for a jaw jerk reflex by gently tapping on the jaw with the mouth slightly open. **B. Sensory function test:** a) Have the patient close his eyes, then lightly touch a piece of cotton to different parts of his face (forehead, cheek chin). b) Have him tell you when and where he feels the sensation	

CN VII facial

A. Inspect facial symmetry



B. **Motor Function Test:** This test indicates the strength of the eye muscles

a) Ask client to frown, smile, puff out cheeks and raise eye brows

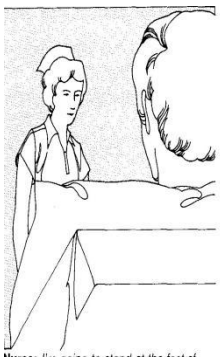
b) Ask patient to close his eyes tightly so that you cannot open them.

C. **Sensory Function Test:**

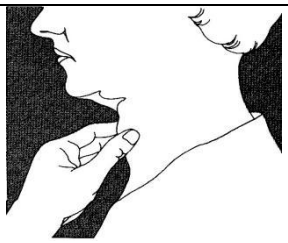
a) Have your patient close his eyes,

b) Put a little salt or sugar on the tip of his tongue,

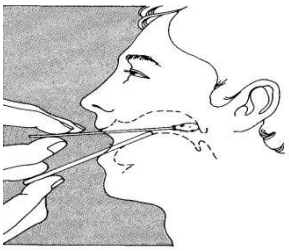
3- ask him to tell you what he tastes



<u>CN IX (Glossopharyngeal) and CN X (Vagus Nerves)</u> :



a) Hold your hands on patient's throat and ask him to swallow to determine swallowing reflex.



b) Ask client to say “ah” while using tongue blade and penlight.

c) Check midline position of uvula and symmetrical rise of uvula and soft palate.

d) Place tongue blade on posterior tongue to elicit gag reflex.

e) Do this by holding his tongue down with a tongue blade and touching a cotton swab to the back of his throat.

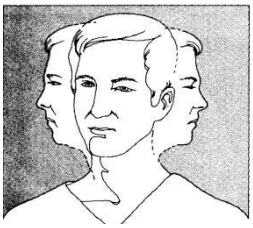
Note:

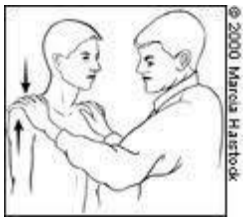
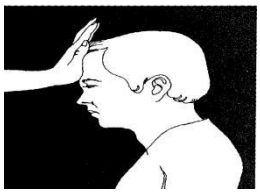
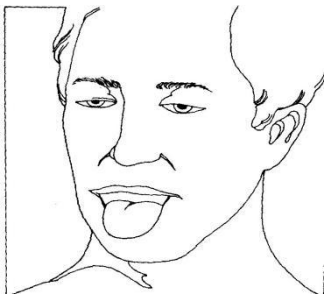
If the patient's swallowing reflex is intact, test his gag reflex. But if there is no swallowing reflex and if the patient is suspected of having increased intracranial pressure, omit gag reflex test.

CN XI (Spinal Accessory):

The spinal accessory nerve controls the trapezius and sternocleidomastoid muscles, which are used in holding the head erect and in shrugging the shoulders.

a) Ask the patient to turn his head from side to side against your hand.



b) Ask patient to shrug his shoulders against resistance of you hands. c) Test for muscle strength by having the patient press his forehead against your hand	 
CN XII (Hypoglossal): The hypoglossal nerve controls the tongue. a) First inspect patient's tongue as it lies in the floor of the mouth. (**Note** any fine twitching movements of the muscle bundle). b) Ask the patient to stick out his tongue and tries to move it from side to side and in and out	

MOTOR FUNCTION

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
1. Test for gross motor and balance		
a. Walking Gait □ Ask the client to walk across the room and back, and assess the clients fait	Upright posture, steady gait, opposing arm swings, maintains balance	Poor posture, unsteady, irregular gait Rigid and no arm movements

b. Romberg's Test ✓ With open eyes, ask client to stand with feet together and arms resting at the side ✓ Repeat procedure with closed eyes for 20 - 30 seconds	Negative Romberg: may sway slightly but is able to maintain upright posture and foot stance	Positive Romberg: moves the feet apart to maintain stance or balance
c. Standing with one foot with eyes closed □ Ask the client to close the eyes and stand on one foot	Maintains balance for at least 5 seconds	Cannot maintain balance for 5 seconds
□ Repeat with the other foot		
d. Heel to Toe Walking ✓ Ask client to walk straight line. ✓ Place the heel of one foot directly in front of the toes of the other foot.	Maintains heel to toe walking along straight line	Assumes wider foot gait to stay upright
2. Test for fine motor of the upper extremities		
a. Finger-to-Nose Test ✓ With eyes closed, ask the client to abduct and extend the arms and shoulder height. ✓ Then rapidly touch the nose alternately with one index finger and then the other.	Touches the nose repeatedly and symmetrically	Misses the nose or gives slow response
b. Alternating Supination and Pronation of Hands on Knees □ Ask the client to pat both knees with the palms of both hands and then with the backs of the hand alternately at an increasing rate	Can alternately supinate and pronate hands rapidly	Slow, not on timing

c. Finger to Nose and to the Nurse's Finger □ Ask the client to touch the nose and then your index finger, held at a distance of 18 inches at a rapid and increasing rate	Coordinated and rapid	Misses the finger and moves slowly
d. Fingers to Fingers □ Ask the client to spread the broadly at shoulder height and then bring the fingers together at the midline, first with open eyes then closed, slowly then rapidly	Accurate and rapid	Slow and unable to touch finger consistently
e. Fingers to Thumb (Same Hand) □ Ask the client to touch each finger of the hand to thumb of the same hand as rapidly as possible	Rapidly touches finger with thumb	Poor and slow movement
3. Test for fine motor of lower extremities		
a. Heel Down Opposite Shin □ In supine or sitting position, ask the client to place heel of one foot just below the opposite knee and run the heel down the shin to the foot	Equal coordination	Tremors Heel moves off
□ Repeat with the other foot.		
b. Toe or Ball of Foot to the Nurse's Finger □ Ask the client to touch your finger with the large toe of each foot	Moves smoothly with coordination	Misses your finger, cannot coordinate movement
4. Perform sensory assessment tests for extremities. With close eyes perform the following:		

a. Light-Touch Sensation ✓ Lightly touch with a wisp of cotton on a specific spot at one side of the body (ex. lower arm, hand, lower leg and foot) ✓ Ask a client to indicate when and where a cotton wisp was felt. ✓ Apply to symmetrical areas of extremities.	Light tickling or touch sensation	No sensation Over sensation
b. Pain: ✓ Ask client to indicate when sharp and dull sensation is felt as you apply sharp and blunt ends of tongue blade to skin surface alternatively ✓ Apply to symmetrical areas of extremities.	Able to identify sharp or dull	Reduced, over or absent pain sensation Ex. peripheral neuropathy
c. Vibration: ✓ Apply stem of vibrating tuning fork to distal joints of toes and fingers. ✓ Have client state when vibration is felt	Able to feel vibration	Reduced, over or absent sensation of vibration
d. Position: ✓ Grasp finger or toe ✓ Holding it side with your thumb and index finger ✓ Ask client to state when finger is up or down. ✓ Repeat with toes	Able to identify readily the position of finger	Unable to determine the position of one or more fingers or toes Ex. Paralysis

e. Temperature: ✓ Touch skin areas with test tubes filled with hot or cold water ✓ Have the client response by saying "hot" "cold" or "i don't know"	Able to identify hot or cold	Loss of sensation to temperature

COURSE: Health Assessment / practical LEVEL: (2)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF NEUROLOGICAL (MENTAL STATUS)

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient in sitting position (for	A						

	bedridden patient, elevate head of bed 45 to 90 degrees) g. Provide privacy							
2	Ask if the client has any history of the following: - presence of pain in the head, back or extremities - disorientation to time, place or person - speech disorder, loss of consciousness, convulsion, trauma, tingling or numbness, tremors, paralysis - loss of memory, mood swings -problem with smell, vision, taste, touch or hearing	A						
3	Assess orientation by asking about: a) name, location, day of week and year	A						

	b) note behavior and appearance							

4*	Apply the Glasgow Coma Scale through assessing the eye response, motor response and verbal response ***Note:*** *The student should be able to state the pointing system for Glasgow Coma Scale.*	C						
5	Document findings.	B						

Steps with stars are vital steps

College instructor **Hospital Instructor**
Head of department

Name Name:

Name:

Level of performance: A -Ability to perform the supervision	Rating 5=Excellent 4=Very Good 3=Good

B- Ability to perform the activity under supervision C**KSA**- Ability to assist with performance of activity D-Knowledge of the activity by observation	2=Unsatisfactory 1=Failed

Signature: Signature:

Signature:

COURSE: Health Assessment / practical LEVEL: (2)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF NEUROLOGICAL (CRANIAL NERVES)

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1.	**First Cranial Nerve (Olfactory)** a) Ask the patient to close eyes, block nostril of one side to	A						

	test each nostril separately. b) Ask the patient to identify the smell, e.g. coffee, lemon or an apple . c) Make sure to use different smell object for each nostril.							
2	**Second Cranial Nerve (Optic): A)** **<u>Tests of visual acuity.</u>** a) Ask patient to cover right eye and tell you how many fingers you are holding up (hold up	A						

	any number of fingers, perhaps two). b) Uncover patient right eye and cover left eye. c) Again ask patient to tell you how many fingers you are holding up. (hold up a different number of fingers, perhaps							

3	**B) Test of visual field:** a) Be sure you are at eye level with your patient and facing him directly . b) Cover your own eye opposite the eye your patient is covering – for example cover your left eye when the patient is covering his right. c) Instruct patient to look straight at you. d) Hold your finger out to the side at arm's length, then slowly bring it toward you and have your patient say when he sees it. e) To test the whole visual field, imagine it's a clock face and test it from the six even numbered positions.	C						

	f) Make sure that your pointed finger is equidistant between you and the patient. g) Repeat the test for the other eye, then for both eyes – Note that a normal person, even when looking straight a head, can detect a moving object almost 90 degrees to the side. h) If you find a defect in either of the patient's visual fields, for example, hemianopia (loss of half of visual field) do more than just record it in your assessment notes. Alert the other nurses as well. Special measures should be taken to ensure patient's safety							

3	**CN III (oculomotor), IV (Trochlear), VI (Abducens)** **<u>A. Extraocular movement (EOM) functioning.</u>** a) While the patient watches with both eyes, b) Hold a small object in front of him. c) Now move it as far as you can up, down, sideways and diagonally, always returning to the central point after each movement. d) Be sure your patient keeps his head still and follows the movement with his eyes only e) As he does so check that both eyes move together and follow the pencil in all directions.	C						

4	**B. Test for pupil's direct and consensual reaction to light (CNIII)** a) Partially darken the room. b) Ask patient to look straight ahead. c) Shine a light on the pupil using a penlight. d) Observe response to the lighted pupil. e) Shine light on the pupil again and observe response on the unlighted pupil. f) Repeat procedure on the other pupil.	C						
5	**C. Test for pupil's reaction to accommodation (CNIII)** a) Hold an object about 10 cm from the bridge of the client's nose. b) Ask the client to look at the object then look away from the object. c) Observe for response. d) Then move the object toward the client's nose.	C						

6	**<u>CN V (trigeminal)</u>** **A. Motor function test:** The trigeminal nerve controls the muscles of mastication and the opening and closing of the jaws a) Feel the masseter muscles during jaw clench. b) Test for a jaw jerk reflex by gently tapping on the jaw with the mouth slightly open. **B. Sensory function test:** a) Have the patient close his eyes, then lightly touch a piece of cotton to different parts of his face (forehead, cheek chin). b) Have him tell you when and where he feels the sensation	D						
7	**<u>CN VII facial</u>** A. Inspect facial symmetry B. **Motor Function Test:** a) Ask client to frown, smile, puff out cheeks and raise eye brows b) Ask patient to close his eyes tightly so that you cannot open them. C. **Sensory Function Test:**	D						

	a) Have your patient close his eyes, b) Put a little salt or sugar on the tip of his tongue, 3- ask him to tell you what he tastes							
8	**<u>CN VIII (Vestibulocochlear Nerve or Acoustic):</u>** **To test hearing:** a) Stand at the foot of patient's bed and whisper something for patient's b)This test also lets you assess his ability to interpret a command and carry it out	D						

Step with stars are vital steps

College instructor **Hospital Instructor**

Head of department

Name Name: Name:

9	**CN IX (Glossopharyngeal) and CN X (Vagus Nerves)** : a) Hold your hands on patient's throat and ask him to swallow to determine swallowing reflex. b) Ask client to say “ah” while using tongue blade and penlight. c) Check midline position of uvula and symmetrical rise of uvula and soft palate. d) Place tongue blade on posterior tongue to elicit gag reflex. e) Do this by holding his tongue down with a tongue blade and touching a cotton swab to the back of his throat.							
10	**CN XI (Spinal Accessory):** a) Ask the patient to turn his head from side to side against your hand. b) Ask patient to shrug his shoulders against resistance of your hands. c) Test for muscle strength by having the patient press his forehead against your hand	D						

11	**CN XII (Hypoglossal):** The hypoglossal nerve controls the tongue. a) First inspect patient's tongue as it lies in the floor of the mouth for position and abnormal movement. b) Ask the patient to stick out his tongue and tries to move it from side to side and in and out	D						

Signature: Signature:

Signature:

Level of performance:
A-Ability to perform the supervision
B- Ability to perform the supervision
C- Ability to assist with p activity
D-Knowledge of the acti

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

COURSE: Health Assessment / practical LEVEL: (2)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF NEUROLOGICAL (MOTOR FUNCTION)

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Provide privacy	A						
2	**Test for gross motor and balance** a. Walking Gait □ Ask the client to walk across the room and back, and assess the clients fait	A						
3	b. Romberg's Test ✓ With open eyes, ask client to stand with feet together and	B						

	arms resting at the side ✓ Repeat procedure with closed eyes for 20 -30 seconds							
4	c. Standing with one foot with eyes closed ✓ Ask the client to close the eyes and stand on one foot ✓ Repeat with the other foot	B						
5	d. Heel to Toe Walking ✓ Ask client to walk straight line. ✓ Place the heel of one foot directly in front of the toes of the other foot.	B						
6	**Test for fine motor of the upper extremities** a. Finger-to-Nose Test ✓ With eyes closed, ask the client to abduct and extend the arms and shoulder height. ✓ Then rapidly touch the nose alternately with one index finger and then the other.	B						

7	b. Alternating Supination and Pronation of Hands on Knees □ Ask the client to pat both knees with the palms of both hands and then with the backs of the hand alternately at an increasing rate	B						

8	c. Finger to Nose and to the Nurse's Finger □ Ask the client to touch the nose and then your index finger, held at a distance of 18 inches at a rapid and increasing rate	B						
9	d. Fingers to Fingers □ Ask the client to spread the broadly at shoulder height and then bring the fingers together at the midline, first with open eyes then closed, slowly then rapidly	B						
10	e. Fingers to Thumb (Same Hand) □ Ask the client to touch each finger of the hand to thumb of the same hand as rapidly as possible	B						

11	**Test for fine motor of lower extremities** a. Heel Down Opposite Shin □ In supine or sitting position, ask the client to place heel of one foot just below the opposite knee and run the heel down the shin to the foot □ Repeat with the other foot.	B						
12	b. Toe or Ball of Foot to the Nurse's Finger □ Ask the client to touch your finger with the large toe of each foot	B						
13	Perform **sensory assessment tests** for extremities. With close eyes perform the following: a. Light-Touch Sensation ✓ Lightly touch with a wisp of cotton on a specific spot at one side of the body (ex. lower arm, hand, lower leg and foot) ✓ Ask a client to indicate when and where a cotton wisp was felt. ✓ Apply to symmetrical areas of extremities.	C						
14	b. Pain: ✓ Ask client to indicate when sharp and dull sensation is felt as you apply sharp and blunt ends of tongue blade to skin surface alternatively ✓ Apply to symmetrical areas of extremities.	C						

15	c. Vibration: ✓ Apply stem of vibrating tuning fork to distal joints of toes and fingers. ✓ Have client state when vibration is felt	C						
16	d. Position: ✓ Grasp finger or toe ✓ Holding it side with your thumb and index finger ✓ Ask client to state when finger is up or down. ✓ Repeat with toes	C						
17	e. Temperature: ✓ Touch skin areas with test tubes filled with hot or cold water ✓ Have the client response by saying "hot" "cold" or "i don't know"	C						
18	Record findings	B						

Steps with stars are vital steps

College instructor **Hospital Instructor**

Head of department

Name Name:

Name:

Signature: Signature:

Signature:

Level of performance:
A
-Ability to perform the a
supervision
B- Ability to perform th
supervision

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

C - Ability to assist with performance of activity

D -Knowledge of the activity by observation

ASSESSMENT OF THE URINARY SYSTEM

Learning Objectives:

1. Define assessment of urinary system and identify its purposes.
2. Identify appropriate equipment for assessment
3. Differentiate normal from abnormal findings
4. Learn and apply correctly the techniques in urinary system assessment

Introduction:

The urinary system which is also known as renal system, mainly eliminates waste products from the body. It comprises of two kidneys, two ureters, one bladder and one urethra.

Definition:

It is the process by which a health care provider examines the urinary system for signs of disease.

Purposes:

1. To promote health and detect health problems at an early stage.
2. To assess problems related to urinary system.

Equipment

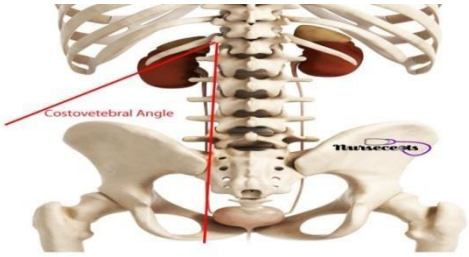
Examination gown and drape

Examination gloves

Stethoscope

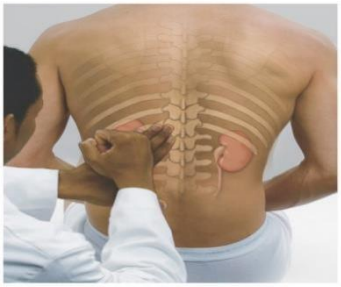
Content

ASSESSMENT OF THE URINARY SYSTEM

ASSESSMENT	NORMAL	ABNORMAL FINDINGS AND EXAMPLES
1. Inspect the abdomen for color, enlargement and enlarged arteries.	Abdomen has uniform color, flat or rounded, no enlargement and no pulsations	Enlarged Arteries distended
2. Inspection of the costovertebral angles 		
3. Auscultate the arteries: Aortic artery, renal arteries, iliac arteries, and femoral arteries	No abnormal sounds	Presence of bruits

4. Palpate the right kidney Procedure: a. Place the client in the supine position b. Place your left hand on the client between lowest rib (in costovertebal angles) and the pelvic bone c. Place your right hand on the client's side below the lowest rib. Your hands are placed together in a "duck-bill" position at the client's right flank . d. Ask the client to take a deep breath. e. At the peak of inspiration, press your right hand and deeply into the RUQ (right upper quadrant),	Both kidneys are not usually palpable A normal right kidney may be palpable in wellrelaxed women	Enlarged kidney Tenderness Kidney mass Ex. Causes of kidney enlargement include hydronephrosis, cyst or tumors Bilateral enlargement
f. Try to capture the kidney between two hands g. Note the enlargement or tenderness. 		suggests polycystic kidney

5. Palpate the left kidney Procedure: a. Search for the left kidney by reaching your left hand across the abdomen and behind the left flank for support. b. Push your right hand deep into the abdomen c. Ask the client to take a deep breath. d. Feel the change while inspiring  		
6. If abdominal pain is present, assess rebound tenderness. Procedure: a. Choose a site away from the painful area b. Hold your hand 90 degrees, or perpendicular, to the abdomen c. Push down slowly and deeply and then lift up suddenly.	As a normal or negative, no pain or release of pressure.	Pain in release of pressure confirms rebound tenderness, which is a reliable sign of peritoneal inflammation. Peritoneal inflammation accompanies appendicitis

		
7. Palpate and percuss bladder. Procedure: a. The bladder normally cannot be examined unless it is distended above the symphysis pubis on palpation. b. Check for tenderness c. Use percussion to check for dullness and to determine how high the bladder rises above the symphysis pubis. 	Normally not palpable and not tender The dome of distended bladder feels smooth and round.	Bladder distension from outlet obstruction Suprapubic tenderness in bladder infection
8. Perform blunt percussion on the kidneys at the costovertebral angles over the 12th rib 	No tenderness or pain Thud-like sound	Tenderness or sharp pain elicited suggests kidney infection (pyelonephritis), renal calculi, or hydronephrosis.

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF URINARY SYSTEM

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Provide privacy	A						
2	**Inspect** the following: a. Abdomen for color, enlargement and enlarged arteries b. Costovertebral angles	A						

3	**Auscultate** the arteries: Aortic artery, renal artery, iliac arteries, and femoral arteries	B						

4*	**Palpate** the right kidney. - Place the client in the supine position - Place your left hand on the client between lowest rib (in costovertebal angles) and the pelvic bone - Place your right hand on the client's side below the lowest rib. Your hands are placed together in a "duck-bill" position at the client's right flank . - Ask the client to take a deep breath. - At the peak of inspiration, press your right hand and deeply into the RUQ (right upper quadrant), - Try to capture the kidney between two hands - Note the enlargement or tenderness.	C						

5*	**Palpate** the left kidney - Search for the left kidney by reaching your left hand across the abdomen and behind the left flank for support. - Push your right hand deep into the abdomen - Ask the client to take a deep breath. - Feel the change while inspiring	B						
6*	If abdominal pain is present, assess rebound tenderness. - Choose a site away from the painful area - Hold your hand 90 degrees, or perpendicular, to the abdomen - Push down slowly and deeply and then lift up suddenly.	B						
7	**Palpate** and **percuss** bladder. -The bladder normally cannot be examined unless it is distended above the symphysis pubis on palpation. - Check for tenderness - Use percussion to check for dullness and to determine	B						

	how high the bladder rises above the symphysis pubis.							
8	Perform blunt percussion on the kidneys at the costovertebral angles over the 12th rib	B						
9	Document findings.	B						

Steps with stars are vital steps

Clinical instructor **Hospital Instructor**

Head of department

Name Name:

Name:

Signature: Signature:

Signature:

Level of performance:
A
-Ability to perform the a supervision
B- Ability to perform th supervision
C - Ability to assist activity
D -Knowledge of th observation

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

INTAKE AND OUTPUT RECORDING

Learning Objectives:

1. List the purposes of intake and output calculation.
2. Mention the parameters of assessments before intake and output calculation.
3. Describe the negative and positive balance.
4. Determine how to calculate the intake and output **Introduction**

Definition:

The process of recording all the fluid that goes into the patient and the fluid that leaves the body. In normal conditions, the intake should equal output in 24 hours.

Purposes:

1. Ensure accurate record keeping.
2. Prevent circulatory overload.
3. Prevent dehydration.
4. Aid in analyzing trends in fluid status.
5. Contribute to accurate assessment record.

Equipment

Intake and Output Chart

SOURCES OF INTAKE AND OUTPUT

- **Intake**
  - ✓ Intravenous fluid
  - ✓ Liquids taken PO
  - ✓ All food items that turn liquid at room temperature
  - ✓ All types of feeding via tubes
- **Output**
  - ✓ Urine
  - ✓ Liquid feces
  - ✓ Blood
  - ✓ Drainage outputs, Suctioned secretions
  - ✓ Emesis

- ✓ Excessive perspiration

FLUID BALANCE

- **Negative balance**

= total intake for the shift < the total output for the shift

- **Positive balance**

= total intake for the shift > the total output for the shift

Content

ACTIVITY

Direction: Compute the intake and output

Situation 1

A patient has recorded the following on a sheet of paper at the bedside:

Breakfast: eggs, toast, one cup of coffee (180 ml); small orange juice (120 ml).

Lunch: sandwich, apple, glass of tea (one glass of tea 240 ml)

Dinner: chicken, broccoli, rice, 2 glasses of tea

Between meals: 4 glasses of water (one glass of water 120

ml). Intravenous Fluid: 1000mL of D5 W infusing IV at 30

mL/hour Calculate the intake for 12 hours shift?

The Answer

- one cup of coffee =180 ml .
- small orange juice = 120 ml .
- 3 glass of tea = 3 × 240 = 720 ml .
- 4 glass of water = 4 × 120 = 480 ml.
- 30 ml IV fluid × 12 hours = 360 ml

Total intake for 12 hours = 180+ 120 + 720 + 480 + 360 = 1860 ml .

Situation 2

The patient recorded the following amounts voided on the sheet of paper: 400 cc at 7:00 am; 100cc at 10:00 am; 200cc at 12 noon; 150 cc at 2:00 pm; 400cc at 6:00pm. The nurse emptied 300cc from a JP tube. The patient vomited 100cc at 4:00 pm What is the total output for the 12 hour shift.

Calculate the output for 12

hours? **The Answer**

- Urine voided = 400 cc +100cc +200cc +150 cc +400cc =1250 ml □ 300cc from a JP tube.
- The patient vomited 100cc.

The total output for 12 hours = 1250 + 100 + 300= 1650 ml .

Content

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: INTAKE AND OUTPUT RECORDING

NO	STEPS Required Frequency: 2	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Explain procedure to patient and/or family	B						
2*	Measure and record all fluid taken by mouth	B						
3*	Measure and record of IV fluid or tube feeding	B						
4*	Ask client t to record amount of urination(if using the toilet) -measure amount of urine in urinary bag	B						
5	Weigh wet linen, pads or dressing and subtract the weight of similar dry items	B						
6*	Collect all amount of intake at the end of each shift	B						
7*	Collect all amount of output at the end of each shift position	B						
8*	At the end of 24 hrs: - Collect total amount of intake and output - Subtract the total amount of output from total amount of	B						

	intake to calculate the fluid body balance.								
9	Reassess client's fluid status	B							
10	Report findings.	B						Done	Repeat

Steps with stars are vital steps

College instructor **Hospital Instructor**

Head of department

Name Name:

Name: Signature: Signature:

Signature:

Level of performance:
A
perform the activity witl
B- Ability to perform th
supervision
C - Ability to assist
of activity
D -Knowledge of th
observation

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

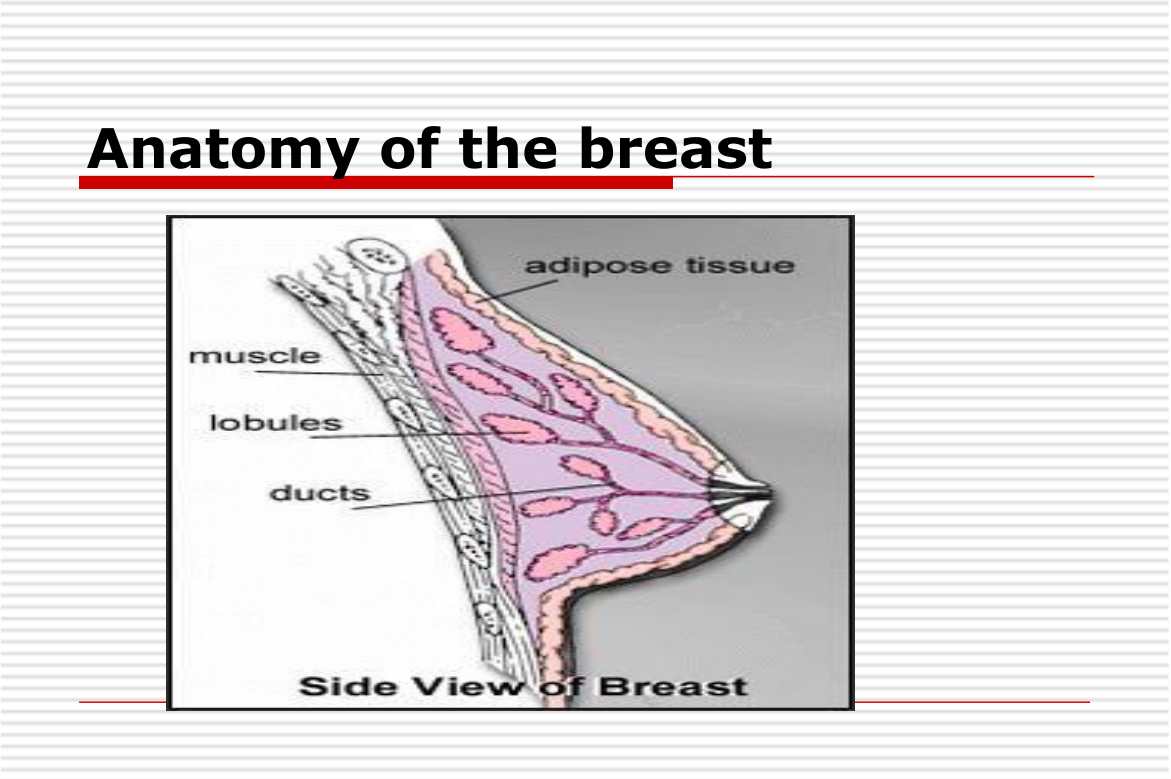
ASSESSMENT OF THE BREAST

Learning Objectives:

1. List the purposes of breast assessment
2. Learn and apply breast assessment in the clinical area

Introduction

Below is the anatomy of the breast.



Each breast has 15 to 20 sections, called lobes, Each lobe has many smaller lobules, which end in dozens of tiny bulbs that can produce milk.

The lobes, lobules, and bulbs are all linked by thin tubes called ducts these ducts lead to the nipple in the center of a dark area of skin called the areola.

Definition:

Assessment of the breast is the process by which a health care provider examine the breast for signs of disease.

Purposes:

1. To promote health, detect health problems at an early stage
2. To assess problems related to breast

Equipment

Centimeter Ruler

ASSESSMENT OF THE BREAST

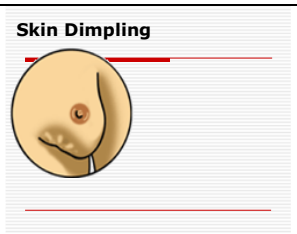
A. Introduce self and explain to the client what you are doing do ,why it is necessary, and discuss how the results will be used in planning further care or treatments.

B. Perform hand washing ,apply gloves, and observe appropriate infection control procedures .

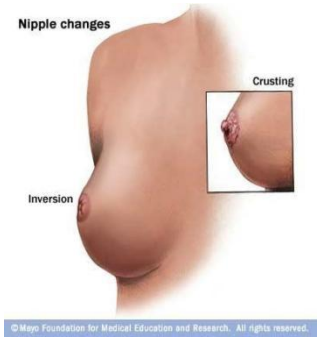
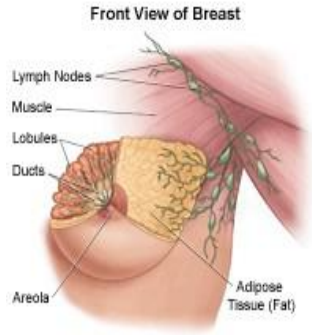
C. Provide for client privacy .

D. Provide information about l history of breast masses and what was done about them ;pain or tenderness in the breasts and relation to the woman's menstrual cycle, discharge from nipple and medication history (as oral contraceptives)

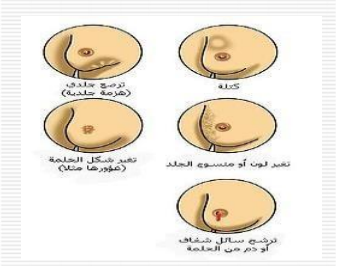
Assessment	Normal finding	Abnormal Finding
1. Put client in a sitting position and Inspect the breast for size, symmetry, and counter or shape 	Rounded shape slightly unequal in size & generally symmetric.	Recent change in breast size, swelling, marked asymmetry 
2. Inspect skin of the breast for localized discolorations or hyperpegmentation, swelling or edema.	Skin uniform in color, skin smooth and intact	Localized discolorations or hyperpigmentation Skin retraction or dimpling. Swelling or edema.

		
3. Emphasize any retraction of the skin by having the client: a. Raise the arms above the head b. Push the hands together with. elbows flexed. c. Press the hands down on the hips.		

		
4. Inspect the areola area for: size, shape, symmetry, color, surface characteristics and any masses or lesions.	Round or oval and bilaterally the same color varies from light pink to dark brown	Asymmetry, mass or lesion. 

5. Inspect the nipples for size, shape, position, color, discharge, and lesions	Round everted and equal in size similar in color soft and smooth. No discharge except from pregnant women	Asymmetricl size and color  Presence of cracks or discharge. Inverted nipples
6. The client sits with the arms abducted and supported on the nurses forearm. Palpate the axillary subclavicular and supraclvicular lymph nodes	No tenderness, masses,or nodules	tenderness, masses, nodules 

7. Put the client in supine position Palpate the breast for masses tenderness, and any discharge from the nipple . Procedure: a. If the client reports breast lump, start with the normal breast to obtain baseline data that will serve as a comparison to the reportedly involved breast. b. To enhance flattening of the breast, instruct the client to abduct the arm and place her hand behind her head, then place a small pillow or rolled towel under the client shoulder c. For palpation use the palm surface of the middle three fingertips and make gently rotary motion on the breast. d. Start at one point for palpation and move systematically to the end point to ensure that all breast surface are assessed. e. Pay particular attention to the upper outer quadrant area and the tail of Spence.	No tenderness, masses , nodule or nipple discharge	Tenderness, masses, nodules, or nipple discharge If you detect masses record the following data location, size, shape, consistency, mobility, skin over the lump, nipple and tenderness

8. Palpate the areola and the nipples for masses. Compress each nipple to determine the presence of any discharge, if present assess for amount and color.	No masses nodules or nipple discharge	Masses nodules or nipple discharge 
9. Teach the client the technique of breast self examination.		

COURSE: Health Assessment / practical LEVEL: (1)

NAME OF STUDENT :----------

SKILL NAME/TOPIC: ASSESSMENT OF FEMALE BREAST

NO	Steps	Required Level of Performance	PERFORMANCE RATING					COMMENTS
			1	2	3	4	5	
1	Perform the following preparation: a. Introduce yourself b. Verify patient's identity using agency protocol c. Explain the procedure to the patient d. Prepare equipment e. Perform hand hygiene and observe appropriate infection control f. Position patient in sitting position (for bedridden patient, elevate head of bed 45 to 90 degrees) g. Provide privacy	A						

2	Ask if the client has any history of the following: - history of breast masses, pain or tenderness of the breast, nipple discharge -taking of contraceptives -smoking, diet	A						
3	Put client in a sitting position and Inspect the breast for size, symmetry, and counter or shape	B						
4*	Inspect skin of the breast for localized discolorations or hyperpigmentation swelling or edema.	B						

5*	Emphasize any retraction of the skin by: a-raise the arms above the head. b-push the hands together with. elbows flexed. c-press the hands down on the hips	B						
6*	Inspect the areola area for: size, shape, symmetry, color, surface characteristics and any masses or lesions.	B						

7	Inspect the nipples for size, shape, position, color, discharge, and lesions	B						
8*	The client sits with the arms abducted and supported on the nurses forearm Palpate the axillary subclavicular and supraclavicular lymph nodes.	B						

9*	Put the client in supine position Palpate the breast for masses tenderness, and any discharge from the nipple. a-If the client reports breast lump, start with the normal breast to obtain baseline data that will serve as a comparison to the reportedly involved breast. b-To enhance flattening of the breast ,instruct the client to abduct the arm and place her hand behind her head, then place a small pillow or rolled towel under the client shoulder c-For palpation use the palm surface of the middle three fingertips and make gently rotary motion on the breast. d-Start at one point for palpation and move systematically to the end point to ensure that all breast surface are assessed. e-Pay particular attention to the upper outer quadrant area and the tail of Spence.	B						
10	Palpate the areola and the nipples for masses, compress each nipple to determine the presence of any discharge, if present assess for amount and color.	B						
12	Teach the client the technique of breast self examination.	B						
13	Record final assessment.	A						

Steps with stars are vital steps

College instructor Hospital Instructor Head of department

Name Name: Name:

Signature: Signature:

Signature:

Level of performance:
A
-Ability to perform the ac
supervision
B- Ability to perform the
supervision
C - Ability to assist w
activity
D -Knowledge of the
observation

Rating
5=Excellent
4=Very Good
3=Good
2=Unsatisfactory
1=Failed

References

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Perry. A. G, and Potter, P.A. (2016): Clinical Nursing Skills and Technique. 3rd ed. St Louise, Missouri. Mosby.

Weber, R.J and Kelley. H.J (2018): Health Assessmentin Nursing, 6th Philadelphia: Lippincott, Williams & Wilkins