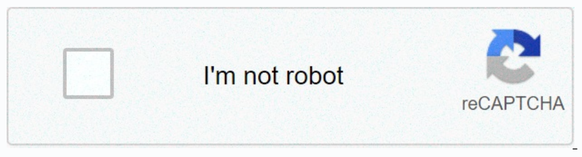

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Nursing admission assessment and examination pdf

Updated: 4/7/2020 Being a nurse means being a lot of things for a lot of people. But one of the basics of nursing is performing a head-to-toe assessment. We've put together a step-by-step guide to what happens in a nursing assessment and how nurses should understand the physical, emotional and mental aspects of someone's body system. Learn from the experts We interviewed two health experts to learn their best practices for conducting head-to-toe assessments. Terri Zucchero PhD, RN, FNP-BC is a nurse physician at Boston Health Care for the Homeless Program. Haynes Ferere, DNP, FNP-BC, MPH, serves as a clinical instructor at the Nell Hodgson Woodruff School of Nursing at Emory University in Atlanta. This article has also been reviewed by our panel of experienced nurses: Tyler Faust, MSN, RN Chaunie Brusie, BSN, RN Kathleen Coduvell Gaines, BSN, RN, BA, CBC What is a Head-to-Toe Assessment? A head-to-toe assessment refers to a physical examination or health assessment, and it becomes one of the many important components for understanding a patient's needs and problems. Head-To-Toe Assessment Basics Types of Assessments There are several types of assessments that can be performed, says Zucchero. A full health assessment is a detailed examination that usually includes a thorough health history and extensive head-to-toe physical examination. This type of assessment can be carried out by registered nurses for patients admitted to the hospital or in community-based settings such as initial home visits. Advanced exercise nurses such as nurse practitioners also perform full assessments when doing annual physical examinations. A problem-focused assessment is an assessment based on certain health care objectives. For example, a nurse who works in intensive care and a nurse who makes home visits between mothers and children have different patient populations and nursing goals, she says. These assessments generally focus on a specific body system such as respiratory or cardiac and pulmonary care. While the whole body is important, there is usually not enough time for a detailed full body assessment. Length of Assessment Ferere explains that the duration of the exam is directly related to the general health status of the patient. Health patients with limited health history can be completed in less than 30 minutes, she says. Many health practices have patients complete health history and pre-visit forms before presentation for a comprehensive visit. Prior review of these forms can certainly reduce the required visit time. How to prepare for assessment Like all clinical settings, standard precautions (previously universal precautions) should always be practiced with each patient to protect both the nurse and patient, said Zucchero. The primary goal of standard precautions is to prevent the exchange of blood and body fluids and include hand hygiene, the use of personal and safe handling and cleaning of potentially contaminated equipment equipment Surfaces. Equipment Checklist Depending on the type of assessment performed, the nurse may need special equipment, Zucchero said. Basic equipment includes: Gloves Thermometer Blood Pressure Cuff Watch Scale Wall Wall Ruler Tape Measure, Penlight Stethoscope Additional equipment for more extensive examinations would include, Otoscope Ophthalmoscope Reflex Hammer Tongue Pusher Sterile Sharp Object (like Toothpick or Pin) Sterile Soft Objects (like cotton ball) Something for the patient to smell (like an alcohol swab) Beginning An assessment When starting an assessment, Zucchero says, establishing a personal relationship of trust and respect between the patient and the nurse is crucial. She adds that it is important during an assessment to assess how the patient is feeling, and make sure they are properly draped and comfortable. She continued: 'In addition, it is important that an assessment is made systematically and effectively in order to minimise unnecessary contact of the patient. For new nursing and nursing students, a head-to-toe assessment is driven by the needs of the patient, the setting of the examination and the relationship with the examiner, Said Angela Haynes. This baseline examination determines knowledge of the patient's health needs, current health status, and patient goals for personalized health outcomes, including health promotion and wellness counseling, she said. What to look for During an assessment Differentiating normal from abnormality is an important skill, Zucchero explains. Some examples of major abnormal findings are changes in normal respiratory rate that indicate respiratory distress, or a change in skin color such as paleness that may indicate anemia or jaundice that typically indicates liver problems. Generally, the human body is bilaterally symmetrical. When examining a patient, note any unusual asymmetry. If a patient is weaker on one side than another, or has a limited range of motion, or one side appears limper or otherwise different from the other side, there may be an underlying neurological or musculoskeletal issue. Building Report With the patient The nurse must always introduce herself to the patient, check that they are with the right patient, and explain what they will do, Zucchero adds. This is a good time to start with a review of paperwork and build a relationship before the physical part of the exam is started, ferere said. It is also appropriate time to talk about the patient's personal preferences about undressing for the exam, as well as the need for lighting, the temperature of the room and any pain or areas of discomfort. The patient may also prefer to have another person in the room for the exam for comfort. This should be allowed whenever possible. Policies usually exist to support the presence of a witness for possible invasive procedures, she adds. Ferere adds that a cooperatively engaged patient visit must not be carried out with the same sequence as a confused patient. Engaging the patient early in the visit increases the likelihood that the patient will take more responsibility for health status and ongoing health needs. Show me nursing programs pay close attention to non-verbal cues from the patient These cues may include grimacing with ambulation, grunting during movement or when in contact with a body system, ferere said. It can also be an avoidance of eye contact or unwillingness to answer questions, she adds. The nurse must pay very close attention to what the patient says and does not say during the visit. Nurses often act as detectives during patient visits and try to put together various findings, conversations and health stories. Head-to-Toe Assessment Sequence Ferere says the sequence is based on the examiner's wishes. Usually, it starts with the least invasive to most invasive allowing time for the patient to become more comfortable with the examiner. It also increases the likelihood that the examiner will not forget a system during the exam. During an assessment, the first thing that should be noted is the patient's overall appearance or general status, Zucchero says. This includes level of alertness, health status/comfort/distress, and respiratory rate. This is done even before taking vital signs. The order of a Head-to-toe Assessment 1. General status Vital signs Heart rate Blood pressure temperature Pulse oximetry Respiratory rate Pain 2. Head, Ears, Eyes, Nose, Throat Note color of lips and humidity Inspect teeth and gums Assess buccal mucosa and palate Examine Tongue Examine tongue Examine at uvula Examine tonsils Palpate nose and assess symmetry Check Septum and inside nostrils Check patency of nares Check patient's sense of smell Palpat sinuses Assess patient's hearing with whisper test Tuning Fork test (Weber's test, Rinne test) Look inside the ear Assess ear discharge and tympanic membrane check conjunctiva and sclera Assess eye symmetry PERRLA Check vision with Snellen Diagram Check six cardinal positions of gaze 3. Throat Palpat lymph nodes Observe and palpattrache and neck Check for Jugular Venous Distention Check neck range of motion Check shoulder twitch ing with resistance 4. Respiratory protective Listen to lung sounds at the front and back Assess airway enlargement level Ask about cough Palpate thorax 5. Cardiac Palpate throat pulse and temporal pulses bilaterally Listen to heartbeat 6. Abdominal One Inspect abdomenOne Listen to 4 quadrants of the abdomen for intestinal sounds Palpate 4 quadrants of the abdomen for pain/tenderness Ask about problems with bowel or bladder 7. Pulses Check pulses in arms/legs/feet including, Radial Femoral Posterior tibial Dorsalis pedis 8. Extremities Assess range of motion and strength in arms/legs/ankles Assess sharp and dull sensation on arms/legs Check capillary filling on nails/toenails 9. Skin Check skin turgas Check for injuries, abrasions, rashes Check soreness, lumps, lesions if the patient is pale, damp, dry, cold, hot, warm, 10. Neurological Oriented x3 Assess once Check coordinationEns assess reflexes Check Glasgow Coma Scale points Show me nursing programs Seek help from Mentors And ferere colleagues adds that new nurses should rely on the basic knowledge gained in nursing school and seek strong, supporting nursing mentors as resources in care delivery settings. Confidence in assessment continues to grow with each assessment carried out. Nurses shouldn't be afraid to ask for help when something doesn't seem right and rely on your instincts and training, she says. Says.