PHYSICAL ASSESSMENT: HEAD TO

Physical assessment

- Is a process by which a nurse obtains a data that describes a person's responses to actual or potential health problems which is analyzed to form pertinent diagnosis.
- Is a head-to-toe review of each body system that offers objective information about the client and allows the nurse to make clinical judgment.

Importance of physical assessment

- To early detect and treat diseases and disorders.
- To identify actual and potential health problems.
- To establish a data based from which the subsequent phases of the nursing evolve.
- To assess the client's impact of activity and exercise on the client's overall level of health.
- To assess the client's routine exercise pattern and observe how the client's body system response to activity and exercise.
- To establish the client-nurse relationship.
- To obtain information about the client's health including, physiologic, psychological, sociocultural, cognitive, developmental and spiritual aspects.
- To identify the client's strength and weaknesses.

Purpose of physical assessment

- To supplement, confirm or refute data obtained in the nursing history.
- To confirm and identify nursing diagnosis.

- To make clinical judgments about a client's changing health status and management.
- To evaluate the physiological outcome of care.
- To obtain and gather data about the client's health basis of data for future assessment.
- An excellent way to evaluate an individual's current health status.

Four basic techniques in physical assessment

- 1. Inspection
- It is the use of one's senses of vision and smell to consciously observe the patient.
- It is also known as concentrated watching.
- It is a close, careful scrutiny; first of the individual as a whole and then of each body system.
- 2. Palpation
- It is the act of touching a patient in a therapeutic manner to elicit specific information.
- It follows and often confirms points you noted during inspection.

Palpation applies your sense of touch to assess these factors

- Texture.
- Temperature
- Moisture
- Organ location and size
- Any swelling, vibration or pulsation
- Rigidity or spasticity
- Crepitation
- Presence of lumps or masses
- Presence of tenderness or pain.

Two distinct types of palpation

a. Light palpation

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