

Liver Span

1. Percuss downward from the chest in the right midclavicular line until you detect the first edge of liver dullness.
2. Percuss upward from the abdomen in the same line until you detect the bottom edge of liver dullness.
3. Measure the liver span between these two points. This measurement should be 6-12 cm in a normal adult.



Splenic Dullness

1. Percuss the lowest costal interspace in the left anterior axillary line. This area is usually tympanic.
2. Ask the patient to take a deep breath and percuss this area again. Dullness in this area is a sign of splenic enlargement.



Palpation

General Palpation

1. Begin with **light palpation** (1 cm deep). At this point you are mostly looking for areas of tenderness. The most sensitive indicator of tenderness is the patient's facial expression (as watch the patient's face, not your hands). Violations of privacy (exposing) may also be present.
2. Proceed to **deep palpation** (4-6 cm deep) after surmising the abdomen lightly. Try to identify abdominal masses or areas of deep tenderness.

Examination Techniques

1. **Inspection** - Visual observation of the patient's appearance.
2. **Palpation** - Touching the patient's body to detect abnormalities.
3. **Percussion** - Tapping the patient's body to detect abnormalities.
4. **Auscultation** - Listening to the patient's body to detect abnormalities.
5. **Measurement** - Measuring the patient's body to detect abnormalities.
6. **Documentation** - Recording the findings of the examination.

NP PA and MD

Advanced Physical Assessment Study Guide

Examination Techniques

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Light

- a) Cover the room lights as necessary.
- a) Ask the patient to look into the distance.
- a) Shine a bright light obliquely into each pupil in turn.
- a) Look for both the direct (same eye) and consensual (other eye) reactions.
- a) Record pupil size in mm and any asymmetry or irregularity.

Accommodation

1. If the pupillary reactions to light are diminished or absent, check the reaction to accommodation (near reaction).
2. **Hold your finger about 10cm from the patient's nose.**
3. **Ask them to alternate looking into the distance and at your finger.**
4. **Observe the pupillary response in each eye.**



Ophthalmoscopic Exam

1. Darken the room as much as possible.
2. Adjust the ophthalmoscope so that the light is no brighter than necessary. Adjust the aperture to a plain white circle. Set the discolor dial to zero and turn the wheel until a yellow cutting for your eyes.
3. Use your left hand and left eye to examine the patient's left eye. Use your right hand and right eye to examine the patient's right eye. Place your free hand on the patient's shoulder for better control.
4. Ask the patient to stare at a point on the wall or corner of the room.
5. Look through the ophthalmoscope and shine the light into the patient's eye from about two feet away. You should see the retina as a "red reflex." Follow the red reflex to move within a few inches of the patient's eye.
6. Adjust the discolor dial to bring the retina into focus. The correct and follow it to the gold disk. Use this as a point of reference from the right disk at least four times any abnormalities.
7. Move nearer from the disk to observe the macula.
8. Repeat for the other eye.
9. Normal color should be creamy yellow-orange to pink.

Nursing Assessment

1. Part of Nursing Process
2. Nurses use physical assessment skills to:
 - a) Obtain baseline data and expand the data base from which subsequent phases of the nursing process can evolve.
 - b) To identify and manage a variety of patient problems (actual and potential)
 - c) Evaluate the effectiveness of nursing care
 - d) Enhance the nurse-patient relationship
 - e) Make clinical judgments

Gathering Data

1. **Subjective data** - Told by the client (H)
2. **Objective data** - Observed by the nurse (O)
3. **Document** - SOAP/AB

Assessment Techniques

The order of techniques is as follows: **Inspection** - **Palpation** - **Percussion** - **Auscultation** except for the abdomen which is **Inspection** - **Auscultation** - **Percussion** - **Palpation**.

A. Inspection - critical observation. **Observe first!**

1. **General appearance** - Observe the patient's overall appearance, including skin color, hair, and facial features.
2. **Head and neck** - Observe the patient's head and neck for any abnormalities, including swelling, redness, and tenderness.
3. **Chest** - Observe the patient's chest for any abnormalities, including shape, size, and color.
4. **Abdomen** - Observe the patient's abdomen for any abnormalities, including shape, size, and color.
5. **Extremities** - Observe the patient's extremities for any abnormalities, including shape, size, and color.
6. **Genitalia** - Observe the patient's genitalia for any abnormalities, including shape, size, and color.
7. **Rectum** - Observe the patient's rectum for any abnormalities, including shape, size, and color.
8. **Perineum** - Observe the patient's perineum for any abnormalities, including shape, size, and color.
9. **Anal** - Observe the patient's anal area for any abnormalities, including shape, size, and color.
10. **Urethra** - Observe the patient's urethra for any abnormalities, including shape, size, and color.
11. **Vagina** - Observe the patient's vagina for any abnormalities, including shape, size, and color.
12. **Cervix** - Observe the patient's cervix for any abnormalities, including shape, size, and color.
13. **Uterus** - Observe the patient's uterus for any abnormalities, including shape, size, and color.
14. **Ovaries** - Observe the patient's ovaries for any abnormalities, including shape, size, and color.
15. **Bladder** - Observe the patient's bladder for any abnormalities, including shape, size, and color.
16. **Prostate** - Observe the patient's prostate for any abnormalities, including shape, size, and color.
17. **Seminal vesicle** - Observe the patient's seminal vesicle for any abnormalities, including shape, size, and color.
18. **Penis** - Observe the patient's penis for any abnormalities, including shape, size, and color.
19. **Scrotum** - Observe the patient's scrotum for any abnormalities, including shape, size, and color.
20. **Testes** - Observe the patient's testes for any abnormalities, including shape, size, and color.

2. Ask the patient to inspire deeply.
3. The level of dullness (diaphragmatic excursion) should go down 3-6 in symmetrically.



Anterior Chest

1. Percuss from the top of the lungs to the bottom of the lungs.
2. Compare the results to the other lung for symmetry.
3. Note the location and quality of the percussion sounds you hear.

Posterior Chest

1. Percuss from the top of the lungs to the bottom of the lungs.
2. Compare the results to the other lung for symmetry.
3. Note the location and quality of the percussion sounds you hear.
4. Find the point of the lungs.

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pages

Nursing Study Guides

Physical Assessment Study Guide

**Carolyn Jarvis APN CNP, Ann L.
Eckhardt**



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objectives and instructions to guide all clinical examinations

Physical Assessment for Nurses Simplified Mark Aquino MSN RN, 2024-05-11

Physical Assessment for Nurses Simplified is an essential guide designed to streamline the learning and application of physical assessments for nurses. Organized according to a 14-point review of systems, this book aligns with the core areas frequently evaluated in patient examinations, making it a valuable educational resource for nursing professionals.

Book Description

Physical Assessment for Nurses Simplified serves as a comprehensive toolkit for both aspiring and experienced nurses, enhancing their capabilities in conducting thorough physical evaluations. This book is meticulously structured to cover all essential aspects of patient assessment through 14 detailed chapters, each dedicated to a specific body system, from general health, skin, and head to more specialized areas such as the cardiovascular and neurological systems.

Starting with the basics, the book introduces the importance of a detailed physical assessment and provides fundamental techniques and tips on how to effectively use this resource. Each chapter dives deep into specific examination procedures, offering step-by-step guides on techniques from skin inspection and palpation to advanced cardiac and neurological assessments. This approach ensures that nurses can quickly identify and address various health conditions, recognize early signs of disease, and effectively monitor ongoing issues.

Highlights include:

- Detailed chapters on each major body system providing focused examination techniques and identifying key symptoms and signs.
- Practical tips on recognizing common disorders and effectively documenting findings.
- Appendices featuring reference tables for normal versus abnormal findings, quick guides for system assessments, and a comprehensive glossary of terms.

Physical Assessment for Nurses Simplified is more than just a textbook; it is a practical guide that prepares nurses for real-world medical settings. The book emphasizes the importance of a systematic approach to physical examination, equipping nurses with the knowledge to perform confident and accurate assessments. This guide is an indispensable resource for anyone in the nursing field, facilitating continuous learning and skill enhancement necessary for high-quality patient care.

Whether you are a nursing student eager to learn the ropes or a seasoned practitioner looking to refresh your physical assessment skills, this book offers the tools you need to succeed in the fast-paced and ever-evolving field of nursing.

Importance of a Thorough Physical Assessment

A thorough physical assessment is integral to the nursing profession. It allows nurses to gather vital data about a patient's health, aiding in the early detection of diseases, evaluation of the effectiveness of treatment plans, and making informed decisions about further diagnostic tests. The initial assessments provide a baseline against which future changes in a patient's condition can be measured. This book underscores the importance of precision and attention to detail in the physical examination process.

How to Use This Book

This book is structured to facilitate both learning and practical application in clinical settings. Each chapter focuses on a specific system or aspect of the physical assessment, providing detailed explanations of examination techniques, practical tips, and visual aids to enhance understanding. Readers are encouraged to use this book as a reference guide in their daily practice as well as a tool for continuous learning. Readers will develop the ability to conduct more comprehensive and

effective physical assessments and improve their clinical competence and patient outcomes About the Author Mark Aquino is a registered nurse in California with a Masters of Science in Nursing Bachelors of Science in Nursing and Masters of Health Administration from West Coast University He has at worked in various psychiatric and mental health settings working alongside psychiatrists therapists and social workers and least 5 years of experience in the front lines as a visiting nurse in home health and hospice care He is author of OASIS NINJA A Home Health Nurse s Guide to Visits Documentation and Positive Patient Outcomes This guide provides nurses with the information they need to provide quality care to their patients in the comfort of their own homes Learn more at OasisNinja.com *Study Guide & Laboratory Manual for Physical Examination & Health Assessment* Carolyn Jarvis, PhD, APN, CNP, Ann L. Eckhardt, 2023-02 Both a comprehensive lab manual and a practical workbook the Study Guide Laboratory Manual for Physical Examination Health Assessment 9th Edition gives you the tools you need to master physical examination and health assessment skills in the lab and in clinical practice Corresponding to the bestselling Jarvis textbook this guide features terminology reviews application activities clinical judgment questions regional write up sheets and narrative summary forms with answers to study questions at the back of the book to facilitate both learning and review The 9th edition has been thoroughly updated with a fresh focus on the Next Generation NCLEX R NGN with case studies featuring new NGN question formats to prepare you not only for the skills laboratory but for success on the NCLEX R and in interprofessional collaborative practice Authoritative review and guidance for laboratory experiences personally written by the textbook authors provide a seamlessly integrated study and clinical experience Consistent format includes Terminology Review Study Guide and Clinical Judgment Questions in each chapter Physical examination forms familiarize students with what they will encounter in clinical practice and offer practice in documenting the patient history and examination findings The only full color illustrated lab manual available for a nursing health assessment textbook with anatomy exercises that align with the main text NEW Clinical judgment exercises equip students for success on the Next Generation NCLEX R NGN including questions with an increased focus on clinical judgment robust single episode case studies that employ the latest NGN question types and unfolding case studies which reflect the language of the NCSBN Clinical Judgment Measurement Model NEW Increased emphasis on activities focused on higher cognitive levels Applying and above UPDATED Critical Thinking Exercises offer suggested readings based on student participation in the skills lab and discussions with instructor UPDATED Content corresponds to the 9th edition of the Jarvis textbook and incorporates the latest research and evidence based practice

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