

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. **Reflexes** - Testing the patient's reflexes to detect abnormalities.
6. **Specialized** - Using specialized techniques to detect abnormalities.

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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).
1. **Hold your finger about 10cm from the patient's nose.**
1. **Ask them to alternate looking into the distance and at your finger.**
1. **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 colors and texture it is the color that you see. Use this as a guide to adjust the discolor dial to at least four from any abnormalities.
7. Move nearer from the disk to observe the details.
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.
 - a) To identify and manage a variety of patient problems (actual and potential)
 - a) Evaluate the effectiveness of nursing care
 - a) Enhance the nurse-patient relationship
 - a) Make clinical judgments

Gathering Data

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

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, texture, and moisture.
2. **Head and neck** - Observe the patient's head and neck for any abnormalities, including the eyes, ears, nose, and mouth.
3. **Chest** - Observe the patient's chest for any abnormalities, including the lungs, heart, and mediastinum.
4. **Abdomen** - Observe the patient's abdomen for any abnormalities, including the liver, spleen, and intestines.
5. **Extremities** - Observe the patient's extremities for any abnormalities, including the arms, legs, and feet.
6. **Genitalia** - Observe the patient's genitalia for any abnormalities.
7. **Rectum** - Observe the patient's rectum for any abnormalities.
8. **Perineum** - Observe the patient's perineum for any abnormalities.
9. **Anal** - Observe the patient's anal area for any abnormalities.
10. **Urogenital** - Observe the patient's urogenital area for any abnormalities.
11. **Neurological** - Observe the patient's neurological status for any abnormalities.
12. **Musculoskeletal** - Observe the patient's musculoskeletal system for any abnormalities.
13. **Endocrine** - Observe the patient's endocrine system for any abnormalities.
14. **Reproductive** - Observe the patient's reproductive system for any abnormalities.
15. **Integumentary** - Observe the patient's integumentary system for any abnormalities.
16. **Respiratory** - Observe the patient's respiratory system for any abnormalities.
17. **Cardiovascular** - Observe the patient's cardiovascular system for any abnormalities.
18. **Digestive** - Observe the patient's digestive system for any abnormalities.
19. **Urinary** - Observe the patient's urinary system for any abnormalities.
20. **Excretory** - Observe the patient's excretory system for any abnormalities.
21. **Immune** - Observe the patient's immune system for any abnormalities.
22. **Other** - Observe the patient's other systems for any abnormalities.

2. Ask the patient to inspire deeply.

3. The level of dullness (diaphragmatic excursion) should go down 3-6 cm symmetrically.

**Anterior Chest**

1. Percuss from the midline outwards to the left and right midclavicular line in the axillary line.
2. Compare one side to the other looking for asymmetry.
3. Note the location and quality of the percussion sounds you hear.

Posterior Chest

1. Percuss from the midline outwards to the left and right midclavicular line in the axillary line.
2. Compare one side to the other looking for asymmetry.
3. Note the location and quality of the percussion sounds you hear.
4. Find the point of the

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pages

Physical Assessment Study Guide

Donita D'Amico, Colleen Barbarito



Physical Assessment Study Guide:

Study Guide & Laboratory Manual for Physical Examination & Health Assessment E-Book Carolyn Jarvis, Ann L. Eckhardt, 2023-01-02 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 NGN with case studies featuring new NGN question formats to prepare you not only for the skills laboratory but for success on the NCLEX 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 you with what you 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 you for success on the Next Generation NCLEX 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 Chapter 33 includes unfolding case studies for the NGN that present opportunities for you to practice prioritizing decision making and using clinical judgment skills NEW Increased emphasis on activities focused on higher cognitive levels Applying and above UPDATED Critical Thinking Exercises offer suggested readings based on your participation in the skills lab and discussions with your instructor UPDATED Content corresponds to the 9th edition of the Jarvis textbook and incorporates the latest research and evidence based practice *PHYSICAL ASSESSMENT* National Learning Corporation, 2019 **Physical Assessment**, 1992

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physical examination process

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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 APN CNP, Ann L. Eckhardt, 2023-02-17

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