Lecture (4) 4th Stage Nursing

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General Physical assessment

General physical assessment :is a comprehensive evaluation of a person's physical health. It involves observing and examining various body systems to check for any signs of illness, disease, or abnormalities.

Physical assessment techniques :

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

Step Of Physical Assessment From (Head To Toe)

Steps	Information
1. General appearance: -Behavior /anxiety -Level of hygiene -Body position -Patient mobility -Speech pattern and articulation	-Alterations may reflect neurologic impairment, oral injury or impairment, improperly fitting dentures, differences in dialect or language, or potential mental illness. - Unusual findings should be followed up with a focused neurological system assessment.

2.Skin, hair, and nails: -Inspect for lesions, bruising, and rashes. -Palpate skin for temperature, moisture, and texture. -Inspect for pressure areas. -Inspect skin for edema. -Inspect scalp for lesions	-Redness of the skin at pressure areas such as heels, elbows, buttocks, and hips indicates the need to reassess patient's need for position changes. Unilateral edema may indicate a local or peripheral cause, whereas bilateral-pitting edema usually indicates cardiac or kidney failure.
3.Head and neck: -Inspect eyes for drainage. Inspect eyes for pupillary reaction to light. -Inspect mouth, tongue, and teeth for moisture, color, dentures . -Inspect for facial symmetry.	-Check eyes for drainage, pupil size, and reaction to light. Drainage may indicate infection, allergy, or injury. Slow pupillary reaction to light or unequal reactions bilaterally may indicate neurological impairment. Dry mucous membranes indicate decreased hydration. Facial asymmetry may indicate neurological impairment or injury..
4.Chest: Inspect: −Expansion/retraction of chest wall/work of breathing and/or accessory muscle use −Jugular distension -Auscultate: −For breath sounds anteriorly and posteriorly −Apices and bases for any adventitious Palpate: −For symmetrical lung expansion	Chest expansion may be asymmetrical with conditions such as atelectasis, pneumonia, fractured ribs, or pneumothorax. Use of accessory muscles may indicate acute airway obstruction or massive atelectasis. Jugular distension of more than 3 cm above the sternal angle while the patient is at 45º may indicate cardiac failure. The presence of crackles or wheezing must be Note the heart rate and rhythm, identify S1 and S2, and follow up on any unusual findings with a focused cardiovascular assessment.

5. Abdomen: Inspect: −Abdomen for distension, asymmetry Auscultate: −Bowel sounds Palpate: Four quadrants for pain and bladder/bowel distension (light palpation only) -Check urine output for frequency, color, odor. -Determine frequency and type of bowel movements.	-Abdominal distension may indicate ascites associated with conditions such as heart failure, cirrhosis, and pancreatitis. Markedly visible peristalsis with abdominal distension may indicate intestinal obstruction. -Hyperactive bowel sounds may indicate bowel obstruction, gastroenteritis, or subsiding paralytic ileum. -Hypoactive or absent bowel sounds may be present after abdominal surgery, or with peritonitis or paralytic ileus. -Pain and tenderness may indicate underlying inflammatory conditions such as peritonitis. -Unusual findings in urine output may indicate compromised urinary function..
6.Extremities: Inspect: −Arms and legs for pain, deformity, edema, pressure areas, bruises Compare bilaterally Palpate: −Radial pulses −Pedal pulses −CWMS and capillary refill (hands and feet)	-Limitation in range of movement may indicate articular disease or injury. -Palpate pulses for symmetry in rate and rhythm. -Asymmetry may indicate cardiovascular conditions or post-surgical complications. -Unequal handgrip and/or foot strength may indicate underlying conditions, injury, or post-surgical complications. **CWMS**: color, warmth, movement, and sensation of the hands and feet should be checked and compared to determine adequacy of perfusion

7. Back area (turn patient to side or ask to sit up or lean forward): -Inspect back and spine. -Inspect coccyx/buttocks	-Check for curvature or abnormalities in the spine. -Check skin integrity and pressure areas
8.Mobility: - Check if full or partial weight-bearing. -Determine gait/balance. -Determine need for and use of assistive devices.	-Assess patient's risk for falls. -Note use of mobility aids and ensure they are available to the patient on ambulation.
9.Report and document assessment findings and related health problems according to agency policy.	Accurate and timely documentation and reporting promote patient safety

BEST WISHES