



## **Focused Physical Examination for the Acute Care Setting**

**This course has been awarded one (1.0) contact hour.**

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## **Acknowledgements**

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...Robin Varela, RN, BSN, and Lori Constantine MSN, RN, C-FNP, the original course author.

## **Purpose & Objectives**

The purpose of this course is to review the process for performing a complete physical exam for adult patients in the acute care setting.

***After successful completion of this course, the participant will be able to:***

1. Describe the details of performing a focused physical exam in an acute care setting.
2. Identify abnormal findings when conducting a head to toe assessment on your hospitalized patient.
3. Describe how to organize a routine physical assessment.

## **Introduction**

Nurses are integral members of a multi-disciplinary healthcare team. In an acute care setting, nurses often have the responsibility and the privilege of performing a focused physical assessment for each of their patients.

This initial assessment provides an important opportunity to evaluate and formulate a plan of care that is best suited to meet your patients' needs (Jarvis, 2012). Note that this course focuses on examination of the adult patient in an acute care setting. The assessment of a pediatric or neonatal patient is specialized and is outside the scope and purpose of this course.

## **Focused Physical Examination for the Acute Care Setting**

Performing a methodical and focused physical examination will allow the nurse to detect obvious and subtle changes in a patients' health status.

The ability to recognize any changes in patient status will depend on the evaluator's level of expertise and knowledge of normal anatomy and physiology. In addition, the environment where the physical exam is to be performed should support a quality exam.

A focused physical assessment begins with an initial survey of the patient and the surrounding environment. When entering the patient's room, note the patient's general appearance and their response to your greeting.

## **Focused Physical Examination for the Acute Care Setting**

It is important to maintain a confident and empathetic professional demeanor. If family members or friends are present this is an opportune time to observe the type of social interactions that occur between the patient and their significant others (Jarvis, 2012).

A systematic physical assessment remains one of the most vital components of patient care. A thorough physical assessment can be completed within a time frame that is practical and should never be dismissed due to time constraints (Zambas, 2010).

## **The Environment**

The nurse should closely observe the environment of the patient to identify any potential safety hazards such as:

- Poor lighting.
- Objects on the floor.
- Wheelchairs or furniture that is moveable or unlocked.
- Excessive clutter.
- Accessibility to mobility aids.

Other considerations include ensuring that the patient has access to:

- Clean eye-glasses (as needed).
- Properly fitting non-slip footwear.
- Personal belongings and call bell.
- Urinal (for males).

In addition, the nurse should ensure that IV tubing and poles are out of walking area, and that the IV poles move freely and are sturdy. The patient's tubes and drains should not be a fall hazard.

## **Setting The Scene: Communication & Privacy**

This initial introductory period is very valuable in building trust and establishing rapport, and provides clues to your patient's ability to comprehend health information and help you identify potential educational needs (Jarvis, 2012). Communication during the physical must be respectful and performed in a culturally-sensitive manner. Privacy is vital, and the healthcare professional needs to be aware of posture, body language, and tone of voice while interviewing the patient (Jarvis, 2012; Caple, 2011).

## **General Survey**

Focus your attention on the patient. Perform a quick, general survey and explain to the patient the importance of performing a focused physical assessment.

This initial general survey usually allows you to note the patient's physical and mental status (alert, confused, relaxed, anxious, disheveled, well-groomed), the presence of IVs or dressings, and the type of equipment the patient is using.

A brief scan of this equipment should indicate if it is functioning properly. If there is doubt about the correct functioning of the equipment, attend to this situation immediately and explain what you are doing to the patient. If there is doubt about the integrity of an IV or a dressing is not intact, this should also be corrected (Jarvis, 2012; Altman, 2010).

## **Vital Signs**

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Vital signs must be reviewed in conjunction with the physical exam.

It is a good idea to consult your patient's chart before you begin the assessment to review previous vital signs and any other pertinent information specific to your patient's status. Identification of trends in vital signs can be crucial to identifying potential problems (such as steadily increasing or decreasing vital signs) (Jarvis, 2012; Edmunds, Ward & Barnes, 2010).

When reviewing vitals, your patient's temperature should be within normal range. Causes of high or low temperatures should be investigated.

Heart rate or pulse should be within normal range. Rates vary according to age and patient history. Typically, adults radial pulse rate should be between 60 and 100 beats per minute. The pulse should be regular. Descriptions of pulse are weak or strong, with a regular or irregular beat. An irregular heart rate should be counted for a full minute (Jarvis, 2012; Altman, 2010). See also section on extremities and pulse quality later in module.

### Respiration & Blood Pressure

You will also want to note the rate and depth of respirations. Again, respiratory rates vary according to age and patient history. It is always important to know your patient's baseline respiratory rate. A normal adult respiratory rate is from 12 to 20, although some sources say 16-24. Regardless, assess their rate and compare to their baseline. Descriptions of respirations are normal (or easy), shallow, deep, labored, or noisy (Jarvis, 2012; Altman, 2010).

Finally, look at your patient's blood pressure. Recall that the systolic reading reflects the pressure exerted by the left ventricle during contraction. The diastolic reading reflects the pressure in the arteries when the heart is at rest. The American Heart Association (AHA) report that a normal blood pressure reading is a systolic blood pressure of less than 120 mmHg and a diastolic pressure of less than 80 mmHg.

Beginning from the age 20 and onwards, the American Heart Association recommends a blood pressure screening at least once every 2 years, if blood pressure is less than 120/80 mm Hg (AHA, 2014).

### Normal Range of Adult Vital Signs

Vital Sign	Range
Pulse/heart rate	60-100 beats/minute
Respiratory rate	12-20 breaths/minute
Blood pressure	Systolic: Less than 120mmHg Diastolic: Less than 80mmHg

(Jarvis, 2012; Altman, 2010)

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## AHA Blood Pressure Categories

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Normal	Less than <b>120</b>	and	Less than <b>80</b>
Prehypertension	<b>120 - 139</b>	or	<b>80 - 89</b>
High Blood Pressure (Hypertension) <b>Stage 1</b>	<b>140 - 159</b>	or	<b>90 - 99</b>
High Blood Pressure (Hypertension) <b>Stage 2</b>	<b>160 or higher</b>	or	<b>100 or higher</b>
<b>Hypertensive Crisis</b> (Emergency care needed)	Higher than <b>180</b>	or	Higher than <b>110</b>

Modified from the American Heart Association [AHA], (2014).

## Test Yourself

Respiratory rates should be assessed in relation to:

1. Other patients
2. The patient's own baseline rate - *Correct*
3. Standard respiratory rates by age group

## Pain Assessment

Conducting an in-depth pain assessment will assist you in developing a comprehensive pain management plan. If patients are able to communicate, it is important to incorporate verbal reports of pain using descriptions and/or appropriate tools. Pain must be assessed and recorded in a manner that promotes reassessment. By using the mnemonic PQRST, you can easily and confidently perform and document a comprehensive pain assessment.

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Use PQRST to assess each symptom and after any intervention to evaluate any changes or responses to treatment (Jarvis, 2012):

P: Provoked or Palliative: What makes the pain better or worse?

Q: Quality: Describe the pain. Is it burning, shooting, aching, stabbing, crushing, etc?

R: Region or Radiation: Does the pain radiate to another body part?

S: Severity: On a scale of 1-10, (10 being the worst) how bad is your pain? Another visual scale may be appropriate for patients that are unable to identify with this scale.

T: Timing: Does it occur in association with something else? (e.g. eating, exertion, movement)

### **Pain Assessment and Reassessment**

Due to the subjectivity of pain, the patient's self-report must be the standard by which pain is measured. A systematic history of the pain and its associated factors provides the healthcare provider with a powerful foundation to control the patient's pain (Jarvis, 2012).

If your patient complains of pain during the initial assessment, do not withhold medications in order to complete an entire assessment (follow your facility procedure for administration of pain medication). Keep in mind, however, that assessment is the first step in satisfactorily managing a patient's pain.

To evaluate the effectiveness of a treatment or medication, the patient's response to the pain intervention must also be reassessed (within your facility's specific time frame).

### **A Comprehensive Review of Systems**

As you perform your physical assessment, keep in mind that physical assessment findings will help to determine the etiology of the diagnosis.

Begin by assessing the patient's head and work your way to their toes, assessing different body systems as you travel from head to toe.

### **Head Assessment**

When inspecting the patient's head, inspect and palpate (if necessary) the scalp, hair, and cranium. Note lesions, tenderness of scalp, and condition of hair/hygiene. Inspect your patient's facial expression and symmetry. This will test the functioning of Cranial Nerve VII, which functions to control most of the muscles of facial expression.

An acute facial nerve paralysis is usually manifested by facial paralysis. Bell's palsy is one type of idiopathic acute facial nerve paralysis, which involves the facial nerve, and most likely results from viral infection and also sometimes as a result of Lyme disease.

### **Facial Assessment**

Voluntary facial movements, such as wrinkling the brow, showing teeth, frowning, closing the eyes tightly (lagophthalmos), pursing the lips and puffing out the cheeks, all test the facial nerve. There should be no noticeable asymmetry (Jarvis, 2012).

## **Pupillary Assessment**

Inspect external eye structure, conjunctivae, sclera, corneas, and irises while shining a penlight at the patient's pupils. Note any discoloring or discharge.

You will need to assess each pupil's size, shape, and symmetry.

Each pupil should constrict briskly when a light is shined into the eye. Each pupil should also have consensual light reflex. This means that when you shine the penlight into the right eye, the left eye constricts and vice versa. When assessing PERRLA (Pupils Equal Round and Reactive to Light and Accommodation), note how many mm before and after constriction with light, and how long for the reaction. The best description for reaction is in seconds rather than "normal" or "sluggish," which can be subjective (D'Amato & Hartlage, 2008).

## **Inspection of Ears, Nose, Mouth & Throat**

The ears, nose, mouth, and throat should be inspected as well at this time. Examine behind the ears for redness and skin condition, check for discharge from ears, response of patient (hearing acuity), and general symmetry. Inspect the mouth, looking at mucosa and teeth. This can identify if the patient needs oral care.

Unless there is an abnormality, no further examination of these sites is needed.

## **Neck Inspection & Palpation**

Inspect the neck for symmetry, lumps, and pulsations.

If necessary, palpate cervical lymph nodes.

Inspect and palpate the carotid pulses. Do not occlude both carotid arteries at the same time.

## **Neck Auscultation**

If the patient has a history of cardiovascular disease, you may want to auscultate the carotid arteries for the presence of bruits by using the bell of your stethoscope. Bruit is French for noise, and is an abnormal sound sometimes heard over an artery or vascular channel, when there is turbulent blood flow. Listening for a bruit in the neck is a simple, safe, and inexpensive way to screen for stenosis of the carotid artery (Edmunds, Ward & Barnes, 2010; Jarvis, 2012).

Test range of motion and muscle strength against resistance (tests cranial nerve XI) by having the patient perform shoulder shrugs while you press down on their shoulders. Rate their strength on a scale of 0-5 (Jarvis, 2012).

## **Test Yourself:**

The presence of bruits in the carotid artery may suggest:

1. Stenosis
2. Turbulent blood flow
3. Both of the above – *Correct!*

## Thorax

**Inspection:** Inspect the chest for asymmetry, deformity, or increased anterior-posterior (AP) diameter and confirm that the trachea is near the midline. A normal AP diameter is approximately 2:1.

Observe the rate, rhythm, depth, and effort of breathing. Note whether the expiratory phase is prolonged. Listen for obvious abnormal sounds with breathing such as wheezes. Observe for retractions and use of accessory muscles (Jarvis, 2012).

**Palpation:** Palpate for symmetric expansion. Identify any areas of tenderness or deformity by palpating the ribs and sternum (Jarvis, 2012).

**Lung Auscultation:** Listen to breath sounds noting adventitious (abnormal) sounds. When auscultating, ensure your room is quiet, auscultate over bare skin, and listen to one sound at a time. Your bell or diaphragm should be placed on your patient's skin firmly enough to leave a slight ring on their skin when removed. Be aware that your patient's hair may also interfere with true identification of certain sounds (Altman, 2010; Jarvis, 2012).

[Click here](#) to listen to normal lung sounds, crackles and wheezes, using The Auscultation Assistant®. (Make sure the volume is turned up on your computer.)

### Assessment of Lung Sounds

Begin with auscultation of the front of the chest, followed by auscultation of the chest from the back. To assess lung sounds, place the diaphragm of your stethoscope on number one on the far right of the front of the chest, and follow the numbers according to the pattern shown. Remember to also listen to the right side of the chest, mid-axillary line, in order to hear the right middle lobe (Altman, 2010; Jarvis, 2012). You should expect to hear 3 normal types of breath sounds in the adult and older child:

- Bronchial breath sounds (B) are loud, harsh and high pitched sounds, heard predominantly over the trachea, bronchi (between clavicles and midsternum) and over the main bronchus.
- Bronchovesicular (BV) breath sounds are blowing sounds with moderate intensity and pitch, and are heard over large airways, on either side of the sternum, at the angle of Louis and between the scapulae.
- Vesicular (V) breath sounds are soft, breezy, low pitched sounds heard over the peripheral lung area, and are most clearly heard at the base of the lungs.

## Lung Sounds

Sound	Description
<b>Bronchial</b>	Heard normally over the trachea. Inspiration = Expiration When heard over areas other than the trachea may indicate fibrosis, atelectasis, or pneumonia (Jarvis, 2008).
<b>Fine Crackles</b>	Also known as rales. Noted as a “popping” sound. May also be referred to as crepitation. If: Early inspiratory crackles – related to bronchitis Mid inspiratory crackles – atelectasis Late inspiratory crackles – pneumonia, congestive heart failure (CHF), pulmonary fibrosis, tuberculosis (Jarvis, 2008).
<b>Coarse Crackles</b>	Loud and low pitched. Usually present with increased fluid or mucous (Jarvis, 2008).

Sound	Description
<b>Wheezes</b>	High-pitched musical quality. Present in conditions that narrow the airways such as obstruction, aspiration, pneumonia, and asthma (Jarvis, 2008).
<b>Stridor</b>	High-pitched, crowing sound heard with upper airway obstruction. Usually indicates an emergency situation (Jarvis, 2008).
<b>Rhonchi</b>	Present with large amounts of airway secretions. May also be referred to as low-pitched wheezes (Jarvis, 2008).
<b>Pleural Friction Rub</b>	A low-pitched, grating, or rubbing sound caused by pleural inflammation (Jarvis, 2008).

### Test Yourself:

Normal breath sounds include:

1. Bronchial sounds – *Correct!*
2. Occasional crackles
3. Intermittent stridor

### Cardiac Assessment

After auscultating the lung fields, focus your attention on the heart.

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**Inspection:** Inspect the precordium for pulsations or a heave.

## **Cardiac Auscultation**

Before you begin your auscultation of the precordium, preface your exam by telling the patient you will be listening in many different places for what might seem a long time. Let your patient know that this does not indicate that anything is wrong.

Then identify the areas you need to auscultate. You may want to inch your stethoscope in a “Z-pattern” across the precordium, from the base of the heart to the apex.

## **Normal Heart Sounds**

The first heart sound (S1): Occurs with the closure of the AV valves and signals the beginning of systole. Although you can hear S1 sounds all over the precordium, it is loudest at the apex. S1 is easily recognized as the “lub” sound.

The second heart sound (S2): Occurs with the closure of the semilunar valves and signals the end of systole. This sound is loudest over the base, and is easily recognized as the “dub” sound.

The third heart sound (S3): Is normally not heard, as it occurs during early ventricular filing. When the ventricles are resistant to filling, a S3 sound may be heard as ventricular filling causes vibrations that can be heard over the chest.

The fourth heart sound (S4): Occurs at the end of diastole, when the ventricle is resistant to filing. The atria contract and push blood into a non-compliant ventricle during presystole. This creates vibrations that are heard as S4 sounds, just before S1.

(Jarvis, 2012).

## **Auscultating Rate and Rhythm**

Auscultate apical rate and rhythm. Note any abnormal heart sounds, their anatomical location, and their timing in relation to S1 and S2. At least one assessment should include both the diaphragm and the bell of your stethoscope to identify any abnormal sounds. Remember that murmurs occur when there is turbulence in the blood flow, which could be from numerous causes. Hearing a murmur is only one piece of the puzzle to assessment (Edmunds, Ward & Barne, 2010; Jarvis, 2012).

[Click here](#) to listen to rubs, gallops and continuous murmurs using The Auscultation Assistant®.

## **Test Yourself:**

An S3 heart sound can be heard when the:

1. Atria fill
2. Semilunar valves close
3. Ventricles are resistant to filling – Correct!

## **Male and Female Breasts**

When examining the thorax it is also important to inspect the breasts of male and female patients.

The male breast should be assessed for any ulcerations or sores, edema, or nodules. Although rare, men can be at risk for developing breast cancer, especially if a mother or sister has been diagnosed with the disease (Jarvis, 2012).

## **Female Breast Examination**

Females require a much more in-depth exam related to the larger amount of glandular tissue that is considered to be a potential site for the growth of cancer cells (Altman, 2010). Female breasts should be examined for size, symmetry, edema, inflammation, lesions and the presence of any discharge. Lymph nodes are not normally palpable in males or females. Any masses that are detected should be palpated to determine location, tenderness, mobility, consistency, diameter, shape and definition of boundaries (Altman, 2010; Jarvis, 2012).

When performing your inspection keep in mind that breast tissue changes with age. Anticipate that older patients will have less elasticity of tissue that can result in pendulous breasts or shrunken nipples.

Also examine the skin underneath breast tissue. Creases provide a warm, moist environment that can grow yeast and bacteria (Jarvis, 2012).

### **Test Yourself:**

Breast tissue does not change with age.

1. True
2. False – Correct!

## **Abdomen**

Inspect the abdomen for previous surgical scarring, bulges, masses, hernias, ascites, or pulsations.

Auscultate for bowel sounds after inspection, but prior to percussion and palpation, since percussion and palpation can increase peristalsis, which can give a false interpretation of bowel sounds. Divide the abdomen into 4 quadrants, by drawing an imaginary line vertically and horizontally across the abdomen, to intersect at the umbilicus.

Right Upper Quadrant (RUQ):

- Liver
- Gallbladder
- Duodenum
- Head of pancreas
- Right kidney and adrenal gland
- Hepatic flexure of colon
- Part of the ascending & transverse colon

#### Left Upper Quadrant (LUQ):

- Stomach
- Spleen
- Left lobe of liver
- Body of pancreas
- Left kidney & adrenal gland
- Splenic flexure of the colon
- Part of the transverse and descending colon

#### Right Lower Quadrant (RLQ):

- Cecum
- Appendix
- Right ovary and tube
- Right ureter
- Right spermatic cord

#### Left Lower Quadrant (LLQ):

- Part of descending colon
- Sigmoid colon
- Left ovary and tube
- Left ureter
- Left spermatic cord

Auscultation should begin in the right lower quadrant. If bowel sounds are not heard, in order to determine if bowel sounds are truly absent, listen for a total of five minutes (Jarvis, 2012).

#### **Abdominal Percussion**

Percuss the abdomen to assess the relative density of abdominal contents, to locate organs and to screen for abnormal fluid or masses (Jarvis, 2012). Begin with light percussion in all 4 quadrants, and progress in a clockwise manner. Findings may include:

- Tympany (Hollow drum-like sound produced when a gas-containing cavity is tapped): Should be present in all 4 quadrants as air in the intestines rise to the surface when the patient is supine.
- Dullness: Occurs over a distended bladder, adipose tissue or a mass.
- Hyperresonance (Low-pitched, booming sound): Present when there is gaseous distention.

#### **Abdominal Palpation**

Lastly, palpate the abdomen lightly then deeply noting any muscle guarding, rigidity, masses, or tenderness.

Palpate tender areas last. Only if indicated, palpate the liver margins, the spleen or the kidneys and percuss the abdomen for general tympany, liver span, splenic dullness, costovertebral angle tenderness, presence of fluid wave, or shifting dullness with ascites (Jarvis, 2012).

### **Male and Female Genitalia**

Inspect the patient's genitalia. Make note of any abnormalities such as redness, swelling or discharge. Also examine the skin creases around the genitalia for redness, tenderness, and odor (Jarvis, 2012).

In the acute care setting, the physician or an advanced practitioner may ask for your assistance collecting swabs to be sent to the lab for testing. Remember that many individuals (male and female) may be very uncomfortable with this part of the exam.

Ensure privacy and provide a clear explanation of why and what you are doing. Allow the patient time to ask questions. Some cultures might require that a family member be present or that an exam be performed by a nurse or physician of the same gender as the patient (Altman, 2010; Jarvis, 2012).

### **Elimination**

While performing an inspection of the patient's genitalia, examine the urinary meatus. Note redness, swelling or discharge. Ask the patient about the color, odor, and amount of urine the patient is producing. Most often, patients with renal or urinary problems will complain about frequent urination, difficult or painful urination, or blood in their urine. Their 24-hour intake should be comparable to their 24-hour output. Check their flow sheet and assess their 24-hour intake and output.

Compare their weight today with yesterday's weight. Weight should not significantly increase from day to day unless there is fluid accumulation or decrease from day to day unless there has been a prescribed therapy aimed at this.

You will also want to note the patient's last bowel movement, its character, and ask the patient if there are any difficulties with producing bowel movements (Jarvis, 2012).

### **Palpation & Assessment of Upper Extremities**

Palpate the peripheral arteries of the upper extremities, namely the brachial and radial arteries. Note the contour and amplitude of each pulsation. These should feel similar bilaterally. As you move further away from the core of the body, you may notice that the contour or upstroke of the pulsation is less rapid. This is normal. It is important, however, that the arteries have similar strength bilaterally.

Inspect and assess upper extremity strength, symmetry and range of motion for the shoulders, elbows, wrists, and hands. Test the strength and symmetry of a hand grip. Assess the strength and symmetry of the bicep and tricep muscles by asking the patient to extend their elbows (triceps) against your resistance, then flex their elbows (biceps) against your resistance (Altman, 2010; Jarvis, 2012).

### **Inspection & Palpation of Lower Extremities**

Inspect the patient's skin for warmth, moisture and edema. Cool, clammy skin results from vasoconstriction; warm, moist skin results from vasodilation.

Note any edema. Edema can result from many disease processes including heart failure, liver failure, or by venous insufficiency, varicosities, and thrombophlebitis. Inspect your patient's hair distribution on their skin of the lower extremities. Lack of hair may indicate arterial insufficiency.

Capillary refill should be tested bilaterally by pressing the nails on fingers. An expected refill with blanching is less than 2 seconds for adults (Jarvis, 2012).

### Inspection & Assessment of Lower Extremities

Palpate the peripheral arteries of the lower extremities. These include the femoral, popliteal, dorsalis pedis and posterior tibial arteries. It may be necessary to only palpate the most distal arteries, namely the dorsalis pedis and posterior tibial. To locate the dorsalis pedis, palpate the artery on top of the foot on the side of the big toe. To palpate the posterior tibial artery, find the bony prominence (the medial malleolus) on the medial ankle. Roll your finger towards the angle of the heel, and feel for the pulse. If they are present you can assume the more central arteries are intact.

Note the contour and amplitude of each pulsation. These should feel similar bilaterally. As you move away from the core of the body, remember that the contour or upstroke of the pulsation is less rapid and this is normal. It is still important, however, that the arteries have similar strength bilaterally (Altman, 2010; Jarvis, 2012).

### Extremities: Pulse & Muscle Strength

Inspect and assess lower extremity strength and range of motion for the hips, knees, ankles, and feet. Ask the patient to flex their legs at the hips. Provide some resistance to this. Examine their strength against resistance when they extend their knees (quadriceps) and dorsiflex and plantarflex their feet. Again, note strength and symmetry of these muscle groups. Capillary refill should also be assessed bilaterally on the feet, and compared with the time for return with upper extremities (Jarvis, 2012).

Consult this edema scale to correctly and objectively rate your patient's edema.

<b>1+</b>	2mm depression, barely detectable. Immediate rebound.
<b>2+</b>	4mm deep pit. A few seconds to rebound.
<b>3+</b>	6mm deep pit. 10-12 seconds to rebound.
<b>4+</b>	8mm: very deep pit. >20 seconds to rebound.

Hogan (2013)

### Test Yourself:

Your patient has pitting edema that disappears within a few seconds. This is considered:

1. 1+
2. 2+ - *Correct!*
3. 3+

### Assessing Peripheral Pulses and Muscle Strength

This table will help you rate the strength of your patient’s peripheral pulses.

Rating	Pulse Strength
0	Absent pulse
1+	Trace or weak pulse
2+	Normal
3+	Stronger than normal
4+	Bounding

Consult this scale to objectively rate your patient’s muscle strength.

Rating	Strength
0	No movement
1+	Trace movement
2+	Severe weakness
3+	Moderate weakness
4+	Mild weakness
5+	Strong

### Skin Assessment

Skin assessment can be performed throughout the physical examination. As each body system is examined, assessment of the skin can be incorporated into findings (Jarvis, 2012).

When assessing the skin, EXAMINE the following:

- General pigmentation (evenness, appropriate for heritage)
- Systemic color changes (pallor, erythema, cyanosis, jaundice)
- Freckles and moles (symmetry, size, border, pigmentation)
- Temperature (hypothermia, hyperthermia)
- Moisture and texture (diaphoresis, dehydration, firm smooth texture)
- Edema (location and degree)
- Bruising (location, pattern, consistent with history – especially in at risk populations)
- Lesions (color, elevation, pattern or shape, size, location, exudates)
- Hair (normal color, texture, distribution)
- Nails (shape, contour, color)

- Remember that skin breakdown is a common problem with ill and hospitalized patients. Skin assessment is vital to identify areas of vulnerability in the prevention of pressure ulcers (Jarvis, 2012).

## **Wound Assessment**

If any wounds or alterations in skin integrity were noted during your exam, you will want to go back and pay closer attention to that site(s). This assessment involves identification of the cause of the wound (i.e. is it venous, arterial, diabetic, traumatic, or pressure-related?), the location, size, and depth of the wound.

Assessment must also include assessing for any undermining or dead space, the type of tissue present, the quality and amount of exudates, the presence of infection, the condition of the wound margins, and an evaluation of any past and current treatments.

Additionally, if the wound is thought to be a pressure wound, you should stage it. Pictures of wounds are also an important component of documentation. Consult your facility's policies and procedures for wound documentation and treatment (Altman, 2010; Jarvis, 2008).

*For a more in-depth review of skin wounds, please see RN.com's Assessment Series Course: Skin Anatomy, Physiology & Assessment.*

### **Stage 1**

#### ***Major Descriptor***

Non-blanchable erythema of intact skin - do not confuse with reactive hyperemia (a transient increase in blood flow following a brief period of occlusion, such as arterial occlusion).

#### ***Characteristics***

- May be either warm or cool to the touch
- May be boggy or firm to the touch
- Pain and itching may be present

#### ***Special Considerations***

Fair Skinned Persons: Ulcers appear as an area of persistent redness.

Darker Skin: Ulcer may appear with persistent red, blue, or purple.

### **Stage 2**

#### ***Major Descriptor***

Partial thickness skin loss involving epidermis and/or dermis

#### ***Characteristics***

- Superficial wound
- Shallow crater

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### ***Special Considerations***

May only appear as a blister or abrasion

### **Stage 3**

#### ***Major Descriptor***

Full-thickness skin loss involving damage or necrosis of subcutaneous tissue

#### ***Characteristics***

A Stage 3 wound is usually described as a deep crater.

#### ***Special Considerations***

Sinus tracts extending into adjacent tissue may or may not be present.

### **Stage 4**

#### ***Major Descriptor***

Full thickness skin loss with extensive destruction, tissue may or may not be present. Muscle and bone injury may be involved.

#### ***Characteristics***

- Necrotic or eschar tissue may be noted
- Muscle, bone, and other supporting structures may be visible

#### ***Special Considerations***

May affect joint, tendons and/or ligaments.

Sinus tracts also may be associated with Stage IV pressure ulcers.

#### ***Staging of Pressure Ulcers***

Pressure ulcers can be classified according to 4 different stages of infiltration:

<b>Stage Ulcer</b>	<b>Description</b>
Stage 1	Skin is reddened, but intact
Stage 2	Epidermal and dermal layers are injured
Stage 3	Subcutaneous tissues are injured
Stage 4	Muscle and perhaps bone are injured

## Test Yourself:

A Stage 3 pressure ulcer will involve injury to:

1. Muscle and bone
2. Subcutaneous tissue – *Correct!*
3. The epidermal and dermal layers

## Conclusion

As the patient's nurse, you must critically analyze all of the data that you collect from a focused physical assessment.

Once you have obtained all of the patient's information, the data must be synthesized into relevant problem focuses and a plan of care devised that is based on the synthesis of the information you have collected.

In addition, as the plan of care is being carried out, reassessments must occur on a prescheduled and as needed basis. The frequency of these reassessments is unique to each patient and depends on their health status. Determining how often to reassess your patient is a critical thinking skill that comes with patient care experience.

Performing a focused physical assessment is an invaluable tool that assists the caregiver to individualize and provide the best quality care available.

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