HNN114: Assessment instructions

Assessment techniques:

- Inspection (looking)
- Auscultation (listening)
- Percussion (tapping body parts)
- Palpation (feeling)

A – airway
B – breathing
C – circulation
D – disability (neurological assessment)
E – exposure and environmental control

C – character
O - onset
L - location
D – duration
S – severity
P - pattern
A – associated factors

Vital signs normal ranges:

- HR – low 60, high 100
- RR – 12-20 breaths a minutes
- BP – systolic 100-130, diastolic 60-90
- O2 saturation – 95 above
- Temp – 36-38

Vital signs terms:

- Low HR – Bradycardia
- High HR – Tachycardia
- Low temp – hypothermia
- Normal temp - afebrile
- High temp – febrile/pyrexia/hyperthermia
- Low BP – hypotension
- Normal BP – normotensive
- High BP – hypertension
- Low RR – bradypnoea
- High RR – tachypnoea
- Low O2 saturation – hypoxia

Week 1: Abdominal assessment:

- Introduce yourself
- Hand hygiene
- Close curtains
- Explain what you will be doing
- Bring a towel to place on the patient
- Pull blanket down and cover lower half with towel
- Use all 4 techniques, Inspect, auscultate, percuss and then palpation
- Inspect:
  - colour, marks on skin, symmetry, land marks
- Auscultate:
  - start in the lower right quadrant as this is where the large bowel begins
  - upper right
  - upper left
  - lower left
  - listen for a minute in each place
  - listen for bowel sounds
  - (if you go to far in the upper right you wont hear anything as you are over the liver)
- Percussion (don't really use it as we use ultrasounds now)
  - if they are distended distinguish between fluid and gas
  - press middle finger into the skin and strike with other hand
- Palpation:
  - looking for any masses (not soft, tenderness, pain, guarding)
  - surface palpation (identify landmarks)
  - surface palpation for any masses
  - light palpation (ask patient if it hurts) pressing 1-2cm into the abdomen

Open and Closed questions:

Open:

- Can you describe what type of pain you are in?
- What makes the pain worse?
- What changes have you made recently e.g diet, exercise

Closed:

- Do you have any pain?
- Do you have a history of stomach problems?
- Have you opened your bowels?

Potential normal and abnormal findings:

Normal:

- Bowel sounds present
- Clicks and gurgles every 5-30 mins
- No pain, No guarding
- Symmetrical
- Colour, skin integrity

Abnormal:

- Hyper/hypoactive bowel sounds – tinkling
- Absent bowel sounds
- Discomfort when lightly pressing
- Distended bladder
- Dull sound over mass or obstruction when percussing

Week 2: Respiratory assessment:

- Introduce yourself
- Hand hygiene
- explain what you are doing
- bring gown down
- inspect
  - work of breathing (WOB)
  - any additional audible sounds e.g. snoring, this indicates increased WOB
  - any use of abdominal or intercostal muscles to help with breathing
  - steady RR
  - skin is pink
- Palpation:
  - feel on back of hand skin temperature
  - sit patient forward
  - feel back and chest as he is taking deep breaths in and out
  - place hands on his back to feel his chest expansion
- Auscultate:
  - listen to front chest (anterior)
  - working way down the chest on both sides to make sure it sounds the same
  - listen to right mid lobe (listen for clear versicular sounds)
  - listen to the back on both sides comparing left to right

Open and Closed questions:

Open:

- Explain what caused the sudden onset of pain?
- What have you done that's different to what you usually do?
-

Closed:

- Are you in any pain?
- Have you taken any medications recently for your chest pain?
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Vital signs to assess:

- RR (normal range 12-20 BPM)
- O2 stats

Potential normal and abnormal findings:

Normal:

- Symmetrical
- Normal WOB
- Constant similar noises when breathing

Abnormal:

- Guarding
- Use of surrounding muscles to breath
- Abnormal sounds (crackling)