NURSING ZONE

Helping to Build a strong base of knowledge in nursing

# NURSING BOOKLET

## IN HOSPITAL

اللهم إني فوضت أمري إليك ثقة وإيمانًا بحسن تدبيرك ربي إختر لي ولا تخيرني،

يارب اكتب لي الخير أينما كان وأرضني به وأشرح لي صدري ويسر لي أمري، الله

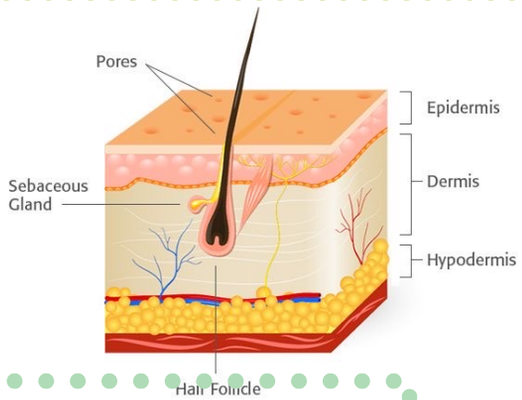
علمنا ماينفعنا ونفعنا بما علمتنا وزدنا علما اللهم وفقنا لهداك واجعل عملنا في رضاك اللهم ارنا

الحق حقا وارزقنا اتباعه.

# Integumentary System Assessment

integumentary system includes the skin, hair, nails, sweat glands, and sebaceous glands. Aemen ofen begin ih an oerall inpecion of he kin condiion and kin aemen is integrated throughout the entire health assessment.

made up of three layers: the epidermis, the dermis, & the subcutaneous tissues.




History of present health concern (C-O-L-D-S-P-A) :

- Character: describe the sign &symptoms
- Onset: when did it begin?
- Location: where is it?
- Duration: how long does it last?
- Severity: how bad is it?
- Pattern: what makes it better or worse?
- Associated factors: what other symptoms occur with it?

History of skin

- Past history of skin disorders? (allergies, hives, psoriasis, or eczema)
- Change in pigmenaion (size or color)?
- Change in a mole? (color, shape & size)
- Excessive drynss or moisture?
- Pruritus
- Trauma to skin (stiches, burn)
- Use of tanning, sun lamps

Integumentary System assessment video

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## Inspection and Palpation of Skin

Color, vascularity, lesions, texture, temperature, A. moisture, turgor, edema, mobility and thickness. Inspect skin color variation for uniformity of skin color, cyanosis, jaundice, redness and pigmentation., wound, Palpate texture for thick, rough or supple (flexible) by fingers tips, Palpate skin temperature.

## Inspection and Palpation of Nails:

smooth texture, angel of fingernail and Inspect nail grooming and cleanliness Inspect fingernail plate for (cover) Shape & contour. Inspect angel between the nail and the nail bed or A Inspect nail color and markings (the intactness of the tissue around). palpate the texture & consistency, noting nail plate is attached to nailbed Palpate the nails to determine thickness, regularity, and attachment to the nailbed Assess capillary refill: Perform blanch test of capillary refill. Press two or more nails between your thumb and index finger; look for blanching and return of pink color to nail bed.

## Validating and documenting findings

Document the findings and abnormalities in the client's record. during data collection: Normal & abnormal finding in subjective data. Normal &abnormal finding in objective data. Record the date and time. Signature. Analysis of data and writing nursing diagnosis Impaired Skin Integrity Acute Pain Disturbed Body Image Hyperthermia

**Figure (1): Cyanosis**

**Figure (2): Jaundice**

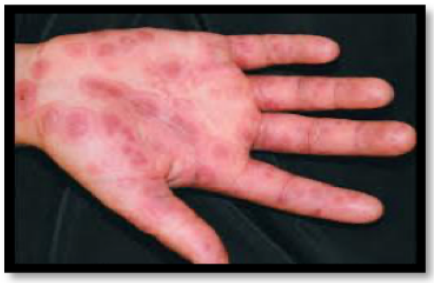

**Figure (3): Erythema**

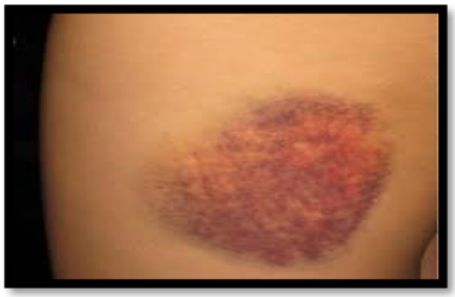

**Figure (4): Ecchymosis**

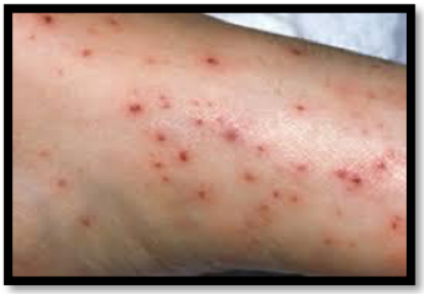

**Figure (5): Petechiae**

**Figure (6): Albinism**

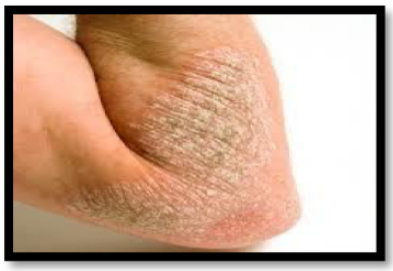

**Figure (8): Scaling**


**Figure (7): Flaking (peeling))**

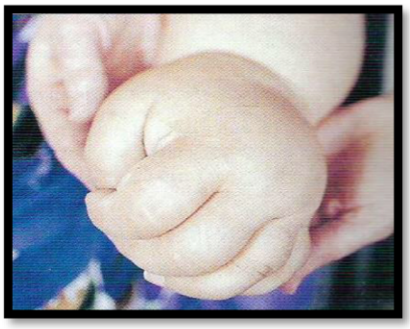

**Figure (9): Pitting edema**

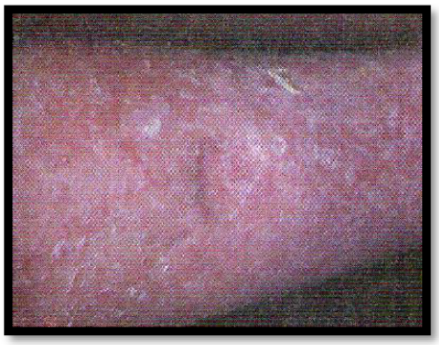

**Figure (9): Pitting edema**

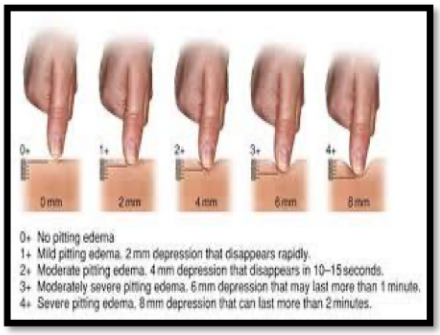


**Figure (10): Pitting edema**

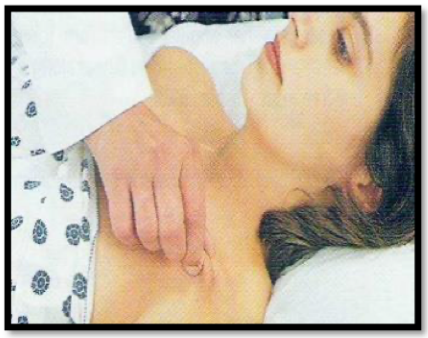

**Figure (11): Turgor**

**Figure (12): Capitis (head lice)**


**Figure (13): Male Pattern Balding**

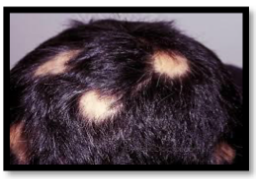

**Figure (14): Alopecia**

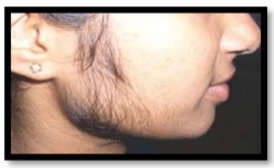

**Figure (15): Hirsutism**

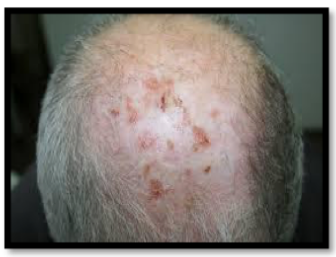

**Figure (16): Wood's lamp**

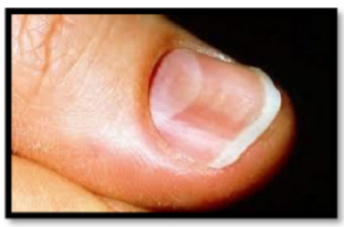

**Figure (17): Koilonychias**

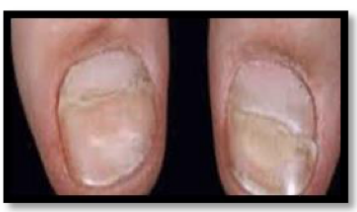

**Figure (18): Beau's lines**

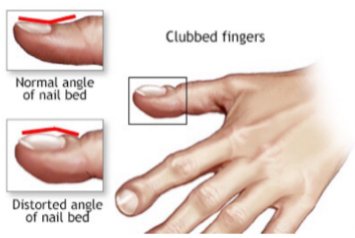


**Figure (19): Clubbing**

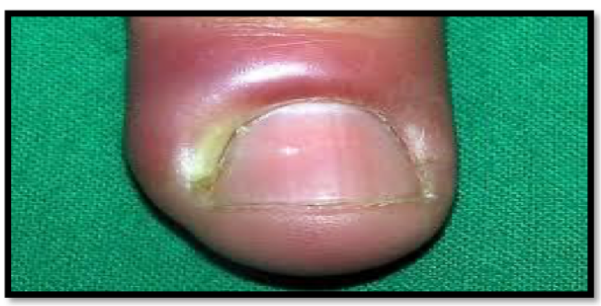

**Figure (20): Paronychia**

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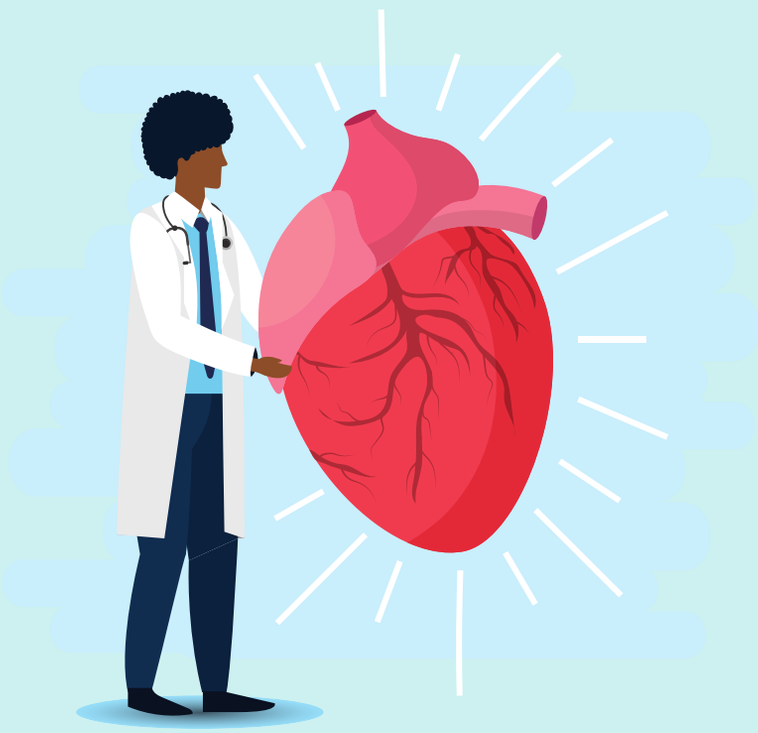
# Heart and blood vessels



Most popular areas for a pulse:

carotid artery

Apical

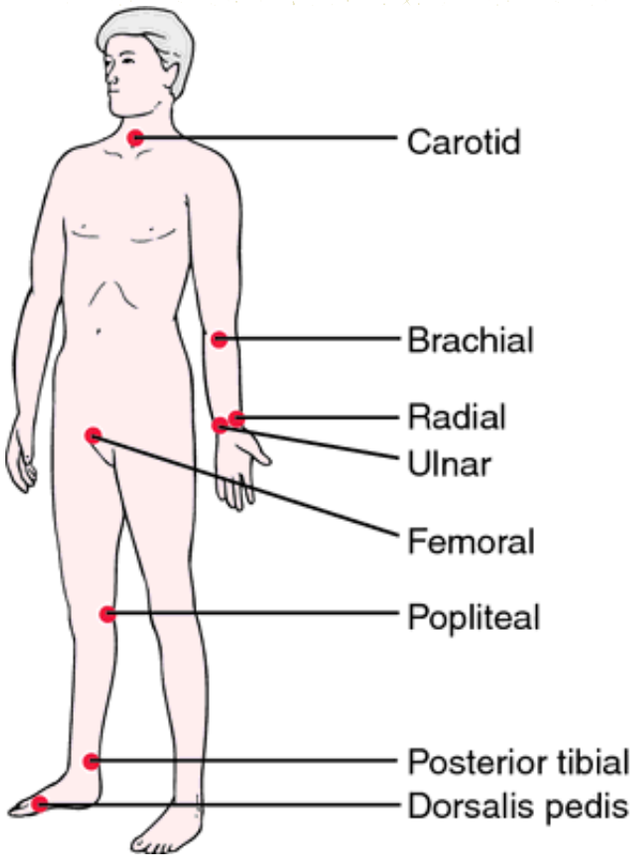
Brachial

radial

Femoral

Popliteal

Posterior tibia




how do we describe the pulse?

On this scale:

0 is absent

1+ weak, fast

2+ normal

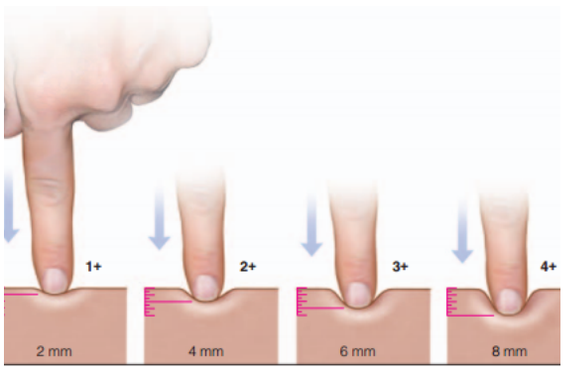
3+ augmentation, complete, briefing

**Inspect:**

If it has any Edema, Cyanosis, or Clubbing

Why?

Because these are often symptoms of heart and blood vessel problems




**-Palpate:**

Here we set up the clubbing test

We do the edema test when you press your finger to go down, and based on the descent, we can determine the level

**auscultation:**

**We hear the sounds of the heart.**

**We have 5 places**

**- Aorta S2 "dub"**

**-Pulmonic S2 "dub"**

**-Erb's Point**

**-Tricuspid S1 "lub"**

**-Mitral S1 "lub"**

normar Heart sound

Heart Assessment

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# Neck assessment

- Inspect for symmetry, masses, scars, gland or lymph node enlargement.
- Inspect the neck as the patient swallows, observing symmetry and alignment.

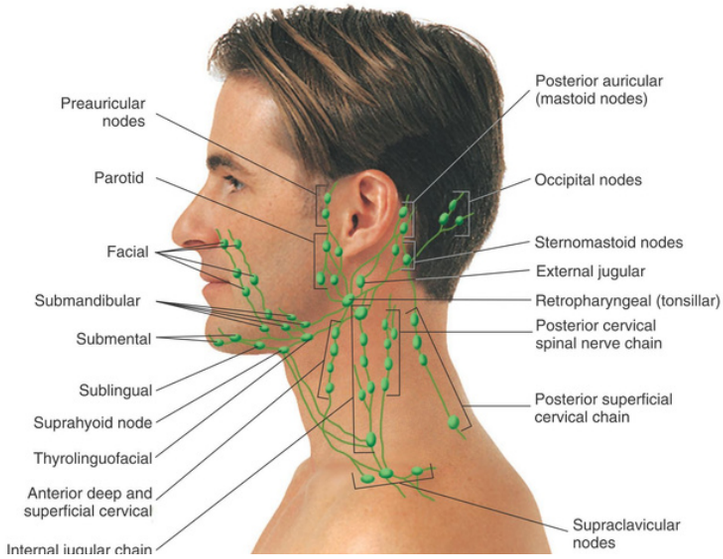
- Head and Neck Lymph Nodes

• Inspect and palpate lymph nodes of the head and neck

• Lymph Nodes

Systematically palpate, normally no palpable nod, no pain.

- Note the size and location of any palpable nodes and whether they were soft or hard, non-tender or tender, and mobile or fixed.
- Evaluate ROM by having patient flex, extend, rotate, and laterally turn the head and neck.



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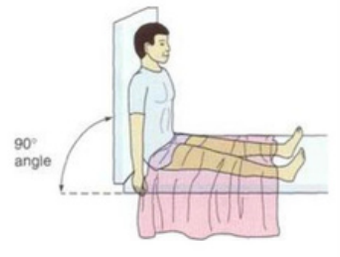
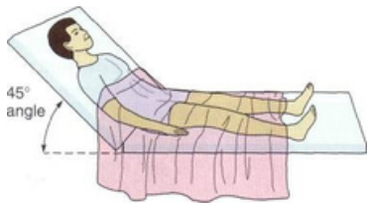
# Assessment Positions

# Positions for assessment

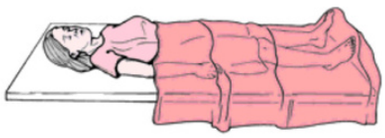



Sitting (High Fowler)

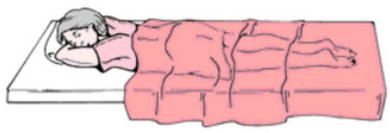



Semi Fowler

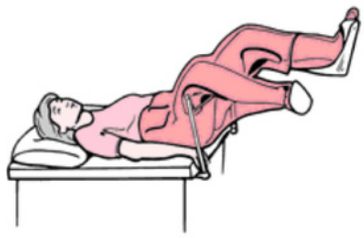
Orthopneic



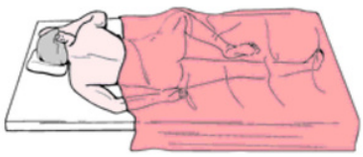
Supine



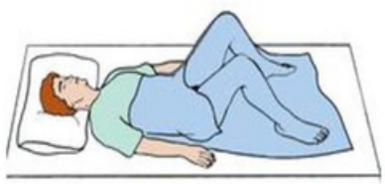
Prone



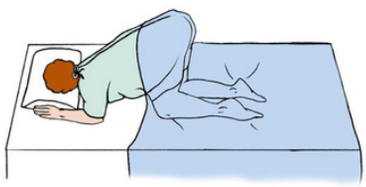
Lithotomy



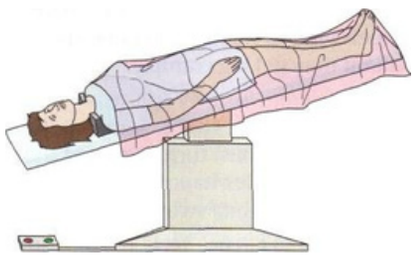
Sims'



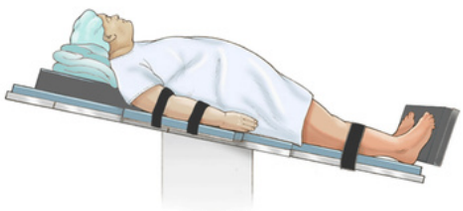
Dorsal recumbent



Knee chest



Trendelenburg



Reverse trendelenburg

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# Pain Assessment

# Pain Assessment

**Subjective Data .. (History) .. COLD SPA**

- Character (describe)
- Onset (when)
- Location (where)
- Duration (how long)
- Severity (how bad)
- Pattern (what makes better/worse)
- Associated factors (symptoms)
- Detailed History
- Past Health History
- Family History
- Life Style & Health History

**Objective Data .. (File)**

- Preparing Client :
- Explained purpose
- Assess knowledge
- Explain use paint chart
- Assess anxiety level
- Select appropriate assessment tool
- Relaxed posture & Calm environment
- No excessive position shifting
- Facial expression is alert and pleasant
- Ask if any pain
- No subjective complaint
- Preparing Equipment :
- Verbal Descriptor Scale (VDS)
- Wong-Baker Faces Scale (FACES)
- Numeric Rating Scale (NRS)
- Visual Analog Scale (VAS)

**Safety measures:**

•Take it to protect nurse & patient

**Physical assessment**

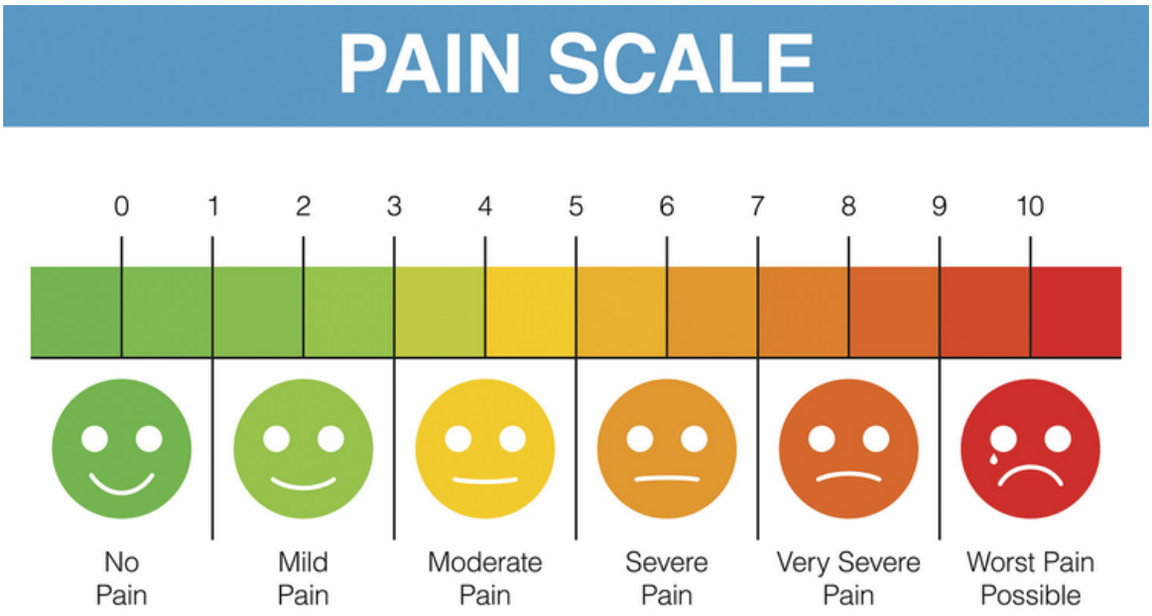
• Inspection for discoloration, swelling, and drainage

**Validating & Documenting**

• Date & time
• COLD SPA
• All associated manifestations of pain
• Scale used
• Any indications or pt. self-report of pain
• Pain score
• Pt./Family education provided

**Analysis & Writing**

• Acute
• Chronic

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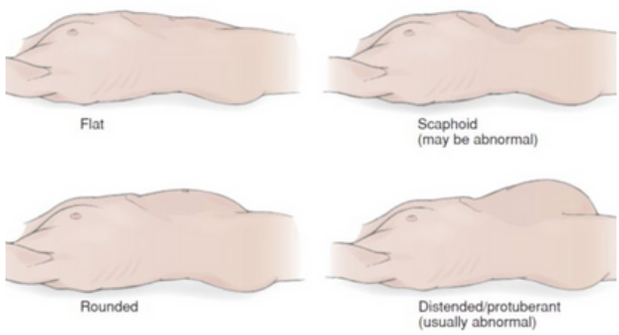
# Abdominal Assessment

3 videos about the abdominal assessmnet

# Abdominal Assessment

- Stand at the patient's right side; helps to detect abnormal shadows and movement.
- Divide the abdomen into four quadrants and 9 segments.

## 1. Inspection




- Contour
  - Flat or Rounded
- Waist circumference
  - Men: < 40 inches (102cm)
  - Women: < 35 inches (88cm)
- Symmetry
  - Shine a light across the abdomen while the pt. takes a deep breath.
  - Symmetric & Smooth
- Skin
  - Color: Homogenous
  - Skin integrity: No scars, lesions or rashes...
  - Striae: White striae due to obesity / pregnancy
  - Venous pattern: Absent dilated blood vessels
- Umbilicus
  - At the midline, flat, and inverted
  - No sign of inflammation / hernias
- Pulsation & movement
  - Aortic pulsations are visible in epigastrium
  - Waves of peristalsis

## 2. Auscultation

◦ Bowel sounds: by diaphragm

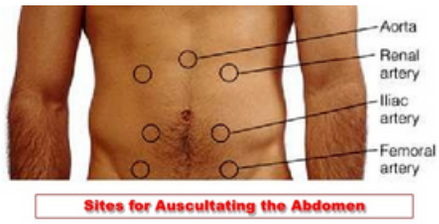
‣ Frequency: 5 - 30 times/min

‣ If suspected the absence of bowel sounds, you must listen for 5 minutes

◦ Vascular sounds: by bell

‣ Check over the aorta, renal arteries, iliac, and femoral arteries.

‣ No vascular sounds, bruits or friction rubs

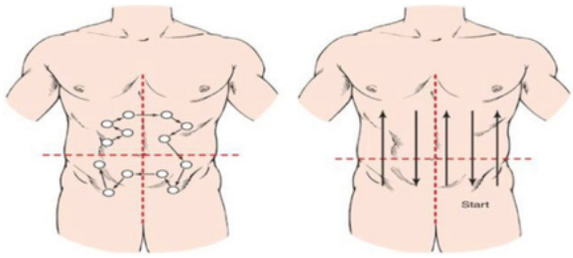


Sites for Auscultating the Abdomen

## 3. Percussion

◦ Bowel :

‣ Tympany & Dullness



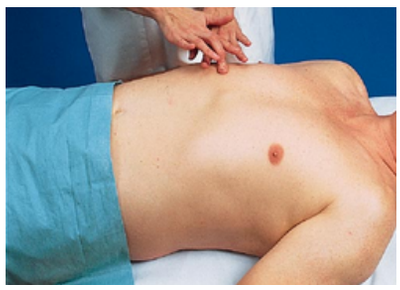

◦ Liver :

‣ The lower border:

• Starting below umbilicus at client's right midsternal line mid clavicular line and (MCL).

• Percuss upward until sound change from tympany to dullness, mark this point as lower border.

‣ The upper border:



• Percuss down ward from the lung until the sound change from resonance in the right (MCL) to dullness and mark this point as upper border.

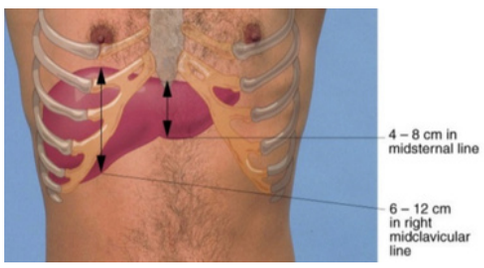
• Measure the distant between the two points to determine the wide border of the liver.

• Then check the small border of the liver from the left midsternum at the same way.

‣ At right (MCL): 6 - 12cm

‣ In midsternum line: 4 - 8cm

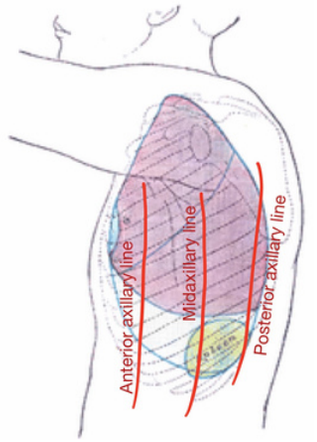
‣ Decrease after 50 years



◦ Spleen :

‣ Begin posterior to left midaxiallry line (MAL) and percuss downward.

‣ Dullness in the spleen approximately 7cm (Small area of dullness at 6th-10th ribs)



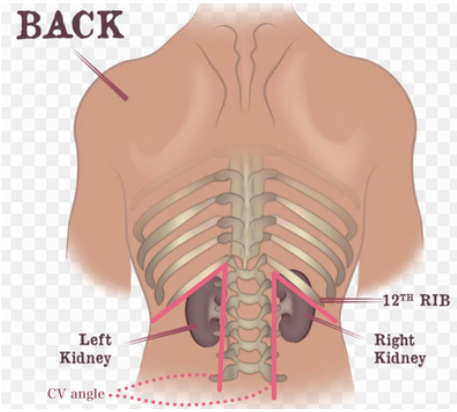

◦ Kidneys :

‣ Place pt. on SITTING with his/her back to you.

‣ Place the ball of one hand in over the 12th rib on the costovertebral angle (CVA).

‣ Perform blunt percussion on Rt & Lt kidneys at costovertebral angle with the ulnar surface of your fist gently.

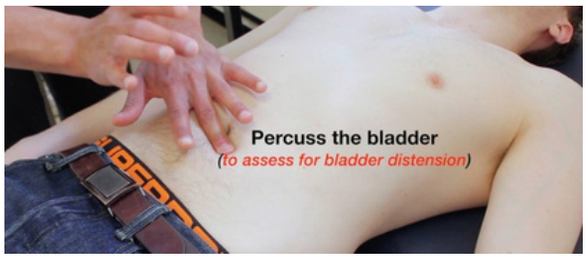
‣ No tenderness or pain




◦ Bladder :

‣ Begins at the midline just above the umbilicus and proceeds downward.

‣ At symphysis pubis



## 4. Palpation

There're two types:

- Light palpation: to determine tenderness or mass.
- Deep palpation: to judge the size, location, and consistency of certain organs.

- Light palpation :

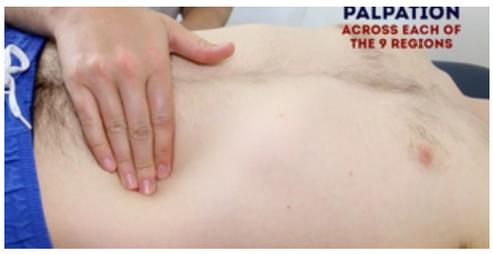
‣ Place pt. in SUPINE position.
‣ Hold the palm of you hand parallel to the abdomen with the first four fingers close together.


‣ Ask the pt. to relax the abdomen.
‣ Begin palpation at non tender quadrant.
‣ Precede abdominal palpation at the nine segments.
‣ Depress the abdominal surface about 1cm.
‣ Make a light and gentle rotary motion, sliding the fingers and skin together.
‣ Lift the fingers and move clockwise to the next location around the abdomen.
‣ Abdomen is soft

- Deep palpation :

- Bimanual palpation of liver :

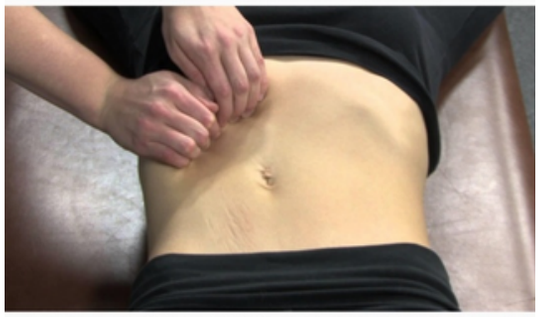
‣ Stand at right of the pt.
‣ Place left hand under the pt's back at the level of 11th ribs.




‣ Lay your right hand parallel to the right costal margin.
‣ Ask the pt. to take deep breath.
‣ Compress upward and down ward with your fingers.

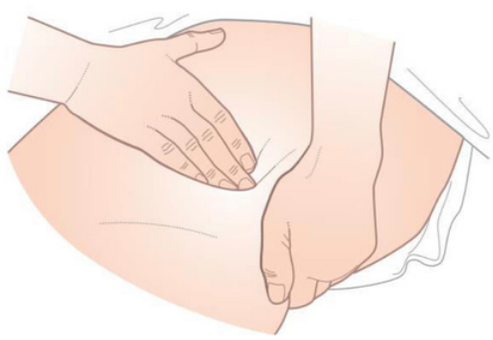
- Hooking palpation of liver :

- Stand at right of the pt. facing pt. feet.
- Hook (curl) with fingers of both hands over the edge of the right costal margin.
- Ask the pt. to take deep breath and gently & firmly pull inward & forward with your fingers.
- Liver is not palpable



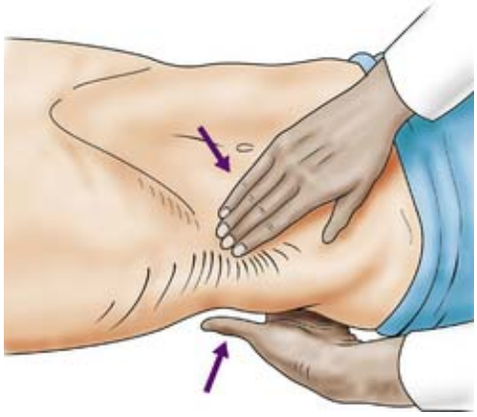
- Spleen :

- Stand at right of the pt.
- Reach over the abdomen with your left arm.
- Place you hand under the posterior lower ribs.
- Pull up gently.
- Place your right hand below the left costal margin.
- Ask the pt. to inhale then press inward and upward.
- Alternatively asking the pt. to turn into the right side this facilitated downward and forward of spleen.
- Spleen is not palpable



- Right Kidney :

- Place the pt. in SUPINE position.
- Place your left hand on the pt's right side between lowest rib and the pelvic bone (flank) to support and exert pressure on the kidney.
- Place your right hand on the pt's right upper quadrant (RUQ). just below the costal margin to locate the kidney size.
- Place hands together in a "duckbill" position at the pt's right flank.
- Ask the pt. to inhale.
- At the peak of inspiration, press your right hand and deeply into the RUQ, just below the coastal margin.
- Exert pressure to try to palpate the lower pole of the kidney.



- Left Kidney :

- The same steps

- No enlargement, tenderness or mass

- Bladder :

- Begin at the symphysis pubis and move inward and outward to estimate the border of the bladder.
- Bladder is not palpable

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# Assessment Techniques

Head to toes assessment

Note : always start from 1,2,3,4 Except in abdomen start from 1,4,2,3

# 1 INSPECTION

INSPECT AS A WHOLE AND THEN OF EACH BODY SYSTEM
COMPARE THE RIGHT AND LEFT SIDES ,THE TWO SIDES ARE NEARLY SYMMETRIC.
INSPECTION REQUIRES GOOD LIGHTING, ADEQUATE EXPOSURE, AND USE OF CERTAIN INSTRUMENTS (OTOSCOPE, OPHTHALMOSCOPE, PENLIGHT, NASAL AND VAGINAL SPECULA).

# 2 PALPATION

FINGERTIPS– FOR FINE TACTILE DISCRIMINATION, TEXTURE, SWELLING, TENDERNESS, RIGIDITY OR SPASTICITY, PULSATION, AND LUMPS

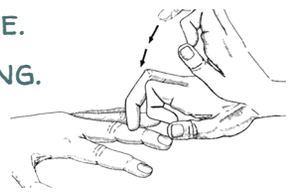
- A GRASPING –TO DETECT THE POSITION, SHAPE, AND CONSISTENCY OF AN ORGAN OR MASS
- THE BACKS OF HANDS – FOR TEMPERATURE
- BASE OF FINGERS OR ULNAR SURFACE – FOR VIBRATION

IT SHOULD BE CALM AND GENTLE . DON,T START FROM PAINFUL AREA.

# 3 PERCUSSION

TAPPING THE PERSON'S SKIN WITH SHORT, SHARP STROKES TO ASSESS UNDERLYING STRUCTURES

RESONANT: CLEAR, HOLLOW,OVER NORMAL LUNG TISSUE.
HYPERRESONANT: BOOMING, NORMAL OVER CHILD'S LUNG.
TYMPANY: DRUMLIKE, OVER AIR–FILLED VISCUS.
DULL: MUFFLED THUD, DENSE ORGAN.
FLAT: A DEAD STOP OF SOUND, , OVER THIGH MUSCLES OR BONE OR OVER TUMOR



# 4 AUSCULTATION

AUSCULTATION IS LISTENING TO SOUND BY STETHOSCOPE. THE ROOM SHOULD BE WARM AND COMFORTABLE, QUIET, PRIVATE, AND WELL LIT,, WET THE HAIRS, EXPOSURE THE AREA.
USE DIAPHRAGM FOR HIGH–FREQUENCY SOUND AND BELL FOR LOW–FREQUENCY SOUNDS.

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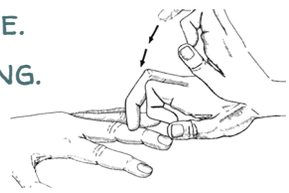

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