



Health Assessment

Self-Assessment Guidelines
for
Licensed Practical Nurses

February 2018



College of Licensed Practical Nurses of Nova Scotia

<http://clpnns.ca>

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Acknowledgement

Many thanks to Claudette MacDonald for her contribution to the development of this document

The College

The [College of Licensed Practical Nurses of Nova Scotia](#) (CLPNNS), or the College, is the [regulatory body](#) for Licensed Practical Nurses (LPNs) in Nova Scotia. The College's [mandate](#) is to protect the public by promoting the provision of safe, competent, ethical, and compassionate nursing services. The College sets, monitors and enforces standards for entry into the profession, practical nurse education, registration and professional conduct. The College creates [Standards of Practice](#), establishes a [Code of Ethics](#), develops and implements a [Continuing Competence Program](#), and publishes policies and [interpretive documents](#) to support the practice of licensed practical nurses in Nova Scotia.

How to Use These Guidelines

This document is an overview of health assessment information. The goal of this document is to support you to perform a self-assessment of your individual competence (knowledge, skill, and judgement) related to health assessment. At the end of each section are reflective practice questions. Ask yourself the following questions as you reflect on your answers.

- **What parts were easy? Difficult? Why?**
- **Do I have the necessary knowledge, skill, and judgment to perform these skills?**
- **What are my strengths? What or where are my gaps in knowledge?**
- **What do I need to do to address any gaps in my knowledge?**

The findings of the self-assessment can be used to identify learning goals in part to help you meet the annual requirements of the Continuing Competency Program (CCP).

Introduction

Licensed Practical Nurses (LPNs) have core nursing knowledge to independently care for clients with an established plan of care. LPNs are an integral part of the health care team, accountable to provide safe, competent, ethical and compassionate care to individuals, families and communities.

It is important to recognize the level of autonomy of LPN practice varies in relation to a number of factors including: the professional and individual scope of practice of the LPN, the practice environment, the context of care and the needs of the client¹.

When the health status of the client changes or the client outcomes become less predictable, the LPN works in collaboration with other health care professionals to implement a plan of care, modified to meet the clients' needs.

More information about the LPN scope of practice can be found on the College website at
<http://clpnns.ca/wp-content/uploads/2015/09/Scope-of-Practice1.pdf>

¹ In this document and where appropriate, client is means the individual, family, substitute decision maker and/or significant others.

Health Assessment²

A health assessment is the process of collecting, verifying, and organizing information about a client within a practice context. This process starts at the initial encounter with the nurse and continues throughout the therapeutic relationship.

LPNs use client data and collaborate with other health care professionals to contribute to the development of the client's plan of care. This data is also used to make decisions in the selection, continuation, change and implementation of nursing interventions or plan of care, and recognition of changes in client status.

Purpose of the Health Assessment

The purpose of the health assessment is to identify the client's health care needs and to gather data to share with the inter-disciplinary team by:

- identifying areas for health promotion;
- recognizing areas of potential concern or risk;
- documenting findings;
- acknowledging positive health qualities; and,
- developing an individualized plan of care.

Nurses gather subjective and objective data from many sources³ such as:

- client - observation, interview, physical examination and interaction;
- clinical record – collaborative medical history, problems, treatments, lab values, diagnostic tests and assessments;
- other health care team members;
- family and significant others – with the client's permission regarding i.e. observations, behavior, changes in health status; and,
- other sources, such as reviewing interdisciplinary reports.

Reflective Practice

Ask yourself the following questions:

1. Do I understand the content?
2. What, if any, other activities will support my learning?
3. If other activities or resources are necessary, what is my plan to access them and increase my knowledge?
4. How will having this knowledge improve my daily practice?
5. How will this make it safer for clients and improve their health outcomes?

² Follow agency policy.

³ Not an exhaustive list

Types of Assessments

While the purpose of an assessment is always the same, it is important to note the type, amount and comprehensiveness of the data collected may vary based on the reason for performing the assessment and the context of care.

PLEASE NOTE: This document is a *suggested guide* to help nurses conduct a self-assessment of their individual competence related to health assessment. Always follow agency policy regarding the nature, frequency and comprehensiveness of assessments required by your employer.

Abbreviated Assessment

This is a general survey of client's appearance, interactions and behaviour, vital signs, and head to toe scan. This may be completed at shift change, change in client assignment, validating client status or temporarily assuming care. The assessment begins with the "A, B, C's".

Focused Assessment

A focused assessment tends to focus on one specific body system. This assessment may be completed throughout a shift, when the client has a specific concern, to monitor progress, evaluate an intervention or medication effects.

Comprehensive Assessment

An in-depth assessment used to contribute to the clients plan of care. It includes a general survey and a head to toe systems assessment. These assessments often occur at admission to a health care facility, when the client changes levels of care, or their health status changes. A health history may be required as part of the comprehensive assessment.

What Every LPN Should Know

New, changed, and unexpected findings in any assessment should be investigated further and communicated with an appropriate health care provider (often the RN) in a timely manner. Together the LPN and RN should discuss the findings and determine the plan to address the issue.

Health History

The health history⁴ is additional client data, that can be used with the health assessment to begin to inform the clients plan of care.

A typical health history may include:

- biographic data;
- current health problems;
- past health history;
- family health history;
- current medication(s), treatments and allergies;
- data on personal and social history;
- assessment of cultural traditions and spiritual beliefs; and,
- questions related to health promotion with attention to exercise, diet and illness prevention.

⁴ Not an exhaustive list, follow agency policy.

Functional Assessment

A functional assessment provides information on the client's ability to manage daily routines, measures the client's need for assistance in activities of daily living (ADLs) and also informs the plan of care. Multiple sources (such as those listed on page 2) may be used to gather data to inform the functional assessment.

Additional details are noted in Appendix B.

Reflective Practice

Ask yourself the following questions:

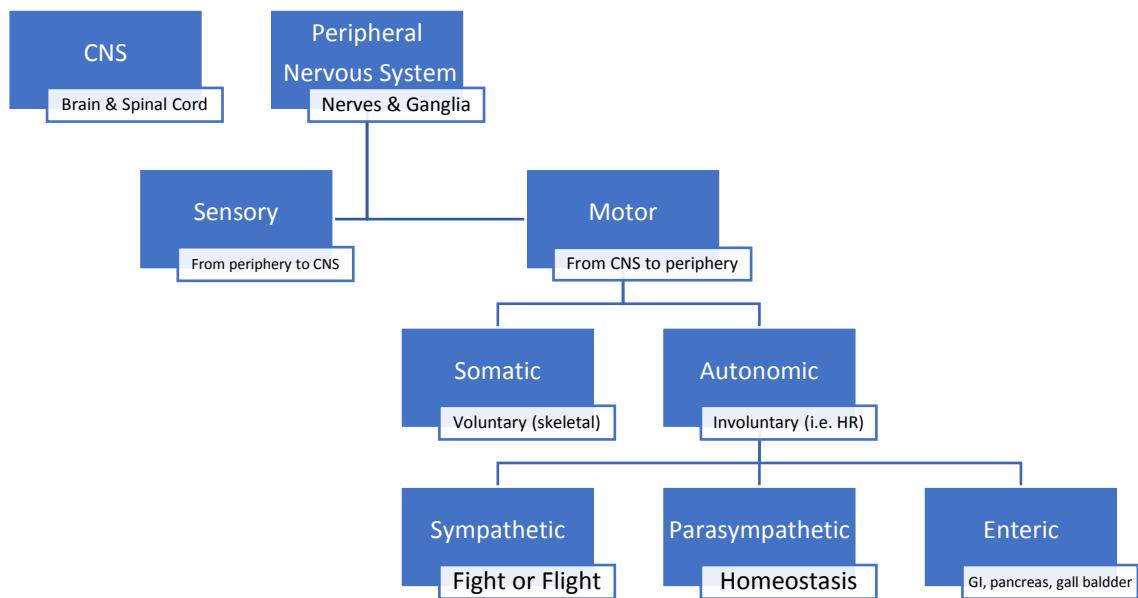
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Systems and Assessment Review

This section of the document provides a *suggested guide* to help nurses conduct a self-assessment of their individual competence related to health assessment. Always follow agency policy regarding the nature, frequency and comprehensiveness of assessments required by your employer.

Nervous System

- The nervous system efficiently organizes and controls the smallest action, thought, or feeling.
- Two main divisions;
 - o Central Nervous System (CNS) processes and responds to input from within and outside the body and includes the brain and the spinal cord; and,
 - o Peripheral Nervous System (PNS) includes the nerves and ganglia and is further divided into sensory (afferent) and motor (efferent) divisions.
 - Sensory - transmits impulses from peripheral organs to the CNS
 - Motor - transmits impulses from the CNS out to the peripheral organs to cause an effect or action. It is divided into the somatic nervous system and the autonomic nervous system;
 - Somatic nervous system - supplies motor impulses to the skeletal muscles, it is also called the voluntary nervous system because the nerves allow conscious control of the skeletal muscles
 - Autonomic nervous system - responsible for the control of heart rate, digestion, respiratory rate, salivation, perspiration, pupillary dilation and micturition. It is further subdivided into sympathetic ('flight or fight' response), parasympathetic (brings the body back to homeostasis) and enteric nervous system (network of nerve fibers that control the entire GI tract).



- The vertebrae that make up the spinal column and are referenced based on their placement include;
 - cervical (C1–C7)
 - thoracic (T1–T12)
 - lumbar (L1–L5)
 - sacrum (S1–S5)
 - coccyx (tail bone)
- Typically, disorders of the nervous system involve some alteration in arousal, cognition, movement, muscle tone, homeostasis and pain.

Nervous System Assessment

Includes neurological observations, cognitive abilities, fine and gross motor skills, sensory function, history of seizures and any other concerns.

Responsiveness

- Do eyes open in response to voice, touch or pain or not at all?

Level of Consciousness and Cognition

- Awake, alert (lethargic, restless, irritable, comatose)
- Orientation to person, place, time
- Communication: response to verbal/nonverbal stimuli, assess clarity, comprehension and coherence
- Memory: assess remote past, recent past, and general recall. Use formal tools (i.e., Mini-Mental State Examination- MMSE or The Montreal Cognitive Assessment -MoCA) as outlined in agency policy.

Head, face and neck

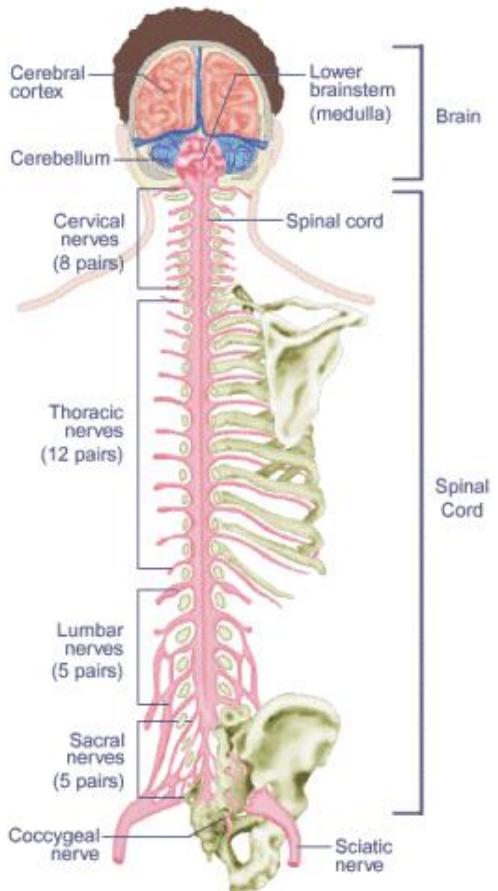
- Size, movement, expression, symmetry, color, lesions, edema, masses, scars.
- Pain, tenderness, stiffness.
- Eyes: appearance, position, response and movement, pain, burning, itching, dryness, drainage.
- Conjunctiva: colour, moisture, lesions, discharge, vascular changes.
- Sclera: color, vascularity, jaundice.
- Ears: appearance, position, cerumen, drainage, tinnitus, pain.
- Nose: appearance, position, patency, sense of smell, secretions, sneezing.

Pupils

- Size and shape, compare left to right, assess for constriction to light and accommodation (PERRLA).

Gross and Fine Motor Movement

- Gross motor: symmetrical, smooth, coordinated movement.
- Strength: right side/left side; upper/lower extremities.



- Fine Motor: handling of pen or similar.
- Gait: smooth, coordinated movement, lack of spasms or limp.
- Cerebral function: touch each fingertip to thumb tip in succession.

Immune system

- Lymph nodes: size, shape, mobility tenderness, enlargement, allergies, immunizations: exposure to infectious/communicable diseases, travel history.

Sensory

- Ability to interpret sensory stimulation: vision, hearing, touch, smell, taste.
- Ability to differentiate sharp, dull, soft, hard, pressure, hot, cold.

Musculoskeletal System

The musculoskeletal system consists of a complex system of bones, joints, skeletal muscles, ligaments, tendons and other tissues providing;

- the body form and shape;
- protection to vital organs (the brain, heart and lungs);
- enables movement;
- houses the marrow contributing to blood cell production; and,
- stores calcium and other minerals.

Musculoskeletal System Assessment

This assessment can start by observing the client in bed or as they move about the room comparing limbs/joints bilaterally.

Interview

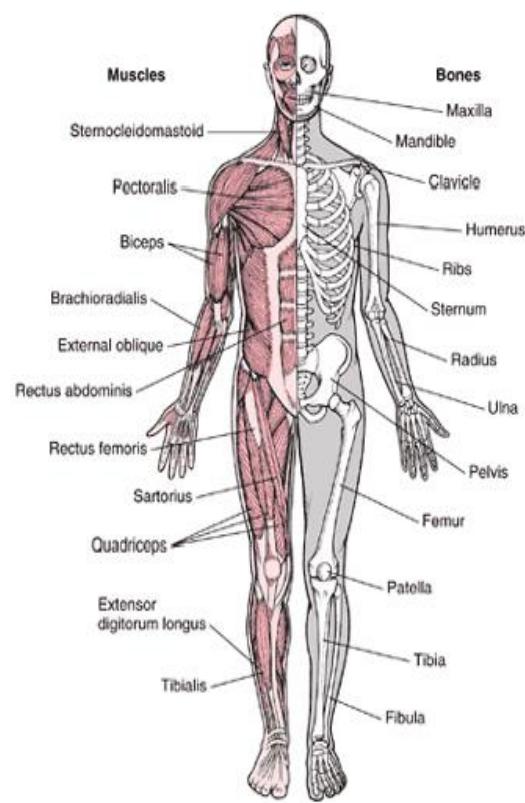
- Gather in-depth information on concerns of pain and any other concerns at rest, movement and exercise.
- Rest and Activity: usual level and pattern, occupation, leisure-exercise patterns, limitations in ambulation, bathing, dressing, toileting (other ADLs).
- Assess sleep patterns, use of sleep aids and feeling rested.
- Use of aids such as splint, brace, prosthetics, walker, cane, wheelchair.
- Environment: living situation, layout of home, stairs, and bathroom; safety needs, home responsibilities.

Inspection

- Assess posture, movement and body symmetry.
- Observe gait and ambulation.
- Inspect limbs for color, symmetry, shape or alterations.
- Inspect joints for redness or swelling.
- Range of motion: is it active or passive? Are limbs moving equally? Note concerns of stiffness or pain.

Palpation

- Document any prosthesis used. Assess wear, movement of parts, cracks. Assess placement on limb for pain, skin breakdown and fit.
- Limbs: assess muscle mass, tone and strength. Note pain, tenderness or numbness.
- Joints: assess for masses, swelling, fluid, bogginess, crepitus. Note pain or tenderness.
- Muscles: size, shape, tone, tremors, weakness. Note concerns of cramps or pain.
- Back: scars, sacral edema, spinal abnormalities.

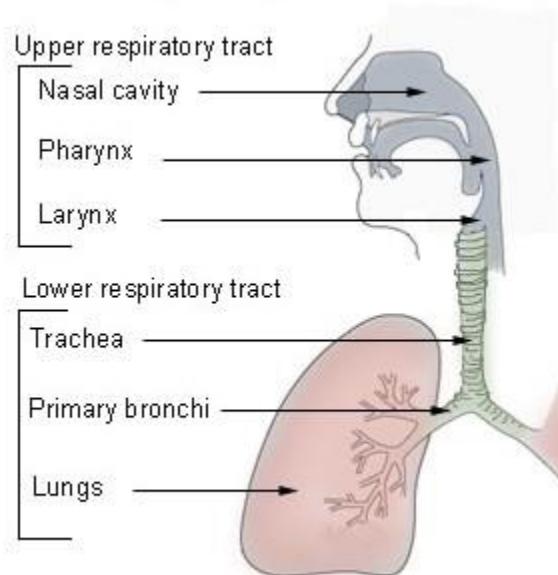


Respiratory System

The respiratory system's primary function is gas exchange. Air enters with inhalation (inspiration) traveling through the respiratory passages, exchanging oxygen (O_2) for carbon dioxide (CO_2) at the tissue level. Carbon dioxide is eliminated on exhalation (expiration). Acid-base balance is also a function of the respiratory system.

The respiratory system is composed of the upper and lower airways.

- Upper airway - nose, mouth, pharynx, and larynx
 - Primary function is to warm, humidify and filter air on its way into the lungs
- Lower airways - trachea, bronchi, and lungs
 - The lungs contain five lobes (three on the right and two on the left) that allow air movement in and out of the lungs, while the alveoli allow exchange of oxygen and carbon dioxide



Respiratory System Assessment

Inspection and auscultation techniques gather valuable information about the lungs. Auscultation provides information on air entry and breath sounds. Abnormal or adventitious breath sounds such as crackles and wheezes can be heard on auscultation.

Interview

- Important to include smoking history (length of time and frequency), exposure to lung irritants (chemicals and asbestos).
- Cough: strength and qualities, productive (color, amount, consistency) or non-productive.
- Use of home oxygen or other aids (ventilator, nebulizer, suction requirement).

Inspection

- Nose: patency, symmetry, flaring, mucosal color, edema, deformities, bleeding, pain, tenderness, sense of smell (i.e. alcohol swab).
- Chest: size, shape, symmetry, symmetrical expansion.
- Breathing patterns: rate, depth, effort, retractions, accessory muscles, position.
- Oxygenation of tissues: oxygen saturation with pulse oximeter, assess for cyanosis, clubbing, mental alertness, nail beds.
- Shortness of breath or dyspnea.

Auscultation

- Auscultate for absence / equality of breath sounds and adventitious noises (wheeze, crackles)
- Auscultate the posterior chest wall, the right upper and middle and left upper lobe are best heard anteriorly.

Reflective Practice

Before reading the next section, ask yourself the following questions:

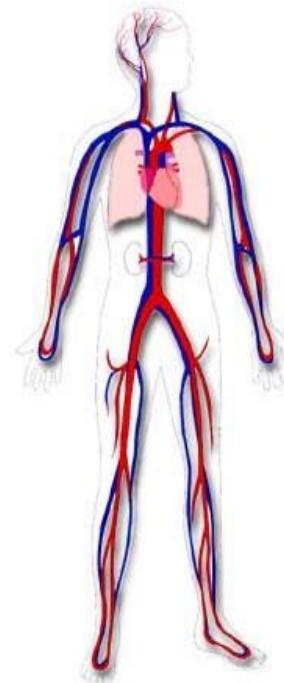
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Cardiovascular System

The cardiovascular system includes;

- the heart (a four-chambered pump that lies in a pericardial sac situated mid-sternum to the left, above the diaphragm);
- blood vessels; and,
- lymphatic vessels.

The cardiovascular, or circulatory system delivers oxygen, nutrient, hormone rich blood to the body's cells. In turn, the blood collects waste products from the cells for detoxification and elimination. Blood is directed to various tissues according to need. Normally the liver, kidneys and brain receive the greatest percentage of the blood from the heart. In cases of sudden stress, the blood is rerouted in favor of the heart and skeletal muscles.



Cardiovascular/Circulatory System Assessment

Skin assessment findings such as temperature, colour, mottling, and bruising are indicators of cardiovascular function. Palpation of peripheral pulses is an indicator of tissue perfusion; it is not necessary to palpate each peripheral pulse for rate. Equality of pulses is determined by comparing counterpart sites i.e. right and left pedal pulses.

Interview

- History of: smoking (length of time and frequency), cardiovascular disease, hyperlipidemia and other risk factors for CVD (diet, exercise, heredity).

Inspection

- Head-to-toe skin assessment (color, temperature, bruising) and assessment of the nail beds for cyanosis or clubbing.

Palpation

- Palpate radial pulse to determine heart rate, rhythm (regular - minimum 30 seconds, irregular- minimum 60 seconds).
- Compare presence of common peripheral pulse bilaterally.
- Capillary Refill Time: normal refill of 3 seconds or less indicates good arterial perfusion.
- Presence of edema, assess the depth (mm) of depression for pitting edema and the rapidity of skin return.

Auscultation

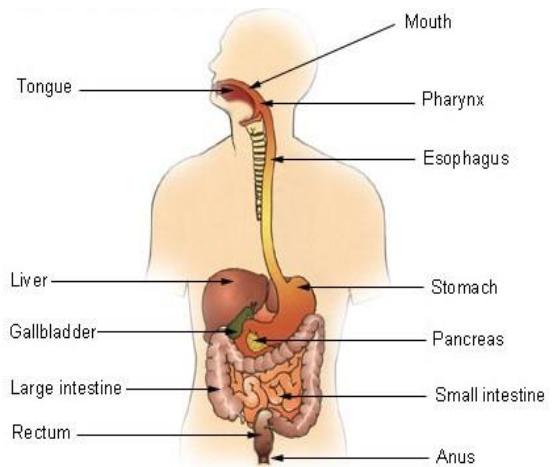
- Auscultate the apical pulse.
- Compare radial pulse and apical pulse for consistency (the rate and rhythm should be similar).
- Identify the "lub-dub" (S1 & S2). Document any unexpected sounds.

Gastrointestinal System

The gastrointestinal system (GI) has the vital task of providing essential nutrients to fuel the body's physiologic activities.

Also known as the alimentary canal, it is a hollow muscular tube beginning at the mouth and extends to the anus. It has two major components:

- the gastrointestinal tract and accessory organs (salivary glands, liver, biliary duct system (gallbladder and bile ducts); and,
- the pancreas.



Normally, air and fluid moving through the bowel by peristalsis yield soft, bubbling sounds without a regular pattern, often heard as soft clicks and gurgles interspersed every 5 to 15 seconds. Sounds occurring one every minute or longer are considered hypoactive and are consistent with alterations in health. Absent bowel sounds are rare. Hyperactive bowel sounds can often be heard without a stethoscope and occur at a rate greater than 30 a minute.

Gastrointestinal System Assessment

Assessment includes: inspection, auscultation and light palpation of the abdomen to identify anomalies (for comfort complete the assessment at a time when the stomach is not full and ensure the client has voided).

Interview

- Feeding: type of feed/patterns / difficulties, TPN, any allergies, intolerances.
- Pain, cramping, nausea, vomiting (frequency, colour, bleeding, consistency).
- Previous history of or current use of: stoma, NG tube, PEG tube, J tube, other.
- Elimination patterns: Route (rectal, ileostomy, colostomy) usual time, frequency; character: color, consistency, constipation, diarrhea, bleeding.
- Elimination aids: laxatives, suppositories, enemas.

Nutrition

- Height, weight, ideal body weight, recent weight change.
- Usual daily food and fluid intake, appetite, food restrictions or preferences, food supplements.
- Food preferences and intolerances, food allergies.
- Swallowing, chewing, feeding problems.
- Method of intake: oral, tube feeds, TPN, intravenous.
- Condition of skin, hair, nails, eyes.

Inspection

- Hydration status: skin turgor, oral mucosa.
- Mouth: sores, condition of teeth and gums, assess for any unusual breath odor.
- Gums: color, edema, bleeding, pain.

- Tongue: size, shape, protrusion, symmetry, color, hydration, markings, ulcers, coating.
- Teeth: number, caries, caps, appliances, dentures (fit and condition), bite, chew, swallow.
- Other: sensitivity to heat or cold, taste; gag reflex, throat soreness, cough, sputum, hemoptysis.

Abdomen

- Shape and symmetry (flat, rounded, distended), hair distribution, striae, rashes, scars.
- Distention: mild, moderate, severe.
- Umbilicus: bulging, scars, piercings, redness, inflammation, discharge.
- Inguinal area: bulging, herniation.
- Stoma site: dressing regimen / frequency and consistency of output.

Rectum

- Hemorrhoids, excoriation, rashes, abscess, lesions, tenderness, pain, itching, burning.

Auscultation

- Four quadrants of abdomen (RUQ, RLQ, LUQ, LLQ) for presence or absence of bowel sounds (frequency / character).

Palpation

- Light palpation to identify guarding, tenderness, pain and note masses, bulges or protrusions. Measure abdominal girth.

Endocrine System

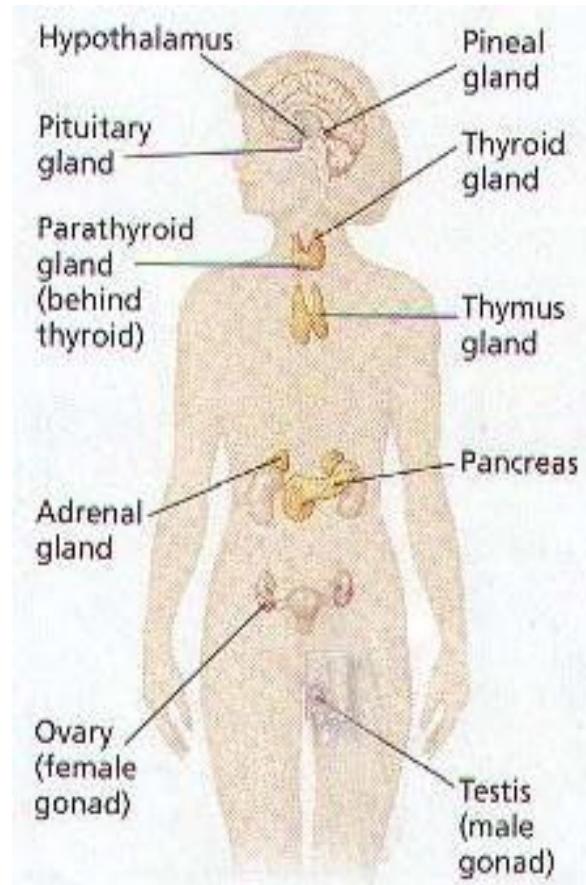
The endocrine system along with the nervous system, regulate the body's metabolic activities and maintain homeostasis. The endocrine system consists of glands, hormones, and receptors.

Processes mediated by the endocrine system include:

- Growth and development of body tissue
- Reproduction and sexual differentiation
- Energy production
- Regulation of metabolism and nutrient supply and
- Stress response.

The endocrine system is highly integrated with other body systems. Relevant data is gathered while carrying out other interdependent systems.

Although eight major endocrine glands are scattered throughout the body, they are still considered to be one system, as they share similar functions, similar mechanisms of influence, and are interrelated. Following is a list of the endocrine glands, hormones secreted, target organs and their primary functions.



GLAND	HORMONE	TARGET ORGAN	HORMONE FUNCTION
Thyroid	<ul style="list-style-type: none"> · Thyroxine (T4) · Triiodothyronine (T3) · Calcitonin 	<ul style="list-style-type: none"> · All tissues · Bone, renal tubules 	<ul style="list-style-type: none"> · Regulate metabolic processes · Lower ionized calcium level
Parathyroid	<ul style="list-style-type: none"> · Parathyroid hormone (PTH) 	<ul style="list-style-type: none"> · Gastrointestinal tract, bone, renal proximal tubules 	<ul style="list-style-type: none"> · Regulate calcium and phosphorus levels
Adrenal Medulla	<ul style="list-style-type: none"> · Epinephrine · Norepinephrine 	<ul style="list-style-type: none"> · Adrenergic receptors in all 	<ul style="list-style-type: none"> · Control vasoconstriction
Adrenal Cortex	<ul style="list-style-type: none"> · Corticoids i.e. <ul style="list-style-type: none"> - glucocorticoid (cortisol) - mineralocorticoids (aldosterone) 	<ul style="list-style-type: none"> · Renal distal tubules 	<ul style="list-style-type: none"> · Metabolize carbohydrates, fats and proteins; anti-inflammatory effect · Sodium, potassium and water balance

Pancreas	<ul style="list-style-type: none"> · Glucagon · Insulin 	<ul style="list-style-type: none"> · Throughout the body · Liver, muscle, adipose tissue 	<ul style="list-style-type: none"> · Raise blood glucose · Lower blood glucose
Testes	<ul style="list-style-type: none"> · Testosterone 	<ul style="list-style-type: none"> · Reproductive tract and other organs 	<ul style="list-style-type: none"> · Maintain growth and development of reproductive organs; stimulates sperm production
Ovaries	<ul style="list-style-type: none"> · Estrogens (estrone & estradiol) · Progesterone 	<ul style="list-style-type: none"> · Reproductive tract and other organs 	<ul style="list-style-type: none"> · Maintain growth and development of reproductive organs; produce eggs in ovaries
Thymus	<ul style="list-style-type: none"> · Thymosin 	<ul style="list-style-type: none"> · Lymphatic system and spleen 	<ul style="list-style-type: none"> · Needed early in life to develop the lymphoid system.
Pineal	<ul style="list-style-type: none"> · Melatonin 	<ul style="list-style-type: none"> · Hypothalamus 	<ul style="list-style-type: none"> · Regulate sleep-wake cycle
Anterior pituitary	<ul style="list-style-type: none"> · Growth hormone (GH) · Thyroid stimulating hormone (TSH) · Corticotropin (=ACTH) · Follicle-stimulating hormone (FSH) · Luteinizing hormone (LH) · Prolactin 	<ul style="list-style-type: none"> · Bones, muscles, organs · Thyroid · Adrenal cortex · Ovaries and seminiferous ducts · Ovaries · Breast, corpus luteum 	<ul style="list-style-type: none"> · Stimulate growth by increasing protein synthesis · Simulate thyroid to produce T3 and T4 · Stimulate secretion of all adrenocorticoids · Promote development of ovaries, secretion of estrogen, and sperm maturation · Promote ovulation and secretion of progesterone · Maintain corpus luteum & progesterone secretion, controls breast milk production
Posterior pituitary	<ul style="list-style-type: none"> · Oxytocin · Antidiuretic hormone (ADH) 	<ul style="list-style-type: none"> · Uterus and breasts · Kidneys (collecting ducts & distal tubules) 	<ul style="list-style-type: none"> · Stimulate uterine contractions and lactation · Promote water reabsorption

Endocrine System Assessment

The above illustrates how the endocrine system is integral to all major body systems. As such, data relevant to the endocrine system is gathered during assessment of the major systems therefore a separate endocrine system assessment is not included. A detailed endocrine assessment rests with the specialized practitioner.

Reflective Practice

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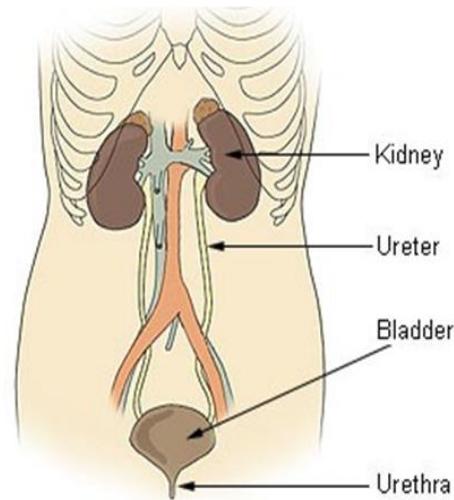
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Renal System

The renal system contributes to homeostasis through management of blood volume and waste excretion, balance of body pH and electrolytes and regulation of blood pressure. The renal system is made up of a pair of kidneys and ureters, the bladder and the urethra.

The bladder has a maximum capacity of 1 to 2 liters. Moderate distention is felt when the bladder contains about 250 ml and discomfort is experienced with 400 ml. When distended, the bladder rises above the pubic bone.

Daily urine production varies from 700 to 2400 ml and is influenced by renal function, vascular integrity, blood volume, cardiac output, intake and temperature.



Renal System Assessment

An assessment of the renal system includes all aspects of urinary elimination.

Interview

- Voiding pattern: frequency, urgency, hesitancy, burning, pain, dribbling, nocturia, oliguria, enuresis, flank pain, polyuria.
- Control: continence, retention, incontinence, stress incontinence, bladder distention.
- Review blood chemistry results: urea, creatinine, electrolytes, albumin and haemoglobin.

Inspection

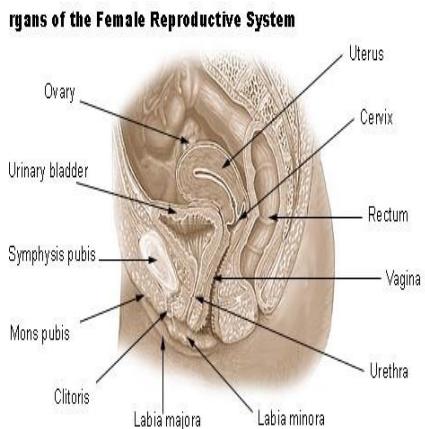
- Route: urethra, assistive devices: catheter, ureterostomy; dialysis.
- Hydration status: fluid balance, BP and weight.
- Urine characteristics: amount, color, concentration, odour, pH, sediment, hematuria.
- Fluid intake or restrictions.
- Fluid balance: positive/negative (intake and output), weight gain, edema.

Palpation

- Skin condition: temperature, turgor and moisture.
- Lower abdomen: distention.

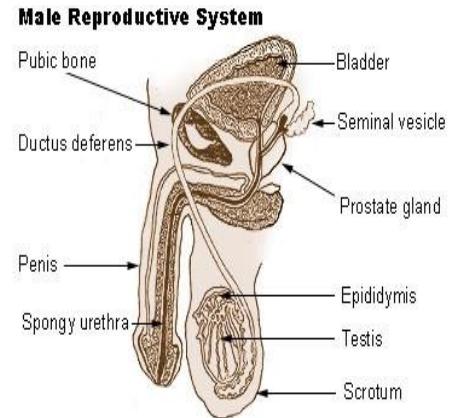
Reproductive System

A functional reproductive system is affected by complex hormonal, neurologic, vascular and psychological factors. *Many diseases and medications can affect the reproductive system and its function.*



The female reproductive system is a series of organs primarily located inside the body and around the pelvic region.

The male reproductive system is a series of organs located outside of the body and around the pelvic region



Sexuality is broader than the reproductive system; it refers to one's emotional, physical, and sexual interests, desires, and attraction to others. It includes gender identity and roles, sexual orientation, attitudes, values and behaviours.

Reproductive System Assessment

Interview

- Sexual activity patterns: is the client sexually active, number of partners in the previous few months, partners in the previous 12 months.
- Sexual activity: frequency, birth control methods, safe sex practice, history of sexually transmitted infections.
- History of any surgeries (breast or reproductive).
- Menstrual flow history, menopause, document para gravida history.
- Self-examination practices (Breast Self-Exam and Testicular Self-Exams).
- Health screening including frequency of mammography, Pap smear, prostate exams, Lab screening (PSA).

Inspection

- Breasts: contour, symmetry, color, shape, size, inflammation, dimpling, swelling,
- Nipples: color, discharge, ulceration, bleeding, inversion; scars; rash

Palpation

- Breasts: masses (note location, and size), tenderness, inflammation
- Axilla: enlargement of nodes, tenderness, inflammation

Assessment of Female Reproductive System

Inspection

- Labia majora and minora, urethral and vaginal orifices: discharge, swelling, ulcerations, tenderness, pain, pruritis.
- Perineum and groin: irritation, excoriation, redness and pain
- Note evidence of prolapse

Assessment of Male Reproductive System

Inspection & Palpation

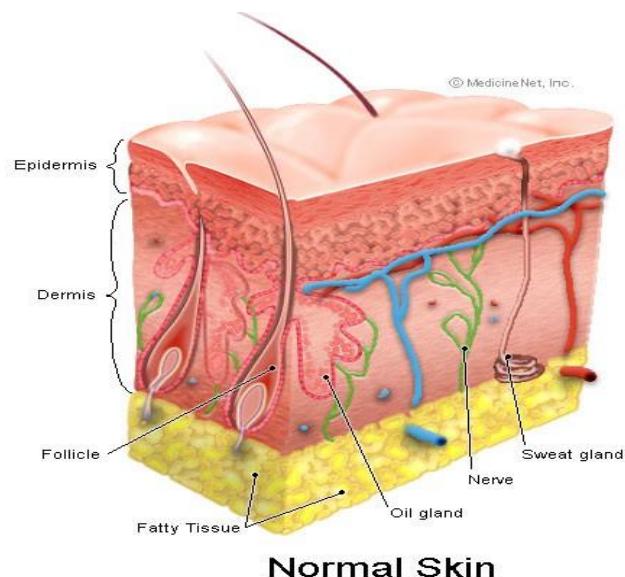
- Penis and foreskin: discharge, ulceration, pain.
- Urethra: inflammation, bleeding, redness or discharge.
- Scrotum/testes: size, color, swelling, ulceration, palpate for tenderness, pain, masses.
- Prostate: date of last assessment i.e. digital rectal exam, prostate specific antigen (PSA).
- Inguinal assessment: redness, pruritis, palpation of nodes, note swelling, pain and palpable masses.

Integumentary System

The skin with its glands, hair, nails and other structures make up the integumentary system, the body's tough outer protective covering

The integumentary system:

- Protects the body against injury and invasion of harmful substances.
- Regulates body temperature.
- Sensory organ.



Integumentary System Assessment

Skin assessment can identify cutaneous problems as well indicate systemic disease and can often be assessed while assessing other health systems.

Inspection

- Colour of the skin: pale/flushed, cyanotic, jaundiced, discolorations.
- Note odors, ulcerations, drainage, necrosis.
- Rash: note the size, colour, texture and shape of the lesions (e.g. raised, fluid filled) and distribution (e.g. sparse, numerous, over limbs), itchy, painful. Obtain a history of the rash.
- Wounds/pressure injuries: assess any existing wounds.
- Surgical incisions, artificial orifices, dressings, drainage tubes.
- Document location, size and coloring of any bruising.
- Examine high-risk areas including bony prominences and equipment sites (masks, casts, tubes, drains, etc.) for pressure injuries.
- Nevi/Moles: Observe for size, any irregular borders, variation in colours.
- Hair: observe the condition of the scalp and hair distribution.
- Nails: intact (splitting, cracking, breaking), smooth (pitting, ridges), shape (rounded, shiny), use of artificial nails.

Palpation

- Skin temperature, moisture, turgor, edema.
- Document masses: size, shape, location, mobility, tenderness.
- Hair texture for brittleness and moisture.
- Nails for capillary refill.

Psychosocial Assessment

Sociocultural factors such as spirituality, values, beliefs and social determinants of health all affect the wellbeing of clients.

In addition, the psychosocial assessment provides data on the client's mental health, which is affected by an interaction of socioeconomic, biological and environmental factors.

Psychosocial Assessment

Observation

- Communication (verbal and non-verbal).
- Mood (anger, withdrawn, impulsive, rushed).
- Ability to focus and answer questions appropriately.
- Eye contact (consider cultural context).
- Activity (restless, agitated, withdrawn) be specific in documenting these behaviours.

Social History

- Education and employment history.
- Type of accommodations: secure housing, neighborhood safety.
- Description of relationships: familial, friends, and professional supports.
- Past or current experiences with physical, emotional or sexual abuse.
- Significant childhood experiences.

Psychological History

- Self-perception of personality and mood.
- Interests, hobbies, recreational activities.
- Speech, thought or sleep disturbances.
- History of depressed mood, anxiety related symptoms, phobias or panic disorders.
- History of other psychological disorders.

Spirituality

- Sources of strength.
- Meaning of illness, health, experiences.
- Religion: importance, type, frequency of practice.
- Cultural practices and spiritual practices that may be impacted by hospitalization.

Coping and Stress

- Decision making process: independent, assisted.
- Willingness to learn and make changes.
- Stress management: diet, sleep, medication compliance, seeking help.
- Expression of loss of control, hopelessness, or difficulty managing stress.
- Use of alcohol or other substances to assist with coping.
- Stressors: finances, legal issues, parenting, abuse, marital problems.
- Self-Care strategies: recreation, meditation, yoga, deep breathing, exercise.

Reflective Practice

Before reading the next section, ask yourself the following questions:

1. Do I understand the content?
2. What, if any, other activities will support my learning?
3. If other activities or resources are necessary, what is my plan to access them and increase my knowledge?
4. How will having this knowledge improve my daily practice?
5. How will this make it safer for clients and improve their health outcomes?

Appendix A

PQRSTUA is an acronym that is useful in gathering data about any client concern, symptom the client may reveal or that the nurse observes i.e. pain, shortness of breath or fatigue

P - Provocative or Palliative

What causes the symptom? What were you doing when you first noticed it? What makes is better or worse? What have you done to get relief?

Q - Quality or Quantity

What is the character of the symptom i.e. pain: is it crushing, piercing, dull, sharp? How intense or severe has it been?

R - Region or Radiation

Where is the symptom? Does it spread?

S - Severity

How does the symptom rate on a severity scale of 1 to 10 with 10 being the most intense? Is it getting better? Has it been getting worse?

T - Timing (onset, duration, frequency)

When did the symptom begin? How long does it last? How often does it occur? Is it sudden or gradual?

U - Understanding

What is the client's perception? What does the client think it means?

A -Associated signs and symptoms

Does the primary problem result in any other clinical manifestations, e.g. is the pain accompanied by diaphoresis, nausea, vomiting?

Appendix B

Functional Assessment

Sensory

- Hearing acuity: response to sounds, use of aids.
- Visual acuity: vision loss, corrective lenses (date of last eye examination), glasses, contacts, prosthesis, glaucoma, cataracts.

Mobility

- Ambulation: Independently, stand-by-assist or with assistance.
- Use of ambulation devices: cane, specific type of walker or wheelchair.
- Transfers: Independent, with assistance, use of transfer belt, use of mechanical lift.
- Mobility goals: increased ambulation, bed rest, other.

Diet

- Consider cultural, religious and individual preferences.
- Type of Diet: Regular, cardiac, diabetic, no added salt, lactose free, etc.
- Evidence of dysphagia: difficulty swallowing, coughing while eating, painful swallowing.
- Diet Consistency: thin, nectar thick, honey thick. Regular, soft, puree.
- Fluid: Normal, thickened, restriction amount, record of ins/outs, individual preferences.
- Feeding: Independent, partial assistance, total assistance.
- Use of specialty devices: utensils, sip cup, feeding tube.

Personal Care

- Bathing: Independent, cueing, partial assistance, total assistance. Individual preferences. Braden score or similar.
- Oral care: Dentures or partials. Independent, cueing, partial assistance, total assistance. Individual preferences.
- Urinary and Bowel care: Independent, cueing, partial assistance, total assistance. Incontinence (bladder or bowel), use of incontinent products, catheters, ostomies.