4.3: Assessment

Assessment is the first step of the nursing process (and the first Standard of Practice set by the American Nurses Association). This standard is defined as, "The registered nurse collects pertinent data and information relative to the health care consumer’s health or the situation." This includes collecting "pertinent data related to the health and quality of life in a systematic, ongoing manner, with compassion and respect for the wholeness, inherent dignity, worth, and unique attributes of every person, including but not limited to, demographics, environmental and occupational exposures, social determinants of health, health disparities, physical, functional, psychosocial, emotional, cognitive, spiritual/transpersonal, sexual, sociocultural, age-related, environmental, and lifestyle/economic assessments."[1]

Nurses assess patients to gather clues, make generalizations, and diagnose human responses to health conditions and life processes. Patient data is considered either subjective or objective, and it can be collected from multiple sources.

Subjective Assessment Data

Subjective data is information obtained from the patient and/or family members and offers important cues from their perspectives. When documenting subjective data stated by a patient, it should be in quotation marks and start with verbiage such as, The patient reports. It is vital for the nurse to establish rapport with a patient to obtain accurate, valuable subjective data regarding the mental, emotional, and spiritual aspects of their condition.

There are two types of subjective information, primary and secondary. Primary data is information provided directly by the patient. Patients are the best source of information about their bodies and feelings, and the nurse who actively listens to a patient will often learn valuable information while also promoting a sense of well-being. Information collected from a family member, chart, or other sources is known as secondary data. Family members can provide important information, especially for individuals with memory impairments, infants, children, or when patients are unable to speak for themselves.
See Figure 4.5 for an illustration of a nurse obtaining subjective data and establishing rapport after obtaining permission from the patient to sit on the bed.

**Example.** An example of documented subjective data obtained from a patient assessment is, “The patient reports, ‘My pain is a level 2 on a 1-10 scale.’”

![Figure 4.5 Obtaining Subjective Data in a Care Relationship](image)

### Objective Assessment Data

**Objective data** is anything that you can observe through your sense of hearing, sight, smell, and touch while assessing the patient. Objective data is reproducible, meaning another person can easily obtain the same data. Examples of objective data are vital signs, physical examination findings, and laboratory results. See Figure 4.6 for an image of a nurse performing a physical examination.

**Example.** An example of documented objective data is, “The patient’s radial pulse is 58 and regular, and their skin feels warm and dry.”
Sources of Assessment Data

There are three sources of assessment data: interview, physical examination, and review of laboratory or diagnostic test results.

Interviewing

Interviewing includes asking the patient questions, listening, and observing verbal and nonverbal communication. Reviewing the chart prior to interviewing the patient may eliminate redundancy in the interview process and allows the nurse to hone in on the most significant areas of concern or need for clarification. However, if information in the chart does not make sense or is incomplete, the nurse should use the interview process to verify data with the patient.

After performing patient identification, the best way to initiate a caring relationship is to introduce yourself to the patient and explain your role. Share the purpose of your interview and the approximate time it will take. When beginning an interview, it may be helpful to start with questions related to the patient’s medical diagnoses to gather information about how they have affected the patient’s functioning, relationships, and lifestyle. Listen carefully and ask for...
clarification when something isn’t clear to you. Patients may not volunteer important information because they don’t realize it is important for their care. By using critical thinking and active listening, you may discover valuable cues that are important to provide safe, quality nursing care. Sometimes nursing students can feel uncomfortable having difficult conversations or asking personal questions due to generational or other cultural differences. Don’t shy away from asking about information that is important to know for safe patient care. Most patients will be grateful that you cared enough to ask and listen.

Be alert and attentive to how the patient answers questions, as well as when they do not answer a question. Nonverbal communication and body language can be cues to important information that requires further investigation. A keen sense of observation is important. To avoid making inappropriate inferences, the nurse should validate any cues. For example, a nurse may make an inference that a patient is depressed when the patient avoids making eye contact during an interview. However, upon further questioning, the nurse may discover that the patient’s cultural background believes direct eye contact to be disrespectful and this is why they are avoiding eye contact. To read more information about communicating with patients, review the “Communication” chapter of this book.

Physical Examination

A physical examination is a systematic data collection method of the body that uses the techniques of inspection, auscultation, palpation, and percussion. Inspection is the observation of a patient’s anatomical structures. Auscultation is listening to sounds, such as heart, lung, and bowel sounds, created by organs using a stethoscope. Palpation is the use of touch to evaluate organs for size, location, or tenderness. Percussion is an advanced physical examination technique typically performed by providers where body parts are tapped with fingers to determine their size and if fluid is present. Detailed physical examination procedures of various body systems can be found in the Open RN Nursing Skills textbook with a head-to-toe checklist in Appendix C. Physical examination also includes the collection and analysis of vital signs.

Registered Nurses (RNs) complete the initial physical examination and analyze the findings as part of the nursing process. Collection of follow-up physical examination data can be delegated to Licensed Practical Nurses/Licensed Vocational Nurses (LPNs/LVNs), or measurements such as vital signs and weight may be delegated to trained Unlicensed Assistive Personnel (UAP) when appropriate to do so. However, the RN remains responsible for supervising these tasks, analyzing the findings, and ensuring they are documented.

A physical examination can be performed as a comprehensive, head-to-toe assessment or as a focused assessment related to a particular condition or problem. Assessment data is documented in the patient’s Electronic Medical Record (EMR), an electronic version of the patient’s medical chart.

Reviewing Laboratory and Diagnostic Test Results

Reviewing laboratory and diagnostic test results provides relevant and useful information related to the needs of the patient. Understanding how normal and abnormal results affect patient care is important when implementing the nursing care plan and administering provider prescriptions. If results cause concern, it is the nurse’s responsibility to notify the provider and verify the appropriateness of prescriptions based on the patient’s current status before implementing them.
Types of Assessments

Several types of nursing assessment are used in clinical practice:

- **Primary Survey**: Used during every patient encounter to briefly evaluate level of consciousness, airway, breathing, and circulation and implement emergency care if needed.

- **Admission Assessment**: A comprehensive assessment completed when a patient is admitted to a facility that involves assessing a large amount of information using an organized approach.

- **Ongoing Assessment**: In acute care agencies such as hospitals, a head-to-toe assessment is completed and documented at least once every shift. Any changes in patient condition are reported to the health care provider.

- **Focused Assessment**: Focused assessments are used to reevaluate the status of a previously diagnosed problem.

- **Time-lapsed Reassessment**: Time-lapsed reassessments are used in long-term care facilities when three or more months have elapsed since the previous assessment to evaluate progress on previously identified outcomes.

Putting It Together

Review Scenario C in the following box to apply concepts of assessment to a patient scenario.
Ms. J. is a 74-year-old woman who is admitted directly to the medical unit after visiting her physician because of shortness of breath, increased swelling in her ankles and calves, and fatigue. Her medical history includes hypertension (30 years), coronary artery disease (18 years), heart failure (2 years), and type 2 diabetes (14 years). She takes 81 mg of aspirin every day, metoprolol 50 mg twice a day, furosemide 40 mg every day, and metformin 2,000 mg every day.

Ms. J.’s vital sign values on admission were as follows:

- Blood Pressure: 162/96 mm Hg
- Heart Rate: 88 beats/min
- Oxygen Saturation: 91% on room air
- Respiratory Rate: 28 breaths/minute
- Temperature: 97.8 degrees F orally

Her weight is up 10 pounds since the last office visit three weeks prior. The patient states, “I am so short of breath” and “My ankles are so swollen I have to wear my house slippers.” Ms. J. also shares, “I am so tired and weak that I can't get out of the house to shop for groceries,” and “Sometimes I’m afraid to get out of bed because I get so dizzy.” She confides, “I would like to learn more about my health so I can take better care of myself.”
The physical assessment findings of Ms. J. are bilateral basilar crackles in the lungs and bilateral 2+ pitting edema of the ankles and feet. Laboratory results indicate a decreased serum potassium level of 3.4 mEq/L.

As the nurse completes the physical assessment, the patient’s daughter enters the room. She confides, “We are so worried about mom living at home by herself when she is so tired all the time!”

**Critical Thinking Questions**

1. Identify subjective data.
2. Identify objective data.
3. Provide an example of secondary data.

Answers are located in the Answer Key at the end of the book.

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