2.1: Introduction

Systematic health assessments are performed regularly in nearly every health care setting. For example:

- A health history is taken when a patient is admitted and whenever additional subjective information is required to inform care.
- Comprehensive head-to-toe assessments are done when a patient is admitted, at the beginning of each shift, and when it is determined to be necessary by the patient’s hemodynamic status and context.
- Brief physical assessments are done as necessary and to identify changes in a patient’s status and for comparison with the previous assessment.
- Focused assessments are done in response to a specific problem recognized by the assessor as needing further assessment of a body system.
- Emergency assessments are done in emergency situations.

A routine physical assessment reveals information to supplement a patient’s database. The assessment is documented according to agency policy, and unusual findings are reported to appropriate members of the health care team. Ongoing, objective, and comprehensive assessments promote continuity in health care.

The ability to think critically and interpret patient behaviours and physiologic changes is essential. The skills of physical assessment are powerful tools for detecting both subtle and obvious changes in a patient’s health. The assessment skills outlined in this chapter are meant to provide a framework to develop assessment competencies applicable and salient to everyday practice as recommended by Anderson, Nix, Norman, and McPike (2014).

Learning Objectives

Physical assessment objectives include being able to:
• Describe the purposes of physical assessment
• Describe the different types of assessment and when they should be used to inform care
• Discuss techniques to promote a patient’s physical and psychological comfort during an examination
• Make environmental preparations before an assessment
• Identify data to collect from the nursing history before an examination
• Incorporate health promotion and health teaching into an assessment
• Use physical assessment techniques and skills during routine nursing care
• Document assessment findings according to agency policy
• Communicate abnormal findings to appropriate members of the health care team