MODULE 9

Components of Physical Examination

The Physical Assessment is the first step in the nursing process.

It provides the **foundation for the nursing care plan** in which your **observations** play an integral part in the in the following phases;

- assessment
- intervention
- evaluation

The chances of overlooking important data are greatly reduced because the physical assessment is performed in an organized, systematic manner, instead of a random manner.

After completing this lesson, the learner should be able to:

- Understand how to effectively interview your patient to gather the necessary subjective and objective medical data and to appropriately document such findings.
- Identify the components of a systemic, head-to-toe physical assessment.
- Cite the procedures and techniques applied during the Physical Assessment to examine each complete body system.

Components of the Physical Assessment will encompass all of the following;

Health History Chief

Complaint

Past Medical History Family

Health History Vital Sign are

as follows;Blood pressure

Temperature

Pulse

Health History. During this assessment step, you interview the patient to obtain a history so that the nursing care plan may be patterned to meet the patient's individual needs.

The history should clearly identify the patient's strengths and weaknesses, health risks such as hereditary and environmental factors, and potential andexisting health problems.

Both the seating arrangement and the distance from the patient are importantin establishing a relaxed and comfortable environment for data collection.

Chairs placed at right angles to each other about 3 feet apart facilitate an easy **exchange of information**.

If the patient is in bed, be seated in a chair at a 45-degree angle to the bed.

If possible, the Medical Professional should**, communicate with the patient ateye level and provide the following information;**

- name
- status
- purpose of the interview.

During the introduction, assess the patient's comfort and ability to participate inthe interview.

Terminate the interview when you have obtained the data you need or thepatient cannot provide more information.

You need the following information in order to form the **subjective database**.

- Chief complaint
- Past medical history
- Family health history

Additionally, record if the patient is adopted and has no access to his biological family's history.

Chief complaint.

Record the chief complaint as a brief statement of whatever istroubling the patient and the duration of time the problem has existed.

The chief complaint is the signs and symptoms causing the patient to seekmedical attention.

Generally, it is the answer to the question, "What brought you into the hospital(or clinic) today?"

If a well person is seeking a routine physical, there is no actual chief complaint.

Record his reason for the visit and the date of his last contact with a medical treatment facility.

Past medical history.

This provides background for understanding the patient asa whole and his present illness. Encompassing the following areas;

- childhood illnesses
- immunizations
- allergies
- medications
- hospitalizations and serious illnesses
- accidents and injuries
- habits

Family health history.

This enhances your understanding of the environment inwhich the patient lives.

Obtaining this information identifies genetic problems, communicable diseases, environmental problems, and interpersonal relationships.

Specific inquiry should be made regarding the general state of health of parents, grandparents, siblings, spouse, and children.

Vital Signs. The patient's vital signs are part of the objective data that helps to better define the patient's condition and helps you in planning care.

The following vital signs may be taken at the time the patient's height andweight

are obtained.

Blood Pressure. Blood pressure may be taken in both arms.

Record whether the patient was lying, sitting, or standing at the time thereading was obtained.

Temperature. Record the temperature and whether it is an oral, axillary, or rectal temperature.

Pulse. Peripheral pulses are graded on a scale of 0-4 (as detailed in forwardslide).

+1 diminished, barely palpable.

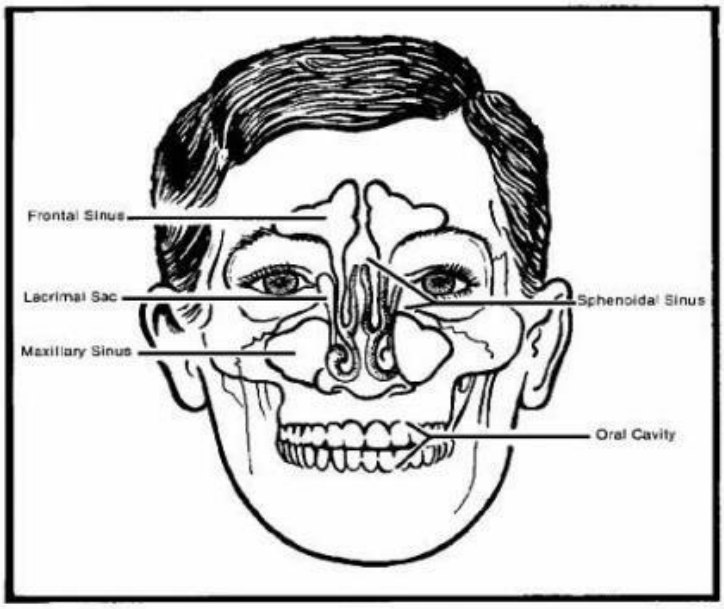
+2 average, slightly weak, but palpable.

+3 z full and brisk, easily palpable.

+4 bounding pulse, sometimes visible.

- Assessment of the head begins with a general inspection.
- Knowledge of the anatomy of the skull is helpful in localizing and describing physical findings.
- Observe the general size of the head. Inspect the skull for shape and symmetry.

  Note any deformities.
- Continue the assessment by examining the eyes, ears, nose, and throat.
- Become familiar with the irregularities in a normal skull, such as those near the suture lines between the parietal and occipital bones.
- Part the hair in several places and inspect the scalp for scaliness, lumps, or
- other lesions.
- Note the quantity, distribution, pattern of loss if any, and texture of the hair.
- Observe the patient's facial expression and contours for asymmetry, involuntary movements, edema, and masses.
- Note the color, pigmentation, texture, and any lesions of the skin.



The pupils and iris are assessed together. Examine the pupils for color, shape,equality, reaction to light, and accommodation. The pupils are normally black in color, round, and equal. If the pupil appearscloudy or discolored, the probable cause is a cataract.

Health of the iris is determined by noting the regularity of the pupil.

An irregular, constricted appearance to the pupil may result from edema due to inflammation of the iris.

Screen visual acuity with any available print.

If the patient cannot read the largest print, test the patient's ability to count your upraised fingers and distinguish light (such as your flashlight) from dark.

The Eye Assessment

Inspect the eyes for symmetry, movement, and the condition of the pupils,iris, and sclera.

Ask the patient to 100k up as you depress both lower lids with your thumbs, exposing the sclera and palpebral conjunctiva (lining Of inner surface Of theeyelids).

The Eye

Note the color and vascular pattern against the white background of thesclera.

The **pupils** and iris are **assessed together**.

Pupillary Reaction

Examine the pupils for briskness, symmetry, and accommodation.

Pupils are normally round and can range in size from *pinpoint" to occupying the entire space of the iris.

Pupils normally constrict with increasing light and accommodation (ability of thelens to adjust to objects at varying distances).

The Ear

The **Ear has three compartments** as follows;

- external ear
- middle ear
- Inner ear

The external ear is comprised of the **auricle** and **ear canal**.

The ear canal opens behind the tragus. Movement of the auricle and tragus is painful in acute external otitis, but not in otitis media. Tenderness behind the earmay be present in otitis media.

The Ear Assessment

Much of the middle ear and all of the inner ear are inaccessible to directexamination.

To estimate hearing, test one ear at a time. Ask the

patient to occlude one ear with a finger.

Stand 1 or 2 feet away, and whisper softly to the enucleated ear.

Speak words with equally accented syllables, such as "homerun" or "four-nine.

Make sure that the patient does not read your lips. Ask him to repeat what youhave

said.

The Ear Assessment

During a Physical Ear Assessment, the ears are assessed as follows for;

hearing

symmetry

discharge

tinnitus (ringing in the ears)

vertigo (dizziness)

Inspect each auricle of the ear and surrounding tissue for deformities, lumps, orskin les Ions.

If ear pain, discharge, or inflammation is present, move the auricle up and down,press the tragus, and press firmly just behind the ear.

The Nose

The nose has two major functions.

It enables us to use our sense of smell and it is the air conditioner of therespiratory system.

Assess the nose for bone alignment and epistaxis (nosebleeds).

The Nose

If the patient has a history of trauma to the nose, ask if there has been a changein his ability to smell.

The nose, in conjunction with the paranasal sinuses, filters, warms, and moistensthe air.

The paranasal sinuses are air-filled cavities with ciliated mucous membranelinings.

Only the frontal and maxillary sinuses are accessible to physical examination.

The Nose Inspection

Inspect the nasal mucosa and septum.

If the patient complains of nosebleeds, ask him about the frequency, amount, and color of the nosebleeds.

Inspect and palpate the outside of the nose.

By using a penlight or otoscope, you can get a partial view of each nasalvestibule.

Note unusual skin markings, obvious deviation of the septum (asymmetry), discharge, or flaring of the nares.

The Throat

Examine the throat. Include the lips, teeth, gums, tongue, buccal mucosa, uvula,and tonsils.

Observe the color and moisture of the lips. Note any cracking, lumps, or ulcers.

The Oral Cavity

Look into the patient's open mouth.

use a tongue blade and light to inspect the buccal mucosa for color, pigmentation, ulcers, white patches, and nodules.

Patchy brown pigmentation is normal in black people.

If the patient wears dentures, offer a container or paper towel and ask the patient to remove them so that you can look at the mucosa underneath.

The oral cavity

Explain what you plan to do and put on gloves.

Look for swelling, bleeding, retraction, discoloration, and inflammation of thegums.

Look for loose, missing, or carious teeth.

Note abnormalities in the position or shape of the teeth.Ask the

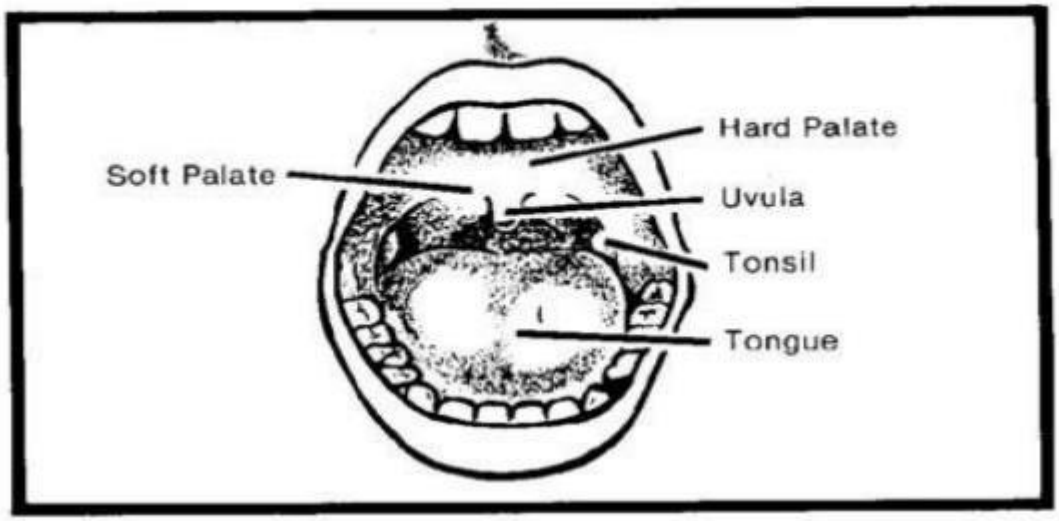
patient to stick out his tongue.

Inspect the back, sides, and undersurface of the tongue.

With one hand, grasp the tip of the tongue with a square of gauze and gentlypull it to the side.

Inspect the side of the tongue, and then palpate it with your other gloved hand, feeling for any hardening of tissue.

The Oral Cavity



The Oral Cavity

Reverse the procedure for the other side of the tongue. With the patient's mouth still open, press the tongue blade down upon the midpoint of the arched tongue and inspect the uvula and tonsils.

Note any evidence of pus, swelling, ulceration, or tonsillar enlargement.Whitish

spots of normal tissue may sometimes be seen on the tonsils.

White patches with redness and swelling, however, suggest pharyngitis.

Break and discard the tongue blade after use. Inspect the neck, noting its symmetry and any masses or scars.

The oral cavity

Look for enlargement of the parotid or submaxillary glands, and note any visible lymph nodes.

NOTE: Determine the last medical check-up in each of these areas and the patient's need for corrective devices such as glasses, hearing aid, or braces.

The procedure to perform a Neurological Assessment is as follows;

There are two approaches to assessment of the neurological system, depending on the condition of the patient and his chief complaint.

If the patient is undergoing a routine health assessment, a screening levelexam is appropriate.

If the patient's chief complaint relates to the neurologic system, a moredetailed assessment is required.

A most important consideration is the cooperation and participation of thepatient.

During the **Neurological Assessment**, the following assessments should bemade.

Mental status. Assess the patient's **level of consciousness** and **orientation** to **time,** place, and person.

Much of the mental status exam can be done during the interview.

The patient's orientation to person, place, and time **are intact if he knows whohe is, where he is, and the time of day.**

Neurological Assessment - altered states of consciousness are as follows;

Conscious—Alert, awake, aware of one's self and environment.

Confusion—Disorientation in time.

Irritability and/or drowsiness.

Misjudgment of sensory input.

Misperception of sensory stimuli.

Shortened attention span.

Decrease in memory Delirium—Disorientation, fear.

Visual and auditory hallucinations.Loss

of contact with environment.

Stupor—unresponsive, but can be aroused back to a near normal state.

Strength

Muscle strength is tested against the resistance of the examiner.

Strength will vary from person to person. Symmetrical responses are significantand permit you to use the patient as his own control.

Assess strength in all extremities, the neck, and back.

To assess strength in the upper extremities, have the patient squeeze your first two fingers with both hands.

The grip should be reasonably strong, but most important; it should be equal inboth hands.

Strength and limb mobility

Apply resistance when the patient flexes the wrist and elbow.

Try to push his arms down to his sides. Instruct the patient to resist your efforts.

Note any pain or weakness the patient has.

To assess shoulder and scapulae resistance, ask the patient to extend

both arms out in front of him and resist the push that you will apply. This

is a common site for sports injuries, arthritis, and bursitis.

Ask the patient to raise both arms above his shoulders.

Note any pain or weakness the patient has.

Strength

Assess the **lower extremities** in a similar manner with the patient lying down.

Ask the patient to raise his leg against your hand, which is applying pressure onthe thigh, trying to flatten the leg.

Ask the patient to flex his knees so that his feet are flat on the table.Place

your hands laterally at both knees.

Note any pain with this movement

Sensation

The sensory functions include as follows:

- touch,
- pain,
- vibration,
- position,
- temperature, and
- discrimination.

If the patient complains of numbness, peculiar sensations, or paralysis, sensation should be checked more carefully over flexor and extensor surfaces of the extremities.

Generally, the face, arms, legs, hands, and feet are tested for touch and pain.

Sensation

Ask the patient to close his eyes and identify which end of the pin is touchinghim.

Compare distal and proximal areas and note any areas of reduced or heightened sensations.

The sense of vibration is tested with a tuning fork held firmly against a bone.

Bones commonly used are located at the thumb side of the wrist, the outsideof the elbow, either side of the ankle, and the knee.

Sensation Assessment

Touch is tested with a wisp of cotton.

Ask the patient to close his eyes and respond whenever the cotton touches hisskin.

Compare the sensation in symmetrical areas of the body, such as the cheeks.

Test the sharpness or dullness of pain by using the pointed and the blunt endof a safety pin.

Test the distal bones of an extremity first. Strike the tuning fork fairly hard and hold it against the patient’s skin.

The patient should feel the vibration or buzz.

Sensation

The middle finger and large toe are used to test the sense of position. Ask thepatient to close his eyes.

While supporting the patient's arm with one hand, grasp the patient's middlefinger firmly between the thumb and index finger of your other hand.

Exert the same pressure on both sides of the patient's finger while moving it.

Sensation

To test the sense of position using the large toe, place the patient's heels onthe examining table and grasp the toe in the same manner.

use a series of brisk up, down, and straight-out movements before coming torest in one of the three positions.

Ask the patient to identify the position.

Temperature - Assessing the Patients ability to determine hot and coldsensation is as follows;

Temperature sensation is determined by touching the patient's skin with tubesfilled with hot and cold water.

Ask the patient to identify which tube feels hot and which feels cold.This

test is unnecessary if the "sensation of pain" test is normal.

Temperature - Procedure to test the Patients ability to determine hot andcold sensation is as follows;

Place small, familiar objects such as a coin, paper clip, or key in the patient'shand and ask him to identify it.

Another way is the one- and two-point stimuli.

Alternate touching the patient's fingertip with two pinpoints simultaneously and then with one pin.

Have the patient discriminate between the one- and two-point stimuli.

Gastrointestinal and Genitourinary

During the **Physical Assessment** the following key system are examined asfollows;

- The Respiratory System
- The Cardiovascular System
- Gastrointestinal System
- Genitourinary Assessment

Learning Outcomes

This lesson will provide the learner with an overview of the techniques and procedures applied in conducting a Physical Assessment of the Respiratory, Cardiovascular, Gastrointestinal and Genitourinary Systems respectively.

On completion of this lesson, the learner should;

Understand the techniques and procedures used to perform a PhysicalAssessment of the Respiratory System.

Identify the different types of breathing sounds and Respiratory Rate.

Understand the techniques and procedures applied in performing aCardiovascular Assessment.

1. Respiration System

The following outlines the techniques and procedure for carrying out a Physical Assessment on the Respiratory System;

Respiration is assessed using inspection, palpation, and auscultation.

Have the patient remove all clothing to the waist and assume a sitting position.

Inspect the chest for posture, shape, and symmetry of expansion.

Warm the diaphragm of the stethoscope in the palms of your hands and place itfirmly against the patient's chest wall.

Ask the patient to breath quietly with the mouth open.

2. Types of Breathing Sounds

There are three types of normal breath sounds as follows;

- Vesicular
- Bronchial
- Bronchovesicular

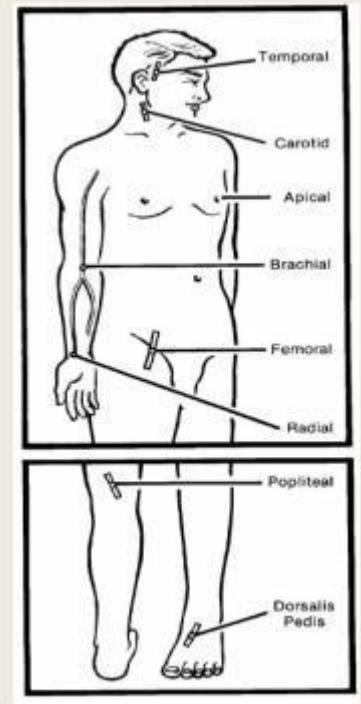
Vesicular sounds are soft, like a quiet rustle or swish.

Bronchial sounds are loud, harsh, hollow blowing sounds usually heard over the trachea and major bronchi.

Assess the respirations for rhythm.

Bronchial sounds are **louder during** expiration.

Bronchovesicular sounds are a **combination of the other**



3. Respiratory Rate

Respiratory rate is the number of breaths in one minute.

Bradypnea is less than 10 breaths per minute.

Dyspnea is difficult or painful breathing.

Orthopnea is difficult breathing except in an upright position.

Note whether the patient's breathing is regular, irregular,labored, or non-labored.

Rhonchi are the rumbling, rattling, or snoring sounds due to mucous and secretions in the bronchial tree.

A wheeze is the raspy whistling or high-pitched sound.

4. Cardiovascular Assessment

Cardiovascular Assessment. Palpation and auscultation examination techniques are used in assessment of the cardiovascular system, which includes blood pressure, peripheral pulses, heart sounds, and circulatory perfusion.

The patient's blood pressure is usually taken at the onset of the assessment and the pulses are palpated while the skin is being examined.

To obtain an accurate blood pressure reading, you will needa stethoscope, a blood pressure cuff, and a sphygmomanometer.

Be sure that the patient is relaxed and use a cuff that is not more than 20 percent wider than the diameter of the patient's limb and longenough to completely encircle it.

If the patient is very obese, it may be necessary to use a thigh

5. Body Pulse to determine Heart Rate

The following outlines the procedure in taking pulse readings to assist with the Cardiovascular element of the Physical Assessment;

Take **the peripheral pulses** with the patient in the **supine position**, using your index and middle finger.

Palpate the apical, radial, dorsalis pedis, and posterior tibia' pulses.

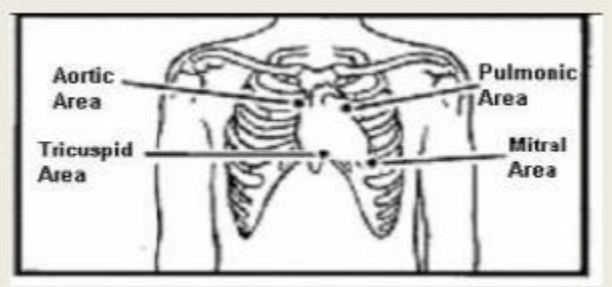
The posterior tibia' pulse is palpable behind and below the protuberance on theinside of the ankle as shown in diagram insert.

6. Heart Sounds

Several heart sounds can be heard by auscultation (as noted in picture insert).The

first two heart sounds are produced by closure of the valves of the heart.

The first heart sound (S1) occurs when the ventricles have been sufficiently filledand the right and left atrioventricular (A-V) valves close. S1 is heard as one dull, low-pitched sound.



1. Measuring Rhythm and Heartbeat

Rhythm is the pattern of the heartbeats and the intervals between the beats.It may be regular or irregular. Normally, equal time elapses between heartbeats. Any deviation from the normal pattern is arrhythmia.

2. Heart Murmurs

Murmurs are produced by turbulent blood flow, may occur at any cardiacauscultation site. The volume of blood flow, the force of the contraction, and the degree ofvalve compromise all contribute to murmur quality. Descriptive terms are used to give the murmur character. Murmurs are "whooshing" sounds. Although the mitral sound is usually loudest, astenotic mitral valve that moves very little may produce a muffled sound

Musculoskeletal System

The practical nurse that is assigned to assist in the physical examination plays an important role in supporting both the patient and the physician or other health care providers during the Physical Assessment which continues and includes as follows;

Physical Assessment of the Musculoskeletal Encompassing Muscle, Joints andBones requires Inspection and palpation.

Physical Assessment of the Integument encompassing the Skin, Hair, and Nails

Physical Assessment of the skin, hair, and nails requires inspection andpalpation

Musculoskeletal Assessment begins the instant you see the patient.

Good observation skills will enable you to gain information about musclestrength, obvious physical or functional deformities or abnormalities, and movement symmetry.

If the patient's chief complaint involves a different body system, the musculoskeletal assessment should represent only a small part of the overallassessment.

After completing the lesson, the learner will:

Understand how to perform a Musculoskeletal Assessment.

Understand the procedure to apply conducting an inspection of the SpinalCurvature.

Understand how to assess Motor skills, Range of Motion, Muscle strength andMuscle mass.

Cite the procedure involved in an Assessment of the Integument.

If the health history or physical findings suggest musculoskeletal involvement,analyze the patient's complaints and perform a complete musculoskeletalassessment.

Observe the patient's general appearance, body symmetry, gait, posture, and coordination.

Inspect and palpate his muscles, joints, and bones.

Evaluate muscle and joint function of body area as you proceed with theexamination.

Compare both sides of the body for size, strength, movement, and complaintsof pain.

Position the patient to allow full range of motion (ROM), but avoid tiring the patient by allowing him to sit whenever possible.

Procedure to inspect spinal curvature is as follows;

Inspect spinal curvature. Have the patient stand as straight as possible and inspect the spine and the shoulders, iliac crests, and scapulae for symmetry ofposition and height.

Normally, the thoracic spine is characterized by convex curvature and the lumbarspine is characterized by concave curvature in a standing patient.

Have the patient bend forward from the waist with arms relaxed and dangling.

Stand behind him and inspect the straightness of the spine, noting flank andthorax position and symmetry.

Procedure to inspect Spinal Curvature is as follows:

- Have the patient stand with his feet

  together.Note the relation of one knee to

  the other.
- The knees should be symmetrical and located at the same height in a forward-facing position.
- To observe and evaluate his posture, pace and length of stride, foot position, coordination, and balance.
- Ask the patient to walk away, turn around, and walk back.
- If the patient is elderly or infirmed, remain close and ready to help if he should stumble or start to fall.
- Normal findings include smooth, coordinated movements, erect posture, and2 to 4 inches between the feet.
- Abnormal findings include a wide support base, arms held out to the side or in front, jerky or shuffling motions, toeing in or out, and the ball of the foot, rather than the heel, striking the floor first.
- Assess muscle mass. Muscle mass is the actual size of a muscle. Assessment involves measuring the circumference of the thigh, the calf, and the upper arm.
- Measure at the same location on each area.
- Abnormal findings include circumferential differences of more than 1/2 inch between opposite thighs, calves and upper arms, decreased muscle size (atrophy), excessive muscle size (hypertrophy) without a history of muscle building exercises, flaccidity (atony), weakness (hypotonicity), spasticity (hypertonicity), and involuntary twitching of muscle fibers (fasciculations).
- To assess gross motor skills, have the patient perform range- of-motion
- (ROM) exercises.

- To assess fine motor coordination, have the patient pick up a small object froma flat surface.
- Assess muscle tone. Muscle tone is the tension in the resting muscle.
- Palpate the muscle at rest and during passive ROM from the muscle attachment at the bone to the edge of the muscle.
- A relaxed muscle should feel soft and

  pliable.A contracted muscle should feel

  firm.
- Assess muscle strength and joint ROM. Have the patient perform active ROM as you apply resistance.
- Normally, the patient can move joints a certain distance (measured in degrees) and can easily resist pressure applied against movement.
- Strength is normally symmetrical.
- If the patient cannot perform active ROM, put the joints through passive

  ROM.use a goniometer to measure the angle achieved.
- Place the center or zero point on the patient's joint. Place the fixed arm perpendicular to the plane of motion.
- As the patient moves the joint, the movable arm indicates the angle in degrees.
- Assessment of the Integument encompasses a Physical Assessment of the skin, hair, and nails requires inspection and palpation.
- Be sure the room is warm to prevent cold-induced vasoconstriction, which may affect skin color.
- Systematically, assess the entire skin surface as you expose each area for
- inspection and palpation of other systems.

  Skin Assessment
- The Skin should feel warm to cool, and areas should feel the same bilaterally. ThePhysical Assessment of skin considers the follows aspects:

- Texture
- consistency

  temperature

  moisture and

  turgor

- Skin texture refers to smoothness or coarseness.
- Consistency refers to changes in skin thickness or firmness and relates more to changes associated with lesions.
- Observe the patient from a distance, noting complexion, general color, and
- overall appearance.

Skin Assessment

- Normal skin usually resumes its flat shape immediately.
-
- A bluish discoloration is due to lack of oxygen in the

  blood.A yellow skin tone (jaundice) indicates liver

  dysfunction.

- Note pigmentation (light and dark areas compared to the rest of theskin), freckles, and moles.
- Assess turgor by gently grasping and pulling up a fold of skin, releasing it, and observing how quickly it returns to normal shape
- Poor turgor may indicate dehydration and connective tissue disorders.

Hair Assessment will observe the following areas;

- The quantity, texture, color, and distribution of hair.
- Rub a few strands of the patient's hair between you index finger and thumb.

  Feel the hair for dryness, brittleness, oiliness, and thickness.

- **Assessment of the nails will observe the following;**
- A Physical **Assessment of the Nails** provides **information about the**

patient'slife- style, self-esteem, and level of self-care as well as health status. Inspectthe nails for cleanliness, length, color, consistency, smoothness, symmetry, and for jagged or bitten edges.

- Note any alterations in skin integrity such as scars, rashes, sores, lesions, bruises, and discoloration.
- If the patient has a dressing, note the type, location, any drainage, and the Amount and character of the drainage.

Documenting findings and results after the Assessment:

Upon completion of the Physical Assessment, **chart that the examination was done**, by whom, the **patient's reaction**, and **any specimens** sent to **the lab** or **special procedures** to **be followed**.

The practical nurse that is assigned to assist in the Physical Assessment plays an important role in **supporting both the patient** and the physician or other healthcare providers.

Vital Signs measurement of a Patient

Monitoring Vital Signs

Soon after a patient arrives on the nursing unit you should begin your nursing assessment.

You should take several measurements to establish a baseline for furtherobservations of that patient.

Among these measurements are height, weight, and vital signs.

Height and Weight

The patient’s height and weight are recorded on admission for several reasons.

Diet Management:

The patient’s ideal weight and may be determined. The
health care team will also be able to monitor weight loss or gain.

Observation of Medical Status:

Taking the patient's height and weight mayindicate that the patient is overweight, underweight, or is retaining fluids (edema).

The following procedure is adhered to when measuring the height andweight of the patient:

- Have the patient stand on the scale with the back to the measuring bar.
- Ask the patient to stand straight. Lower the bar so that it slightly touches the top of the patient's head.
- Record the height in inches or centimeters in accordance with local policy.

Measuring the height of a bed bound or immobile patient is as follows:

- If the patient cannot stand, obtain an approximate height in bed.
- Have the patient lie on his back and stretch as much as possible.
- Place a mark on the bottom sheet at the patient's heel and at the top ofthe patient's head.
- Measure between these two marks on the taut bottom sheet.

Principles related to weighing the patient.

Weight the patient before breakfast, at the same time each day. Use the samescale each time.

Ensure that the scale is properly balanced.

Weight the patient in the same amount of clothing each day (i.e. hospital gownor pajamas).

Have the patient void before weighing.

Avoid weighing any equipment attached to the patient such as drainage bagsor telemetry units.

Hold the equipment while actually weighing the patient.

A helpless patient may be weighed while lying down on a litter scale.

This scale is sling-type device that looks like a suspended hammock.

You will need assistance to place the patient on the scale

Record the patient’s weight on the graphic sheet and in the nurse’s notes.

Temperature

Body temperature is defined as the measure of the heat inside the body: thebalance between heat produced and heat lost.

Being human, we are homoeothermic; we are warm-blooded and maintainbody temperature independently of our environment.

Our body generates heat as it burns food. It loses heat through the lungs (breathing), through the skin (sweating), and in body discharges (urine, feces,vomitus, or blood)