Physical Assessment in Older Adults: Performing

What Is Involved in Physical Assessment of Older Adults?

- A physical assessment is a noninvasive physical examination undertaken to obtain preliminary information on a patient’s body system function, mental/behavioral status, and overall health
  - What: A physical assessment is performed regularly during outpatient sick- and well-visits. In the inpatient setting, physical assessments are performed by nurses during each 4-, 8- or 12-hour shift depending upon the level of care, the patient’s condition, and facility protocol. Each of the patient’s body systems is systematically evaluated to identify abnormal findings that signal the presence of an underlying disease or a change in the patient’s condition. The head-to-toe assessment described in this Nursing Practice & Skill is typical of the patient assessment performed by nursing staff once per shift or as needed when a patient’s condition changes or to assess the effect of therapeutic interventions
  - How: During the physical assessment of an older adult, the clinician uses inspection, auscultation, palpation, and percussion to assess the patient’s body systems sequentially from the head and neck toward the toes. Vital signs are obtained, functional status is assessed, and the patient is questioned about the presence of pain or other discomfort in any part of the body. Standard precautions are observed throughout the assessment
  - Where: Physical assessment can take place in any healthcare setting, including inpatient facilities, physician’s offices, and, in the case of homecare or emergency medical care, within the community
  - Who: Physical assessment of the older adult can be performed by nurses, physicians and other advanced practice practitioners, and emergency medical staff, and should not be delegated to assistive staff members. It is common and appropriate for a family member to be present during the physical assessment; however, the patient might prefer that the procedure be performed privately

What Is the Desired Outcome of Physical Assessment in Older Adults?

- The purpose of the physical assessment is to gather preliminary information about the patient’s physical condition to identify abnormalities that warrant further evaluation and/or intervention. The head-to-toe physical assessment can
  - establish a baseline against which future measurements are compared
  - identify current or potential problems
  - evaluate the effectiveness of nursing and medical interventions

Why Is Physical Assessment in Older Adults Important?

- Due to the rising aging population, it is essential that clinicians understand the physiologic changes that occur as adults age and how to tailor their assessment to the older adult (see Facts and Figures, below)
- Older adults are at greater risk than younger individuals for systemic and degenerative diseases, nutritional deficits, and cognitive impairments. It is often during the physical assessment that signs of physiologic disease are first detected. These abnormal findings identify the need for more in-depth examination of the affected body system (e.g., an
abnormal heart rate and/or chest discomfort can prompt the treating clinician to order an EKG or echocardiogram.

› If the physical assessment is performed on a conscious individual, this assessment can serve as a means to identify psychological and emotional conditions in addition to physical abnormalities. If the patient’s responses to the clinician’s questions suggest the possible presence of a psychological or emotional disturbance (e.g., depression, anxiety, psychosis), this will prompt additional mental health evaluation and/or prescribed treatment (e.g., antidepressant medication)

### Facts and Figures

› The U.S. Census Bureau reported that 13% of the American population was 65 years of age or older in 2010 (U.S. Census Bureau, n.d.)
  • The United States Centers for Disease Control and Prevention (CDC) estimates that by 2050 nearly 89 million Americans will be over age 65 (CDC, 2013)
› One third of inpatient surgeries are performed on persons 65 years of age and older (Jones et al., 2013)
› Older adults are at greater risk for cognitive impairment because cognitive function typically begins to decline around age 50 and accelerates after age 65. Multiple factors can increase this risk, including cigarette smoking, alcohol consumption, sedentary lifestyle, depression, female gender, and lack of social support (Wu et al., 2011)
› Researchers evaluated a sample of 235 older adults scheduled for elective colorectal or cardiac surgeries and reported that, independent of advancing patient age, a history of one or more falls within 6 months prior to surgery increases the older adult’s risk for postoperative complications, the need for institutionalization following discharge, and 30-day readmission rates (Jones et al., 2013)
› Older adults are less likely to participate in physical exercise than younger adults; however, exercise continues to be beneficial in older age. Investigators in a study published in 2011 determined that higher levels and intensity of physical exercise reduce mortality in older adults by improving physical and psychological health and by reducing risk for chronic diseases associated with inactivity such as obesity and hypertension (Hrobonova et al., 2011)
› Older adults should be screened, using a validated, facility-approved screening tool, for frailty (e.g., gait speed, cognition, and physical functioning) as frailty is associated with a poor quality of life (QOL) and an increased risk for death (Fernandez-Alonso et al., 2013)
› Authors of a systematic review and meta-analysis determined that inpatient geriatric consultation teams—interdisciplinary groups that collectively evaluate the older adult, engage in group discussion about the patient, and establish a treatment plan—significantly reduce patient risk for death at 6 and 8 months after discharge, but do not appear to influence functional status, readmission, or length of hospital stay (Deschodt et al., 2013)

### What You Need to Know Before Performing the Physical Assessment in an Older Adult

› Understanding of the normal physiologic changes that occur with aging and the impact of these changes on risk for systemic and degenerative disease is important
  • Age-related changes and changes related to diseases that occur more frequently in older adults include
    –changes in the skin, including wrinkling, loss of elasticity and turgor, and increased risk for bruising and tearing. In addition, patients with mobility concerns or in long-term care are at increased risk for pressure injuries (formerly called pressure ulcers)
    –changes in the musculoskeletal system, including loss of muscle mass, reduced range of motion (ROM), balance disturbances, gait disorders, tremors, and arthritic changes. Patients with musculoskeletal disorders are at increased risk for falls and might be unable to function or perform activities of daily living (ADLs) independently, which can reduce QOL
    –vision and hearing impairments
    –difficulty in recalling health history
  • Healthcare concerns particular to the older patient population include
    –multiple comorbidities. Older adults often have several disorders, with treatment for one disorder often impacting other systems and perhaps worsening other disorders
    –underreporting of symptoms. The older adult might attribute symptoms to aging and not report them to the healthcare provider
    –missed or delayed diagnoses. The first sign of a disorder in an older patient might be a change in mental or emotional status, which can be discounted as dementia and not evaluated to determine the true cause
    –polypharmacy. As older patients are prescribed medications for numerous disorders, they become at increased risk for drug interactions and inappropriate prescribing
Elder abuse. Signs and symptoms of elder abuse include unexplained bruising, burns, physical neglect, and fear in the presence of the caregiver.

Cognitive impairment. Older adults with cognitive impairment might be less inclined or capable of cooperating with the physical assessment.

- For these patients, flexibility in the clinician’s approach is important; a systematic approach to the assessment might not always be possible, but the assessment should be comprehensive, including all body systems.

- Older adults often present with nonspecific, mild, or atypical rather than classic symptoms of disease. For example,
  - myocardial infarction in the older adult might cause nausea, fatigue, epigastric discomfort, diaphoresis, weakness, and confusion, without severe chest discomfort.
  - some older adults with pulmonary edema do not manifest obvious pulmonary symptoms but become confused, lethargic, or anorexic.
  - infection in the older adult might not be accompanied by a significant increase in body temperature because older adults have lower than average body temperature; in the older adult, an oral temperature of 99 °F (37.2 °C) or higher can indicate fever.
  - Other signs and symptoms can include delirium and urinary incontinence or frequency or fatigue.
  - hyperthyroidism in the older adult can manifest with fatigue, weight loss, and slowed motion.
  - hypothyroidism in the older adult can cause confusion, agitation, and weight gain.
  - depression in the older adult can result in slowed mental function, vague gastrointestinal symptoms, sleep disturbances, change in appetite, and altered activity level.

Familiarity with essential components of the head-to-toe physical assessment is necessary.

- During the head-to-toe physical assessment, the clinician uses inspection, auscultation, palpation, and percussion to identify physiologic abnormalities.
  - Inspection is often described as the most important assessment technique, because it begins immediately upon meeting the patient, is continued during the entire patient interaction, and helps to guide the clinician’s attention to obvious abnormalities.
  - Auscultation is the use of a stethoscope to listen to the different sounds produced by the body. Auscultation is an especially important technique for assessing the heart, lungs, and bowel. The clinician typically listens for the strength, rate, and rhythm of heart sounds; the clarity of breath sounds; and the presence and frequency of bowel sounds. (For details about proper technique during auscultation, see Nursing Practice & Skill ... Stethoscopes: Using and Caring for.)
  - Palpation is the use of the hands to feel for abnormalities of the skin and underlying tissues. Palpation can detect skin turgor, abnormal growths in or below the skin, edema, bladder or abdominal distention, the location and quality of peripheral pulses, and the temperature, texture, and moisture level of the skin.
  - When performing palpation, keep the fingernails short, warm the hands to promote patient comfort, and wear gloves if contact with mucus membranes or bodily fluids is anticipated.
  - Light palpation is applied by depressing the skin 0.5–0.75 inches (1–2 cm) with the pads of the fingers.
  - Deep palpation is applied by depressing the skin 1.5–2 inches (4–5 cm) using firm pressure, and is used to assess for pain or for the size, shape, and tenderness of internal organs or masses.
  - Percussion, which is typically not used as often as the other assessment techniques, is the use of the fingers to tap or gently strike different body parts to produce sounds that indicate whether the underlying structure is air- or fluid-filled as well as solid or hollow. Doing so can help the clinician detect undesirable fluid or estimate the size of certain internal organs, such as the liver.

- Assessment of vital signs is a key part of the physical assessment. The clinician should possess understanding of normal vital sign parameters, normal variations in vital signs, and appropriate intervention(s) if vital sign measurements are outside normal limits. For more information, see the following reference papers:
  - Nursing Practice & Skill ... Blood Pressure Reading, Indirect: Taking -- Adult Patient
  - Nursing Practice & Skill ... Arterial (Radial) Pulse: Taking
  - Nursing Practice & Skill ... Oral Temperature: Taking
  - Nursing Practice & Skill ... Respiratory Rate Assessment: Performing in Adults

- Pain is often referred to as the “fifth vital sign.” Patients should be evaluated using a validated, facility-approved pain assessment tool for the presence of pain and level of pain intensity during every physical assessment, and after the administration of analgesic medications. Patients should be asked whether or not they feel pain, and their body language...
and vital signs monitored for indications of pain (e.g., flinching, guarding, increased heart rate, increased respiratory rate). (For more information, see the Nursing Practice & Skill series on pain assessment in specific patient groups)

Familiarity with age-appropriate assessment techniques and validated assessment tools is important

- When assessing the older adult, it is essential to use facility-approved, age-appropriate validated instruments to assess the patient’s functional status and identify problems, such as mobility or balance impairment, cognitive impairment, or incontinence. Multiple functional assessment tools are available for use in the older adult population, including the Katz Index, Barthel Index and Scale, and the Minimum Data Set.

  - The SPICES assessment tool developed by Fulmer is used to assess functional status and to identify the following six geriatric syndromes (i.e., age-related, preventable conditions):
    - Sleep disorders
    - Problems with eating
    - Incontinence
    - Confusion
    - Evidence of falls
    - Skin breakdown

  - Functional impairment often leads to falls in older adult patients. Using a validated fall risk assessment tool, such as the Tinetti Balance and Gait Evaluation, Get-Up-and-Gotest, or Functional Reach Test can help identify risk for falls in these patients.

  - The rate of falls that lead to fracture and mobility impairment is increased in older adults due to increased use of medications causing dizziness or drowsiness, diminished muscle strength and coordination, and decreased bone mineral density and osteoporosis. In older adults, especially in post-menopausal women, a fall risk assessment followed by lifestyle modification and pharmacologic intervention (e.g., increase in resistance exercise and calcium supplementation) are essential to prevention of fracture related to falls (Rahmani et al., 2009).

  - Validated cognitive assessment tools that can be used in the older adult patient include the Mini-Cognitive Assessment tool, Geriatric Depression Scale, and Lawton Scale.

Preliminary steps that should be performed prior to the physical assessment of an older adult include the following:

- Review the facility/unit-specific protocol for the head-to-toe physical assessment or for specific components of the procedure, if one is available.
  - Note unit-specific guidelines for the frequency of the physical assessment and how to notify the treating clinician of abnormalities.

- Review the treating clinician’s order for the physical assessment, if one exists, although it is generally not necessary to obtain a physician’s order as the head-to-toe assessment is a standard part of nursing duties.

- Review the manufacturer’s instructions for all equipment to be used and verify that the equipment is in good working order.

- Verify completion of facility informed consent documents.
  - Typically, the general consent for treatment that is executed by patients at the outset of admission to a healthcare facility includes standard provisions that encompass the physical assessment.

- Review the patient’s medical history/medical record for:
  - Information obtained during patient history taking about any known or suspected illness or injury.
  - Results of laboratory or other diagnostic tests.
  - Results of previous assessments for comparison.
  - Any allergies (e.g., to latex, medications, or other substances); use alternative materials, as appropriate.

Gather the necessary supplies, which typically include the following:

- Nonsterile gloves; additional personal protective equipment (PPE; e.g., gown, mask, eye protection) can be necessary if exposure to body fluids is anticipated.

- Thermometer (e.g., digital oral, axillary, or rectal thermometer).

- Stethoscope.

- Penlight.

- Blood pressure cuff of appropriate size for the patient.

- Floor or bed scale.

- Measuring tape.

- Facility-approved pain assessment tool.

- Facility-approved falls assessment tool.
Additional supplies to be provided for well-patient physical assessment (i.e., more detailed assessment performed by advanced practice nurses, physician assistants, and physicians, often assisted by nurses), including
- otoscope/ophthalmoscope
- reflex hammer

How to Perform the Physical Assessment in an Older Adult

› Perform hand hygiene and don PPE as appropriate
› Identify the patient according to facility protocol
› Establish privacy by closing the door to the patient’s room and/or drawing the curtain surrounding the patient’s bed
› Introduce yourself to the patient and family member(s), if present; explain your clinical role in the physical assessment; assess the coping ability of the patient and family and for knowledge deficits and anxiety regarding the physical assessment
› Determine if the patient/family requires special considerations regarding communication (e.g., due to illiteracy, language barriers, or deafness); make arrangements to meet these needs if they are present
   – Use professional certified medical interpreters, either in person or via phone, when language barriers exist
› Explain the procedure for physical assessment; answer any questions and provide emotional support as needed
› Obtain verbal consent
› Provide the patient with a gown, if not already wearing one; provide privacy to undress and don the gown, or help the patient undress and don the gown, as appropriate
› Assess the patient’s general health status, including his/her level of pain using a facility-approved pain assessment tool
› Observe standard precautions throughout the physical assessment
› Assist the patient into a comfortable position that provides the clinician with easy access to the patient. Verify that there is adequate light to perform the assessment
› Inspect the patient’s overall appearance and identify any obvious physical abnormalities. At the same time, ask the patient about any unusual symptoms. This will provide important preliminary information that can guide the physical assessment. Be aware that older patients often exhibit atypical symptoms and might be reluctant to disclose symptoms that they attribute to normal aging
› Ask the patient how he/she feels and about any physical symptoms that have developed or changed recently. Briefly inquire about each of the body systems; ask about changes in appetite or bowel, bladder, or sleep habits; presence of nausea or vomiting; emotional disturbances; and pain
› Ask about social habits such as whether or not the patient participates in regular physical exercise and pattern of alcohol or drug consumption, if present
› Consider the general appearance of the patient while looking for clues to poor health. Note restlessness, any indication that the patient is experiencing pain, and whether or not the patient verbally reports pain. Observe patient’s affect and body position, and note the presence or absence of self-care measures such as hygiene and grooming. Observe for signs of neglect (see Red Flags, below). Consider whether the patient’s age is congruent with his/her appearance
› If the patient is physically or cognitively impaired, observe his/her interaction with his/her caregiver for familial or relationship problems
› Measure the patient’s vital signs, including temperature, pulse, respirations, and blood pressure. Compare findings with established reference values appropriate to the age of the patient to identify abnormalities
› Assess for pain by utilizing the self-report method (i.e., asking the patient directly whether or not he or she has pain, the duration of time he/she has had pain, where it is located, the type of pain [e.g., burning, aching], how severe it is, and what makes it better or worse) and/or by utilizing a facility-approved pain assessment tool intended for use by older patients
› Measure the patient’s height, weight, and waist circumference; do not rely on self-report as patients are often unreliable when reporting height and weight. Calculate the patient’s body mass index (BMI; i.e., an index of weight-for-height) and compare with established reference values to determine if the patient is underweight, overweight, or obese, and/or has an abnormally high proportion of abdominal fat, which can contribute to risk for diabetes mellitus
   • A BMI calculator and weight classifications is available online at http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm
   • Assess nutritional status and take a dietary history, as indicated
› Examine each of the body systems
   • Skin (for detailed information, see Nursing Practice & Skill ... Skin Assessment: Performing )
Ask the patient about any skin lesions, areas of irritation, or other changes in the skin, and any precipitating factors.

Assess the skin as you assess each of the body systems, exposing only the area of skin to be assessed and keeping the rest of the body covered to promote privacy. Inspect the patient’s skin for scars, lesions, wounds, injuries, rashes, irritation, color, and areas of redness or cyanosis.

- Take care to assess within folds of skin, the sclera, mucus membranes, the nailbeds, the scalp, the palms of the hands, and the soles of the feet.
- Use a facility approved assessment tool to assess risk for PrUs.
- Palpate the patient’s skin to assess for temperature, elasticity/turgor, moisture, edema, and pain.

• Neurological status (for detailed information, see Nursing Practice & Skill ... Neurological Assessment: General Considerations, or another paper in the series of papers regarding components of the neurological assessment).

Assess level of wakefulness, consciousness, and orientation, and for sensory deficits. Use a facility-approved cognitive assessment tool, as available.

- If the patient is awake and alert (i.e., responsive to stimuli), assess the patient’s understanding of person, place, time, and situation, the four spheres of orientation. This can be done through conversation or, more explicitly, by asking the following four questions:
  - “What is your name?”
  - “Can you tell me where you are?”
  - “What day is it?”
  - “Why are you here?”
- If the patient can answer all four questions, he or she is awake, alert, and oriented to all four spheres of orientation. If the patient knows his or her name, but is unable to answer the other three questions, he or she is considered awake, alert, oriented to person, and disoriented to place, time, and situation.
- Recognize that delirium in the older adult can be an early indication of infection.

Note pupillary size, symmetry, and reaction to light.

Assess hand strength (e.g., strength and symmetry of grip).

Use the reflex hammer to check for the presence and strength of the patellar reflex.

• Assess the head (including eyes, mouth, ears, nose, and throat).

Inspect the skin, eyes, sclera, inner and outer ears, mucus membranes, and scalp.

- Observe color of sclera
- Note moisture and color of mucous membranes
- Note presence of discharge from eyes, ears, or nose
- Notes texture and distribution of hair
- Inspect and palpate the thyroid gland for enlargement, nodules, or masses
- Assess for problems with speech (e.g., aphasia or dysphasia) or swallowing, which can be the result of stroke or other brain injury.
- Inspect the mouth for condition of the teeth and gums, and for lesions. Assess breath odor, as halitosis (i.e., foul breath odor) can indicate poor oral hygiene or tooth decay.
- Palpate for swelling or masses, lesions in the mouth or elsewhere, and for pain or tenderness.
- Percuss over the sinuses to assess for pain or tenderness.

• Respiratory system (for detailed information, see Nursing Practice & Skill ... Physical Assessment: Performing a Respiratory Assessment in Adults).

Use inspection to note whether the patient is using the normal respiratory muscles or is relying on use of accessory muscles (i.e., sternocleidomastoid, scalene, trapezius, intercostal, and rhomboid muscles) to breathe. Assess for equal chest expansion, the position of the trachea, and for cyanosis.

- Note oxygen saturation level (see Nursing Practice & Skill ... Oxygen Saturation Measuring: Pulse Oximetry). Assess for any clubbing of the fingertips, which is an indication of chronic respiratory insufficiency.
- Verify the presence of airway devices/oxygen therapy (e.g., endotracheal tube) and confirm that they are positioned and working correctly.
- Auscultate breath sounds over the anterior and posterior chest and all lobes of the lungs. Notes character and quality of sounds.
- Palpate for fremitus (i.e., a palpatory vibration) to assess for lung consolidation (increased fremitus) or pleural effusion (decreased fremitus). Assess for subcutaneous emphysema (i.e., small pockets of air under the skin that can occur with pneumothorax or other thoracic trauma; also call crepitus).
– Percuss over the chest wall to assess for areas of consolidation or other changes. Measure lung/diaphragmatic excursion as desired

• Cardiovascular system (for detailed information, see Nursing Practice & Skill ... Physical Assessment: Performing a Cardiovascular Assessment in Adults)
  – Inspect over the area of the heart for bulging or heaving. Place the patient at a 45° angle and assess for jugular venous distention (JVD)
  – Lightly palpate over the area of the heart for thrills/vibrations that can be caused by murmurs
  – Assess the carotid, radial, femoral, posteriortibial, and dorsalis pedis pules. Compare the strength of pulses on each side of the body. Assess the color of the nail beds and capillary refill time. Normal capillary refill time is < 3 seconds
  – Assess the carotid pulses one side at a time
  – Percuss to determine the borders of the heart
  – Auscultate the apical pulse for rate, rhythm, and strength, ideally while the patient is in the sitting position
    - Note S1 and S2 heart sounds, the combination of which equals one heartbeat
    - Assess heart rate by counting the number of heartbeats over the course of one minute; assess heart rhythm by comparing the intervals between heartbeats, which should be evenly spaced, or regular; assess the strength of the apical pulse by noting whether heart sounds are easy or difficult to hear. Be aware that a weak apical pulse can indicate insufficient pumping of blood by the heart
    - For detailed information, refer to Nursing Practice & Skill ... Physical Assessment: Auscultating Heart Sounds in Adults and Nursing Practice & Skill ... Physical Assessment: Auscultating Heart Sounds in Children
    – Auscultate over the carotid arteries to assess for bruits
    – Palpate the radial pulse while auscultating the apical pulse. Note whether the radial pulse is slower than the apical pulse, as is common in patients with atrial fibrillation; this is considered a pulse deficit
    – Palpate the lower extremities for edema and, if present, if pitting and the extent of pitting, which is determined by applying pressure over a bony prominence with one fingertip for approximately 2 seconds, releasing the pressure, and noting how long it takes for the indentation to refill. With trace pitting edema, the indentation refills as soon as the pressure is removed; with 4+ pitting edema, the indentation remains for at least 2 minutes after pressure is removed
    – Check for leg or calf pain during passive ankle flexion, which could indicate deep vein thrombosis
    – Assess the blood pressure in each arm

• Lymphatic system
  – Palpate lymph nodes in the neck, supraclavicular, axillary, and inguinal areas for tenderness or swelling. Note size, shape, motility, and tenderness
    - The supraclavicular nodes are typically not palpable unless enlarged

• Abdomen (for detailed information, see Nursing Practice & Skill ... Physical Assessment of the Abdomen in Adults: Performing)
  – Inspect the abdomen for color, rashes, scars, distended blood vessel, distention, and obvious areas of swelling (e.g., hernias)
  – Auscultate bowel sounds over the four abdominal quadrants
    - For the purposes of the physical assessment, the abdomen is divided into the right lower quadrant (RLQ), right upper quadrant (RUQ), left upper quadrant (LUQ), and left lower quadrant (LLQ), with the umbilicus as the midpoint. Auscultating in this order tracks the path of the large intestine from the ascending colon to the transverse colon to the descending colon and sigmoid
    - Auscultation is performed prior to palpation because palpation can temporarily alter bowel sounds
  – Auscultate over the abdominal aorta for bruits
  – Percuss over the four abdominal quadrants, noting any abnormalities. The abdomen should sound tympanic other than over abdominal organs. Percuss in the RUQ for the borders of the liver and in the LUQ for splenic enlargement
  – Palpate over the four quadrants for tenderness, distention, or masses
    - Perform light palpation to assess for tenderness or distention by depressing the skin 0.5–0.75 inches (1–2 cm) with the pads of the fingers (Figure 1)
Figure 1: Light palpation is performed by depressing the skin 0.5–0.75 inches (1–2 cm) with the pads of the fingers. Copyright ©2015, EBSCO Information Services

- Perform deep palpation to assess for the size, shape, and tenderness of internal organs or masses by depressing the skin 1.5–2 inches (4–5 cm) using firm pressure. Place a second hand over the first to provide firmer pressure, as needed, particularly if the patient is obese or muscular. (Figure 2)

Figure 2: Deep palpation is performed by depressing the skin 1.5–2 inches (4–5 cm) using firm pressure. Copyright ©2015, EBSCO Information Services

- Palpate the liver, spleen, and kidneys, assessing for tenderness and/or enlargement. Normally only the liver edge is palpable, the kidneys and spleen are not felt unless enlarged
- Ask about bowel patterns, verifying that the patient has had a bowel movement within the past three days
- If the patient has a colostomy or ileostomy, assess the surrounding skin for signs of irritation and assess the contents of the stoma pouch (for more information, see *Nursing Practice & Skill ... Ostomy Care: an Overview*)

• Genitourinary system
  - Ask about voiding patterns and urine characteristics
    - Assess for urinary incontinence
    - Verify that the patient has voided sometime within the last 8 hours. If the patient has not, palpate over the bladder to check for distention
    - Inquire about any discomfort during urination or whether the patient has urinary urgency or frequency
  - Note the presence of assistive devices (e.g., indwelling urinary catheter) and confirm that they are working correctly

• Musculoskeletal system
  - Inspect for symmetry, deformities (e.g., breaks, contractures), and range of motion (ROM). Observe the gait and posture, and for the presence of assistive devices and whether they are working correctly
  - Assess functional status and ability to perform ADLs using a facility approved assessment tool, as available
- Assess risk for falls using a facility approved assessment tool, as available
- Assess for pain with movement
  - Assess the symmetry and strength of upper and lower extremities
  - Palpate the joints for crepitus, which is often present with osteoarthritis
- Assist the patient into a comfortable position in a bed or chair
- Provide the patient with privacy to redress or help the patient to redress, as appropriate
- Clean/disinfect reusable equipment according to facility protocol
- Dispose of other procedure materials and PPE, and perform hand hygiene
- Update the patient’s plan of care, as appropriate, and document the physical assessment in the patient’s medical record, including the following information:
  • Date and time the assessment was completed
  • Patient assessment findings from each portion of the assessment, including pain experienced and any deviation from normal
  • Results of any assessment tools administered (e.g., to assess risk for falls)
  • Any special considerations that were made (e.g., due to cognitive or other impairment)
  • Laboratory specimens collected and sent for analysis
  • Patient’s response to the procedure, including any pain/discomfort/anxiety during or immediately following the assessment
  • Any unexpected patient events or outcomes, interventions performed, and whether or not the treating clinician was notified
  • Patient/family member/caregiver education, including topics presented, response to education provided/discussed, plan for follow-up education, and details regarding any barriers to communication and/or techniques that promoted successful communication

Other Tests, Treatments, or Procedures That May be Necessary Before or After Performing a Physical Assessment in Older Adults

  › Notify the treating clinician of abnormal findings and/or significant changes in previous assessments so that the treatment plan can be established or modified. Request referral to additional clinicians (e.g., registered dietitian), as needed
  › Reassessment will be conducted in accordance with facility protocol. Reassessment should be conducted more frequently
    • to evaluate the outcome of interventions
    • if the patient’s condition changes
    • if the patient is medically unstable
  › Collect/arrange for collection of blood or other body fluids (e.g., urine) for laboratory tests (e.g., lipid panel, electrolytes), as ordered, and review results as they become available
  • Following the physical assessment, laboratory tests might be ordered to assess for health risk factors and to follow up on physical assessment findings or reported symptoms

What to Expect After Performing the Physical Assessment in an Older Adult

  › The patient’s physical condition will be systematically evaluated and any abnormalities will be identified

Red Flags

  › Signs of neglect (e.g., poor hygiene, malnourishment, dehydration) can indicate elder abuse, which should be reported to the appropriate authorities according to local and state laws and facility protocol. For more information, see Quick Lesson About ... Elder Abuse
  › Older adults are at increased risk for falls. For details on how to perform a fall risk assessment, see Evidence-Based Care Sheet: Falls, Accidental: Risk Assessment
  › Self-reported pain scores or descriptions may not be accurate in older adult patients with cognitive impairment; alternative pain assessment tools (e.g., observational assessment of pain behaviors) should be used

What Do I Need to Tell the Patient/Patient’s Family?

  › Before beginning your assessment, educate the patient/caregiver about why the physical assessment will be performed, what to expect during and after the procedure, and any follow-up testing that might be necessary
    • Reinforce information about healthy lifestyle choices (e.g., diet recommendations, exercise, quit smoking)
  › If laboratory testing is ordered, explain how these tests are performed and when the results will likely become available
References


