KINDERSPITAL ZÜRICH

The Physical Examination

A core competence within the assessment of paediatric continence care

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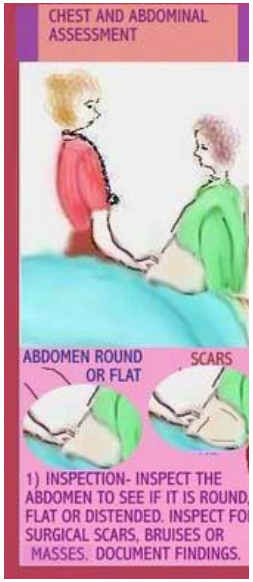


ESPU-N 2013 Genoa

What we will look at before lunch

- Definition and Development
- Continence Care Assessment Skills
- Clinical Example
- Conclusions and Discussion

The assessment – Basis of the process of nursing

(Taylor et al., 2005; Hogston & Simpson, 2002; Ahrens & Tucker, 1999; Mower et al., 1997)

Definition of assessment

"… a systematic method of **collecting all types** of **data** that identify the clients strengths, weaknesses, **physiologic status**, knowledge, motivation, support systems, and coping ability that may influence the client's health either positively or negatively."

(American Nurses Association, 2001)

"Clinical assessment by professional nurses relies up on appropriate gathering and interpretation of relevant subjective and objective **biopsychosocial** data."

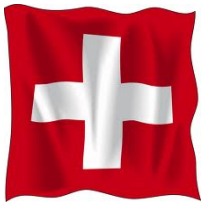
(Lindpaintner, 2007)

Different development

- USA

1960 Physical assessment introduced in Nurse Practitioner (NP) programs
1970 Introduced in baccalaureate programmes
Today firmly embedded

(Lesa et al. 2007; Secrest et al. 2005; Reaby, 1991)



- Switzerland

2000 First Bachelor & Master of science in nursing education program starts with focus on Advanced Nursing Practice (APN)

2007 Introduction of a consensus standard for clinical assessment skills at the BSN level

(Lindpaintner et al., 2009)

Why integrating physical assessment?

- Tertiary nursing education
  - Improved bedside assessment skill provided an practical focus to counter criticism of “over-academization”
- Changes in the health system
  - Increasing patient dependency (chronicle and/or critical illness)
  - Multidisciplinary teams
  - Advances in monitoring technology

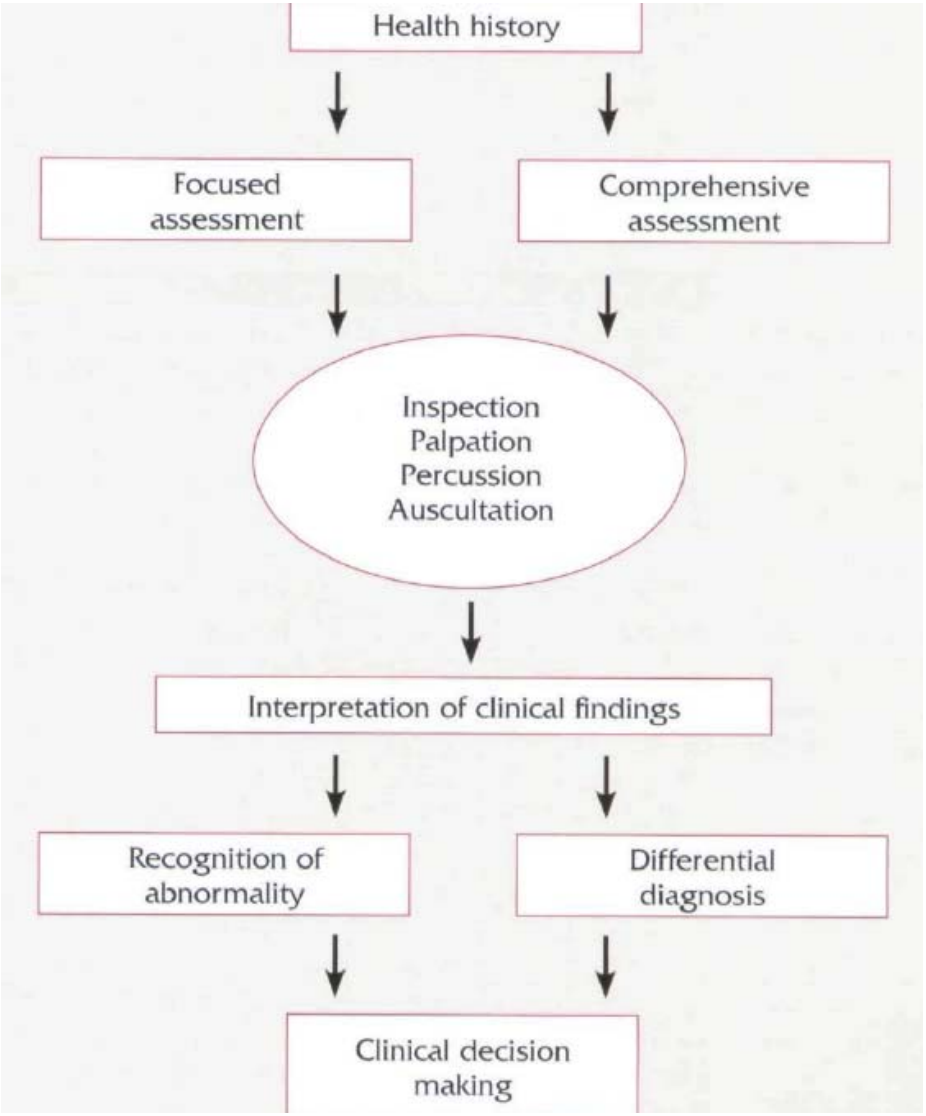
(Lindpaintner, 2009; 2007)

Definition of physical assessment

Assessment, which includes physical assessment skills, has been defined as the systematic and ongoing collection of patient data using the skill of inspection, auscultation, percussion and palpation.

(Taylor et al., 2005; Secrest et al., 2005; Bickley & Hoekelman, 1999)

Physical assessment framework



(Baid, H., 2006)

Nurses` top assessement skills

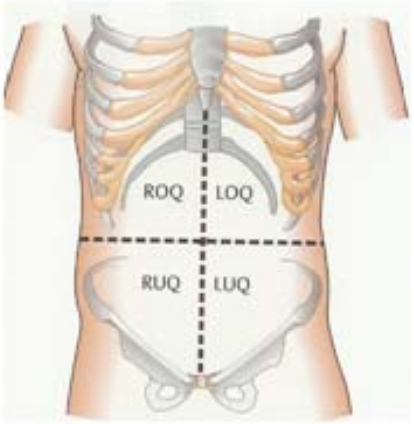
- Light abdominal palpation
- Auscultation of bowel sounds
- Assessment of cardiovascular system
- Percussion /auscultation of chest
- Assessment of skin lesions
- Inspection of ears, mouth, eyes and nose
- Assessment of cranial nerve function

(In Baid, 2006; Sony 1992; Reaby & James, 1990; Colwell & Smith, 1998)

Inspection of abdomen

- External examination by observation
- Use of visual skills to gather information on a particular system, or the patient as a whole.

- Abdominal distension
- Visible peristaltic waves



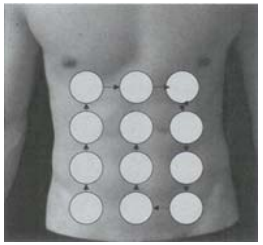
The 4 quadrants of the abdomen (Bickley, 2000)

Reimann, S. (2008). *Befunderhebung. Grundlagenwissen für Physiotherapeuten und Masseure*. München: Urban&Fischer. S. 64-67.

Auscultation of abdomen

- Detecting of physical changes by listening
- Listening of sounds produced by the abdomen (colon)
- Using a stethoscope
  - hypoactive
  - normoactive
  - hyperactive

- Gastroenteritis
- intestinal obstruction (mechanical, paralytic)



Systematic percussion
(Rosenecker & Schmidt, 2008)

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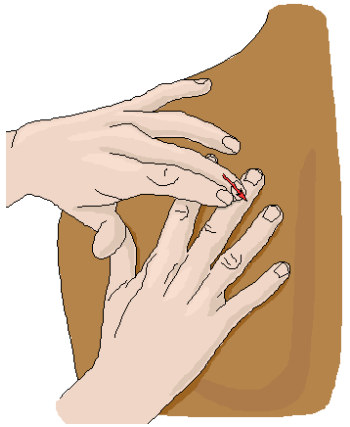
Percussion of abdomen

- Tapping of the skin with short, sharp strokes to assess underlying structures.
  - directly by tapping on an organ with the middle finger
  - indirectly by tapping with the middle finger of the other middle finger lying on a body portion
  - Characteristic sound depicts the location, size and density of underlying organs
- Bladder filling
- Meteorism



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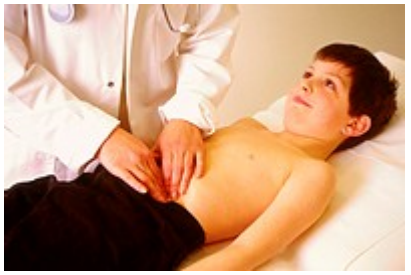
Palpation of abdomen

- Use of the sense of touch
- Assess texture, temperature, moisture, organ location and size, swelling, vibration, pulsation, rigidity/spasticity, masses and pain



- Constipation
- Overflow encopresis
- Bladder filling

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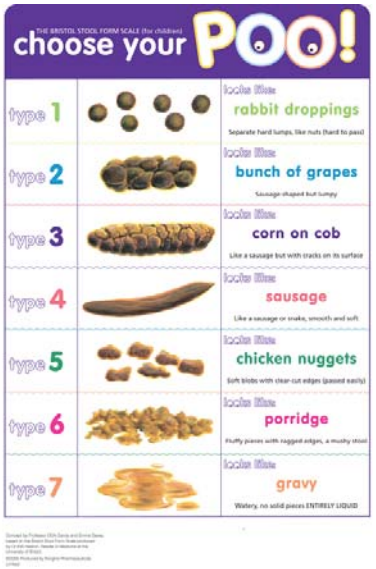
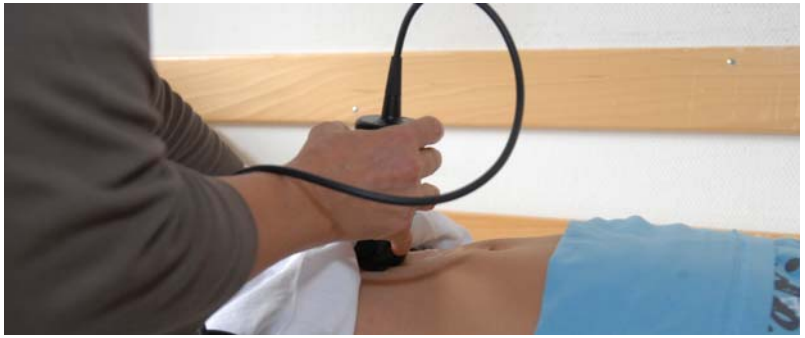
Additional assessment tools in continence care

- Charts e.g.
  - Fluid balance
  - Urinary diary
- Scales e.g.
  - Bristol Stool Form scale
  - Cleveland Clinic Incontinence score
  - Rome criteria for constipation
- Examination, diagnostic, monitoring e.g.
  - Rectal digital examination
  - Bladder Scan/Uroflow
  - color / odour/ urine & stool analysis

Depending the symptoms or intervention

- ADL-Index, Pain scale, Glasgow Coma Scale





Case 1 (Marc)

- 5-year old boy
- Born with ARM and Fallot Tetralogy (corrected)
- Bladder and Bowel incontinence
- Hospital stay for bowel management (BM)
- Goal: social faecal continence before starting school

Nursing Process (1)

- Clinical assessment:
  - Data collection of health history: trauma, stenosis
  - Physical assessment abdomen
    - Inspection, auscultation, palpation and percussion of the bowel
    - Rectal digital assessment
- Nursing diagnoses:
  - Constipation
  - Pain because of an anal stenosis
- Nursing intervention:
  - BM with Peristeen® anal irrigation system (failed)
  - Change of BM to a silicon catheter
- Nursing evaluation:
  - Nursing assessment enabled adaptation to therapy

Case 2 (Joy)

- 7- year old girl
- Lipomyelomeningocele
- Neurogenic bladder and bowel dysfunction
- Aims of consultation:
  - learning self CIC
  - management of faecal incontinence

Nursing Process (2)

- Clinical Assessment:
  - Health history with focus assessment on bowel function
  - Physical assessment abdomen
    - Inspection, auscultation, palpation and percussion of the bowel
- Nursing Diagnosis:
  - Overflow encopresis caused by constipation
- Nursing intervention:
  - Bowel desimpaction and adjustment with laxative following the Bristol Stool Form scale
  - Nursing Evaluation:
  - Successful conservative treatment

Case 3 (Sam)

- 7-year old boy
- Hypoxic encephalopathy after drowning
- Severe dystonia (Baclofen Pump)
- Urinary retention after dystonic crisis
- Urinary incontinence
- Palliative care

Nursing Process (3)

- Physical assessment
  - Palpation and percussion of the bladder
- Nursing diagnosis
  - Urinary retention due to hyperactive bladder sphincter
- Nursing intervention
  - Fluid diary and control of liquids
  - Bladder scan
  - CIC only when necessary
- Nursing evaluation
  - Increased quality of life for the patient

Conclusion

- Physical assessment can make a difference for patients, families and professionals
- Physical assessment in nursing leads to a nursing diagnosis and not to a medical diagnosis

Challenges

- Crossing professional borders
- Educational programs

Discussion

- What is your experience with Physical Assessment?
- Whose role is it anyway?
- Continuous ‘medicalization’ of nursing or a move towards greater nursing independence?
- What’s necessary to extend the skill repertoire?

(Baid, 2006; West, 2006)

Abdomen

- http://www.youtube.com/watch?v=_v3UANVXSas
- http://www.youtube.com/watch?v=jqQ4U_DXKf8
- http://www.youtube.com/watch?v=oJ1CsJJHZCQ

“For it may safely be said,
not that the habit of ready and correct observation will by itself make us useful nurses,
but that without it
we shall be useless with all our devotion”

(Florence Nightingale 1860)