# SYSTEMS ASSESSMENT GUIDE
## NURS 44 School of Nursing

**Present situation:**
State the age and gender of the patient. Why admitted to the hospital and on what date? Any surgery done during this admission? If so, state what and how many days ago (i.e. POD #). What was their state of health prior to admission? List pertinent, chronic conditions like diabetes, CHF, COPD, HTN, etc. List any allergies, and include code status.

**Pain Status:**
State client's current pain status. Include any pertinent past pain responses/treatment.

**Neurological System Status:**
- Level of consciousness (LOC) includes level of arousal and orientation. Level of arousal: note whether alert, attentive to their environment or drowsy, with little motor activity
- Orientation: has 3 spheres—Person, Place, Time (may also include orientation to situation as $4^{th}$ sphere)

Communication: coherent, clear, logical or slurred speech?
Verbal responsiveness: able to express themselves clearly? What languages do they speak? Able to follow and understand simple commands?

Motor function: examine muscle strength; moves all extremities? Steady gait? Any weakness or paralysis?
Sensory function: numbness, tingling? Any lack of sensation to any area?

Do they have headaches, history of seizures or stroke, memory loss, or mood changes?

**Mental status:**
Depressed? Anxious? Grieving a loss? Speech and mannerisms match mood state?
Gives eye contact? Asks lots of questions? Makes jokes? Sexually inappropriate?

**Cardiovascular:**
Heart tones—"$S_1$ and $S_2$" is the normal assessment; any murmurs?
Heart rate—What is the rate? (give a number)
Heart rhythm—regular/irregular?
Blood pressure—state the blood pressure readings. Does the patient take antihypertensive medication?
Edema—note where it is if present; 1+ (barely detectable) to 4+ (leaves a persistent pit about 1" deep); may also have non-pitting edema or no edema at all. Edema in the extremities is often bilateral, if not state whether it is unilateral.
Skin vitals—warm, dry, cool or moist? Nail beds pink, cyanotic, pale? Capillary refill is < 3 seconds or > 3 seconds?
Peripheral pulses—dorsalis pedis, post tibial: are they equal? Grade the pulse amplitude using 3+ scale, i.e. 0 = absent; 1 = weak; 2 = normal; 3 = bounding.

**Respiratory:**
Respiratory rate, rhythm—and what is their oxygen saturation? Uses supplemental oxygen? Any respiratory treatments or inhalers?
Lung sounds (& where any abnormal sounds heard)
Shortness of breath, DOE?
Chest expansion equal? Use any accessory muscles to breathe?
Cough? Character of sputum—clear, white, tan, bloody, creamy, yellow / thick or thin?
Clubbed fingers? Do they have to sleep sitting up in order to breathe?
Do they smoke? Did they ever smoke—for how long?
Do they have a tracheostomy?— (IF THEY DON'T HAVE ONE DON'T MENTION IT) If tracheostomy is present, describe secretions, appearance of stoma, suctioning required.
History of sleep apnea? Uses BiPap or CPAP device at night?

**Gastrointestinal:**
Abdomen: soft, flat, distended, non-distended, tender, non-tender? Scars?
Bowel sounds: absent, hypoactive, hyperactive
Had BM today? What is normal pattern—daily or less often? Color of stool: brown, green, black, bloody. Character of stool: soft, formed, liquid, mucoid?
Do they have an NG tube? **If yes,** state color and character of drainage? Is the tube connected to suction? Is it patent? If they do not have an NG tube please do not mention it in your assessment.

**Hydration & Nutrition:**
Do they take in enough fluid? (normal amount is about 30cc/Kg of body weight) Are they fluid restricted? Take fluids orally or do they have an IV for hydration? State how much fluid they are receiving and whether it is adequate. What is the condition of their mucous membranes (mouth)? Is it —dry, moist, cracked?
Has their sense of taste changed? Do they have decreased appetite or decreased saliva production? What is the condition of their teeth? Do they wear dentures? Do they fit properly? Any trouble swallowing food? What is their weight? Recent weight loss or gain?

**Genitourinary:**
Continent or incontinent? Voids in the urinal or has a foley or other urinary diversion device? State color, character, and quantity of urine. Do they have dysuria, urgency, frequency or retention? Do they awaken at night to urinate? Do they have a shunt or fistula for hemodialysis? Peritoneal catheter for CAPD?

**Integumentary / peripheral vascular:**
Skin intact? Is it paper-thin, oily, shiny, dry or flaking? Any pruritis, skin tears, loss of hair, yellowing toenails? Any bruises (ecchymoses) or hematomas? Pressure ulcers—if yes, what stage (I, II, III, IV). Appearance of wounds, incisions—any drains or dressings? Stasis ulcers? Brown discoloration or hair loss to lower extremities? IV site, describe it, including where it is on your client. You can include pulses here or in cardiovascular section.

**Musculoskeletal (Mobility/ADLs):**
Assess all joints for decreased ROM, swelling, tenderness, or deformities (esp. feet/toes). Do they have arthritis, degenerative joint disease (DJD), or an amputation? Can they perform ADLs independently or with assistance? Do they use any assistive devices to ambulate?

**Family assessment/ significant others:**
Do they live alone? Who cooks for them? What do they value most about their relationships?

**Work / leisure activities/hobbies:** What kind of work do they or did they do? This information might tell something about past exposure to harmful substances that may have affected their health, i.e. asbestos, radiation, chemicals, etc. What do they do in their spare time? Belong to any social or volunteer groups? Do they read the newspaper everyday? How much TV do they watch? Is leisure time important to them? Has it changed recently because of illness? Education level gives clues about health knowledge. Where do they get their health information?—MD, friends, books, internet?

**Effects of illness on activities of daily living:**
How do they feel about what has happened with their health? Are they frustrated or accepting? Do any changes need to be made in their living situation because of the illness? If chronic pain management is an issue—you might discuss it here.

**Stress Assessment:**
What helps them handle stress? What is their normal sleep pattern? Trouble falling asleep? Sleep all the time? Wake up often and can't get back to sleep? Exercise regularly? Do they drink alcohol, smoke tobacco, use sleeping pills or other drugs?

**Spiritual / Cultural influences on client systems:**
Are they actively involved in a religion? Does it help them cope with life situations? Do they practice yoga, meditation, or prayer? Do they use folk medicine, herbs, vitamins or alternative therapies?

**Learning needs:**
Teaching is an important aspect of nursing. Common topics include medications, post-op teaching, safety issues, pain management and nutrition. Does the patient have chronic illnesses such as diabetes, arthritis, COPD, CHF, or chronic pain? If so, they may benefit from referral to other disciplines like the diabetes educator, dietitian, social worker, or community support groups. Being aware of the patient's learning needs helps us know what referrals to suggest.

**Note*** The assessment is the foundation for the nursing process. It helps you to formulate nursing diagnoses and then plan, implement and evaluate care. The nurse puts together subjective data from the patient and objective data from the physical exam. Once that is done the nurse formulates impressions about the patient symptoms and what needs to be done. Nursing diagnoses are then determined based on assessment and observations. Nursing diagnoses allow the nurse to plan what outcomes or goals are expected within a specified length of time (i.e., 24 hours, or next shift). Nursing interventions are selected for each diagnoses to achieve the patient goals. After the interventions are implemented evaluate the outcomes/goals within the time frame.