**Interpreting Nursing Assessment Findings**

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| **Assessment Components** | **Normal Findings** | **Unusual Findings** |
| **HEARING**  Note capacity to hear normal conversation  Speak in whisper and determine capacity to hear  Place your hand over your mouth or turn your back and speak to determine if resident depends on lip reading  Hold a watch over each ear and determine ability to hear  If hearing aid is used ask how long, how obtained, and how effective.  Inspect ears for cerumen accumulation.  If hearing deficit present, ask resident how it has impacted ADLs and what means he/she uses to hear communication | Some degree of sensorineural hearing loss, known as presbycusis, is common with age. This causes difficulty hearing high-pitched sounds.  Cerumen accumulation is common in older adults. | Significant hearing loss that interferes with ability to hear normal conversation. Discuss with physician need for audiometric exam.  Cerumen impaction. With age the keratin in cerumen is of harder consistency and can easily cause a cerumen impaction.  Itching in ear, associated with cerumen impaction, ear infection.  Ringing in ear (tinnitus), associated with hypertension, adverse drug reactions. |
| **VISION**  Inspect eyes for redness, tearing, dryness, edema, drooping of eyelids, discharge, discolored sclera, turning in (entropian) or out (ectropian) of eyelid, symmetry.  If resident uses eyeglasses, have them worn during assessment. Ask about age of prescription and effectiveness.  Ask about date of last opthalmological exam; if greater than one year refer for exam.  Give resident a newspaper for gross assessment of visual acuity and ask if all sized print can be read. Note specific deficits.  Check pupil response to light.  Determine peripheral vision by positioning yourself at eye level with resident, approximately 3 feet away. Extend your arm so that your hand is outside visual field. Point your finger and ask resident to look at your eyes. Slowly bring finger in and ask resident to say when your finger is first seen. Repeat at different points along a 360° area. | Loss of skin elasticity around eyes.  Sclera should be white; can be slightly yellow discoloration in black-skinner persons.  Greater sensitivity to glare due to cataract formation.  Most older adults will have presbyopia: reduction in accommodation that causes difficulty with near vision.  Reduced peripheral vision | Yellow sclera, associated with liver disease.  Edematous eyelids, associated with infection, heart failure, allergy.  Asymmetry of eyes.  Drooping eyelids (ptosis).  Blind spots in visual field, associated with macular degeneration.  Blindness in same half of both eyes (homonymous hemianopsia) associated with CVA.  Eye pain with dilated pupils and perception of halos around lights, associated with acute glaucoma.  Tearing, poor vision, associated with chronic glaucoma. |
| **ORAL CAVITY**  Ask resident about condition of and problems with teeth/dentures and gums.  Inspect oral cavity using flashlight and tongue depressor. Note condition of teeth and mucous membrane, moisture, color, and integrity of membrane.  Inspect color, surface, and movement of tongue.  If dentures are worn assess for fit. Ask resident to remove them and note condition.  Note breath odors. | Although tooth loss is not a normal outcome of aging, many older adults have experienced tooth loss and have dentures.  Drier, thinner oral mucosa.  Black-skinner persons may have bluish hue to lips. | Bleeding and swollen gums, associated with periodontal disease.  White patches on tongue, associated with moniliasis infection or leukoplakia.  Bright red spots on tongue and palate, associated with nicotine stomatitis.  Bright red tongue, associated with deficiency of iron, vitamin B12, or niacin.  Bluish, black line along gumline, associated with lead, mercury, or arsenic poisoning.  Dry oral cavity, associated with dehydration.  Sweet fruity breath, associated with ketoacidosis.  Urine odor to breath , associated with uremic acidosis.  Extremely foul breath odor, associated with poor oral hygiene, decaying teeth, or lung abscess. |
| **CARDIOVASCULAR STATUS**  Note general coloring and energy level.  Ask about chest pain, fatigue, edema, shortness of breath, headaches, dizziness, nosebleeds.  Inspect condition of nails and response to blanching.  Inspect for varicosities, discoloration, edema.  Assess apical and radial pulse.  Measure blood pressure in lying, sitting, and standing positions.  Auscultate heart. | Pulse rate between 60-100. Some tachycardia may be present if there has been recent activity or stress as it takes longer for older adults' to recover from these events. | Clubbing, associated with cardiac disease.  Thickness, dryness of nails, slow response to blanching, associated with circulatory insufficiency.  Hair loss, discoloration, and edema of extremities, associated with poor circulation.  Bruit (abnormal swishing sound or murmur heard over major artery).  Thrill (vibration felt during palpation over artery where bruit is heard.  Arrhythmias, associated with infection, cardiac disease, digitalis toxicity, hemoorhage.  Postural drops in blood pressure greater than 20 mmHG with position changes.  Systolic BP >140 and/or diastolic BP>90, associated with hypertension. |
| **RESPIRATORY STATUS**  Observe coloring, ease of breathing, fullness of lung expansion, unusual sounds with breathing.  Ask about dyspnea, shortness of breath, coughing, bloody mucus, chest pain or tightness, runny nose, sputum production.  Inspect chest for equal expansion of both sides of chest during respiration, discoloration, structural abnormalities.  Auscultate lungs.  Percuss the lungs over intercostal spaces. | Older adults may have less expansion of lungs during respiration, reduced cough response, and slight increase in anteroposterior chest diameter. | Bluish discoloration to face and neck, associated with chronic bronchitis.  Pink, ruddy color to face, neck and trunk, associated with COPD.  Significant increase in anterior-posterior diameter, associated with COPD.  Dyspnea, shortness of breath, or cough, associated with respiratory infection or disease.  Asymmetrical lung expansion, associated with pleural effusion, collapsed lung, fractured rib, pain.  Rales or crackles (crackling sound heard at end of inspiration), associated with extra interstitial fluid.  Rhonchi (rattling sound heard at end of expiration), associated with increased mucus production as with bronchitis as with pneumonia, bronchitis, CHF, pulmonary edema.  Wheeze (groaning sound), associated with presence of large amounts of mucus as with asthma.  Dull, flat sound during percussion, associated with fluid or solid matter filling space. |
| **GASTROINTESTINAL STATUS**  Ask about appetite, swallowing ease, choking, indigestion, nausea, vomiting, pain, constipation, diarrhea, flatus, bowel continence, and use of antacids and laxatives.  Inspect abdomen. Note bulges, dilated vessels, scars, and discoloration.  Ask resident to raise his/her head and note if any bulge appears on abdomen.  Auscultate abdomen. Use bell portion of stethoscope to auscultate over major arteries. Use diaphragm side to listen over intestines for bowel sounds.  Percuss the abdomen.  Palpate all quadrants of the abdomen. | Food should be able to be swallowed without difficulty.  Foods should be able to be swallowed and digested without difficulty.  Regular bowel movements without straining or use of laxative.  Normal heartbeat over vessels  Peristaltic sounds irregularly every 5-15 seconds. (If no sounds heard after listening for several minutes flick finger along abdomen to stimulate activity.)  A high pitched, hollow sound produced over air filled spaces. | Excessive thirst, excessive salivation, choking, difficulty swallowing, indigestion, frequent belching, regurgitation, frequent nausea, vomiting, constipation, diarrhea, bowel incontinence, pain anywhere along GI tract.  Jaundice, associated with cirrhosis, pancreatitis, gallstones.  Pink or blue striae (stretch marks) associated with problems that can cause stretching (e.g., weight gain, ascites, masses)  Bulge appearing in abdomen when head is raised, associated with hernia.  Murmurs over abdominal aorta, associated with aneurysm.  No bowel sounds, associated with late bowel obstruction, electrolyte imbalance, peritonitis.  Increased bowel sounds, associated with diarrhea, early bowel obstruction.  Flat, dull sound over intestines, associated with presence of fecal matter, mass.  Mass, pain |
| **GENITOURINARY STATUS**  Ask about voiding pattern, frequency, pain with voiding, loss of urine when coughing or sneezing, incontinence, characteristics of urine.  If incontinence is a problem ask how long it has been present, if it accompanied another event (e.g., illness, new med), how much is released, and how it affects life.  Ask men about penile discharge, scrotal and penile pain.  Ask women about vaginal pain, itching, discharge, bleeding, soreness; ask about breast pain and discharge.  Ask about sexual function, symptoms, date of last GYN or prostate exam.  Obtain urine sample, as per facility protocol. | Urinary frequency and nocturia are common in older residents.  Drier vaginal canal common in older women.  Reduced libido and sexual activity common with advanced age.  Prostate enlargement present in most older men. | Urinary incontinence, associated with urinary tract infection, enlarged prostate, altered cognition, tumor, medications.  Increased urinary frequency, associated with urinary tract infection, diuretic use, increased fluid intake, diabetes.  Penile discharge, associated with prostatitis, urethritis, venereal disease.  Scrotal pain and swelling, associated with orchitis, cancer.  Vaginal odor, discharge, associated with vaginitis.  Hematuria, associated with urinary tract infection, bladder cancer.  Cloudy odorous urine and urinary frequency, associated with urinary tract infection.  Yellow-brown urine, associated with jaundice, obstructive bile disease. |
| **MUSCULOSKELETAL STATUS**  Ask about joint pain, changes in ability to walk or move, balance, tremors, spasms, and restricted movement.  Place all joints through active and passive range of motion.  Test resident's strength by asking him/her to grab and squeeze your hands; note weakness, differences between hands.  If resident is ambulatory, ask resident to walk the length of a hallway, or at least 50 feet. Look for ability to initiate and stop gait, coordination of movements, toe and foot lift, base of gait, smoothness and steadiness of gait, movement of legs, position and swing of arms, and ease of ambulation. Describe abnormalities.  Test coordination by asking resident to walk touching the heel of one foot to the toe of the other as he/she steps. Hold the resident’s hand if he/she appears unsteady. (This test is referred to as *tandem walking*.) | Reduced muscle mass and strength common in older adults.  Osteoarthritis is a common problem in older adults. | BAck or joint pain, associated with arthritis, osteoporosis. |
| **SKIN STATUS**  Ask the resident to remove clothing and examine all surfaces of the body. Observe the general status of the skin. Note color, cleanliness, moisture, temperature and abnormalities.  Ask about itching, burning or other symptoms. If symptoms are present, question as to how long symptoms have been present and pattern (e.g., all the time, worsens at night). Review history to determine factors that could be associated with symptoms .  Using the back of your hands, touch the cheeks and extremities of the resident to obtain a gross assessment of skin temperature. Note inequalities between sides. Test skin turgor by gently pinching various areas of the skin. (Since many older persons have decreased turgor due to age-related changes, poor turgor is a common finding. However, the skin over the sternum and forehead areas tends to lose less turgor than other areas, thus these are good areas to test.)  If lesions are present, describe them in as much detail as possible in relation to color, type, and distribution  If a pressure ulcer is present, describe exact location, size (measure diameter and depth), stage, and drainage. A photograph of the ulcer may be useful as a means to accurately record the status of the ulcer and evaluate progress. Stage pressure ulcers based on the following criteria: | In older adults skin can be more fragile and sensitive.  Dry, flaky skin, know as *ash,* can be a normal finding in black-skinned individuals . | Bruises, cuts, associated with injuries.  Unclean skin, associated with functional deficits, cognitive deficits.  Cold discolored lower extremities, associated with poor peripheral circulation.  With stasis ulcer, the affected extremity will feel cool, although it may look red and inflamed, poor circulation can cause coolness of the skin surface.  Pressure ulcer:  *Stage 1:*Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.  *Stage 2:*Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.  *Stage 3:*Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.  *Stage 4:*Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.  Unstageable ulcers are assessed separately as:  *Unstageable - Non-removable dressing***:** Known but not stageable due to non-removable dressing/device  *Unstageable - Slough and/or eschar***:** Known but not stageable due to coverage of wound bed by slough and/or eschar  *Unstageable - Deep tissue***:** Suspected deep tissue injury in process.  *Reverse staging is not appropriate.* |
| **MENTAL STATUS**  Note general appearance, appropriateness of dress, body language, general behavior, language, speech, affect, and responses to questions.  Ask if resident feels sad, unusually nervous, suspicious of others; sees or hears things that others don't; or, has thought about suicide.  Test cognitive function using tool accepted by facility. Areas of function assessed include:   * *Orientation:* This includes the person's knowledge of his/her own name, current location, date, time of day, and season. * *Language:* Spontaneous speech and appropriateness of responses throughout the interview assist in assessing language function. In addition, the person can be asked to name objects that are pointed to or repeat phrases. * *Memory:* At the start of the examination the person is given three unrelated words (e.g., dog, cup, bed) and asked to repeat the words and remember them. Midway through the examination and again at the end, the person is asked to repeat the words. * *Attention and concentration:* The person is asked to spell the word *world* backwards or to count backward from 100 by 7s. * *Executive function:* The person is asked to state what two words have in common (e.g., apple and banana, shoe and sock, coffee and tea) or to list in a minute as many words as possible starting with the same letter. * *Ability to follow three-stage command:* The person is given instructions to follow three basic acts, such as pick up the piece of paper, fold it in half, and hand it to me. * *Judgment:* A situation that requires simple problem-solving is presented to the person, such as asking what actions he/she would take if fire was seen coming out of the bathroom. As an alternative, the person can be asked to explain the meaning of a saying such as *an ounce of prevention is worth a pound of cure.* * *Visuospatial functioning:* The person is asked to draw something (face of a clock, copy a simple diagram) that demonstrates his/her ability to understand the spatial relationship of objects. | Orientation to person, place, and time.  Appropriate use of language.  Ability to recall words.  Ability to spell word world backwards or count backwards from 100 by 7s for 5 times.  Ability to identify similarity in words.  Ability to follow three-stage command.  Ability to offer appropriate explanation.  Ability to draw image that represents object. | Inappropriate dress or behaviors, associated with delirium, dementia, depression.  Extreme sadness, associated with depression.  Nervousness, associated with anxiety.  Suspiciousness, associated with paranoia.  Seeing or hearing things others do not, associated with delusions, hallucinations.  Suicidal thoughts.  Altered cognitive function, associated with delirium or dementia. |
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