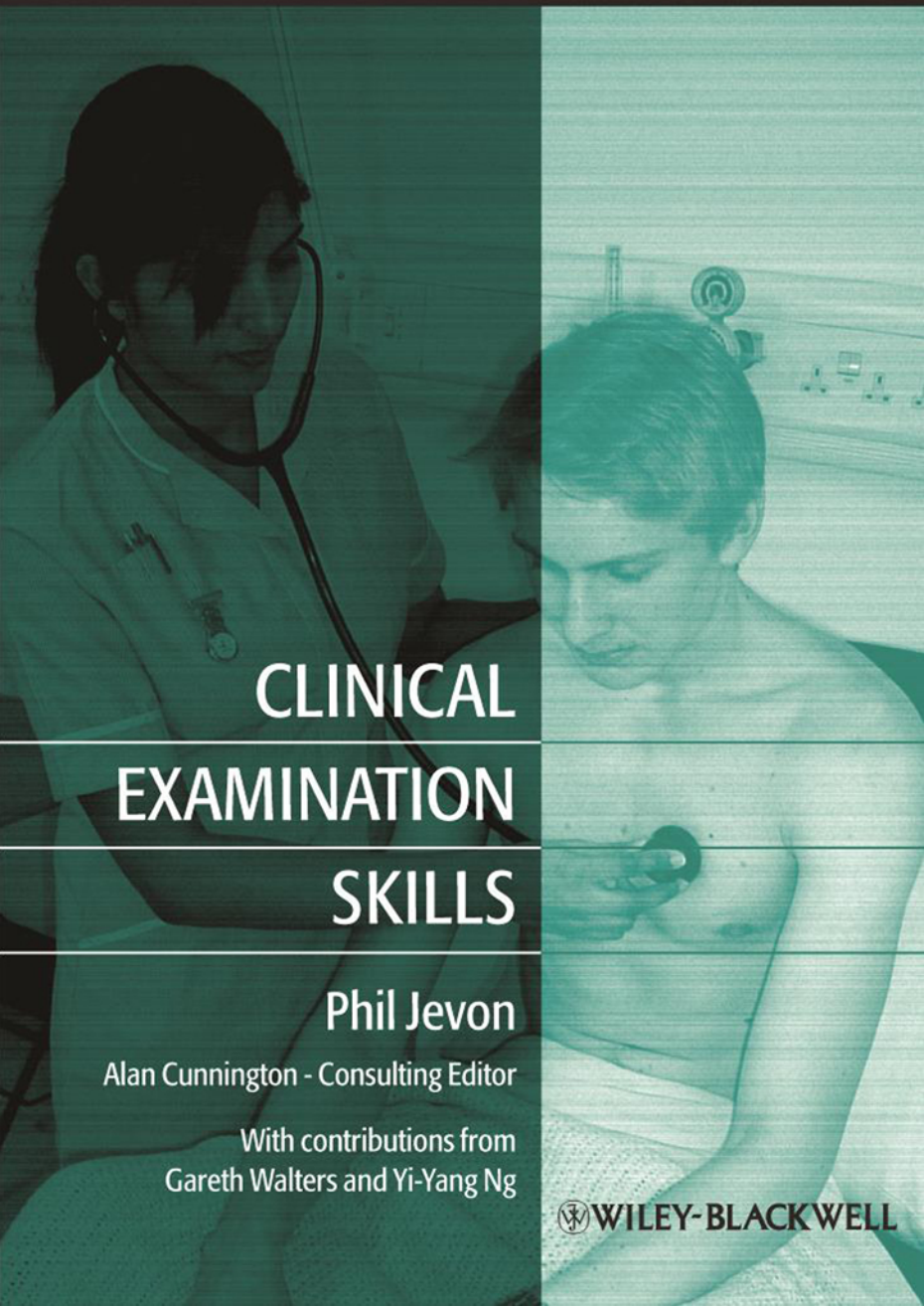
ESSENTIAL CLINICAL SKILLS FOR NURSES



CLINICAL EXAMINATION SKILLS

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With contributions from
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WILEY-BLACKWELL

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Clinical Examination Skills

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Contents

Foreword

Clinical examination has always been a cornerstone of nursing practice, and the development of examination skills is a crucial part of nurses' professional development. Examination skills enable nurses to monitor their patients and know when and how to act if there are causes for concern.

In the past, the majority of examinations undertaken by nurses would have been part of the ongoing monitoring and assessment performed between examinations undertaken by doctors. Although this is often still the case, nurses are taking a lead on patient care in a growing range of situations, and may be the only healthcare professional examining a particular patient. Even when they are working as part of a multidisciplinary team, nurses are often the only professionals in a position to see changes in a patient's condition at an early stage when intervention can avert a crisis.

Whatever the circumstances, it is vital that nurses undertake clinical examinations competently and thoroughly, and that they understand the implications of their results. This book will be an invaluable aid to this – both for nurses who are developing these skills for the first time and for those who want to refresh them and ensure that they are maintaining their competency. It offers a thorough exploration of all aspects of each examination, giving a clear rationale for undertaking it, putting symptoms in context and explaining the significance of the results. The different bodily systems and their examination are discussed separately, enabling readers to focus on each in turn, but the importance of combining them into a single, rounded intervention is emphasized. Learning outcomes for each chapter mean readers can test themselves to

ensure that they have grasped the essentials, while the clear and logical format makes the book an ideal reference resource to return to for quick reminders.

Some examination procedures are often seen as 'routine' or 'basic' care to be delegated to the most junior member of the team. This misses the point. Although the individual practical procedures may be easily developed, it requires rather more to learn how to undertake a full clinical examination thoroughly, efficiently and sensitively – and to understand the implications of the results. It is refreshing, therefore, to see that the discussion is not restricted to practical skills. Readers are reminded to take a holistic approach, using communication skills and developing rapport in order to understand the patient's personal circumstances and how these might influence their condition. This often involves a certain amount of detective work, looking for clues to direct history taking and ongoing assessment along what might not be the most obvious route. Therefore, although it may be appropriate for junior staff to take on a certain amount of monitoring and assessment, we must not lose sight of the importance of having the input of an experienced practitioner at frequent intervals.

We hope that this book will help nurses to develop or refresh their examination skills and also to appreciate the importance of these skills and to see beyond the apparent simplicity of many individual elements of a clinical examination. A well-conducted examination may look straightforward, but it is the synthesis of a sophisticated array of skills and knowledge, as this valuable text clearly demonstrates.

Ann Shuttleworth and Kathryn Godfrey
Clinical Editors
Nursing Times

Preface

When I undertook my student nurse training in 1983–6, clinical examination was the realm of doctors. However, healthcare delivery is changing. With the emergence of nurse-led clinics, nurse-led minor injury units, walk-in centres, hospital-at-night services, etc., more and more nurses are now being required to perform some or all aspects of clinical examination. This trend is set to continue following the implementation of the European Union's Working Hour Directives and the reduction of junior doctors' working hours. Aspects of clinical examination skills are now included in pre-registration nursing curriculums.

'*Clinical Examination Skills*' is a new book written specifically for nurses. Providing an introduction to clinical examination (and history taking) skills, the book follows a methodical approach, describing each of the major bodily systems in turn. Although described separately in different chapters, the examination routines for each system should not be considered as entirely separate entities: when examining several systems at once, a single fluid routine should be used throughout the clinical examination; this will come with practice.

When undertaking clinical examination, the nurse must respect the patient as an individual, obtain consent and protect confidential information provided by the patient; in addition, the nurse should ensure that professional knowledge and competence in examination skills are maintained (Nursing and Midwifery Council, 2008).

It must be stressed that a different approach is advocated if the patient is critically ill; Chapter 8 outlines the ABCDE approach to assessment in this possibly life-threatening situation.

Philip Jevon

REFERENCE

Nursing and Midwifery Council (NMC) (2008) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. NMC, London.

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Philip Jevon

Overview of History Taking and Clinical Examination

1

INTRODUCTION

History taking (discussing patients' complaints with them) and clinical examination, together with performing or ordering relevant investigations, are important when trying to establish a diagnosis (Cox & Roper, 2005). Despite the advances in modern diagnostic tests, history taking and clinical examination remain fundamental to determining the most appropriate treatment (if any) for patients.

History taking and clinical examination require a structured, logical approach to ensure that all the relevant information is obtained and that nothing important is overlooked. History taking and clinical examination skills are difficult to acquire and, above all, require practice (Gleadle, 2004).

The aim of this chapter is to provide an understanding of the principles of history taking and clinical examination.

LEARNING OUTCOMES

At the end of this chapter, the reader will be able to:

- ❏ Discuss the objectives of history taking.
- ❏ Outline how to establish a rapport with the patient.
- ❏ Discuss the sequence of history taking.
- ❏ Discuss the symptoms of disease.
- ❏ Provide an overview to clinical examination.
- ❏ Outline the role of tests and investigations.

OBJECTIVES OF HISTORY TAKING

History taking is important for making a provisional diagnosis; clinical examination and investigations can then help to confirm

or refute it. The history will provide information about the illness as well as the disease; the illness is the subjective component and describes the patient's experience of the disease (Shah, 2005a). A carefully taken medical history will provide the diagnosis or diagnostic possibilities in 78% of patients (Stride & Scally, 2005).

The objectives of history taking are to:

- Establish a rapport with the patient.
- Elicit the patient's presenting symptoms.
- Identify signs of disease.
- Make a diagnosis or differential diagnosis.
- Place the diagnosis in the context of the patient's life.

HOW TO ESTABLISH A RAPPORT WITH THE PATIENT

Establishing a rapport with the patient is essential. If patients believe that they are getting the nurse's full attention, they are more likely to try to accurately answer questions and recall past events.

To establish a rapport and to put the patient at ease, it is helpful to start the examination/interview by considering such issues as:

- *Positive initial contact*: shake the patient's hand whilst introducing yourself.
- *Privacy*: reassure patients that their privacy and dignity will be maintained.
- *Patient's name*: establish how the patient would like to be addressed (forename or surname).
- *Patient's physical comfort*: ensure that the patient is in a comfortable position and position yourself so that the patient is not sitting at an awkward angle.
- *Confidentiality*: reassure patients that all of their information will be treated as confidential.
- *Posture*: avoid standing up, towering over the patient; ideally sit down at the same level as the patient (Figure 1.1).
- *Effective communication skills* (Box 1.1): in particular, allow time to listen to what the patient is saying and avoid appearing to be rushed.

Fig 1.1 Helping to establish a rapport with the patient: sit down at the same level

Box 1.1 Effective communication skills required for history taking

History taking involves effective communication skills such as:

- Opening and closing a consultation.
- Using open and closed questions.
- Using non-verbal language.
- Active listening.
- Showing respect and courtesy.
- Showing empathy.
- Being culturally sensitive.

(Shah, 2005a)

- *Appropriate language*: appropriate language and understanding are important aspects of history taking; as the patient may not understand a particular word or phrase, always have an alternative available, e.g. 'sputum' or 'phlegm'; ensure that the

patient understands the question or any information given (Shah, 2005b). Also, if the patient does not understand English, if possible communicate through an interpreter.

SEQUENCE OF HISTORY TAKING

The following sequence of history taking is recommended:

- Introduction.
- Presenting complaint and history of current illness.
- Systemic enquiry.
- Past medical history.
- Drugs.
- Allergies.
- Family history.
- Social and personal history.
- Patients' ideas, concerns and expectations.

(Source: Ford *et al*., 2005)

Introduction

It is important to introduce yourself to the patient, e.g. name, position. Confirm the identity of patients: ask their name and how they prefer to be addressed. Consent should then be sought for history taking and clinical examination.

Presenting complaint and history of current illness

By far the most important part of history taking and clinical examination is the history of the patient's presenting complaint and history of current illness; the information elicited usually helps to make a differential diagnosis and provides a vital insight into the features of the complaints that the patient is particularly concerned about (Gleadle, 2004).

Therefore, a large part of history taking involves asking questions concerning the patient's presenting complaint(s) to establish the main symptom(s). The objective is to obtain a chronological account of the relevant events, including any interventions and outcomes, together with a detailed description of the patient's main symptoms (Ford *et al*., 2005).

Ask patients to describe what has happened to bring them to hospital or to seek medical help. Their narrative will provide important clues as to the diagnosis and their perspective of the illness. Allow patients ample time to do this and it is important not to interrupt. Short responses, such as 'please tell me more', 'go on', etc., will encourage patients to elaborate.

Once the presenting complaint has been established, it must be carefully evaluated in detail:

- Start date/time.
- Who noticed the problem (patient, relative, caregiver, healthcare professional)?
- What initial action did the patient take (any self-treatment) – did it help?
- When was medical help sought and why?
- What action was taken by the healthcare professional?
- What has happened since then?
- What investigations have been undertaken and what are planned?
- What treatment has been given?
- What has the patient been told about the problem?

(Source: Shah, 2005a)

Systemic enquiry

The systemic enquiry is a series of questions related to the bodily systems, which allows more information to be obtained that can be linked to the presenting complaint; considered as a safety net, it reduces the risk of missing an important symptom or disease (Shah, 2005b).

However, the systemic enquiry can cause confusion and misdirect the clinician if the patient has multiple symptoms or is talkative or garrulous. It should therefore be undertaken systematically and carefully: a suggested 'checklist approach' is detailed in Box 1.2.

It is standard practice to start with the most relevant system(s) to the presenting complaint. For example, if the patient presents with chest pain, questions about the cardiovascular and

Box 1.2 Systemic enquiry

General:

- Well/unwell.
- Weight gain or loss.
- Appetite good or poor.
- Fevers.
- Sweats.
- Rigors.

Cardiovascular:

- Chest pain.
- Breathlessness.
- Orthopnoea.
- Paroxysmal nocturnal dyspnoea.
- Ankle swelling.
- Palpitations.
- Collapse.
- Exercise tolerance.
- Syncope.

Respiratory:

- Shortness of breath.
- Haemoptysis.
- Cough.
- Sputum.
- Wheeze.
- Pleuritic pain.

Nervous system:

- Headaches.
- Fits.
- Blackouts.
- Collapses.
- Falls.
- Weakness.
- Unsteadiness.
- Tremor.
- Visual and sensory disorders.
- Hearing disorder.

Gastrointestinal:

- Nausea.
- Vomiting.
- Diarrhoea.
- Abdominal pain.
- Mass.
- Rectal bleeding.
- Change in bowel habit.
- Dysphagia.
- Heartburn.
- Jaundice.
- Anorexia/weight loss.

Musculoskeletal:

- Weakness.
- Joint stiffness.
- Joint pain/swelling.
- Hot/red joints.
- Reduced mobility.
- Loss of function.

Genitourinary:

- Dysuria/urgency.
- Haematuria.
- Frequency.
- Nocturia.
- Urinary incontinence.
- Urethral/vaginal discharge.
- Menstrual cycle.
- Sexual function.

Skin:

- Rash.
- Lumps.
- Itching.
- Bruising.

respiratory systems should initially be asked (Shah, 2005b). The depth of questioning will depend on personal experience, the individual patient, the presenting complaint, the situation and circumstances.

Past medical history

It is useful to establish the patient's past medical history because:

- If the patient has a long-standing disease, there is a strong possibility that any new symptom could relate to it.
- It could help with making the correct diagnosis.
- It is helpful when establishing the most appropriate treatment for the patient.

Ask patients if they have ever had any serious illness, been admitted to hospital previously or had surgery. It is usual practice to record whether they have suffered from/suffer from any of the following illnesses:

- Jaundice.
- Anaemia.
- Tuberculosis.
- Rheumatic fever.
- Diabetes.
- Bronchitis.
- Myocardial infarction/chest pain.
- Stroke.
- Epilepsy.
- Asthma.
- Problems with anaesthesia.

(Gleadle, 2004)

Drugs

Obtaining a drug history is helpful because:

- Side-effects of drug therapy could be the cause of the patient's presenting complaint.
- Before starting or adjusting drug treatment, it is important to be aware of what the patient is already taking, e.g. old drug therapy could be ineffective or may interact with new drug therapy.

Establish if the patient is taking any of the following:

- Prescription drugs.
- Over-the-counter drugs, i.e. drugs bought without a prescription, e.g. aspirin.
- Herbal or 'natural' treatments.
- Illegal or recreational drugs.

(Shah, 2005b)

If the patient is taking medications, establish the dose, route of administration, frequency and duration of treatment. The possibility of non-compliance with prescription drugs should also be considered.

Patients may be unsure about what drugs they are taking. Under these circumstances, it is worthwhile using the medical history and asking them if they are taking any treatment for each problem, e.g. 'do you take anything for your arthritis?' (Shah, 2005b).

In addition, if patients know what drugs they are taking, it can be helpful to ask them what they are taking them for, because this may sometimes provide helpful additional information related to their illnesses (Shah, 2005b).

Allergies

An accurate and detailed description of any allergic responses of the patient to drugs or other allergens should be recorded; in particular, the patient should be asked about allergy to penicillin. If the patient has an allergy, try to determine what actually happened in order to differentiate between an allergy and a side-effect (Shah, 2005b): a side-effect refers to an effect of a drug which is not that which the doctor and patient require, whereas an allergy is a term usually used to describe an adverse reaction by the body to a substance to which it has been exposed (Marcovitch, 2005). The wearing of a 'medic alert' bracelet or similar (Figure 1.2) and the reason for doing so should be noted.

Family history

It is important to establish the diseases that have affected the patient's relatives, because there is a strong genetic contribution to many diseases (Gleadle, 2004).

Fig 1.2 Medic alert devices (image supplied by Medic Alert, reproduced with permission)

Shah (2005b) recommends the following approach to taking a family history:

- Ascertain who has the problem: is it a first- or second-degree relative?
- Determine how many family members are affected by the problem.
- Clarify what exactly is the problem. For example, 'a problem with the heart' could be several things – hypertension, ischaemia, valve problems, etc. Be exact as to the nature of the problem, because several family members may have 'heart problems', but they may be completely different and therefore not relevant to the patient's particular problem.
- Determine at what age the relative developed the problem; obviously, early presentation is more likely to be important than presentation later in life.
- Ascertain if the patient's parents are still alive and, if not, at what age they died and the cause of death.

Social and personal history

Social history

It is important to understand the social history of patients: their background, the effect of their illness on their life and on the life of their family (Gleadle, 2004):