

Introduction to Patient Assessment

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Fundamental concepts, steps, and tools for gathering reliable clinical information.

1. Purpose of Patient Assessment

- **Identify health status** – baseline and changes over time.
 - **Detect problems early** – prevent complications and guide interventions.
 - **Prioritize care** – determine urgency and allocate resources.
 - **Document baseline** – essential for legal, ethical, and continuity of care reasons.
 - **Evaluate outcomes** – measure effectiveness of treatment plans.
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2. Core Components (The “ABCDE” Framework)

Component	What It Covers	Key Observations
A – Airway	Patency, obstruction risk	Voice quality, coughing, stridor, gag reflex
B – Breathing	Respiratory rate, effort, oxygenation	Chest expansion, use of accessory muscles, auscultation findings, SpO ₂
C – Circulation	Heart rate, rhythm, perfusion, blood pressure	Skin color/temperature, capillary refill, pulses, blood pressure, ECG
D – Disability (Neurologic)	Level of consciousness, neurologic function	AVPU scale, Glasgow Coma Scale, pupil size/reactivity, motor response
E – Exposure/Environment	Full body inspection, temperature regulation, privacy	Skin integrity, rashes, wounds, ambient temperature, patient comfort

Note: In many settings the assessment expands to **F – Family/social history**, **G – Goals of care**, etc., but the ABCDE model remains the rapid bedside foundation.

3. Systematic Assessment Process

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1. Preparation

- Verify patient identity (name, DOB, MRN).
- Review reason for visit, medical record, and any recent labs/imaging.
- Gather necessary equipment (stethoscope, BP cuff, pulse oximeter, thermometer).
- Ensure privacy, introduce yourself, explain the process, obtain consent.

2. Data Collection

- **Subjective Data** – patient's own report.
 - Chief complaint (CC) in the patient's own words.
 - History of present illness (HPI): onset, location, duration, character, aggravating/relieving factors, timing, severity (OLDCART).
 - Review of systems (ROS) – pertinent positives/negatives.
 - Past medical, surgical, medication, allergy, family, and social histories (PMHx, PSHx, Meds, Allergies, FHx, SHx).
- **Objective Data** – clinician's observations and measurements.
 - Vital signs (BP, HR, RR, Temp, SpO₂, pain score).
 - Physical exam (inspection, palpation, percussion, auscultation) organized by systems.
 - Diagnostic results available at the time (labs, imaging, ECG).

3. Analysis & Synthesis

- Compare findings to normal values and to the patient's baseline.
- Identify **pertinent positives** (abnormal findings that explain the problem) and **pertinent negatives** (expected findings that are absent).
- Generate a prioritized list of **problems/diagnoses** (e.g., "1. Acute dyspnea – possible COPD exacerbation; 2. Hypertension – uncontrolled").

4. Planning

- Set **SMART** goals (Specific, Measurable, Achievable, Relevant, Time-bound).
- Choose interventions (pharmacologic, non-pharmacologic, diagnostic, referrals).
- Determine need for immediate actions (e.g., oxygen,