Assessment of the Adolescent, Pre-Teen, and Teen Student for School Nurses

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Objectives

1. Distinguish normal assessment findings from abnormal or high risk findings
2. Implement school nurse protocol during assessment and utilize said protocol if an abnormal finding is identified
3. Observe, discuss, and demonstrate the rationale for assessment techniques demonstrated

Chief Complaint

- What brings you here today?
- Was this visit initiated by the student, teacher, parent, etc.?
Medical History

- Chronic illnesses
- Surgeries
- Procedures
- Vaccinations
- Allergies
- Current Medications

Psychosocial History

- Family and Home Life
- Friends
- School Performance
- Self-Esteem
- Drug use
Vital Signs

- Height
- Weight
- Temperature
- Pulse
- Respiratory Rate
- Blood Pressure
- Oxygen Saturation

Normal Vital Signs

- Temperature: 98 F (36.7 C)
- Pulse:
  - Resting: 70-100
  - Exercise/Fever: less than 200
- Respiratory Rate: 16-19
- Oxygen saturation: 93%-100%
Normal Vital Signs

- Blood Pressure: depends on gender, height, and weight
  - Ranges from 90/50 - 140/90
- Orthostatic Hypotension
  - Take blood pressure when individual is lying down
  - Wait one minute
  - Take blood pressure when individual is sitting up
  - Wait one minute
  - Take blood pressure when individual is standing up
  - If BP drops by 10-20, it's considered positive orthostatic hypotension

Pain

- Numeric Pain Scale
- Faces Pain Scale

Faces Pain Rating Scale

Consists of six cartoon faces ranging from a smiling face for “no pain” to a tearful face for “worst pain.”

Recommended Age: Children as young as 3 years.

Image from: https://foreverchoosingjoy.files.wordpress.com/2011/10/faces_pain_rating_scale_442x320.jpg
General Appearance

- Overall state of health
- Hygiene
- Posture
- Clothing
- Mood/affect

Approaches to the Review of Systems

- Head to Toe Assessment
- System by System Assessment
- Focused Assessment
- Proper order of any assessment:
  - Inspect
  - Auscultate
  - Palpate
Focused Assessments

- In cases of urgency or emergency
- Assess ABCs first
  - Airway
  - Breathing
  - Circulation

Skin

- Color
  - Pale
  - Cyanosis
  - Jaundice
  - Bruises
  - Rashes
  - Erythema
Skin

- **Texture**
  - Clean
  - Dry
  - Clammy
  - Oily

- **Turgor**
  - Indicates dehydration

Hair

- Clean
- Oily
- Dry
- Lice
- Lesions/bruises/scars
Eyes
- PERRLA- using a pen light
  - Pupils equal, round, and reactive to light and accommodation
- Gaze
- Vision
  - Inflammation, tearing, drainage from lining of the eyelids

Ears
- Auditory Tests
- To visualize ear:
  - Have child tilt head toward opposite shoulder
  - Pull pinna up and back to visualize tympanic membrane
- Report redness, inflammation, pain, drainage
Head and Neck

- Symmetrical
- Range of Motion
- Nose
  - Bleeding, swelling, discharge, dryness, pain
- Teeth
  - Discoloration, plaque
- Throat
  - Tonsils inflamed, redness, swelling, pain

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Head and Neck

- Lymph Nodes
  - Report tender, enlarged, swollen, red lymph nodes
Neuro

- Sensory Function
- Balance
- Reflexes
  - Triceps
  - Biceps
  - Patellar
  - Achilles

Neuro

- Cranial Nerves:
  - Smell
  - Sight
  - ROM of eyes
  - Taste
  - Facial Movements
  - Hearing
  - Gag Reflex
  - Movement of Tongue
  - Shrug Shoulders
Chest

- **Movement**
  - Symmetrical rise and fall of the chest
  - Paradoxic respirations- chest falls on inspiration and rises on expiration

- **Rhythm of breathing**
  - Regular or irregular or apneic
  - Tachypnea, bradypnea, dyspnea

- **Depth of breathing**
  - Deep or shallow

- **Quality of breathing**
  - Effortless or difficult/labored

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Breath Sounds- Stethoscope Placement

Images From:
Breath Sounds

- Normal Breath Sounds
  - Clear, equal on bilateral lung fields

- Abnormal Breath Sounds to report
  - Diminished: softer lung sounds
  - Absent: EMERGENCY
  - Crackles: fluid in the lungs
  - Wheezing: high pitched “singing” sound
  - Stridor: EMERGENCY, something is obstructing upper airway

Heart Sounds- Stethoscope Placement

Image From http://www.sharinginhealth.ca/images/valve_locations.jpg
Heart Sounds

- S1 and S2- “lub dub”
- Palpate carotid pulse or radial pulse
  - Do they match up with the apical pulse?
- Rhythm: regular or irregular
- Murmurs: muffled, irregular
  - Some are innocent, but all should be reported

Cardiovascular

- Inspect for color
- Pulses
- Capillary Refill
- Edema
- Swelling
Abdomen

- Inspect for: hernias, masses, symmetry, movement during inspiration and expiration
- Auscultate: each bowel quadrant for one minute
- Palpate:
  - Superficial: gently palpate for tenderness, hernias
  - Deep: deeper palpation, feeling for masses and deeper tenderness
  - Femoral pulses

Image From:
http://nursing-skills.blogspot.com/2014/01/abdomen-abdominal-organs.html#.VwfcxfkrLIU
GI and Urinary Function

- When was your last BM?
  - Was it hard or soft?
  - Loose or formed?
  - Color?
- How often do you pee?
  - Color?
  - Odor?
  - Burning or urgency?

Musculoskeletal

- Spine:
  - Curvature
  - Scoliosis
  - Range of Motion
- Gait and posture
- Arms and Legs:
  - Inspect: symmetrical, color
  - Palpate: tenderness, temperature, radial or pedal pulses
  - Range of motion
  - Test strength of arms and legs:
- Joints: inspect for immobility, tenderness, swelling, warmth
Questions?

Scenario One

You are called to assess a student who is shaky, pale, diaphoretic, and confused. The student is a known diabetic. What is your first plan of action to assess this student? What is your school nurse protocol during this situation?
Scenario Two

A student broke his arm and had a cast placed on it yesterday. He is now complaining the arm hurts and he cannot move his fingers on that arm. How do you go about performing your assessment? What exactly do you assess for and report? How do you go about reporting your findings?

Scenario Three

A student is complaining of abdominal pain. He has also been nauseous and vomiting. How do you perform your assessment on this student?

1. Vital signs- he has a fever
2. Inspect the abdomen- it looks normal
3. Auscultate the bowel sounds- they sound normal
4. Palpate the abdomen- he has RLQ tenderness
5. Follow your school protocol to report these findings
Scenario Four

A student was found passed out in the bathroom. He is slowly coming around but is very confused. No one saw what happened to him. How do you perform your assessment?

1. Check his ABCs- his airway is open, he is breathing on his own, and his circulation is normal
2. If possible- get some vital signs
3. Check neuro status- he is confused
4. Check PERRLA- his pupils are pinpoint
5. Report per protocol

Scenario Five

A teacher brings her student to you because she is concerned he is not breathing normally. You are aware the student has asthma. How do you go about performing your assessment?

1. Check his ABCs: his airway is open, his circulation is normal, but he is clearly breathing with distress
2. Get vital signs: his respiratory rate is high and his O2 sat is low
3. Inspect his breathing: it’s rapid, shallow, short of breath
4. Auscultate: you hear wheezing
5. Administer breathing treatment as ordered and report per protocol
In Closing/Review

- What are the different types of assessments?
- What should you always assess first in case of urgency or emergency?
- What is the proper order of any assessment?
- How do you go about determining if the abnormal assessment finding is an emergency or non-emergency? What is your action plan based on your school protocol?

References