E-Learning Module M:
Assessment Review

This Module requires the learner to have read Chapter 12 of the Fundamentals Program Guide and the other required readings associated with the topic.

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Please reference as follows:

GETTING STARTED

This e-Learning Module has been designed to consolidate key concepts from the required readings and provide an opportunity to begin applying these concepts through self-directed reflection, in preparation for the coaching sessions.
GETTING STARTED

In this module you will review the content highlights associated with Chapter 12 to prepare you for the coaching session.

It will be best if you have read Chapter 12 in advance and have the Program Guide with associated tools available for reference.

You may be prompted to write down your thoughts or ideas during this module. You can do so in the ‘notes’ section at the end of Chapter 12 in your Program Guide. These questions will be used by the Fundamentals Coach to guide discussion during your final coaching session.
TOPICS COVERED

✓ Physical Assessment
✓ Physical Assessment: Equipment and Tools
✓ Physical Assessment: Techniques
✓ Physical Assessment: Emergent Conditions
✓ Physical Assessment: Look, Listen and Touch
✓ Head to Toe Assessment
✓ The Nurse’s Role
✓ Assessment Tool: ESAS-r
✓ Assessment Tool: the OPQRSTUV Acronym
✓ Assessment Tool: Palliative Performance Scale (PPS)
PHYSICAL ASSESSMENT

Assessment is the starting point of the nursing process and critical thinking in all care interactions.

This assessment process allows the nurse to collect the information that promotes critical thinking and the development of a plan of care. A thorough assessment should consist of the following:

✓ A medical history
✓ Lab results
✓ Diagnostic test results
✓ Physical assessment
PHYSICAL ASSESSMENT

Nurses are always considering how each identified issue impacts the quality of life of both the person and family.

Remember the concept of Total Pain and how the mind, body, spirit and social issues are all intertwined. It is crucial to assess issues in all of the domains.

During assessment, the role of the hospice palliative care nurse is to establish what is important to the person for their quality of life at the various stages of the illness trajectory, (i.e. diagnosis, active treatment, discontinuation of treatment and active dying).
PHYSICAL ASSESSMENT

So that the nurse can define, interpret, identify and manage all of the issues, assessment requires an understanding of bodily systems such as:

✓ Integumentary
✓ Cardiovascular
✓ Pulmonary
✓ Gastro intestinal
✓ Neurological
✓ Renal
PHYSICAL ASSESSMENT: EQUIPMENT AND TOOLS

Assessment involves all of the senses and requires the following:

✓ Appropriate equipment such as a stethoscope and person’s own flashlight

✓ An environment conducive to a comprehensive assessment (e.g. providing privacy, quiet space)

✓ Validated assessment tools such as ESAS-r, PPS, and the OPQRSTUV acronym
PHYSICAL ASSESSMENT: TECHNIQUES

Techniques to conduct a physical exam involve:

- **Inspection**: use the senses: vision, smell, hearing, touch
- **Palpation**: a combination of light and deep touching
- **Percussion**: done by tapping body parts with fingers, hands, or small instruments
- **Auscultation**: direct (without a stethoscope for loud audible sounds) or indirect (with a stethoscope)
PHYSICAL ASSESSMENT: EMERGENT CONDITIONS

It is important that the nurse understand the symptoms that are usually experienced in the context of any given diagnosis; however he/she must also be suspicious of emergent conditions.
For example, a woman with metastatic ovarian cancer has been having increased issues with constipation. The nurse knows that she is on opioids and that opioids cause constipation, but is also aware that one of the emergent conditions related to ovarian cancer is a potential for bowel obstruction.

- Take the time to look, listen and touch. Follow every clue and continue to observe and ask yourself: What now? What else? What next?
PHYSICAL ASSESSMENT: LOOK, LISTEN AND TOUCH

Start with the mouth: Open it and look for signs of oral candidiasis (thrush), mouth sores, bleeding gums, dental problems

Listen to the chest with a stethoscope for crackles and wheezes, hyperventilation, no breath sounds

Listen to the abdomen with a stethoscope for the type of bowel sounds, or lack of bowel sounds in all 4 quadrants. Important: Touch the abdomen after listening to it; touching might stimulate peristalsis and provide false information upon auscultation
PHYSICAL ASSESSMENT: LOOK, LISTEN AND TOUCH

Look at and touch the extremities for signs of:

- Swelling, for example looking at the legs, is the swelling bilateral (possible cardiac failure) or unilateral (possible DVT)
- Discolouration, redness, cyanosis
- Pitting (e.g. with edema an indentation occurs when pressed by the finger, no pitting occurs with lymphedema)
- Strength/weakness of limb
Think about a man with a past history of diabetes, heart failure and recent diagnosis of lung cancer. His PPS is 40% and his ESAS-r scores indicate:

✓ Pain – 6/10
✓ Tiredness – 5/10
✓ SOB – 8/10

Taking into consideration the information on previous slides, and knowing the person’s PPS and ESAS scores, what would you do to further assess this man and the symptoms he has noted as issues? Write down your responses.
HEAD TO TOE ASSESSMENT

A comprehensive assessment will establish base-line data that enables the health care provider to create person centered care, set goals and identify changing needs.

Referring to the Head to Toe Assessment chart in the Program Guide, start with a general assessment that includes:

- **Physical appearance**: examples skin colour, hygiene, posture
- **Body structure**: evidence of anorexia or cachexia
- **Skin**: colour, temperature, turgor, any surgical sites
- **Weight**: any weight loss or gain
- **General**: history of fractures, sleep patterns
- **Vital signs**: consider illness stage, e.g. last hours
Refer to the Head to Toe Assessment chart in the Program Guide and write down the most important elements of the comprehensive assessment that you would initiate in each of the following two cases:

1. The man with heart failure, diabetes and cancer of the lung has received 4 chemotherapy treatments and his ESAS-r for nausea and vomiting is 7/10 and appetite is 9/10.

2. A woman has ovarian cancer and has not had a bowel movement for 5 days. She has had a sudden decline of PPS from 60% to 30%. Her ESAS-r scores are:
   • Pain – 8/10
   • Fatigue – 8/10
   • Appetite – 10/10
   • Nausea and Vomiting – 8/10
   • Bowels – 10/10
THE NURSE’S ROLE

The 2 most important initial assessment questions that nurses can ask the person and family are:

1. What is your greatest concern?
2. How can I help?
ASSESSMENT TOOL: THE ESAS-r

The Edmonton Symptom Assessment System (ESAS-r) is a tool to assist in the screening of nine symptoms that are common in persons receiving palliative care.

The severity at the time of assessment of each symptom is rated from 0 – 10 on a numerical scale; with 0 meaning the symptom is absent and 10 that it is the worst possible severity.

The ESAS-r is used as the screening portion of a holistic clinical assessment. It is also used as an outcome measurement tool to determine the effectiveness of specific symptom management.
ASSESSMENT TOOL: THE OPQRSTUV ACRONYM

The OPQRSTUV provides an organized approach to assessment of palliative care symptoms, a standardized way to collect data and acts as an aid to communication amongst team members.
ASSESSMENT TOOL: THE OPQRSTUV ACRONYM

The acronym refers to the following (the descriptors for each assessment question are found in your Program Guide):

- **O** – Onset
- **P** – Provoking or Palliating (what makes it better, what makes it worse)
- **Q** – Quality
- **R** – Region and Radiation
- **S** – Severity
- **T** – Treatment
- **U** – Understanding/Impact
- **V** – Values
ASSESSMENT TOOL: THE OPQRSTUV ACRONYM

This level of assessment is the basis of being able to understand the symptom.

☐ Consider possible causes, and implement interventions.
ASSESSMENT TOOL: THE PALLIATIVE PERFORMANCE SCALE (PPS)

The PPS is a validated tool used to measure a person’s functional status in 10% increments. The 100% to 0% PPS levels are further subdivided into 3 general stages:

1. Stable stage 100% - 70%
2. Transitional stage 60% - 40%
3. End-of-life stage 30% - 0%
ASSESSMENT TOOL: THE PALLIATIVE PERFORMANCE SCALE (PPS)

The PPS is used in the palliative care setting as:

✓ A communication tool amongst team members; simply stating the PPS provides a quick summary of the person’s health status

✓ A communication tool to indicate the initiation of discussions related to end-of-life care planning with the person and family

✓ A workload measurement tool; as the PPS decreases the care needs increase

✓ A care planning tool; e.g. when caring for a person diagnosed with a Deep Vein Thrombosis (DVT) and a PPS of 20% may have different goals of care than the person with a DVT and a PPS of 60%

✓ A care planning tool when discussing place of death; a nurse’s assessment of the person’s PPS is essential as it may be an indicator for hospice placement, or transitioning to a palliative care unit in the acute care setting
BRINGING IT TOGETHER

The nurse’s role in hospice palliative care involves team collaboration, effective communication and the ability to facilitate a change in the illness experience. Consistent practice using all of the elements of a physical assessment cannot be overstated.

The use of validated tools such as the ESAS-r, OPQRSTUV and PPS contribute to the development of goals of care and implementation of appropriate care plans along the illness journey.
WHAT HAPPENS NEXT

To prepare for the next e-Learning Module, you will need to read the associated Program Guide chapter in advance. In order to complete the next e-Learning Module you will need both the Program Guide and the associated tools with you.