



# MODUL PRAKTIKUM **BAHASA INGGRIS I**

>> WRITTEN BY:

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PROGRAM STUDI D-III KEPERAWATAN MALANG  
JURUSAN KEPERAWATAN  
POLITEKNIK KESEHATAN KEMENKES MALANG



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**DISUSUN OLEH**  
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**POLITEKNIK KESEHATAN KEMENKES MALANG  
JURUSAN KEPERAWATAN  
PRODI D-III KEPERAWATAN MALANG  
TAHUN 2018**

**VISI DAN MISI**  
**PROGRAM STUDI D-III KEPERAWATAN MALANG**  
**JURUSAN KEPERAWATAN**  
**POLITEKNIK KESEHATAN KEMENKES MALANG**

**Visi:**

**“Menjadi Program Studi Diploma III Keperawatan yang Berkarakter dan Unggul Terutama di Bidang Keperawatan Komunitas pada Tahun 2019”**

**Misi:**

1. Menyelenggarakan program pendidikan tinggi vokasi bidang keperawatan dengan keunggulan keperawatan komunitas sesuai Standar Nasional Pendidikan Tinggi dan Kerangka Kualifikasi Nasional Indonesia, berdasarkan Pancasila, didukung teknologi informasi, dan sistem penjaminan mutu
2. Melaksanakan penelitian terapan dibidang keperawatan terutama keperawatan komunitas
3. Melaksanakan pengabdian kepada masyarakat berbasis hasil penelitian terapan di bidang keperawatan terutama keperawatan komunitas
4. Meningkatkan kuantitas dan kualitas sarana dan prasarana kegiatan Tri Dharma Perguruan Tinggi di bidang pendidikan keperawatan
5. Mengembangkan kerjasama Nasional dan Internasional dalam rangka Tri Dharma Perguruan Tinggi di bidang keperawatan
6. Melaksanakan tatakelola organisasi yang kredibel, transparan, akuntabel, bertanggungjawab, dan adil
7. Meningkatkan kualitas dan kuantitas Sumber Daya Manusia yang profesional dalam melaksanakan Tri Dharma Perguruan Tinggi

## LEMBAR PENGESAHAN

Modul Praktikum mata kuliah Bahasa Inggris I Tahun 2018 adalah dokumen resmi dan digunakan pada kegiatan Pembelajaran Praktikum Mahasiswa Program Studi D-III Keperawatan Malang Jurusan Keperawatan di Lingkungan Politeknik Kesehatan Kemenkes Malang

Disahkan pada tanggal .....Juli 2018

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## **Preface**

This module is intended to improve students' capabilities in using spoken and written English. It is expected that this module can equip students with necessary patterns, vocabularies, and functions to be used in communication using English language, especially dealing with nursing subjects. By learning those factors related in language study, students will produce more communicative and effective language.

This module is far from perfect, so suggestions and criticisms are very much welcome. Thank you.

The writer

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## **CHAPTER I**

### **INTRODUCTION**

#### **1.1.DESCRPTION**

Modul Praktikum Bahasa Inggris 1 consists of:

1. Practicum 1: Nursing Assessment
2. Practicum 2: Health Assessment

#### **1.2. LEARNING OUTCOMES**

Students are able to:

- Understand English structure
- Understand English vocabularies especially in nursing terms
- Understand English conversation
- Understand communication techniques in English
- Conduct conversation especially in nursing field

#### **1.3. PARTICIPANTS**

Students of semester 3

## CHAPTER II

### THEORETICAL BASIS AND INSTRUCTIONAL TECHNIQUE

#### PRACTICUM 1 (DURATION : 14 x 170 minutes)

#### NURSING ASSESSMENT

By : Eka Wulandari, S.Pd., M.Pd.

##### A. Theoretical Basis

The systematic collection of all data and information relevant to the care of patients, their problems, and needs. The initial step of the assessment consists of obtaining a careful and complete history from the patient. If this cannot be done because the mental or physical condition of the patient makes communication impossible, the nursing history is obtained from those who have information about the patient and the reason(s) for his or her need of medical and nursing care. Obtaining an accurate and comprehensive history requires skill in communicating with individuals who are ill, including those who are reluctant or unable to share important life experiences and medical data. The skilled nurse will be able to obtain the essential information despite resistance. Next in the assessment is the physical examination of the patient in order to determine how the disease has altered physical and mental status. To do this requires that the nurse be capable of performing visual and tactile inspection, palpation, percussion, and auscultation and have knowledge of what represents deviation from the norm and how disease and trauma alter the physical and mental condition of a patient. After these two steps have been completed, the nurse will be able to establish a nursing diagnosis.

##### B. Definition of Terms

Admission assessment: Comprehensive nursing assessment including patient history, general appearance, physical examination and vital signs.

Shift Assessment: Concise nursing assessment completed at the commencement of each shift or if patient condition changes at any other time.

Focused assessment: Detailed nursing assessment of specific body system(s) relating to the presenting problem or current concern(s) of the patient. This may involve one or more body system.

### **C. Admission Assessment**

An admission assessment should be completed by the nurse with a parent or care giver, ideally upon arrival to the ward or preadmission, but must be completed within 24 hours of admission. Admission assessment should be recorded in the patient's progress notes. Privacy of the patient needs to be considered all times.

#### **Patient history**

Nursing staff should discuss the history of current illness/injury (i.e. reason for current admission), relevant past history, allergies and reactions, medications, immunisation status, implants and family and social history. Recent overseas travel should be discussed and documented.

#### **General Appearance**

Assessment of the patients' overall physical, emotional and behavioral state. This should occur on admission and then continue to be observed throughout the patients stay in hospital.

Considerations for all patients include: looks well or unwell, pale or flushed, lethargic or active, agitated or calm, compliant or combative, posture and movement.

#### **Vital signs**

Baseline observations are recorded as part of an admission assessment and documented on the patient's observation flowsheet. Ongoing assessment of vital signs are completed as indicated for your patient.

Temperature: tympanic temperatures for children older than 6 months. Less than 6 months use digital thermometer per axilla.

Respiratory Rate: count the child's breaths for one full minute. Assess any respiratory distress.

Heart Rate: Palpate brachial pulse (preferred in neonates) or femoral pulse in infant and radial pulse in older children. To ensure accuracy, count pulse for a full minute.

Blood Pressure: Baseline measurement should be obtained for every patient. Selection of the cuff size is an important consideration. A rough guide to appropriate cuff size is to ensure it fits a 2/3 width of upper arm. For neonates without previous hospital admissions do a blood pressure on all 4 limbs.

Oxygen Saturation: Monitor as clinically indicated. Note oxygen requirement and delivery mode.

Pain: Use FLACC, Faces, numeric scale, Neonatal Pain Assessment Tool as appropriate to the age group. Areas such as PICU and NICU use specialised pain scales for intubated and sedated patients.

**Additional Measurements:**

Weight: on admission and/or weekly/daily as clinically indicated.

Height: as clinically indicated.

Head circumference: as clinically indicated.

Blood sugar level (BSL): as clinically indicated.

Physical assessment:

A structured physical examination allows the nurse to obtain a complete assessment of the patient. Observation/inspection, palpation, percussion and auscultation are techniques used to gather information. Clinical judgment should be used to decide on the extent of assessment required. Assessment information includes, but is not limited to: Primary assessment (Airway, Breathing, Circulation and Disability) and Focussed systems assessment.

**D. Shift Assessment**

At the commencement of every shift an assessment is completed on every patient and this information is used to develop a plan of care. Initial shift assessment is documented on

the patient care plan and further assessments or changes to be documented in the progress notes. Clinical judgment should be used to decide on the extent of assessment required.

Patient assessment commences with assessing the general appearance of the patient. Use observation to identify the general appearance of the patient which includes level of interaction, looks well or unwell, pale or flushed, lethargic or active, agitated or calm, compliant or combative, posture and movement.

Assessment information includes, but is not limited to:

Airway: noises, secretions, cough, any artificial airways

Breathing: bilateral air entry and movement, breath sounds, respiratory rate, rhythm, work of breathing: - spontaneous/ laboured/supported/ ventilator dependent, oxygen requirement and delivery mode.

Circulation: pulses (location, rate, rhythm and strength); temperature (peripheral and central), skin colour and moisture, skin turgor, capillary refill time (central and Peripheral); skin, lip, oral mucosa and nail bed colour. ECG rate and rhythm if monitored.

Skin: Colour, turgor, lesions, bruising, wounds, pressure injuries.

Hydration/Nutrition: Assess hydration and nutrition status and check feeding type- oral, nasogastric, gastrostomy, jejunal, fasting, and breast fed, type of diet, IV fluids.

Output: Assess Bowel and Bladder routine(s), incontinence management urine output, bowels, drains and total losses. Review fluid balance activity

Blood sugar levels as clinically indicated.

Focused Assessment: assessment of presenting problem(s) or other identified issues, e.g. cardiovascular, respiratory, gastrointestinal, renal, eye, etc.

Risk Assessment: pressure injury risk assessment ([link to pressure guideline](#)), falls risk assessment ([link to Falls guideline](#)).

Wellbeing: Assess for Mood, sleeping habits and outcome, coping strategies, reaction to admission, emotional state, comfort objects, support networks, reaction to admission and psychosocial assessments.

Social: This may include discussing a wide range of factors including Parents/ carers/ guardian, siblings, living arrangements, visiting plans, transport, specific cultural requirements, schooling, discharge plan etc. Pertinent social assessment information such as court orders can also be documented in the FYI tab to alert all members of the health care team.

Review the history of the patient recorded in the medical record. It may be necessary to ask questions to add additional details to the history.

### **E. Focused Assessment**

A detailed nursing assessment of specific body system(s) relating to the presenting problem or other current concern(s) required. This may involve one or more body system. Nursing staff should utilise their clinical judgement to determine which elements of a focussed assessment are pertinent for their patient.

### **Neurological System**

A comprehensive neurological nursing assessment includes neurological observations, growth and development including fine and gross motor skills, sensory function, seizures and any other concerns.

### **Neurological observations**

Assess Level of Consciousness. Use a modified version of the Glasgow coma scale to assess and interpret the degree of consciousness and is documented on neurological observation chart.

Importance of Vital signs. Vital sign changes are late signs of brain deterioration. Respiratory pattern provides a clear indication of brain functioning.

### **Respiratory assessment**

An assessment of the renal system includes all aspects of urinary elimination

A musculoskeletal assessment can be commenced while observing patient in bed or as they move about their room.

Skin assessment can identify cutaneous problems as well as systemic diseases.

Inspection of the eye should always be performed carefully and only with a compliant patient.

Assessment of ear, nose, throat and mouth is essential as upper respiratory infections, allergies; oral or facial trauma, dental caries and pharyngitis are common. This includes a thorough examination of the oral cavity.

### **Evaluation of assessment**

In the evaluation phase of assessment, ensure the information collected is complete, accurate and documented appropriately. The nurse must draw on critical thinking and problem solving skills to make clinical decisions and plan care for the patient being assessed. If any abnormal findings are identified, the nurse must ensure that appropriate action is taken.

Read through this intermediate-level dialogue between a patient and nurse either with a partner or silently, and then test your understanding with the short, multiple-choice quiz at the end.

## **F. Sample dialogs**

### **Sample 1**

#### **A. Conversation between a patient and a nurse**

Patient: Nurse, I think I might have a fever. It's so cold in here!

Nurse: Here, let me check your forehead.

Patient: What do you think?

Nurse: You feel a bit warm. Let me get a thermometer to check.

Patient: How do I raise my bed? I can't find the controls.

Nurse: Here you are. Is that better?

Patient: Could I have another pillow?

Nurse: Certainly, Here you are. Is there anything else I can do for you?

Patient: No, thank you.

Nurse: OK, I'll be right back with the thermometer.

Patient: Oh, just a moment. Can you bring me another bottle of water, too?

Nurse: Certainly, I'll be back in a moment.

*After a moment*

Nurse: (coming in the room) I'm back. Here's your bottle of water. Please put the thermometer under your tongue.

Patient: Thank you. (puts the thermometer under the tongue)

Nurse: Yes, you have a slight fever. I think I'll take your blood pressure as well.

Patient: Is there anything to worry about?

Nurse: No, no. Everything's fine. It's normal to have a bit of fever after an operation like yours!

Patient: Yes, I'm so glad everything went well.

Nurse: You're in good hands here! Please hold out your arm...

Nurse: Did you call me?

Patient: (Speaks with some discomfort) Yes, I did. I've body ache and mild fever since I woke up this morning.

Nurse: Let me check.

(The nurse checks the patient's temperature and blood pressure.)

Nurse: You've mild fever, but your blood pressure is normal. Nothing to worry about. The doctor will come on morning round between 9:30 and 10:00 AM. Tell him about this when he is here. In the meantime, you can have your breakfast.

Patient: OK.

## **Sample 2**

### **Conversation between an attendant and a nurse**

Attendant: Are there more tests the patient needs to undergo and when will the patient be discharged?

Nurse: Like I said before, blood test on fasting state will be done tomorrow, and the patient will be discharged most likely day after tomorrow. However, doctor will take the final call on the discharge date.

Attendant: What is the discharge process?

Nurse: In the morning on discharge day, you should first clear all dues with the accounts department. Thereafter, the doctor will speak to you on post-discharge care and hand over a discharge report. The process will easily take 60-90 minutes.

Patient: Nurse, I'm having trouble adjusting the inclination of the bed. Can you show me how to do it?

Nurse: Sure.

(She maneuvers the control and makes one-half of the bed rise.)

Nurse: Here you go. Anything else?

Patient: No, thank you.

### **Sample 3**

#### **Conversation between nurses**

Gary: Oh, hello Brad. I didn't know you were working a morning shift today too.

Brad: Hi Gary, yes, I've just finished, and I am glad the work's over. It's been rather a tough day in my ward. How was it in yours?

G: Same. But we can't expect it to be easy, can we?

B: You've got a point there. So what did you do today?

G: Well I arrived earlier than usually and the nurses from night shift were still filling out the reports, so I waited at the reception and chatted to Jackie, do you know her?

B: She's new, isn't she? I haven't met her yet as last week I attended a 3-day workshop on pharmacology and I think she started then.

G: Oh yes, the workshop. Anyway, when my shift began, I had to provide some hands-on care to the older patients in my ward. You know, some of them have problems washing and dressing.

B: I know what you mean, I do it from time to time only as there are fewer elder patients in my ward than in yours. Our boss always says we should proceed in such a way so as to keep their dignity intact.

G: That's indeed very important to make them feel safe and comfortable. Afterwards, I dressed some minor wounds of a patient after a traffic accident and later on had to provide pre-operation care to another patient who was about to undergo appendectomy. It was also my task to obtain informed consent from her regarding anaesthesia, which I found rather challenging as I had difficulties in developing rapport with this particular lady.

B: Were successful with the consent?

G: Yes, I was, and the patient has already undergone surgery. If there are no complications she will be discharged in two days.

B: Do you have any special procedures regarding the convalescents in your ward?

G: Hmm, let me think. Oh yes, we need to instruct them how to self-administer medications after they return home. Moreover the supervisor of our ward pays special attention to the provision of emotional support, especially in cases when recovery is going to require patient's determination and may be painful.

B: Right. What was the second half of your day like?

G: Well, it was much less busy I must say. There was just one more patient who had reported to the A&E department himself but was later transferred to our ward. I only needed to evaluate his symptoms and devise a sound treatment plan. Finally I filled in some documents as we have to keep records about every patient's condition. Ok, enough about me! How was your working day?

B: Well, my day was completely different than yours, as instead of working with patients, I had to do some work which is more technical than medical.

G: Technical? What exactly do you mean?

B: Well, the supervisory nurse ordered me to carry out routine maintenance of the equipment in our ward.

G: Maintenance? What kind of maintenance can you do on a stethoscope?

B: Ha ha ha, very funny. Try carrying out maintenance on a pump or a drainage system and then we will talk. It's absolutely essential to do it in order to ensure smooth operation of the equipment and I am sure it is also routinely done in your ward. Anyway, it took me almost

three hours to complete. Afterwards I went through our inventory and realized we were about to run out of some supplies for example bandage, disinfectant and such, so I placed an order at a wholesaler.

G: Well, that doesn't sound too bad! Anyway, it was really nice meeting you Brad. Have a good evening and see you tomorrow.

B: Yes, see you!

## **G. Technical Implementation**

In the following activity you are asked to practice doing nursing assessment with one of your friends using the following question list. When you have finished the assessment, report the result in turns.

### **Question List**

1. In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?
2. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?
3. Over the past 2 weeks, how often have you felt nervous, anxious, or on edge?  
 Not all  
 Several days  
 More days than not  
 Nearly every day
4. Over the past 2 weeks, how often were you not able to stop worrying or control your worrying?  
 Not all  
 Several days  
 More days than not

Nearly every day

5. Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

Not all

Several days

More days than not

Nearly every day

6. Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

Not all

Several days

More days than not

Nearly every day

7. In general, would you say your health is:

Excellent

Very good

Good

Fair

Poor

8. How would you describe the condition of your mouth and teeth, including false teeth or dentures?

Excellent

Very good

Good

Fair

Poor

9. Have you suffered a personal loss or misfortune in the last year?

(For example: a job loss, disability, divorce, separation, jail term, or the death of someone close to you.)

No

Yes, one serious loss

Yes, two or more serious losses

10. How often do you have trouble taking medicines the way you have been told to take them?

- I do not have to take medicine
- I always take them as prescribed
- Sometimes I take them as prescribed
- I seldom take them as prescribed

11. Over the past 7 days:

a. How many times did you eat fast food or snacks or pizza?

- 0
- 1
- 2
- 3 or more times

b. How many servings of fruits or vegetables did you eat each day?

- 3 or more servings
- 2
- 1
- 0

c. How many sodas and sugar sweetened drinks (regular, not diet) did you drink each day?

- 0
- 1
- 2
- 3 or more sweet drinks

12. Over the past 7 days, how many servings of fruits or vegetables did you eat each day?

- 3 or more servings
- 2
- 1
- 0

13. In the past 7 days, how much pain have you felt?

- None
- Some
- A lot

14. Which of the above health topics is the most important one to talk with your doctor about today? \_\_\_\_\_
15. Do you always fasten your seat belt when you are in a car?  
\_\_\_ Yes  
\_\_\_ No
16. Do you ever drive after drinking, or ride with a driver who has been drinking?  
\_\_\_ No  
\_\_\_ Yes
17. On how many of the last 7 days did you engage in moderate to strenuous exercise (like a brisk walk)?  
\_\_\_ 7  
\_\_\_ 6  
\_\_\_ 5  
\_\_\_ 4 days  
\_\_\_ 3  
\_\_\_ 2  
\_\_\_ 1  
\_\_\_ 0
18. On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise at this level? \_\_\_\_\_ minutes
19. In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?(This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that may be part of your job.)  
  
\_\_\_ 7  
\_\_\_ 6  
\_\_\_ 5  
\_\_\_ 4 days  
\_\_\_ 3  
\_\_\_ 2

1

0

20. Do you snore or has anyone told you that you snore?

No

Yes

21. In the past 7 days, I was sleepy during the daytime...

Never

Rarely

Sometimes

Often

Always

22. How often do you get the social and emotional support you need?

Always

Often

Sometimes

Rarely

Never

23. Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

0 No distress

1

2

3

4

5

6

7

8

9

10 Extreme distress

24. How often is stress a problem for you in handling such things as:

Your health? Your finances? Your family or social relationships? Your work?

Never or rarely

Sometimes

Often

Always

25. How many times in the past year have you used an illegal drug or used a prescription medication for non medical reasons?

0

1

2

3 or more times

26. In the last 30 days, have you used tobacco?

a. Smoked cigarettes:

No

Yes

b. Used a smokeless tobacco product:

No

Yes

27. Have you smoked one or more cigarettes in the past month?

No

Yes

Create your own conversation discussing a health problem between a patient and a nurse.

Then act it out!

## **PRACTICUM 2**

### **HEALTH ASSESSMENT**

By : Eka Wulandari, S.Pd., M.Pd.

#### **A. General Health Assessment**

The nursing health assessment is an incredibly valuable tool nurses have in their arsenal of skills. A thorough and skilled assessment allows you, the nurse, to obtain descriptions about your patient's symptoms, how the symptoms developed, and a process to discover any associated physical findings that will aid in the development of differential diagnoses. Assessment uses both subjective and objective data. Subjective assessment factors are those that are reported by the patient. Objective assessment data includes that which is observable and measurable.

During the assessment period, you are given an opportunity to develop a rapport with your patient and their family. Remember the adage "first impressions are lasting impressions?" That adage is also very true in healthcare. You are often the first person your

patient sees when admitted to your unit, returns from testing, or at the beginning of a new shift. Your interactions with your patient gives the patient and family lasting impressions about you, other nurses, the facility you are working in, and how care will be managed (Jarvis,2012).

All assessments should consider the patient's privacy and foster open, honest patient communications.

## **B. Definition of a Health Assessment in Hospital**

Assessment is a broad term that is used to describe a process of measuring your health and ability to perform everyday skills during a hospital stay.

Assessments can involve a set list of questions or tasks that staff members will ask you to perform. These are used to help work out whether or not there is a problem. Assessments are often repeated in order to help measure your progress and identify your ongoing needs. This helps make sure you get the best care in hospital and helps with planning for when you leave hospital.

For some assessments you need to answer questions, for others you need to perform certain tasks. Staff may also want to talk to your family, carers and your GP to understand more about your needs.

## **C. Purpose of Health Assessments in Hospital**

Regular assessments of patients by hospital staff help to identify problems quickly. If health issues are not picked up early, they can get worse. This can mean a longer hospital stay or more severe health problems later.

It is important for you and your family to participate in the assessment process and to tell staff if you have concerns.

Your healthcare team in hospital are always checking your health and ability to do everyday skills. Part of their role is to identify and diagnose problems that will impact on your quality of life. Your healthcare workers look at your medical issues and they also investigate your social, physical, and psychological health.

Ongoing assessment by hospital staff means they can also recommend the best care plan for you when you are discharged from hospital, and put you in contact with services that can support you outside of hospital.

#### **D. Tips for participating in a health assessment in hospital**

When answering assessment questions, remember your privacy will be respected. Hospitals and hospital staff are not allowed to share information about you and your health without your consent (except when medically or legally necessary).

Examples of the types of questions that a person may be asked during a hospital health assessment include:

Before the illness or injury that brought you to hospital, did you need someone to help you on a regular basis?

In general, do you see well?

Do you take more than three different medications every day?

Examples of tasks that a person may be asked to perform if they are able include:

standing or walking with or without assistance

drawing a clock

other memory and thinking tests.

It is important to:

Be open and honest when answering assessment questions.

Tell staff what matters to you and if you have any concerns.

Perform assessment tasks to the best of your ability.

Tell hospital staff straightaway if you:

feel very unwell

don't understand why you are being asked questions or are performing tasks

are in pain during an assessment.

You may be asked the same types of questions many times during your stay, such as when your health changes or you are moved to a different ward. Answer each time to the best of your ability.

You may need ongoing assessments for other problems while in hospital. Some assessments are done routinely and some are performed as a precaution.

During your hospital stay it's important that you and your family and carers tell hospital staff if you have any concerns about your health or about your ability to do activities.

### **Principles**

In planning and performing health assessment, the nurse needs to consider the following:

1. An accurate and timely health assessment provides foundation for nursing care and intervention.
2. A comprehensive assessment incorporates information about a client's physiologic, psychosocial, spiritual health, cultural and environmental factors as well as client's developmental status.
3. The health assessment process should include data collection, documentation and evaluation of the client's health status and responses to health problems and intervention.
4. All documentation should be objective, accurate, clear, concise, specific and current.
5. Health assessment is practised in all healthcare settings whenever there is nurse-client interaction.
6. Information gathered from health assessment should be communicated to other health care professionals in order to facilitate collaborative management of clients and for continuity of care.
7. Client's confidentiality should be kept.

### **Responsibilities of the nurse**

1. The nurse has the responsibility to carry out health assessment on every person under

his/her care.

2. The nurse should regularly perform focused assessments in response to client needs.
3. The nurse needs to obtain client's consent prior to health assessment.
4. The nurse should demonstrate a caring attitude, respect and concern for each client when doing a health assessment.
5. The nurse has the responsibility in keeping confidentiality about the data being collected from his/her client.
6. The nurse obtains information on a client using various techniques and tools, such as history taking, physical examination, reviewing clients' records and results of diagnostic tests. He/She has to draw inferences from data collected in order to make appropriate and sound clinical judgement.
7. The nurse has to acquire specialized skills and competence in collecting accurate and relevant information on the patient's health in performing health assessment in order to make sound clinical decisions.
8. The nurse should document the results of health assessment, analyze the data collected, evaluate the client's response to health problems and interventions, and provide feedback to the client as appropriate.
9. The nurse should continuously advance their competence in health assessment throughout one's nursing career.
10. The nurse who takes up an advanced practice role has the responsibility to prepare himself/herself in order to perform advanced and focused health assessment.

## **E. Sample dialog**

### **1. The General Survey**

\*Knock on the door, open the door, and provide privacy (either close the door or close the curtain)\*

Hello, Mrs./Mr. \_\_\_\_\_, my name is \_\_\_\_\_ and I'm a student nurse. I'll be helping out your nurse to take care of you today. Is that alright?

Great. I'm just going to wash my hands over here and then I'll just take a listen to your heart, lungs, and tummy and see how you're doing today. (Wash your hands)

While you're washing your hands: Can you hear me alright? Am I talking too quietly? (This is your first test for hearing, and to make sure they can actually hear you)

I have just a few routine questions I need to ask before we get started. They'll help me take the best care of you that I can.

Can you tell me what day of the week it is? (Establishes that they are alert and oriented (A&O) to time)

Great, can you tell me where you are? (Establishes that they are alert and oriented (A&O) to place)

Wonderful. So what brought you here? (Establishes that they are alert and oriented (A&O) to the situation)

By now you will be finished washing your hands. Put on gloves. Walk over to their bed and take a look at their name bracelet.

And can you tell me your name and date of birth please? I know you've already done this a million times already, but I will check every time I come in just to make sure I'm giving you what YOU need and not someone else's. (Establishes that they are alert and oriented (A&O) to person)

**CRITICAL POINT:** You must use at least 2 patient identifies to verify their identity: having them verbalize their name and birth date, as well as looking at their wrist band is the easiest.

Are you in any pain at all right now?

If yes: Where does it hurt?

On a scale from 1 to 10, with 1 being hardly any pain and 10 being the worst pain you've ever felt, how would you rate it?

Can you describe the pain for me? Is it shooting, burning, aching, radiating, pins and needles?

Do you use anything to get around, like a walker, wheelchair, or cane?

Are you able to do things like cook, bathe, brush your hair, and brush your teeth? Or do you usually have someone help you with that?

Physical Assessment

Alright, thanks for answering all of my questions. I know it was a lot.

So now I'm just going to look you over a bit, see how you're doing, and listen to your heart, lungs, and tummy. I will keep you covered as much as I can, and please let me know if you have any new pain at all during this process.

Head:

I'll start at your head up here.

Feel their head for symmetry, shape, lumps, bumps, and bruises. Inspect their hair, and note the color, amount and distribution. Take a look at their face to look for symmetry and any missing facial features.

Eyes:

Now I'm going to take a peek into your eyes. Do you wear contacts or glasses? Is your vision clear?

I'm just going to pull down your eyelids a bit here. Gently pull down their eyelids and look at their conjunctiva. Note the color and if it is moist or dry.

Now I'm going to make sure your pupils are doing what they should be doing. So I have a little light here and I'm going to shine it twice into each eye. (This checks for pupil constriction and consensual constriction)

Now, can you focus on my penlight as I bring it to your nose? (This checks for accommodation)

Please note: Pupil constriction, consensual constriction, and accommodation gives you PERRLA (pupils are equal, round, reactive to light, and accommodation)

Ears:

Now I'm going to take a peek into your ears.

Do you wear hearing aids? (Throughout the assessment, note if they show signs of not being able to hear you very well: asking for you to repeat yourself, talking loud, looking confused, etc).

Check their ears to make sure there is no redness or discharge, and that the skin is intact (especially if they are on oxygen, which can cause skin breakdown behind the ears).

Mouth:

Can you open your mouth for me please?

Shine your penlight to take a look at their cheeks, gums, tongue, and throat. Note if it is red, swollen, patchy, or anything else that's not the normal "pink and moist."

Do you wear dentures?

If yes: Are they uppers, lowers, or both?

Nose:

Take a look at their nose to check for symmetry.

Do you have a runny nose or are feeling stuffy at all?

I'm just going to take a quick look inside your nose. Check for discharge, redness, or anything abnormal.

Neck:

Now I'm going to feel your neck. Please let me know if you feel any discomfort or pain.

Palpate around their neck, check for swelling, tenderness, or pain.

Can you move your head to the right for me? Now to the left? Now up, and down? Did that cause any pain or discomfort at all?

I'm going to feel your collar bone here. Gently check for skin turgor by gathering a little bit of skin between your thumb and index finger, right below their collar bone.

Arms and Fingernails

I'm going to feel your arms now.

If your patient is a woman, ask: Have you ever had breast surgery, including a mastectomy?

If yes, ask: Which side?

DON'T put a lot of pressure on that arm and DO NOT take a blood pressure on that arm. After your assessment, document in their chart that they had breast surgery on that side and follow facility policy on what to label in the room. Often times, you will put up a sign that says "No BP's on \_\_\_ side."

Gently feel their arms all the way down to their hands. Note any swelling that is present. Feel their radial pulses on both wrists, and note if the pulses are thready, weak, strong, or bounding, and if they are happening at the same time or not.

Check their fingernails for hygiene and nutrition (clean, trimmed, smooth, clear) and gently press on their fingernails to check for capillary refill.

Lungs:

Have you been coughing at all lately?

If yes: Is stuff coming up when you cough?

If yes: What color is it? Is it thick or thin?

I'm just going to pull down your gown a little here, I'll keep you covered as much as possible.

Inspect their chest for symmetry and shape, and note the size of their costal angle.

Now I'm going to take a listen to your lungs. I'll move my stethoscope to multiple places so that I can get a really good listen.

Check out this blog post for how to position your stethoscope during a lung assessment.

Each time you move your stethoscope to a new place, ask your patient: Please take a deep breath in, and out through your mouth.

Listen for a full respiratory cycle at each site. Note their breathing rhythm, effort and depth, as well as if their rib cage is moving symmetrically.

Note: Don't count the patient's respiratory rate during the lung assessment. Often times they are breathing abnormally because they are aware of their breathing. I like to check their respiratory rate during the cardiac assessment.

I'll need to listen to your lungs on your back as well. Do you need help rolling over?

Have your patient roll over, take a listen to their lungs on their backside (again, having them breathe in and out through their mouth each time you move your stethoscope).

Inspect the skin on their back and bottom. Note if it is red, intact or not, bruised, moist, or anything else you see.

Alright, now let's roll you back over.

Heart:

I'm going to listen to your heart now. You can just relax and breathe normally.

Check out this blog post for how to position your stethoscope during a cardiac assessment.

While you're listening to the patients PMI (point of maximal impulse, a.k.a. the mitral valve stethoscope placement), count their heart rate for a full minute and their respiration's for one full minute.

Move their gown back up.

Abdomen:

Now I'm going to take a look and a listen to your tummy. I'll just pull up your gown a little bit here, but I will keep you covered as much as possible. (Keep their bikini area covered with blankets and pull up their gown enough to see their belly).

Is your belly tender at all?

Make sure to follow the correct assessment order when doing your abdominal assessment (inspect, auscultation, percussion, palpation).

Look at their belly first. Then listen with your stethoscope for 15 seconds in each quadrant. Then percuss with your fingers. And lastly, palpate by pressing lightly around their belly.

Move their gown back down.

Legs, Feet and Toenails:

Now I'm going to take a look at your legs and your feet.

Do you have any pain or discomfort in your legs or feet right now?

Palpate down their legs. Note if their skin is intact, if there are any bruises or swelling, if their leg hair is patchy or evenly distributed, and if you can see their veins.

Do you get leg cramps?

If yes: When do they happen? Is there anything that helps them go away: position changes, walking or sitting, or anything else?

Check their toenails for hygiene and nutrition (clean, trimmed, smooth, clear) and gently press on their toenails to check for capillary refill.

Feel their dorsalis pedis pulses at the same time (one on each foot) and their posterior tibialis pulses at the same time (one on each foot). Note if it is thready, weak, strong, or bounding.

Cover their legs back up.

Finishing Up:

Alrighty, we are all done. Thanks so much for your patience.

**CRITICAL POINT:** Make sure the bed is in the lowest position, it's locked, the rails are up or down (depending on their safety plan), and that their call light is within reach.

Is there anything I can get for you?

If no: Alright. I will be back in later. You can use your call light if you need anything sooner. I'm the big red button on your call light (or whatever button it is at your facility).

Wash your hands.

## **B. Technical Implementation**

1. In the following activity you are asked to practice doing health assessment with one of your friends using the above sample script. When you have finished the assessment, report the result in turns.

2. Create a dialog of your own based on the script above

## **RULES AND REGULATION**

1. Students must be present 10 minutes before the practicum begins
2. Students must wear uniform clothing complete with name tags.
3. Students must prepare equipment that will be used in practical work.
4. During the practicum students are not allowed to:
  - a. Eat and drink.
  - b. Joke.
  - c. Discuss issues that are not related to the practical material.
  - d. Doing other things that are not related to the practicum.
5. All students must actively participate in practicum.
6. After completing the practicum, students must return the equipment that is used intact, and clean to the person in charge of the laboratory. If there is damage to the tool during the practicum caused by student negligence, students are required to fill out a form to replace, and immediately replace the tool.
7. After the practicum, students must return the post-practicum equipment.
8. The presence of students in practicum must be 100%. If students cannot attend the practicum due to illness, or for other reasons, are required to send a valid letters and must be submitted within 1 week. Students must also immediately report to the person in charge of practicum to plan a replacement.

## **SANCTION**

1. Too late to take part in practical activities.
2. Conducting noise during the practicum.
3. Using electronic devices without permission.

Penalty: 10 points

Range of practical score 65 to 100.

1. Dressing inappropriately during the practicum.
2. Leave the laboratory room during the practicum.
4. Eating and drinking during the practicum

Penalty: 15 points.

Range of practical score 65 to 100.

1. Not following the practicum activities without a clear reason.

Penalty: 20 points.

Range of practical score 65 to 100.

## **EVALUATION**

Based on the four language skills scoring rubrics (reading, speaking, listening, and writing)

## **REFERENCES**

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## **SOP untuk Pemeriksaan Umum**

### **Definisi**

Pemeriksaan tubuh pasien secara keseluruhan mulai dari ujung kepala sampai ujung kaki yang dilakukan dengan cara inspeksi, palpasi, persekusi dan auskultasi.

### **Tujuan**

Mengumpulkan data tentang tingkat kesehatan dan kesejahteraan individu / klien.

### **Prinsip**

Pertimbangkan taham perkembangan klien, latar belakang budaya, status sosial – ekonomi, pekerjaan, tingkat kecerdasan, dan faktor lain yang berhubungan.

### **Alat**

1. Alat tulis
2. Formulir perngkajian
3. Meteran
4. Timbangan berat badan
5. Seperangkat pengukuran tanda vital
6. Spatel lidah
7. Senter / pen light
8. Replek hamer
9. Bengkok
10. Garpu tala

### **SOP Pemeriksaan Fisik Umum**

#### **Tindakan**

1. Mengucapkan salam terapeutik
2. Melakukan evaluasi / tindakan
3. Melakukan kontrak ( waktu, tempat, topic )
4. Menjelaskan langkah – langkah tindakan
5. Mencuci tangan
6. Mempersiapkan alat
7. Mengkaji usia / tahap perkembangan dan jenis kelamin
8. Mengobservasi cara berpakaian
9. Mengobservasi kebersihan diri
10. Mengobservasi postur dan cara berjalan
11. Mengobservasi bentuk dan ukuran tubuh
12. Mengkaji status mental ( lihat melalui cara bicara, bahasa tubuh, ekspresi wajah, kesesuaian )
13. Mengkaji orientasi terhadap orang, tempat dan waktu
14. Pasang sampiran
15. Mengukur tinggi badan dan berat badan klien
16. Mengukur tanda – tanda vital ( suhu, denyut nadi, laju pernafasan, tekanan darah )

17. Lakukan pemeriksaan kepala dengan cara inspeksi, palpasi, perkusi, dan auskultasi, yang meliputi : kondisi rambut dan kepala, mata, hidung, telinga, mulut dan gigi.
18. Mengkaji vena juguralis
19. Bantu klien untuk membuka pakian bagian atas
20. Pemeriksaan jantung, mengauskultasi dada : bunyi jantung I dan II, suara pernapasan ( tracheal, bronchial, vesikuler ), suara ubnormal
21. Menginspeksi tangan, jari dan kuku klien
22. Bantu klien dalam membuka pakaian bagian bawah
23. Melakukan inspeksi, palpasi, auskultasi, dan perkusi daerah abdomen
24. Inspeksi daerah kelamin dan rectum
25. Lakukan pemeriksaan kaki dan reflek fungsi sensori
26. Pasang kembali pakaian klien
27. Mengevaluasi respon klien
28. Merencanakan tindak lanjut
29. Melakukan kontrak yang akan datang ( waktu, tempat, topic )
30. Melakukan dokumentasi tindakan dan hasil

### **Dokumentasi**

Hasil pemeriksaan fisik dalam formulir pengkajian.