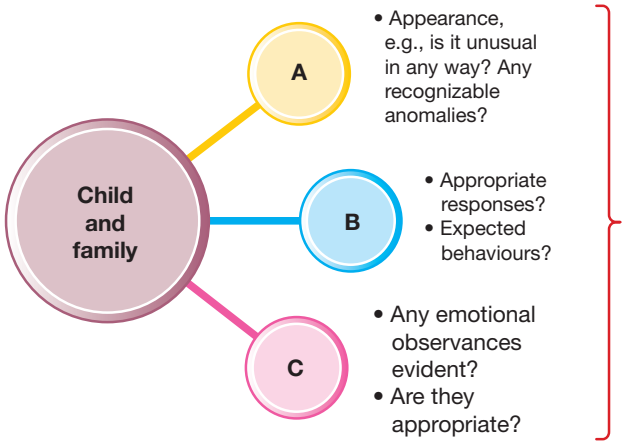
1 Initial assessment: subjective

Subjective assessment of the child's general appearance: Overview



Subjective assessment according to stage of development: Examples

Neonate (0–28 days) and infant (up to 1 year)	Parent–infant interaction. Normal behaviours, reflexes, e.g. rooting, sucking. Expected behaviours, crying, sleeping, consolability Physical signs: body movements, spontaneous, position, symmetry, facial feature
Toddler (1–2 years)	Parent–toddler interaction. Normal behaviours, e.g. separation anxiety, follow simple instructions. Expected developmental milestones, e.g. crawling, walking, early speech
Pre-school / (2–5 years)	Parent–child interaction. Normal behaviours, e.g. able to follow simple instructions Expected developmental milestones, e.g. physical abilities, able to speak/communicate/ answer questions
Older child (5–12 years)	Parent–child interaction. Normal behaviours, e.g. greater autonomy Expected developmental milestones, e.g. physical abilities, able to hold a conversation
Adolescent (>12 years)	Parent–teenager interaction. Normal behaviours, e.g. articulation and explanations, social skills. Self-consciousness, body image, state of hygiene

Subjective assessment according to body system: Examples

Respiratory	Presence of audible breathing, cough, wheeze, grunting (babies). Breathing pattern and effort, dyspnoea, shortness of breath, depth and symmetry of breathing efforts, colour – see below
Cardiovascular	What is the colour of the skin, oral mucosa and nail beds? Are these pink? Is there cyanosis present? Or is the skin colour flushed?
Disability: Neurological	Presence of normal or abnormal movements, gait, coordination, and head size and shape? Behavioural responses. Intact senses?
Ear, nose and throat/face	Is a runny nose visible? Is the voice normal or is there huskiness/croakiness/loss of voice? Can the child hear normally? Is the throat red? What is the position of the ears, eyes and facial features? Are there any dysmorphic features?
Fluid balance	Does the child look dehydrated? Sunken eyes, skin colour with reduced turgor, dry, cracked lips, sunked fontanelle (baby)? Is there presence of oedema?
Gastrointestinal	Abdomen size and shape, is there vomiting? Are the weight and size appropriate for age? Is there presence of obesity or failure to thrive? Is the child in pain, holding/guarding their abdomen? Appearance of the umbilicus (baby)
Homeostasis	Does the child feel or look hot/cold? Is there any jitteriness (infant) in the case of a low blood sugar/metabolic disturbances?
Other systems	Appearance may indicate generalized infection. Musculo-skeletal: body/limb proportions, tone, posture, symmetry; is the spine straight or is there any curvature? Skin: nature and distribution of lesions, wounds, bruises, rashes; is there a suspicious appearance?

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Assessment overview

Assessment is an important component of nursing practice, necessary for the planning and delivery of patient and family-centred care. A comprehensive nursing assessment includes both subjective (qualitative) and objective (quantitative/measurable) elements, namely, general appearance, patient history, physical examination and measurement of vital signs. Of these four components, the area of subjective assessment and observation of clinical appearance is the focus of the present chapter. Objective physical assessment, including history taking and monitoring will follow in subsequent chapters.

Subjective assessment

Subjective nursing assessment is an individualized, qualitative approach that does not use objective, measurements, tools or equipment. Rather, it is based on individualized clinical *observation* relating to the physical, emotional and behavioural characteristics of the child and family. Therefore, by its very nature, such a form of assessment can be open to interpretation and opinion. However, it also serves as an essential starting point to any holistic assessment of a child and family. Inspection and observation of general appearance and behaviour are therefore an integral part of an *initial* assessment before any objective data can be recorded. The skills of performing sound, clinical observation and judgement develop over time and through experience by nursing students and beyond into qualification. The importance of such skills should not be underestimated. It should also be remembered that parents or primary caregivers are best placed to recognize concerns and will report these based on subjective observations of changes in their child's physical or emotional state. This information should be considered alongside nursing assessment data.

How to perform a subjective assessment

The initial nursing assessment of a child should be undertaken with a parent or known caregiver upon arrival to a ward, on pre-admission or, in the case of out-of-hospital care, at the first meeting following introduction to a new child and family in line with any referral for ongoing care. Ideally, initial assessment should be completed within 24 hours of admission and any key information should be documented clearly using appropriate records.

Observation can be carried out while taking the history and establishing rapport. This can be done in conjunction with observations by and from the parents, if present, along with sound clinical nursing judgement. For example, you can observe the child's behaviour, level of understanding and general appearance on admission at first introduction and consider this with the parents' own reports. General appearance of the child and family includes observation of their physical, behavioural and emotional state. At any age, considerations for the subjective assessment of the child or young person include:

- Do they look well or unwell?
- Are they pale, blue or flushed?
- Are they moving, active or lethargic?
- What is the general posture?
- Are they agitated or calm?
- Are they able to respond appropriately to questioning and are they obeying requests? Or are they resistant in their responses and reaction?
- What is the family reaction and perceived emotional state?

Subjective assessment according to age

Care of the child encompasses a wide range of ages from newborn up to the adolescent period. Although some of the principles of assessing children are similar to assessing adults, children are not just small adults, and the approach to assessment and content can be quite different. Moreover, assessment changes in relation to what to observe as children develop and get older so that eventually, in the young person, it is similar to adults. The Figure aims to highlight the important differences to give some general principles and provide an outline of subjective assessment in different age groups. This emphasizes that the approach to subjective assessment is influenced by a child's age, stage of development and level of understanding.

In the neonatal and infant period, physical assessment includes, for example, observation of facial features, symmetry, posture, movement and tone of the limbs. Behavioural elements include presence of a strong cry and normal responses to being held/consoled. Emotional elements include observation of interaction between them and their parents. In the young child, gross physical and fine motor skills can be observed according to age expectations, with refinement occurring as the child gets older. Age-appropriate speech and language can also be noted. Behaviour can be observed by a child's mood and, again, interaction with parents. In an adolescent, similar points can be addressed but in line with behaviours applicable to teenage years, including level and type of communication and emotional reaction.

Subjective assessment according to body system

Subjective assessment can also be carried out according to the biological system, as is commonly used in the systematic approach to holistic physical examination. This will be covered in greater detail in Chapter 3. A full examination of all the systems is the most thorough way to gain a complete physical picture of the child or young person. The subjective components of these systems are displayed in the Figure.

To conclude, sound clinical judgement goes hand in hand with subjective nursing assessment and should be used to make decisions on the need for further, more objective, and possibly more invasive assessment methods.

Key points

- Subjective nursing assessment should include inspection and general observation. These are the important parts of any initial assessment or examination, undertaken in conjunction with the parents or caregivers where possible.
- Subjective assessment should include the physical, behavioural and emotional characteristics of the child or young person and their family.
- The approach to subjective assessment is influenced by the age of the child or young person, their developmental stage and level of understanding.

Further reading

Broom, M. (2007) Exploring the assessment process. *Paediatric Nursing*, **19**(4), 22–25.

Engel, J. K. (2006) *Mosby's Pocket Guide to Pediatric Assessment*, 5th edn. Mosby, New York.

Roland, D., Lewis, G. and Davies, F. (2011) Addition of a subjective nursing assessment improves specificity of a tool to predict admission of children to hospital from an emergency department. *Pediatric Research*, 70, 587.