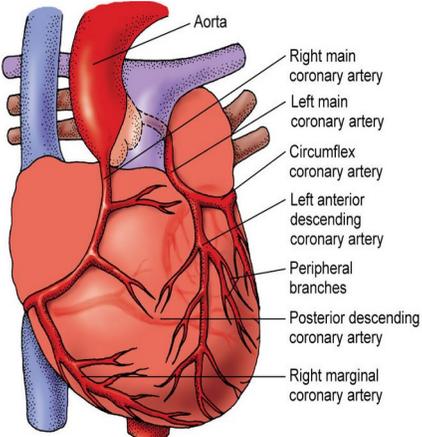
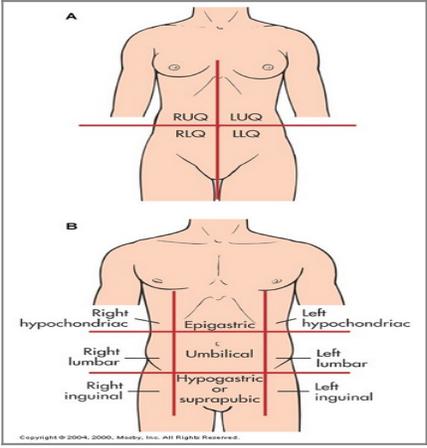


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N101- Foundations of Nursing
Health Assessment Clinical Guide Head to Toe Assessment

Assessment	Instructions	Comments
<p style="text-align: center;">Introduction</p> 	<p>Shake hands as you greet your patient stating your name & role of student nurse noting:</p> <ul style="list-style-type: none"> • Orientation-person, place, time, & situation • Eye contact/Pupil Size • Speech-clear, rambling, slurred • Facial Symmetry/Expression • Skin (warm & dry) • Capillary refill of fingers <3 seconds • Turgor Anterior Forearm • Check gait if walking • Walking, wheelchair, chair -need assistance? • Pain Assessment (numeric scale 0-10) 	<p>When you are ready to do more in depth assessments you can say to your patient:</p> <p>” I need to listen to your heart, lungs, abdomen, and check your circulation. Since I am learning, it will take me longer than the nurse. I may need to have my instructor come in and listen. This does not mean anything is wrong. I am just checking to be sure I am hearing things correctly”.</p>
<p style="text-align: center;">Neuro</p> 	<ul style="list-style-type: none"> • Pupils equal & round • Recent Memory • Remote Memory • Coordination • Sensation 	<ul style="list-style-type: none"> • Recent memory-“What did you have for breakfast”? • Remote memory -“Where were you born”?
<p style="text-align: center;">Cardiac</p> 	<ul style="list-style-type: none"> • S1 @ apex 5th ICS • S2 @ base 2nd ICS • Apical rate & rhythm • Skin Turgor • Pulses-carotid, radial, pedal, posterior tibial. • Edema (shin bone) <ul style="list-style-type: none"> • +1=2mm • +2=2-4mm • +3=5-7mm • +4=8mm • Capillary refill of fingers & toes • Homan’s Sign 	<ul style="list-style-type: none"> • Best position-supine • During lab instructor counts radial while student auscultates apical. • If elderly patient, you may use the sternum for skin turgor if forearm inelastic • Palpate pulses bilaterally & simultaneously except for the carotids. • Edema-pretibial & feet, press 5 seconds each area & document depth:

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<p style="text-align: center;">Pulmonary</p> 	<p style="text-align: center;">Anterior & Posterior</p> 	<ul style="list-style-type: none"> • Listen anteriorly & if easy for patient to sit up then posteriorly. <i>If patient has limited movement wait until last but you must perform posterior assessment.</i> • Best position-sitting up with arms crossed in lap. (expands chest) Review your notes for adventitious sounds.
<p style="text-align: center;">Abdomen</p> 	<p style="text-align: center;">Listen all 4 quadrants</p> 	<ul style="list-style-type: none"> • Listen for bowel sounds <i>Hypoactive, active, hyperactive, absent</i> • Listen for 5 minutes to declare absent. • Sounds occur every 5-15 seconds • Sounds like clicks & gurgles
<p style="text-align: center;">Musculoskeletal</p> 	<p style="text-align: center;">Assess muscle strength & gait in all extremities</p>	<ul style="list-style-type: none"> • Strength-Cross fingers before patient squeezes, • Perform push/pull hands feet, • Assess shoulder resistance • Gait-steady or unsteady, needs assistance or device
<p style="text-align: center;">Health Assessment Lab</p> 	<p style="text-align: center;">Bring to your assessment practice and to your assessment lab!</p>	<p>For health assessment lab the student will:</p> <ul style="list-style-type: none"> • Palpate pulses & compare bilaterally • Palpate for urinary bladder distention • Document per faculty instructions

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