Focused Assessment Guide for Nursing Students

Neurological (Neuro) Assessment
Steps:
• Assess level of consciousness (alert, oriented x4).
• Evaluate pupil size and reactivity to light using a penlight. Measure in millimeters.
• Test motor strength (bilateral hand grips, foot pushes).
• Note speech clarity and response time.

Example Documentation:
• "Patient alert and oriented to person, place, time, and situation. Pupils 3 mm bilaterally, reactive to light. Speech clear. Strong, equal hand grips and foot pushes bilaterally."

Normal Limits:
• Pupil Size: 2-4 mm in bright light, 4-8 mm in dim light.
• Motor Strength: Equal bilaterally, no drift or weakness.

Respiratory Assessment
Steps:
• Inspect respiratory effort (rate, depth, symmetry).
• Auscultate anterior/posterior lung fields.
• Check for skin breakdown near oxygen equipment (nares, cheeks, ears).
• Assess for any accessory muscle use.

Example Documentation:
• "Respirations 16/min, even and unlabored. Breath sounds clear bilaterally in anterior and posterior fields. No use of accessory muscles. Skin intact at nares and behind ears."

Normal Limits:
• Respiratory Rate: 12-20/min.
• Breath Sounds: Clear bilaterally without wheezes, rales, or rhonchi.

Cardiac Assessment
Steps:
• Palpate apical pulse and auscultate heart sounds (Aortic, Pulmonic, Tricuspid, Mitral).
• Note rhythm (regular/irregular).
• Identify rate (count for a full minute if irregular).

Example Documentation:
• "Apical pulse regular at 72 bpm. S1 and S2 audible without murmurs or extra heart sounds."

Normal Limits:
• Heart Rate: 60-100 bpm.
• Rhythm: Regular without murmurs or clicks.

Peripheral Neurovascular (PNV) Assessment
Steps:
• Assess for bilateral symmetry in color, temperature, sensation, and movement.
• Palpate distal pulses (pedal, post-tibial).
• Check capillary refill (<2 seconds).
• Introduce the 6 Ps: Pain, Pallor, Pulses, Paresthesia, Paralysis, and Pressure.

Example Documentation:
• "Skin pink, warm, and dry bilaterally. Capillary refill <2 seconds. Posterior tibial and pedal pulses palpable bilaterally. No reports of pain or tingling."

Normal Limits:
• Capillary Refill: <2 seconds.
• Pulses: 2+ and equal bilaterally.

Abdominal Assessment
Steps:
• Inspect for distention, scars, or abnormalities.
• Auscultate bowel sounds in all four quadrants.
• Palpate for tenderness or masses (light palpation only).

Example Documentation:
• "Abdomen flat, soft, and non-tender. Bowel sounds active in all four quadrants. No masses or distention noted."

Normal Limits:
• Bowel Sounds: Active in all quadrants (5-30 sounds/min).
• Palpation: Soft, non-tender without masses.

Genitourinary (GU) Assessment
Steps:
• Assess for urinary output (color, clarity, amount).
• Inspect catheter insertion site (if present) for redness or drainage.
• Palpate bladder for distention if needed.

Example Documentation:
• "Urine clear, yellow, and adequate output. No redness or drainage noted at catheter site. Bladder non-distended on palpation."

Normal Limits:
• Urine: Clear, pale yellow, without foul odor.
• Bladder: Non-palpable or non-distended.

Skin Assessment
Steps:
• Inspect entire body, focusing on pressure points and equipment sites (ears, nares, heels, sacrum).
• Describe wounds using location, size, and drainage.

Example Documentation:
• "Skin intact over sacrum, heels, and nares. Midline incision from epigastric area to LMQ, approx. 10 cm, edges approximated, no drainage."

Normal Limits:
• Skin: Warm, dry, intact without redness or breakdown.
• Wounds: Edges approximated without drainage.

Tips for Documentation
• Use descriptive terms: Avoid vague terms like "normal."
• Be concise yet specific: Include measurements, locations, and objective findings.
• Practice using reference points for measurements (e.g., finger width, hand span).

Peripheral Neurovascular (PNV) Assessment: A Comprehensive Guide

Purpose of PNV Assessment
• Ensure proper circulation, nerve function, and extremity condition
• Detect early signs of neurovascular compromise, which could indicate conditions such as compartment syndrome or peripheral vascular disease.

Steps for PNV Assessment
Inspect the Limb:
• Look for color changes (e.g., pale, red, cyanotic).
• Check for swelling, bruising, or visible deformities.
• Assess for skin integrity (e.g., wounds, ulcers).

Palpate Pulses:
• Palpating pulses is critical to assessing blood flow and perfusion. Ensure you palpate bilaterally for comparison.

Common Locations for Palpating Pulses:
• Radial Pulse: Located at the wrist on the thumb side.
• Brachial Pulse: Found on the inner arm, just above the elbow crease.
• Femoral Pulse: Found in the groin area, midway between the pubic bone and anterior superior iliac spine.
• Popliteal Pulse: Located behind the knee, best palpated with the knee slightly flexed.
• Posterior Tibial Pulse: Found on the inner side of the ankle, just behind the medial malleolus.
• Dorsalis Pedis Pulse: Located on the top of the foot, slightly lateral to the extensor tendon of the big toe.

Pulse Grading Scale:
• 0: Absent (emergency, notify the provider immediately).
• 1+: Weak or thready.
• 2+: Normal (expected finding).
• 3+: Increased.
• 4+: Bounding.

Tips for Palpation:
• Use the pads of your index and middle fingers.
• Apply gentle pressure—too much pressure can occlude the pulse.
• If you can’t locate a pulse, try repositioning slightly or using a Doppler device.

Assess Capillary Refill:
• Press on the nail bed or a distal pad of the affected limb and release.
• Observe the time it takes for color to return.
• Normal: <2 seconds.
• Delayed: >2 seconds, which may indicate impaired circulation.

Evaluate Skin Temperature:
• Use the back of your hand to feel the skin along the limb.
• Compare bilaterally to detect differences:
• Warm: Indicates normal blood flow.
• Cool/Cold: May signal compromised circulation.
• Hot: Could indicate inflammation or infection.

Assess Sensation:
• Ask the patient about numbness, tingling, or unusual sensations.
• Lightly touch the skin with a cotton swab or fingertip, asking the patient to report any differences in sensation between limbs.

Evaluate Movement:
• Ask the patient to wiggle their toes and fingers actively.
• Observe for symmetrical movement and note any weakness or inability to move.

The 6 Ps:
• Pain: Disproportionate or increasing pain can be a sign of compartment syndrome.
• Pallor: Pale or mottled skin indicates poor perfusion.
• Pulse: Diminished or absent distal pulses suggest impaired blood flow.
• Paresthesia: Numbness or tingling may indicate nerve involvement.
• Paralysis: Inability to move a limb indicates severe neurovascular compromise.
• Pressure: Swelling or tightness may indicate compartment syndrome.

Pulse Palpation and Documentation Example
Normal Findings:
• “Radial, posterior tibial, and dorsalis pedis pulses palpable at 2+ bilaterally. Skin pink, warm, and dry. Capillary refill <2 seconds. No reports of numbness or tingling. Full active range of motion in fingers and toes bilaterally.”

Abnormal Findings:
• “Right lower extremity pale and cool to touch. Capillary refill >3 seconds. Posterior tibial pulse 1+, dorsalis pedis pulse absent. Patient reports tingling and inability to move toes. Notified provider immediately.”

Key Tips:

• Know Your Landmarks: Practice locating each pulse on yourself or peers to build confidence.

• *Always* Compare Bilaterally: This helps detect asymmetries that could indicate compromise.

• Don't Forget the Doppler: Use a Doppler device for difficult-to-find pulses, particularly in edematous or obese patients.

• Document What You Find: Be specific—mention which pulses were palpated and their strength.

Normal Limits for PNV

• Color: Pink, no cyanosis or pallor.
• Temperature: Warm and symmetrical.
• Pulses: 2+ and equal bilaterally across all locations.
• Capillary Refill: <2 seconds.
• Sensation: No numbness or tingling.
• Movement: Full range of motion without pain.

Clinical Scenarios Practice

For each scenario, determine the **best** type of focused assessment is to perform.

Scenario 1: A 65-year-old patient recovering from a stroke is suddenly confused and has difficulty answering questions. The nurse notices the patient has a right-sided facial droop.

Scenario 2: A 50-year-old post-op patient reports shortness of breath and fatigue. You notice their respiratory rate is 24 breaths per minute, and they appear to be using accessory muscles.

Scenario 3: A 40-year-old patient with a cast on their left leg reports new, intense pain that is not relieved by pain medication. You notice their left toes are cool and pale compared to the right side.

Scenario 4: A 25-year-old patient reports sharp pain in the right lower quadrant of their abdomen and nausea. They also mention that the pain worsens with movement.

Scenario 5: A 70-year-old patient recovering from a myocardial infarction reports feeling dizzy and having palpitations. Their heart rate is irregular at 110 bpm.

Scenario 6: A 55-year-old patient with a surgical incision reports redness and warmth at the site. You notice mild swelling and serous drainage on the dressing.