

**Performing a Basic Head to Toe Assessment**

Student Name \_\_\_\_\_

Date \_\_\_\_\_

**Goal:** The assessment is completed without the patient experiencing anxiety or discomfort; findings are accurate and communicated appropriately.

| <b>Edvance360 Video Resources- Basic Head to Toe Assessment video</b> |                                                                                                                                                            | <b>S</b> | <b>NI/U</b> |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------|
| 1.                                                                    | Gather equipment for vital signs, penlight, stethoscope, and watch with second hand                                                                        |          |             |
| 2.                                                                    | Identify patient, introduce self, explain purpose of the assessment, answer questions                                                                      |          |             |
| 3.                                                                    | Provide patient privacy by closing curtain around bed                                                                                                      |          |             |
| 4.                                                                    | Perform hand hygiene and put on gloves as appropriate                                                                                                      |          |             |
| 5.                                                                    | Adjust bed position and height                                                                                                                             |          |             |
| <b>ASSESS VITAL SIGNS</b>                                             |                                                                                                                                                            |          |             |
| 6.                                                                    | Obtain vital signs – T, P, R, BP, and SpO2                                                                                                                 |          |             |
| 7.                                                                    | Assess pain (rating, location, type, duration, associated symptoms, aggravating factors, etc.)                                                             |          |             |
| <b>SKIN (anterior and posterior)</b>                                  |                                                                                                                                                            |          |             |
| 8.                                                                    | Continuous observation of the skin throughout the assessment- including behind the ears, perineal area, and bony prominences (heels, elbows, coccyx), etc. |          |             |
| 9.                                                                    | Inspect skin color and turgor; palpate skin for temperature and moisture                                                                                   |          |             |
| 10.                                                                   | Inspect skin intactness – lesions, wounds, rash, ecchymosis, erythema; presence of dressings, drains, tubes –IV, foley, oxygen, etc.                       |          |             |
| <b>NEURO</b>                                                          |                                                                                                                                                            |          |             |
| 11.                                                                   | Establish LOC – Alert, Responds to Verbal Stimuli, Responds to Painful Stimuli Only, Unresponsive                                                          |          |             |
| 12.                                                                   | Establish orientation to person, place, and time – Oriented, Disoriented, Inappropriate, Incomprehensible, No verbalization                                |          |             |
| 13.                                                                   | Assess speech- clear, aphasic, garbled, slurred, etc.                                                                                                      |          |             |
| 14.                                                                   | Observe motor response- moves all extremities to command                                                                                                   |          |             |
| 15.                                                                   | Assess sensation of extremities- presence of numbness, tingling, burning, etc.                                                                             |          |             |
| <b>HEAD</b>                                                           |                                                                                                                                                            |          |             |
| 16.                                                                   | Inspect facial symmetry – smile, eye brow lift                                                                                                             |          |             |
| 17.                                                                   | Observe eyes for sclera and conjunctiva color                                                                                                              |          |             |
| 18.                                                                   | Observe pupil size, symmetry, shape, reactivity to light, and accommodation                                                                                |          |             |
| 19.                                                                   | Assess mouth (oral mucosa color, moisture, intactness, and teeth)                                                                                          |          |             |
| <b>UPPER EXTREMITIES</b>                                              |                                                                                                                                                            |          |             |
| 20.                                                                   | Palpate radial and brachial pulses bilaterally – noting regularity and strength                                                                            |          |             |
| 21.                                                                   | Compress nail bed for capillary refill bilaterally                                                                                                         |          |             |
| 22.                                                                   | Evaluate hand grasp for equality in strength                                                                                                               |          |             |
| 23.                                                                   | Assess ROM for shoulders and elbows                                                                                                                        |          |             |
| <b>CHEST</b>                                                          |                                                                                                                                                            |          |             |
| 24.                                                                   | Inspect breathing pattern- symmetry of chest movement, depth of respirations, ease of breathing, presence of cough, sputum                                 |          |             |
| 25.                                                                   | Auscultate heart sounds – aortic, pulmonic, tricuspid, and mitral                                                                                          |          |             |
| 26.                                                                   | Auscultate anterior breath sounds (6 locations)                                                                                                            |          |             |
| 27.                                                                   | Auscultate lateral breath sounds (1 location bilaterally)                                                                                                  |          |             |
| 28.                                                                   | Auscultate posterior breath sounds (6 locations)                                                                                                           |          |             |
| <b>ABDOMEN</b>                                                        |                                                                                                                                                            |          |             |
| 29.                                                                   | Last BM, usual bowel habits                                                                                                                                |          |             |
| 30.                                                                   | Presence of nausea, vomiting, flatus, diarrhea, constipation                                                                                               |          |             |
| 31.                                                                   | Inspect abdominal contour                                                                                                                                  |          |             |
| 32.                                                                   | Auscultate bowel sounds in four quadrants                                                                                                                  |          |             |
| 33.                                                                   | Palpate the four quadrants of the abdomen- note firmness, tenderness, and distension                                                                       |          |             |

| GENITOURINARY     |                                                                                              |  |  |
|-------------------|----------------------------------------------------------------------------------------------|--|--|
| 34.               | Assess for changes with urination- frequency, burning, urgency, incontinence, nocturia, etc. |  |  |
| 35.               | Assess for presence of urinary tubes/catheters and the necessity to remain in place          |  |  |
| 36.               | Assess urine color and appearance                                                            |  |  |
| LOWER EXTREMITIES |                                                                                              |  |  |
| 37.               | Inspect for skin integrity and edema                                                         |  |  |
| 38.               | Assess ROM for hips and knees                                                                |  |  |
| 39.               | Compress nail bed for capillary refill bilaterally                                           |  |  |
| 40.               | Palpate dorsalis pedis & posterior tibial pulses– noting regularity and strength             |  |  |
| 41.               | Assess planter & dorsal flexion                                                              |  |  |
| SAFETY            |                                                                                              |  |  |
| 42.               | Fall within the last 6 months                                                                |  |  |
| 43.               | Gait, use of ambulatory aid                                                                  |  |  |
| 44.               | Note number of side rails up and bed position                                                |  |  |
| 45.               | Cover the patient and help him or her to a position of comfort.                              |  |  |
| 46.               | Lower the bed and put the side rail up.                                                      |  |  |
| 47.               | Discuss findings with the patient.                                                           |  |  |
| 48.               | Remove gloves. Perform hand hygiene. Cleanse equipment.                                      |  |  |
| 49.               | Compare VS and assessment to the patient's baseline data. Report abnormal data.              |  |  |
| 50.               | Document VS and assessment in the computer.                                                  |  |  |

**Each item must be completed at a Satisfactory level in order to obtain an overall Satisfactory on this skill. You may receive up to two general prompts from the faculty following completion of the skill. Any items that were omitted or performed incorrectly and not addressed to a satisfactory level during prompting will be evaluated as unsatisfactory and your overall evaluation will result in an Unsatisfactory. Unsatisfactory evaluation will require remediation and satisfactory re-demonstration of the skill.**

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Faculty Signature \_\_\_\_\_

Overall Evaluation \_\_\_\_\_