Firelands Regional Medical Center
School of Nursing

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.

Edvance360 NF Video Resources- Assessment video		**S**	**NI/U**
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		
ASSESS VITAL SIGNS			
6.	Obtain vital signs – T, P, R, BP, and SpO2		
7.	Assess pain (rating, location, type, duration, associated symptoms, aggravating factors, etc.)		
SKIN (anterior and posterior)			
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.		
NEURO			
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.		
HEAD			
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)		
UPPER EXTREMITIES			
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		
CHEST			
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)		
ABDOMEN			
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 3 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 _____

Firelands Regional Medical Center

School of Nursing

VITAL SIGNS

Student: _____ Date: _____

Goal: The patient's vital signs are assessed accurately without injury and the patient experiences minimal discomfort.

Potter & Perry (9th ed.)- p. 291-315, 282, 288; ATI Vital Signs Skills Module- All step by step videos; Edvance360 Video Resources- All vital sign videos		**S**	**NI/U**
1.	Check physician's order or nursing care plan for frequency and route of vital sign measurement. More frequent vital sign measurements may be appropriate based on nursing judgment.		
2.	Gather equipment.		
3.	Introduce self and explain the purpose of measuring vital signs.		
4.	Provide patient privacy by closing curtain around bed.		
5.	Perform hand hygiene and put on gloves as appropriate.		
6.	Identify the patient.		
7.	Adjust bed position and height; lower the side rail.		
Assessing Oral Temperature			
8.	Wait 20 minutes if the patient has just smoked, chewed gum, or ingested any food or drink.		
9.	Remove the thermometer probe from the charging unit. Use the thermometer probe with the **blue top** for oral or axillary temperature measurements.		
10.	Slide the thermometer probe into a disposable probe cover until it snaps into place.		
11.	When the thermometer screen reads "OrL °F", place the probe beneath the patient's tongue in the posterior sublingual pocket. Ask the patient to close his or her lips around the probe.		
12.	Continue to hold the probe until you hear a beep. Note the temperature reading.		
13.	Remove the probe from the patient's mouth. Dispose of the probe cover by holding the probe over an appropriate receptacle and pressing the blue probe release button.		
14.	Sanitize the thermometer and probe; return to the storage place within the unit.		
Assessing Axillary Temperature			
15.	Remove the thermometer probe from the charging unit. Use the thermometer probe with the **blue top** for oral or axillary temperature measurements.		
16.	Move the patient's clothing to expose only the axilla.		
17.	Slide the thermometer probe into a disposable probe cover until it snaps into place.		
18.	When the thermometer screen reads "OrL °F", raise the patient's arm away from the torso and place the end of the probe in the center of the axilla. Lower the arm over the probe and cross the arm over the chest.		
19.	Hold the thermometer in place until you hear a beep. Note the temperature reading.		
20.	Remove the probe from the patient's axilla. Dispose of the probe cover by holding the probe over an appropriate receptacle and pressing the blue probe release button.		
21.	Sanitize the thermometer and probe; return to the storage place within the unit.		
Assessing Rectal Temperature			
22.	Apply clean gloves.		
23.	Assist the patient to a side-lying position with the upper leg flexed. Move the patient's gown and blanket to expose the rectal area only.		
24.	Remove the thermometer probe from the charging unit. Use the thermometer probe with the **red top** for rectal temperature measurement.		
25.	Slide the thermometer probe into a disposable probe cover until it snaps into place.		

26.	Apply a liberal amount of water-soluble lubricant to the end of the probe (approximately 1-1.5 inches).		
27.	When the thermometer reads "rec °F", separate the patient's buttocks with your nondominant hand.		
28.	Ask the patient to take slow deep breaths and gently insert the thermometer probe into the anus towards the direction of the umbilicus approximately 1-1.5 inches. Do not force the thermometer.		
29.	Hold the thermometer in place until you hear a beep. Note the temperature reading.		
30.	Remove the probe from the patient's anus. Dispose of the probe cover by holding the probe over an appropriate receptacle and pressing the red probe release button.		
31.	Wipe any excess lubricant from the anus with tissue and discard. Assist the patient to a comfortable position. Remove gloves and perform hand hygiene.		
32.	Apply clean gloves and wipe the probe with a disinfecting wipe and return the thermometer probe to the storage place within the unit.		
33.	Remove gloves and perform hand hygiene.		
Assessing Radial Pulse			
34.	Wait 5-10 minutes before assessing the pulse if the patient has been active.		
35.	Rotate the wrist so the patient's hand is resting with the palm side up.		
36.	Place your first two to three fingers over the radial artery (located on the thumb side of the inner wrist). Lightly compress the artery so pulsation can be felt and counted.		
37.	Using a watch with a second hand, count the number of pulsations felt for 30 seconds. Multiply this number by 2 to calculate the rate for 1 minute.		
38.	Note the rhythm and strength of the pulse.		
39.	If the rate, rhythm, or strength of the pulse is abnormal in any way, palpate and count the pulse for 1 minute or longer.		
Assessing Apical Pulse			
40.	Wait 5-10 minutes before assessing the pulse if the patient has been active.		
41.	Assist patient to a sitting or supine position. Move the patient's clothing to expose only the apical site.		
42.	Locate the angle of Louis. Shift your fingers over to the left second intercostal space. Count down the left side of the sternum to the fifth intercostal space and shift to the left midclavicular line. Place the stethoscope over this area (the apex of the heart).		
43.	Listen for heart sounds ("lub-dub"). Each "lub-dub" counts as one beat. Using a watch with a second hand, count the heartbeat for 30 seconds. Multiply this number by 2 to calculate the rate for 1 minute.		
44.	Note the regularity of the heartbeat.	.	
45.	If the rate or rhythm of the pulse is abnormal in any way, count the pulse for 1 minute or longer.		
46.	Cover the patient and help him or her to a position of comfort.		
47.	Clean diaphragm of the stethoscope with an alcohol swab.		
Assessing Respirations			
48.	While your fingers are still in place for the pulse measurement and after counting the pulse rate, discretely observe the patient's respirations.		
49.	Note the rise and fall of the patient's chest. Note the depth and rhythm of the respirations.		
50.	Using a watch with a second hand, count the number of respirations (1 inspiration and expiration equals 1 respiration) for 30 seconds. Multiply this number by 2 to calculate the respiratory rate per minute.		
51.	If respirations are abnormal in any way, count the respirations for at least 1 full minute.		
Assessing Blood Pressure			
52.	Wait 5-10 minutes before assessing the BP if the patient has been active.		
53.	Select appropriate limb and appropriate cuff size for BP measurement.		
54.	Have the patient assume a comfortable lying or sitting position with the arm straight and supported at the level of the heart with the palm of the hand facing upward. Make sure the patient's legs are not crossed.		

55.	Expose the brachial artery by removing garments. Remove restricting clothing.		
56.	Palpate the location of the brachial artery.		
57.	Apply the BP cuff: • Center the bladder of the cuff over the brachial artery (many cuffs have an area marked to line up with the artery). • Midway on the upper arm, so that the lower edge of the cuff is about 1-2" above the inner aspect of the elbow. • The tubing should extend downward from the edge of the cuff nearer the patient's elbow. • Wrap the cuff around the arm smoothly and snugly, and fasten it.		
58.	Check that the needle on the gauge is at the zero mark. Assume a position that is no more than 3 feet away from the gauge and easily visualized straight on.		
59.	Place the stethoscope earpieces in your ears. Direct the earpieces forward into the ear canal and not against the ear itself.		
60.	Place the stethoscope firmly over the brachial artery. Do not allow the stethoscope to touch clothing or the cuff. You will not hear anything at this point.		
61.	Ask the patient to remain still and avoid talking during the BP measurement.		
62.	Tighten the screw valve clockwise on the air pump until it is closed (not too tightly).		
63.	Using the bulb, quickly pump the pressure to 30 mm Hg above the patients baseline systolic BP.		
64.	Open the screw valve counterclockwise and allow air to escape **slowly** (allowing the gauge to drop 2-3 mm Hg per second).		
65.	Note the point on the gauge at which the first faint, but clear sound appears. Note this number as the systolic pressure. Read the pressure to the closest even number. Do not reinflate the cuff once the air is being released to recheck the systolic pressure reading.		
66.	Continue to slowly deflate the cuff and note the pressure at which the sound disappears. This will be recorded as the diastolic pressure. Listen for an additional 20-30 mm Hg after the last sound.		
67.	Allow the remaining air to escape quickly. Repeat any suspicious reading, waiting 30 to 60 seconds between readings to allow normal circulation to return in the limb. Deflate the cuff completely between attempts to check the blood pressure.		
68.	Remove the cuff, sanitize, and store the equipment.		
Assessing Orthostatic Blood Pressure			
69.	After the patient has been lying in the supine position for at least 3-5 minutes, take the BP reading in each arm. Select the arm with the highest systolic reading for all subsequent measurements. Count the heart rate as well.		
70.	Leaving the BP cuff in place, help the patient to a sitting position.		
71.	Assess for orthostatic symptoms: dizziness, weakness, light-headedness, feeling faint or sudden pallor. At any point throughout the orthostatic BP measurements, if these symptoms develop stop the BP measurement and return the patient to a supine position.		
72.	After 1-3 minutes in the sitting position, take the BP and heart rate.		
73.	Leaving the BP cuff in place, assist the patient to a standing position.		
74.	After 1-3 minutes of standing, take the BP and heart rate for the 3rd time.		
75.	Assist the patient back to a comfortable position and remove the BP cuff.		
76.	Document the BP and heart rate measurements in each position (supine, sitting, and standing). Note any additional symptoms that may present (such as dizziness).		
Assessing Oxygenation with a Pulse Oximeter			
77.	Determine the most appropriate site for placement of the pulse oximeter (finger, earlobe, bridge of the nose, toe, or forehead). If the capillary refill is greater than 2 seconds, the site is cool to touch, nail polish is present, or there are any alterations in skin integrity choose a different site.		
78.	Apply probe securely to finger and turn the pulse ox on.		
79.	Observe the pulse waveform/intensity display. Correlate the pulse rate on the oximeter to the radial pulse. This will ensure oximeter accuracy.		
80.	After approximately 10-30 seconds, note the pulse oximeter reading.		
81.	Remove pulse oximeter, turn off, sanitize, and return to the appropriate storage location.		

82.	NOTE: If continuous pulse oximeter is ordered by the physician: Set alarms on pulse oximeter. Remove sensor on a regular basis and check for skin irritation or signs of pressure (every 2 hours for spring tension sensor or every 4 hours for adhesive finger or toe sensor).		
83.	Cover the patient and help him or her to a position of comfort.		
84.	Lower the bed and put the side rail up.		
85.	Discuss findings with the patient.		
86.	Remove gloves. Perform hand hygiene.		
87.	Cleanse equipment and return to the appropriate storage locations.		
88.	Compare vital signs to the patient's baseline data. Report abnormal data.		
89.	Document T/P/R, BP, and pulse ox in the computer.		

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