**Head to Toe Assessment in 5 Minutes**

**(Well, maybe a little longer than that)**

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**Objectives**

Objectives: At the conclusion of this program the participant will be able to:

1. Identify components of a head to toe assessment.
2. Identify components of a systems by system assessment.
3. Differentiate between normal and abnormal vital sign parameters.
4. Identify key components of the neurological exam.
5. Identify key components of heart assessment.
6. Identify key components of respiratory assessment.
7. Describe the Mental Status Exam.
8. Identify key components of a basic head to toe assessment by following a flow chart.
9. Complete exam components at 85% competency.

A head to toe assessment is the baseline and ongoing data that is needed on every patient. Once a systematic technique is developed, the assessment can be completed in a relatively short period of time.

Assessment is done at the beginning of each shift, and at regular intervals during the shift. Since many healthcare professionals work 12 hour shifts, assessment needs to be done more than once.

Our hope is that this packet will give you some techniques, rationale and a process to make the assessment process more predictable for you. Some helpful components of this packet include:

* Overview of Vital Signs
* Neurological Assessment
* Heart Assessment
* Respiratory Assessment
* Mental Status Exam
* Assessment Check List
* Sample Narrative Charting
* Head to Toe Assessment Template

**HEAD TO TOE ASSESSMENT IN 5 MINUTES or MORE**

**Introduction to Assessment**  
The head to toe assessment provides baseline data about your patient. It is the standard of care to assess each patient in your care. Only by evaluating your patient can you determine if changes have occurred. Since licensed personnel often have responsibility for many patients, a comprehensive, systematic method is necessary to assure a complete assessment in a timely manner. The following is a suggested format for patient assessment:

**Washed Hands**  
Washing hands between each patient is the single most significant factor in preventing the spread of disease. Utilize Standard Precautions in assessing the patient.

**Introduction to the Patient**  
Introducing yourself to the patient and explaining the purpose of the head to toe assessment helps the patient to know your role and why you are completing this assessment. At times, the patient may feel that there is something wrong with them or their condition has changed when they are frequently assessed. Explaining to the patient the need for the assessment to identify changes in condition often allays the anxiety.

**General Survey**  
Look at the patient for eye contact, appearance, hygiene and appropriateness for personal space. The general survey can often be a key to observing mental status.

**Head and Neck**  
Palpate the head for tenderness, bumps, and abraisons. Observe for head lice. Observe the ears for signs of skin breakdown or abraisons.

**Vital Signs**  
Basic vital signs are considered to be the temperature, pulse, respiration, and blood pressure. Pain assessment has now been added as the 5th vital sign. Assessing vital signs is 'vital' to determining changes in condition. Vital signs provide a baseline physiologic parameter.

**Orientation**  
Orientation is checked by determining if the patient can state their name, the day or date, where they are, and the purpose. This is documented as oriented times 4. When assessing orientation, use open-ended statements. For example, "Tell me your name", " What year is this?", "Tell me where you are." “Tell me why you are here.” You don't want to say "Is your name Mrs. Jones?", since a yes/no answer is not an accurate measure of orientation.

**Pupil Check**  
Pupils are checked in a number of ways. One acronym used is PERRLA

**P**upils **E**qual in size **R**ound **R**eact to light **A**ccommodation

Pupils are checked by shining a light in from the side. As you view each pupil, note equality of size. When the light is shone, do the pupils react equally by constricting. Is this reaction sluggish, normal, or brisk? Is there no change in pupil size when the light is shone? A millimeter scale is often used to check pupil size. For example the pupils may change from 4 mm to 3 mm with the light. Accommodation tests the ability of the pupils to constrict to a closer moving object. Have the patient follow a pen or your finger as you bring the object closer to the patient. The pupils will constrict as the object comes closer. Accommodation cannot be checked if the patient is confused, blind, comatose, or unable to follow the object. In that case, chart PERRL, and leave the 'A' off.

**Neck Veins**  
Neck veins should be checked by having the patient sit at a 45 degree angle. In this position, the jugular veins should be flat. Distended neck veins at 45 degrees are an indicator of over hydration or fluid overload.

**Heart Tones**  
Heart tones are checked by listening to the apical pulse. This pulse is auscultated with the diaphragm and the bell of the stethoscope. Check the apical pulse for rate, rhythm, and clarity of the sounds of the S1 and S2 otherwise known as "lub and dub". Any abnormalities should be reported.

**Bilateral Checks**  
Bilateral checks for comparison need to be done for:

* radial pulses - check rate, strength, and regularity
* hand strength - have patient grip two of your fingers at the same time. Check for equality in strength. Never offer a patient your entire hand to grasp. A patient with a strong grip can injure your hand, but cannot hurt two fingers.
* leg strength - place your hands on the patient's thighs. Have the patient push legs against the resistance of your hands. Check for equality in strength.
* pedal pulses - are located on the top of the foot. Check rate, strength, and regularity
* capillary refill - can be done on the fingers or toes. Press down on the nail bed. The color will blanch. Assess the time for the color to return. Capillary refill should return in 3 seconds or less. A delay in capillary refill may indicate impaired circulation.

**Skin**  
Skin turgor is checked to determine hydration. Delayed skin turgor may indicate dehydration. Skin turgor should return within 1 to 3 seconds. Although you may have learned to check for skin turgor on the hands, the sternum is not as affected by aging changes. Assess skin turgor by gently pinching the sternum. Indicate the time it takes for the skin to go back to the baseline. Since not everyone is 'pink', skin color is best checked by observing mucous membranes on the inside of the lip or the conjunctiva. Despite skin pigmentation, the mucous membranes are the same for all of us. Skin color can generally be described as pink, pale, jaundiced, or cyanotic. Skin temperature is checked by using the back of your hand placed on the patient's skin. Skin can be hot, warm, or cool.

**Breath Sounds**  
The diaphragm of the stethoscope is used for assessing breath sounds. The apices of the lungs are very high, extending above the clavicles. Assess anterior and posterior breath sounds listening for side to side comparisons. The right middle lobe is assessed by listening on the patient's right side. Have the patient take deep breaths in and out of their mouth. Patients often want to help, and each time we place the stethoscope on the chest the patient takes a deep breath. Be careful not to move the stethoscope to rapidly to avoid hyperventilating the patient. Nose breathing can create air turbulence that may alter the sounds. Breath sounds should be clear bilaterally with good air flow.

**Bowel Sounds**  
To assess bowel sounds, the abdomen is divided into 4 quadrants, using the umbilicus as the mid point. It is very important to auscultate the abdomen before touching. Palpation of the abdomen prior to auscultation may disrupt normal sounds. If the patient is on nasogastric suction, turn the machine off prior to listening for bowel sounds. Bowel sounds can be described as hypoactive, active, hyperactive, or absent. To chart absent bowel sounds, each quadrant must be assessed for 5 minutes. In other words, absent bowel sounds infers a 20 minute assessment.

**Peripheral Edema**  
Edema, or fluid in the tissues tends to go to dependent areas of the body. This may be the hands, feet or sacrum. For the bed rest patient, the dependent area is most often the sacrum. To check for edema push your finger down on the feet, hands, and sacrum. Observe for indentation or pitting.

**Assessing for Pain - Pain is the 5th Vital Sign**

* Ask the patient if they are having any pain. Assess for location, duration, radiation, alleviating factors, precipitating factors, quality and intensity.
* Where is the pain, how long has it lasted?
* Does the pain travel anywhere?
* What makes the pain feel better, what makes the pain worse?
* Describe how the pain feels. Is it sharp, dull, pressure, stabbing?
* On a scale of 1 to 10, with 10 being the worst pain you could possible have, tell me the level of pain you are experiencing."

**Skin Breakdown Check**  
Check the entire body for redness or skin breakdown. Be sure to check bony prominences.

**Homan's Sign**  
Homan's sign indicates possible thrombophlebitis. Ask the patient to dorsiflex both feet. Ask the patient if there is any pain in the calf. Calf pain may indicate thrombophlebitis.

**Closure**  
Let the patient know you are finished and when you will be back. Leave the bed down, rails up as indicated, and the call light within reach.

**ASSESSMENT BY BODY SYSTEMS**

An alternate method of assessment is by body systems. Whether you assess from head to toe or by systems does not matter as long as you follow a systematic format each time. Each method of assessment lends itself to a format and a systematic approach.

1. Introduction to the client
   1. Establish rapport by using eye contact (when culturally appropriate), sitting at the level of the client if possible, and even if you are feeling rushed, do not convey that to the client.
   2. Communication is extremely important. Let the client know who you are, your level of licensure, and why you are there. Remember to listen to what the client tells you. Be sure to explain any procedures that may be done.
2. Vital Signs (See Vital Sign Reference Sheet)
   1. Temperature
   2. Pulse
   3. Respirations
   4. Blood Pressure
   5. Weight
   6. Pain Assessment
3. Neurological Assessment (See Neurological Assessment Reference Sheet)
   1. Level of Consciousness
      1. Stimulus Response
      2. Glasgow Coma Scale
   2. Pupils
      1. PERRLA
      2. consensual reaction
   3. Extremity Strength
   4. Sensation
4. Cardiac Assessment (See Heart Sounds Reference Sheet)
   1. Pulses - Apical, radial, pedal quality and rate bilaterally
   2. Capillary refill
   3. Neck Veins
   4. Edema - check dependent areas such as feet, hands, sacrum, scrotum
   5. Heart Sounds
      1. S1 (lub) and S2 (dub)
      2. rhythm
      3. murmurs
      4. rubs
   6. Signs and Symptoms of Shock
      1. increased heart rate
      2. decreased blood pressure
      3. cool, clammy skin
   7. Lab Values
      1. WBC, RBC, Hgb, Hct
5. Respiratory Assessment (See Lung Sounds Reference Sheet)
   1. Inspection
      1. skin color
      2. barrel chest (as seen in emphysema)
   2. Auscultation
      1. Lung sounds
         1. rales/crackles
         2. rhonchi
         3. wheezes
         4. rubs
   3. Sputum - color, consistency
   4. Cough - productive, nonproductive
   5. Oxygen administration and response
   6. Incentive spirometer
   7. Pulse Oximetry (Sa02)
6. Gastrointestinal and Abdominal Assessment
   1. Inspection
      1. flat
      2. rotund
      3. distended
   2. Auscultation - Always listen before you touch.
      1. bowel sounds 4 quadrants
         1. hypoactive, active, hyperactive.
         2. absent bowel sounds require a 5 minute listen in each quadrant!
      2. listen for abdominal aorta bruit
   3. Palpation
      1. pain on palpation
      2. deep palpation only to determine liver margins
   4. Percussion
      1. air?
      2. fluid?
   5. Nausea, vomiting, dyspepsia, anorexia
   6. Nutrition
      1. % intake and tolerance
      2. pain related to eating
      3. likes and dislikes
      4. appetite
   7. Lab Values - protein, prealbumin
7. Fluids and Electrolytes
   1. Intake and Output
   2. Peripheral Edema
   3. Diaphoresis
   4. I.V. Site
   5. Lab Values - electrolytes
8. Elimination
   1. Urinary Assessment
      1. color
      2. odor
      3. amount
   2. Stool

Last bowel movement color, character and consistency of stools

* 1. Diaphoresis
  2. Drainage from dressing, drains
  3. Lab Values
     1. BUN
     2. Creatinine
     3. Specific Gravity
     4. stool occult blood

1. Musculoskeletal Assessment
   1. Muscle strength
   2. Casts
   3. Traction
   4. Effects of Immobility
      1. tolerance to range of motion
      2. ability to transfer, ambulate and tolerance
2. Endocrine/ Regulation
   1. Senses
      1. hearing
      2. vision
   2. Diabetic
      1. blood glucose levels
      2. observe feet and overall skin integrity
      3. acetone breath (few facilities check for acetone/ketones anymore)
      4. hypoglycemic symptoms (irritable, hungry, altered level of consciousness)
   3. Thyroid
      1. monitor heart rate
      2. blood pressure
3. Integumentary System
   1. Decubiti
      1. stage 1 - redness
      2. stage 2 - break in skin
      3. stage 3 - to muscle
      4. stage 4 - to bone
   2. Nutrition
      1. % intake
      2. likes/ dislikes
4. Psychosocial Aspects (See Mental Status Exam Reference Sheet)
   1. Affect of illness on role such as work, family
   2. Inappropriate independence, dependence?
   3. Check for depression, suicidal ideation if needed.

**SPECIAL CONSIDERATIONS FOR THE CLIENT WITH DEVELOPMENTAL DISABILITIES**

1. Physical disability?
   1. Contractures
   2. Spasticity
   3. Hyperextension
   4. Other
2. Verbal limitations
3. Feeding or Swallowing considerations?
4. Client with a tracheostomy

**VITAL SIGNS - TEMPERATURE, PULSE, RESPIRATION, BLOOD PRESSURE**

|  |  |
| --- | --- |
| **Temperature**  Oral - mouth Time period 3 minutes Normal range: 97.6 - 99.6 degrees  Absolute: 98.6 degrees Rectal - Anus Time period 3 minutes  Position -Lateral Sims Normal range: 98.6 - 100.6 degrees  Absolute: 99.6 degrees Axillary - Armpit Time period 10 minutes Normal range: 96.6 - 98.6  Absolute: 97.6 degrees Otic or Tympanic Time period 10 sec. or less Degree range is calibrated to rectal or oral Hypothermia - Low body temperature Hyperthermia - High body temperature Pyrexia - High fever Febrile - High fever Afebrile - No fever Things that can effect temperature: smoking, fluids, oxygen use, food, colds, or flu  **Pulse**  Rate is: Number of beats per minute Rhythm is: Regularity of beats Normal range of adults: 60 - 100 per minute Pulse: Can be weak, bounding or absent for short period of time Rhythm: Can be regular or irregular Palpate for: Rhythm, rate, and strength Optimal finding: 80 per min. strong, and reg.  Tachycardia: Over 100 beats per minute Bradycardia: Under 60 beats per minute To measure pulse: count 30 sec.X 2 For irregular pulse: count the full 60seconds Auscultate: Use stethoscope Pulse deficit: Difference of apical and radial.  **Pulse Sites**  Apical: Over the heart (auscultated) Temporal: Fon temple, side of head Carotid: On neck on either side of the trachea Brachial: Inside of elbow Radial: Side of thumb away from fingers Ulnar: Opposite radial  Femoral: In the crease of the groin area Popliteal: Behind the knee Dorsalis pedis or pedal: On top of the foot Posterior tibialis: On the inside of ankle | **Respirations**  Respirations : How many breaths per minute Adults: 12 - 20 / Infant slightly higher 20 - 40 Inhalation and Exhalation equals: 1 breath To count breaths: Count 30 seconds by 2 Look for : Rhythm, rate, depth, and quality Bradypnea: Under 12 breaths Tachypnea: Over 20 breaths Eupnea: Normal rate and depth Apnea: Not breathing maybe 30 seconds or at all Dyspnea: Difficulty in breathing Orthopnea: Over bedside 90o postural position Hyperpnea: Fast respirations Cheyne Stokes: Increasing in rate and depth then periods of apnea - cyclic. Kussmaul: Metabolic acidosis,usually the Diabetic. Rapid, very deep respirations intended to blow off carbondioxide.  **Blood Pressure**  Blood Pressure: Pressure of blood against the walls of the arteries Systolic: Number that is on the top, and when heart is contracting Diastolic: Number that is on the bottom, and when heart is at rest Systolic range: 90 - 140 Diastolic range: 60 - 90 Hypertension : High blood pressure, above 140 systolic or over 90 diastolic Hypotension: Low blood pressure, under 90 over 60 To measure systolic: Sound of first beat To measure diastolic: No beat is heard Hypertension thickens heart muscle (hypertrophy) and reduces chamber in size Thigh cuff for large arms, Small cuff pediatrics Sphygmomanometer is instrument use to take blood pressure Pulse pressure: Difference between systolic and diastolic |

**NEUROLOGICAL ASSESSMENT**

1. DETERMINE MENTAL STATUS
   1. Determine State of Alertness:
      1. Stimulus Response
         1. Auditory stimuli: calls patient's name. If no response, proceed to b
         2. Touch, shake patient. If no response, proceed to c
         3. Moderate to deep pain; applies sternal pressure. Pinch trapezius.
         4. Ability to follow simple commands; "open eyes", "blink", etc.
         5. Charts level of arousal by description of:
            1. Stimuli needed to elicit response
            2. Type of response elicited
      2. **Glasgow Coma Scale**

|  |  |  |
| --- | --- | --- |
| **FACULTY MEASURED** | **RESPONSE** | **SCORE** |
| Eye Opening | Spontaneously To verbal command To pain No response | 4 3 2 1 |
| Motor Response | To verbal command To painful stimuli -  - Localizes pain - Flexes and withdraws - Assumes flexor (decorticate) posturing - Assumes Extensor (decerebrate) posturing No response | 6  5 4 3 2 1 |
| Verbal Response (Arouse patient with painful stimuli if necessary) | Oriented and converses Disoriented and converses Uses inappropriate words Makes incomprehensible sounds No response | 5 4 3 2 1 |
| **Total 3 to 15** | | |

1. Determine Orientation
   1. Ask to state name, date, purpose, and location.
   2. Chart level of orientation to each.
2. CHECKS PUPILS
   1. Observes Both Pupils Simultaneously For: Equality, Size and Shape.
      1. Compares pupils for equality.
      2. Determines size, dilated, constricted, pinpoint.
      3. Determines irregularities in shape.
   2. Observes Direct Pupillary Light Reflexes.
      1. Checks one pupil at a time.
      2. Shines flashlight into eye from side.
      3. Repeat other eye.
   3. Observes Consensual Pupillary Reflex
      1. Shines flashlight into each eye alternately.
      2. Observes opposite pupil. Opposite pupil should constrict when light shore.
      3. Charts description of pupils: Equality, size, shape, reaction to light.
   4. Observes pupillary response to accommodation
      1. Have patient follow a closer moving object such as a pen.
      2. Pupils will constrict (or accommodate) to the closer moving object. \* cannot be tested on blind or confused persons.
   5. Observes Extraocular Movements

1. Asks patient to focus on object. 2. Moves object; medical, lateral, superior, inferior and circular. In the pattern of an "H." 3. Observes movement of both eyes in each of above directions; notes abnormalities or weakness. A. Charts extraocular movements as "full" if no abnormalities or "unable to move eyes laterally, medially etc."

1. DETERMINES MOTOR FUNCTIONING
   1. Observes Facial Symmetry
      1. Observes for unilateral flat nasolabial fold.
      2. Asks pt. to show teeth, raise eyebrows, frown.
   2. Checks Hand Grips
      1. Asks pt. to squeeze tightly and simultaneously examiners first two fingers with both hands.
      2. Charts both strength and symmetry of grip.
   3. Checks Movement and Strength of Extremities
      1. Ask pt. to extend both arms forward, palms up; then close eyes and hold position 30 sec. Observe for change of arm position.
      2. Ask pt. to raised each leg individually, as high as possible (90 degrees) without bending his knee.
      3. Tests for dorsiflexion; asks pt. to pull his toes toward nose and hold them while the nurse stands at the foot and tries to pull them back.
      4. Checks plantar reflexes; Asks pt. to again pull toes up toward up nose. Examiner then puts her hands on bottom of feet and asks pt. to push her away.
      5. Checks knee lifts by placing her hands on both knee caps; ask pt. to bend against resistance.
      6. Charts description of movement; eg.; "no movement on command," "R. leg slightly stronger than L. leg," "no upper extremity drift."

**HEART ASSESSMENT**

Cardiac assessment and assessing of heart tones an assessment technique that takes practice and learning how to really listen. For nurses, this is often the one assessment technique that gets the least attention. The best way to learn heart tones, is to listen. Learn how to tell what a normal heart sound is, then when an abnormality is present, correlate that with the description and validate with a mentor who is familiar with the skill.

**Areas for Auscultation** - similar placement to the 12 lead precordial leads.

1. Aortic - 2nd right intercostals space
2. Pulmonic - 2nd left intercostal space
3. Erbe’s point - 3rd left intercostals space
4. Tricuspid - 5th left intercostals space
5. Mitral - 5th left intercostals space, medial to the midclavicular line

**Heart Sounds** - hearts sounds can give you valuable information about your patient. Heart sounds art though to result from the vibrations from closure of the heart valves and the acceleration and deceleration of blood flow.

1. **S1 - the lub** sound that represents closure of the tricuspid and mitral valves. Heard best at the apex.
2. **S2 - the dub** sound. This represents closure of the aortic and pulmonic valves. It is the onset of ventricular diastole and is heart best at the aortic area.
3. **S1 split** - a slight difference in valve closure timing. This is a normal variation heard best at the right 4th intercostals space. The lub sound will have a barely distinguishable split or two sounds.
4. **S2 split** - this is a splitting of the dub, or the second sound. This may be due to increased venous return to the right side of the heart during inspiration and by a prolonged delay in the closure of the pulmonic vales. Heart best during inspiration at the pulmonic aria. Usually disappears in the sitting position
5. **S3 (ventricular gallop)** - normal in healthy children and young adults and is produced vibrations of the ventricles due to rapid distention. This may be seen in left ventricular failure. Heard best at the apex with the patient lying on the left side. Heard with the bell of the stethoscope and sounds like “Kentucky”. May indicate incompetence of the mitral and tricuspid valves.  
   **S1  S2   S3  
   Ken tuck ee  
   Lub dub dub**
6. **S4 (atrial gallop ro presystolic gallop)** - occurs in the later part of diastole. Heard best over the apex with theptietn lying supine. Results from vibrations of valves supporting structures of the ventricles during atrial ejection of blood into the ventricles. Indicative of increased resistance to filling and may be associated with coronary artery disease, hypertension, aortic stenosis, or the elderly. This sound is heart best with the bell of the stethoscope over the left lower sternal border. It sounds like “Tennessee”.  
   **S4 S1   S2  
   Ten ne see  
   Dub lub dub**

**Heart Murmurs** - are caused by increased flow through normal structures. Murmurs may also represent forward flow across a stenotic valve, backward flow through an incompetent valve, flow from a high pressure chamber or vessel through an abnormal passage, or flow into a dilated chamber.

1. Classifications
   1. **Diastolic Murmurs** - occur between S2 and S1. Seen in mitral or tricuspid stenosis, aortic or pulmonic insufficiency.
   2. **Msystolic murmurs** - occur between S1 and S2. seen in aortic or pulmonic stenosis or mitral or tricuspid insufficiency. They are also called holosystolic or parasystolic murmurs.
2. Areas for Auscultation - mitral murmurs are heard best with the patient in the left lateral position. Aortic murmurs are heard best with the patient sitting and leaning forward after complete exhalation.
3. Description of a murmur - when documenting a murmur, indicate the location where you heard the murmur best. Murmurs are also graded on a scale of I - VI. A I is barely audible, while a VI has so much vibration you could almost feel it. An example of charting for a murmur would be:  
     
   ***A III/VI systolic murmur heard at the apex with the patient sitting in high Fowler’s position.***

**Extra Cardiac Sounds** - These are sounds heard that are outside of the heart tones.

1. Pericardial Friction Rub - may be heard anywhere over the heart. A rub is a very course, grating sound. Rubs can also be heard over the lungs. To differentiate between a pericardial rub and a pleural rub, have the patient hold his breath. If the rub continues when the breath is held, it is of cardiac origin. Pericardial rubs may indicate pericarditis or pericardial effusion.
2. Mediastinal Crunch - indicates air in the mediastinum and sounds very much like popcorn crunching.

**AUSCULTATION OF BREATH SOUNDS**

|  |  |
| --- | --- |
| *WHAT YOU'LL HEAR* | |
| **NORMAL SOUNDS** Bronchial Pitch: High Intensity: Loud, predominantly on expiration Normal findings: A sound like air blown through a hollow tube, heard over suprasternal area and lower trachea or mainstem bronchus Abnormal findings: If heard over peripheral lung, may indicate atelectasis or consolidation  Bronchovesicular Pitch: Moderate Intensity: Moderate Normal findings: A blowing sound heard over airways on either side of sternum, at angle of Louis, and between scapulae Abnormal findings: If heard over peripheral lung, may indicate consolidation  Vesicular Pitch: High on inspiration, low on expiration Intensity: Loud on inspiration, soft to absent on expiration Normal findings: Quiet, rustling sounds, heard over periphery Abnormal findings: If decreased over periphery, may indicate early pneumonia, emphysema, pneumothorax, pleural effusion, or atelectasis  **Auscultate in this pattern:**  **Pattern Image** | **ADVENTITIOUS SOUNDS** Crackles (Rales) Where to auscultate: Over lung fields and airways; heard in lung bases first with pulmonary edema Timing:More obvious during inspiration Cause: Moisture, especially in small airways and alveoli Description: Light crackling, bubbling; nonmusical  Rhonchi (Gurgles) or Coarse Crackles Where to auscultate: Over larger airways Timing: More pronounced during expiration Cause: Airways narrowed by bronchospasm or secretions Description: Coarse rattling, usually louder and lower-pitched than crackles; described as sonorous, musical, or sibilant  Wheezes Where to auscultate: Over lung fields and airways Timing: Inspiration or expiration Cause: Narrowed airways Description: Creaking, Whistling; high-pitched, musical squeaks Pleural Friction Rub Where to auscultate: Front and side of the lung field Timing: Inspiration Cause: Inflamed parietal and visceral pleural surfaces rubbing together. Description: Grating or squeaking |
| Listening sequence (front): Place stethoscope diaphragm above each clavicle to hear lung apexes. Alternating from side to side of sternum, listen down the chest until you reach lung bases (8th to 10th rib) | Listening sequence (back): Place stethoscope diaphragm above scapulae (toward the neck) to hear lung apexes. Alternating from side to side of spine, listen down the back until you reach lung bases (10th to 12th spinous process). |
| ***TIPS*** | |
| * Press diaphragm firmly against patient's skin. Ask patient to inhale and exhale slowly through his mouth. * Proceed systematically, always comparing one side of patient's chest or back with the other. | |
| **Document your findings.** | |

**MENTAL STATUS EXAM**

The mental status exam, is an assessment tool that helps identify psychological symptoms that may assist the practitioner determine if there is a psychogenic problem. When assessing mental status, it is important to adjust questions and categories to avoid age and/or cultural bias.

|  |  |
| --- | --- |
| **Category** | **Description** |
| Appearance | General appearance, grooming and gait. This is best observed as the client comes into the room. Grooming is one of the earliest areas to deteriorate when mental function has diminished. |
| Behavior | Speech, eye contact, body language, response to the environment. Observe for appropriate use of personal space. Does the person come right into your face, or stand an unusual distance away. |
| Insight | The ability of the client to be aware of one’s own abilities. The ability to analyze a problem objectively. Ask the client to explain a problem. |
| Intellectual Functioning | Simple calculations, ability to abstract or think symbolically and categories of association. This is done through direct questioning using math, proverbs or analogy. |
| Judgment | Assesses decision-making abilities. Ask client What he would do in a dilemma regarding an important decision. |
| Memory | Immediate recall, recent memory, remote memory. Ask the client about a recent current event that both you and the client should know. Ask about some event in the past that should be known by both. Be very careful in this area to avoid cultural bias. |
| Mood and Affect | Mood relates to the emotions of the moment while affects refers to the range of emotions displayed such as happy, sad, or unchanging. Compare in relation the client’s probable everyday behavior. |
| Orientation | Assess for awareness of person, time, place, and purpose. |
| Perceptual Processes | Awareness of self and one’s thoughts, reality and fantasy. Ask about delusions, illusions and hallucinations. Do not hesitate do ask direct questions. |
| Sensorium | Ability to concentrate, perception of stimuli. |
| Thought Contents | This assesses themes in conversation and is assessed by observing what the client discusses spontaneously in conversation. |
| Thought Processes | This measures a stream of conscious or mental activity as indicated in speech. Observe for rate, flow, and ability to pursue a topic logically. |

**SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)**

**Purpose:** Assessment of organic brain deficit in the elderly clients.

**Remember:** This is a general mental status questionnaire and has questions that can tend to have an educational, cultural, and age bias.

Ask questions 1-10 in this list and record all answers.

1. What is the date today?
2. What day of the week is it?
3. What is the name of this place?
4. What is your telephone number? (if they have a phone)
5. What is your street address?
6. How old are you?
7. When were you born?
8. Who is the President of the U.S. now?
9. What was your mother’s maiden name?
10. Subtract 3 from 20 and keep subtracting 3 from each new number, all the way down.

Total number of errors = \_\_\_\_\_\_\_\_\_  
  
Scoring:

* 0 - 2 Errors   intact Intellectual Functioning
* 3 - 4 Errors   Mild Intellectual Impairment
* 5 - 7 Errors   Moderate Intellectual Impairment
* 8 - 10 Errors   Severe Intellectual Impairment

Allow one more error if subject has had only a grade school education.  
  
Allow one less error if subject has had education beyond high school.

**Head To Toe Assessment Checklist**

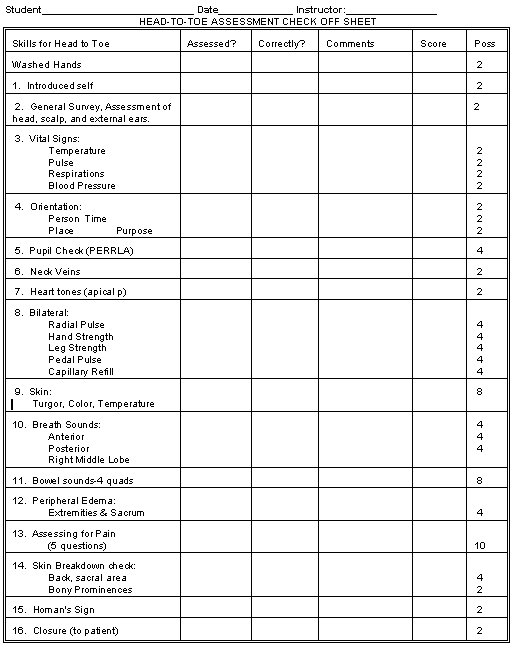
|  |  |
| --- | --- |
| **Wash Hands** ( ) Completed - Standard Precautions **Introduction** ( ) Completed - Introduce self & purpose of assessment to relieve anxiety and role function identification. **Vital Signs** Pulse\_\_\_\_\_\_\_\_\_\_ Rate, Strength, Regularity Temperature\_\_\_\_\_\_\_\_ Oral, Rectal, Tympanic B / P\_\_\_\_\_\_\_\_\_ Respiration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Orientation** ( Oriented x 4 )  What year is this ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tell me your name ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tell me where you are ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tell me why you are here?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pupil Check**  ( PERRLA ) Pupils, Equal, Round, React to light, Accommodate Sluggish ( ) No Change ( ) Brisk ( ) Normal ( ) Accommodation Yes ( ) No ( ) **Neck Veins** Patient at 45o angle ( ) Neck Veins Flat ( ) Distended ( ) **Heart Tones** Apical Pulse with Stethoscope Rate ?\_\_\_\_\_\_\_\_\_\_\_\_\_ Rhythm ?\_\_\_\_\_\_\_\_\_\_\_ Clarity of Sounds ? \_\_\_\_\_\_\_\_\_ Abnormal ? ( ) Explain ! \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Bilateral Checks** ( Radial Pulses ) - Rate, Strength, Regularity Right\_\_\_\_\_\_\_\_\_\_\_\_\_ Left\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( Hand Strength ) - 2 fingers only Right Stronger ( ) Left Stronger ( ) Equal ( ) ( Pedal Pulses ) - Top of Foot Right Foot \_\_\_\_\_\_\_\_\_\_ Left Foot \_\_\_\_\_\_\_\_\_\_\_\_ ( Capillary Refill ) -On fingers or toes 3 seconds or less Right Fingers ( ) sec. Left Fingers ( ) sec.  Right Toes ( ) sec. Left Toes ( ) sec. Delay or abnormal refill return ? Yes ( ) ie., \_\_\_\_ **Skin** Skin Turgor - 1 to 3 second return, on Sternum Return was ( ) sec. Abnormal ( ) sec. Skin Color - Check on inside of Lip or Conjunctiva Lip ( ) Conjunctiva ( ) Pink ( ) Pale ( ) Jaundice ( ) Cyanotic ( ) Skin Temperature - Use back of hand to check Hot ( ) Warm ( ) Cool ( ) | **Breath Sounds** Assess anterior and posterior and from side to side, also right lobe. Have patient take deep breaths, do not move stethoscope to rapidly to avoid hyperventilating on patients part. Clear Bilaterally ( ) Left only ( ) Right only ( ) Both poor bilaterally ( ) ie.,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Good air flow ( ) Poor air flow ( ) **Bowel Sounds** Assess all 4 quadrants, do not touch stomach before auscultation, as it may disrupt normal sounds. If irregular, 5 minute assessment on each quadrant. Umbilicus is mid point. ( Stomach ) - Check for condition Soft ( ) Hard ( ) Distended ( ) Other  RUQ Active ( ) Absent ( ) Hyperactive ( ) Hypoactive ( ) RLQ Active ( ) Absent ( ) Hyperactive ( ) Hypoactive ( ) LUQ Active ( ) Absent ( ) Hyperactive ( ) Hypoactive ( ) LLQ Active ( ) Absent ( ) Hyperactive ( ) Hypoactive ( ) **Peripheral Edema** Edema is found in dependent areas such as the feet, hands, sacrum. Check with finger by pressing down. Observe for pitting or indentation. Feet Yes ( ) No ( ) Pitting ( ) R ( ) L ( ) Hands Yes ( ) No ( ) Pitting ( ) R ( ) L ( ) Sacrum Yes ( ) No ( ) Pitting ( ) Indent ( ) **Assessing For Pain** Where is the pain ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long has it lasted ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the pain travel anywhere ?\_\_\_\_\_\_\_\_\_\_\_\_\_ What makes it feel better ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What makes pain worse ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Descrip. of pain ? Sharp ( ) Stabbing ( ) Dull ( )  On a scale of 1 - 10, 10 being the worst \_\_\_\_\_\_\_ **Skin Breakdown Check** Check entire body for redness or skin breakdown. Check all prominences. Normal ( ) Abnormal ( ) Explain condition and area effected\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Homan's Sign** Ask patient to dorsiflex both feet. Pain in right calf Yes ( ) No ( ) Pain in both calfs Yes ( ) No ( ) **Closure** Let the patient know you are finished and when you will be back.  Bedrails up ( )Bed in low position ( )Call light in reach ( ) |

**SAMPLE CHARTING ENTRY**

Date:\_\_\_\_\_\_\_   
Time:\_\_\_\_\_\_\_

Temp 98.4 T, Radial pulse 72, strong and regular. Respirations deep and regular at 14 per min., BP 124/66. Oriented x4. PERRLA, neck veins flat at 45 degree angle. Apical pulse S1,S2 clear without rubs or murmurs. Radial and pedal pulses strong and regular bilaterally at 70 per min. Hand and leg strength strong bilat. Capillary refill hands and toes returns 1 sec. bilat. Skin turgor returns 1 sec. Skin warm, color pink. Lung sounds clear bilaterally to auscultation with good air flow. Right middle lobe clear. Bowel sounds present and active 4 quadrants. No peripheral edema extremities or sacrum. No c/o pain. Skin intact without breakdown. No pain on dorsiflexion.

Signature and Title



This concludes the module on head to toe assessment. Assessing the patient is essential at the beginning or your care, to develop a baseline, and at regular intervals as needed. As many nurses work a 12-hour shift, one assessment is not enough. With practice, one should be able to do a rapid assessment on the patient that incorporates most aspects that are needed. The assessment will probably take more than 5 minutes, especially if the patient has critical parameters to be assessed.

Post Test NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| 1. Liver margins are usually assessed via: |
| |  | | --- | | Inspection | | Auscultation | | Deep palpation | |
| 2. When listening to breath sounds, the order of sequence is: |
| |  | | --- | | Superior to inferior, bilateral comparison | | Inferior to superior, all of left side, then the right | | Axillary, anterior, posterior | |
| 3. Lab values are part of the patient's assessment data: |
| |  | | --- | | True | | False | |
| 4. Peripheral edema is routinely assessed in all of the following locations except: |
| |  | | --- | | Feet | | Sternum | | Sacrum | | Hands | |
| 5. Which of the following heart sounds is considered abnormal? |
| |  | | --- | | S1 split | | S2 split | | S2 | | S3 | |
| 6. Capillary refill is assessed to check for: |
| |  | | --- | | Hydration | | Circulation | | Neurological status | |
| 7. Pulse pressure is defined as: |
| |  | | --- | | The description of a pulse as weak or bounding | | The difference between the systolic and diastolic blood pressure | | The difference between the apical and radial pulse | |
| 8. The most accurate method for taking the temperature is via which route: |
| |  | | --- | | Tympanic | | Axillary | | Oral | | Rectal | |
| 9. The 5th vital sign is: |
| |  | | --- | | Temperature | | Respirations | | Pain assessment | | Mental status function | |
| 10. The lowest score a patient can have on the Glasgow Coma Scale is: |
| |  | | --- | | 1 | | 2 | | 3 | | 4 | |
| 11. The skin turgor check is done to determine hydration status. Where should the examiner perform this assessment? |
| |  | | --- | | On the patient's sternum | | On the patient's hand | | On the patient's sacrum | | On the patient's foot | |
| 12. Neck vein distention may be a sign of fluid overload. To check the neck veins, the patient is best positioned in the following way: |
| |  | | --- | | Supine | | Sitting at a 90 degree angle | | Prone | | Sitting at a 45 degree angle | |
| 13. The best way to differentiate a pericardial friction rub from a pleural friction rub is: |
| |  | | --- | | Use the bell of the stethoscope | | Use the diaphragm of the stethoscope | | Listen very carefully to when the patient breathes | | Have the patient hold his breath | |
| 14. Which breath sound is most likely to clear with coughing? |
| |  | | --- | | Wheezes | | Rubs | | Ronchi (gurgles) | | Crackles (rales) | |
| 15. Which observation of a client may indicate deteriorating mental function? |
| |  | | --- | | Unable to count backwards by 7's. | | Grooming has deminished. | | Does not know the current date. | |
| 16. The client who is developmentally disabled may need additional assessment for: |
| |  | | --- | | Spasticity | | Feeding problems | | Verbal limitations | | All of the above | |
| 17. When you palpate a pulse that is irregular, a standard procedure is to: |
| |  | | --- | | Take the pulse for a full minute | | Take the heart rate from the cardiac monitor reading | | Notify the physician | |
| 18. The mental status exam has an inherent risk for cultural bias: |
| |  | | --- | | True | | False | |
| 19. Signs and symptoms of shock include all except which of the following? |
| |  | | --- | | Cool, clammy skin | | Hypotension | | Bradycardia | |
| 20. Breath sounds are best assessed using which part of the stethoscope: |
| |  | | --- | | Bell | | Diaphram | |
| 21. When checking a patient's hand grips, an important concept is: |
| |  | | --- | | Grasp the right hand, then the left | | Grasp the patient's hand with your dominant hand | | Have patient squeeze two fingers of the examiners simultaneousl | |
| 22. To document that a patient is fully oriented, the best statement to use is: |
| |  | | --- | | Patient alert and oriented | | Responds to verbal prompts | | Oriented X 4 | |
| 23. Which charting entry is considered normal? |
| |  | | --- | | S1, S2 clear | | S4 heard at the apex | | Grade III/VI systolic murmur at the base | | Mediastinal crunch | |
| 24. A stage 3 decubitus is described as: |
| |  | | --- | | Redness on the skin | | A break in the skin | | Involvement to the muscle | | Involvement to the bone | |
| 25. The best rationale for doing an assessment in Head to Toe sequence is: |
| |  | | --- | | Always start with the head, first | | It provides a systematic format to avoid errors | | The format follows the charting form | |
| 26. To check for Accommodation, instruct the patient to: |
| |  | | --- | | Follow a closer moving object such as the examiner's finger to the nose. Observe for pupil constriction | | Follow a closer moving object. Observe for laterality | | Ask the patient to dangle, than slowly stand | | Have the patient identify if the room is light or dark | |
| 27. Whistling, high-pitched sounds on auscultation are called: |
| |  | | --- | | Wheezes | | Rubs | | Ronchi (gurgles) | | Crackles (rales) | |
| 28. When assessing bowel sounds, which concept is most important? |
| |  | | --- | | Assess all 9 sections | | Auscultate before palpating | | Percuss from top to bottom | | Document absent bowel sounds if there are no sounds for 2 minutes | |
| 29. Eye contact, speech and body language is assessed by observing the patient's: |
| |  | | --- | | Sensorium | | Behavior | | Insight | | Judgment | |
| 30. Normal range for respirations is: |
| |  | | --- | | 16 - 20 | | 12 - 20 | | 8 - 16 | | 18 - 24 | |