COMPLETE INPATIENT REASSESSMENT

Date _____

Examiner _____

Patient _____ **Age** _____ **Gender** _____

Occupation _____ **Reason for admission** _____

Introduction

1. Check for flags or markers at doorway
2. Introduce yourself
3. Perform hand hygiene
4. Make eye contact
5. Offer water
6. Check name band
7. Ask appropriate interview questions, including current pain
8. Elevate the bed to appropriate height

General Appearance

1. Facial expression _____
2. Body position _____
3. Level of consciousness _____
4. Skin color _____
5. Nutritional status _____
6. Speech: articulation, pattern, content appropriate _____
7. Hearing _____
8. Personal hygiene _____

Measurement

1. Temperature _____
2. Pulse _____
3. Respiration _____
4. Blood pressure _____
5. Pulse oximetry _____
6. Weight on admission or if daily weight is indicated _____
7. Rate pain level on 1-to-10 scale; note ability to tolerate pain _____
8. Pain reassessment, if appropriate to scenario _____

Neurologic System

1. Eyes open:
   a. Spontaneously _____
   b. Name _____
2. Motor response _____
3. Verbal response _____
4. Pupil size in mm and reaction
   a. R _____ b. L _____
5. Upper muscle strength
   a. R _____ b. L _____

6. Lower muscle strength
   a. R _____ b. L _____
7. Any ptosis, facial droop _____
8. Sensation _____
9. Communication _____
10. Ability to swallow _____

Respiratory

1. Oxygen by mask, nasal prongs; check fitting _____
2. FIo_2 _____
3. Respiratory effort _____
4. Auscultate breath sounds:
   Anterior lobes:
   Right upper _____
   Left upper _____
   Right middle _____
   Right lower _____
   Left lower _____
   Posterior lobes:
   Left upper _____
   Right upper _____
   Left lower _____
   Right lower _____
   Cough and deep breathe; any mucus? Check color and amount _____
   Educate on use of incentive spirometry if ordered

Cardiovascular System

1. Auscultate rhythm at apex: regular, irregular? _____
2. Check apical versus radial pulse
3. Assess heart sounds in all auscultatory areas: first with diaphragm, repeat with bell
4. Check capillary refill _____
5. Check pretibial edema
   a. R _____ b. L _____
6. Palpate posterior tibial pulse
   a. R _____ b. L _____
7. Palpate dorsalis pedis pulse
   a. R _____ b. L _____
8. Pulses by Doppler, if assigned _____
9. IV fluid and rate, if present _____

Skin (may be integrated with rest of assessment)

1. Color _____
2. Temperature _____
3. Pinch up a fold of skin under the clavicle or on the forearm _____
4. Note any lesions; check any dressings _____
5. Note skin around IV site _____
6. Standardized scale regarding skin breakdown _____
7. Settings and application of specialized surface, if present _____

Abdomen

1. Contour of abdomen: flat, rounded, protuberant _____
2. Bowel sounds in all four quadrants _____
3. Check any tube drainage and site _____
4. Inquire if passing flatus or stool _____
5. Can patient tolerate current diet? Should diet be advanced or changed? _____

Genitourinary

1. Inquire if voiding regularly _____
2. Urine for color, clarity, quantity _____
3. Bladder scan, if indicated _____

Activity

1. If on bedrest, check head of bed, risk for skin breakdown _____
2. Any SCDs, TED hose, foot pumps? Must be hooked up/on _____
3. Transfer to chair _____
4. Note any assistance needed, how movement is tolerated, distance walked to chair, ability to turn _____
5. Need for any ambulatory aid or equipment _____
6. Standardized scale regarding falling _____

Closure

1. Return bed to lowest height
2. Verify that brakes are locked
3. Make sure appropriate rails are up
4. Ensure call bell is available
5. Verify bed alarm, if indicated
6. Thank the patient for his/her attention and cooperation
7. Initiate or continue appropriate Plan of Care
8. Complete assessment and document into computer