Ace Nursing – Complete Head-to-Toe Assessment

❖ General Guidelines

- Before you read this make sure you check out How to Obtain a Health History, Physical Assessment Techniques, and Everything You'll Ever Need to Know about Vital Signs.
- Carefully note any abnormalities and be prepared to document them or report them to the physician as needed
  - Work in a systematic order. It might not be exactly head-to-toe, but cover each body system working in a head-to-toe direction.

❖ Preparation

- Wash your hands on entering the room
- Introduce yourself to the patient
- Explain what a head-to-toe assessment is and why you are completing it
  - It is an assessment of each of the body systems to get an understanding of the patient's current general health status

❖ General Survey

- As you introduce yourself to the patient and obtain a health history note the following:
  - Asleep, awake, easily aroused?
  - Eye contact (signs of abuse or cultural differences)
  - Appearance (dressed appropriately for weather?)
  - Hygiene
  - Respiratory effort
  - Skin color (flushed, pale, etc.)
  - Speech (education level; impairments?)
  - Pain
  - Signs of distress
  - Alert and oriented (A&O) - to person, place, and time
- Start with this to get a broad idea of their mental status

❖ Vital Signs

- Body temperature
  - 98.6°F
- Pulse (chart)
  - Rate (60-100bpm)
  - Rhythm (steady)
  - Intensity
  - Compare pulses bilaterally and compare

PULSES: Peripheral pulses should be compared for rate, rhythm, and quality.	
0	Absent
+1	Weak and thready
+2	Normal
+3	Full
+4	Bounding

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- Respirations
  - Number of breaths taken per minute (12-20)
    - Count number of breaths taken in 30 seconds and multiply by 2
    - One inhalation and one exhalation = one breath
    - Do not tell patient you are measuring their breathing rate – it affects the results
- Blood pressure
  - 90-120mmHg/60-80mmHg
- Oxygen Saturation
  - 95%-100%

❖ Nutrition Status

- Height (cm)
- Weight (kg)
- Lifestyle (active/moderate/sedentary)
- Diet
- Risk factors for altered nutrition status

❖ Neurological

- Stimulus response
- Chart level of arousal by:
    - **1. Stimuli needed to elicit response** (auditory, physical, painful)
    - **2. Type of response elicited** (no response, wincing, eye-opening, etc.)
- Glasgow Coma Scale
  - Best response: 15
  - **<u>Comatose client</u>: 8 or below**
    - Indicates severe head injury
  - Totally unresponsive: 3

Glasgow Coma Scale

BEHAVIOR	RESPONSE	SCORE
Eye opening response	Spontaneously	4
	To speech	3
	To pain	2
	No response	1
Best verbal response	Oriented to time, place, and person	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	No response	1
Best motor response	Obeys commands	6
	Moves to localized pain	5
	Flexion withdrawal from pain	4
	Abnormal flexion (decorticate)	3
	Abnormal extension (decerebrate)	2
	No response	1
Total score:	*Best response*	15
	Comatose client	8 or less
	Totally unresponsive	3

- Pupils – PERRLA
  - <u>P</u> – Pupils
  - <u>E</u> – Equal (size)
  - <u>R</u> – Round (shape)
  - <u>R</u> – Reactive to
  - <u>L</u> – Light and
  - <u>A</u> – Accommodation

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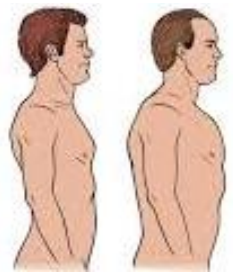
- Deep tendon reflexes
  - **0+** = reflex absent
  - **1+** = sluggish/diminished
  - **2+** = normal
  - **3+** = slightly hyperactive
  - **4+** = hyperactive with clonus
- Motor function
  - Squeeze with both hands at same time
  - Push with both feet at same time
  - Note any one-sided weakness or drooping
- Sensory function
  - Touch
  - Pain
  - Temperature
  - Pressure
  - Vibration
  - Vision
  - Hearing
  - Smell
  - Taste
- Mental status exam
  - Appearance
  - Behavior
  - Insight
  - Intellectual functioning
  - Judgement
  - Memory
  - Mood and affect
  - Orientation
  - Perceptual processes
  - Sensorium
  - Thought content
  - Thought processes
- Short Portable Mental Status Questionnaire (SPMSQ)
  - Series of 10 common knowledge question related to orientation
  - **0-2 errors** = intact intellectual functioning
  - **3-4 errors** = mild intellectual impairment
  - **5-7 errors** = moderate intellectual impairment
  - **8-10 errors** = severe intellectual impairment

❖ Respiratory

- Anteroposterior : transverse diameter = 1:2
  - 1:1 = barrel chest (COPD)



1:2 1:1 (barrel chest)

- Breathing difficulty
- Both sides rise evenly
- Sputum
  - Color
  - Consistency

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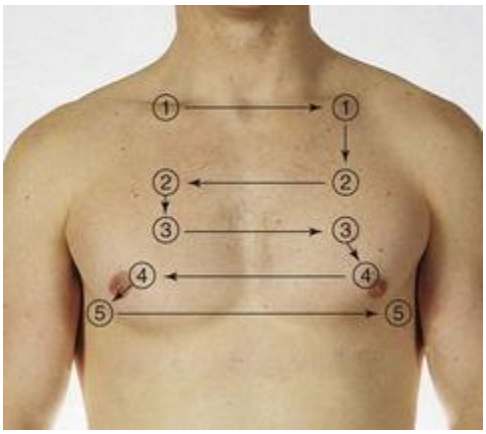
- Cough
  - Productive
  - Nonproductive
- Is patient receiving supplemental oxygen?
- Breathing patterns
  - **Abdominal respirations** – breathing accomplished by abdominal muscles and diaphragm
  - **Apnea** – temporary cessation of breathing
  - **Cheyne-Stokes** – breathing becomes deeper and faster, then decreases to apnea, then repeats
  - **Dyspnea** – difficult or painful breathing
  - **Hyperpnea** – extremely deep breathing
  - **Hyperventilation** – extremely rapid, deep breathing
  - **Hypoventilation** – extremely slow breathing
  - **Kussmaul's** – marked increase in depth and rate (appears hungry for air)
  - **Orthopnea** – body must be upright to breathe
  - **Paradoxical** – one lung deflates during inspiration
  - **Periodic** – pauses in breathing for 10 seconds followed by rapid shallow breaths
- Breathing Sounds
  - **Crackles** – brief rattling sound caused by explosive opening of small airways, usually due to inflammation.
  - **Rales** – small clicking, bubbling, or rattling sounds in lungs heard on inhalation. May be described as moist, dry, fine, or coarse
  - **Rhonchi** – low-pitched, snoring, gurgling sound
  - **Stridor** – extremely high-pitched "wheeze" usually due to blockage of air flow in trachea
  - **Wheeze** – high-pitched sound produced by a narrowed or obstructed airway best heard on exhalation (asthma)



Order of auscultation

❖ Cardiac

- 5 P's of circulation
  1. **Pain** – is it present?
  2. **Pallor** – is extremity losing color?
  3. **Paralysis** – is extremity losing mobility?
  4. **Paresthesia** – is there a tingling sensation?
  5. **Pulse** – is it palpable?

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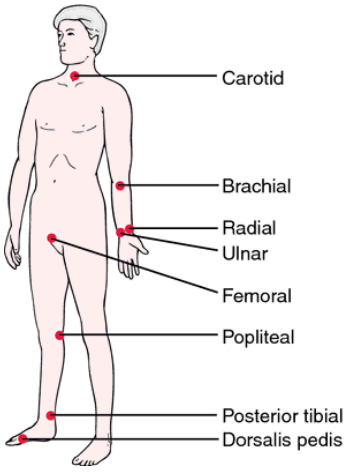

Common areas to palpate a pulse

- Capillary refill (<3 seconds)
- Jugular veins
- Telemetry (heart rhythm)
- Edema (especially in legs) (chart)

EDEMA: Assess by placing thumb over dorsum of the foot or tibia for 5 seconds	
0	No edema
1+	Barely discernible depression
2+	A deeper depression (< 5 mm) w/ normal foot & leg contours
3+	Deep depression (5-10 mm) w/ foot & leg swelling
4+	Deeper depression (> 1 cm) w/ severe foot and leg swelling

- Normal heart sounds
  - **S1 ("lub")**
    - Closure of tricuspid and mitral valves. Dull and low-pitched.
  - **S2 ("dub")**
    - Closure of aortic and pulmonic valves
- Abnormal heart sounds
  - **S1 split**
    - S1 sounds like it is split in half
  - **S2 split**
    - S2 sounds like it is split in half
  - **S3 (ventricular gallop)**
    - Normal in healthy children
    - Abnormal in adults
    - Sounds like "*Kentucky*"

S1	S2	S3
"Ken"	"tuck"	"ee"
"Lub"	"dub"	"dub"

  - **S4 (atrial gallop)**
    - Sounds like "*Tennessee*"

S1	S2	S3
"Ten"	"ne"	"see"
"Dub"	"lub"	"dub"

  - **Pericardial friction rub**
    - Coarse, grating sound over heart
    - Have patient hold his breath. If sound continues, it is of cardiac origin (not pleural)
  - **Mediastinal crunch**
    - Sounds like popcorn crunching
    - Indicates air in mediastinum
- Heat Murmurs (include chart)
  - Caused by increased flow through normal structures
  - **Systolic murmur** – occur between S1 and S2
  - **Diastolic murmur** – occur between S2 and S1

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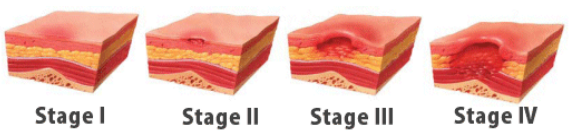
- Grades of murmurs:

Grade I	Faint; heard with concentration
Grade II	Faint murmur heard immediately
Grade III	Moderately loud, not associated with thrill
Grade IV	Loud and may be associated with a thrill
Grade V	Very loud; associated with a thrill
Grade VI	Very loud; heard w/stethoscope off chest, associate w/a thrill

- Order to auscultate
  - Mnemonic to remember each one: **A**ll **P**eople **E**njoy **T**he **M**all – 2, 2, 3, 4, 5 (intercostal spaces)
  - **A** - Aortic – 2nd right intercostal space
  - **P** - Pulmonic – 2nd left intercostal space
  - **E** - Erb's Point – 3rd left intercostal space
  - **T** - Tricuspid – 4th left intercostal space
  - **M** - Mitral – 5th left intercostal space

❖ Integumentary

- Color
  - Pink (normal)
    - In patients with dark skin, it is easier to assess the mucous membrane or conjunctiva
  - Pale
  - Flushed
  - Red
  - Brown
  - Yellow (jaundice)
  - Mottled
- Texture
  - Dry
  - Moist
  - Diaphoretic
- Injuries (find out cause)
  - Scars
  - Bruises
  - Lesions
  - Rash
- Temperature
  - Warm
  - Hot
  - Cool
- Turgor
  - Pinch skin – tented **less than 3 seconds** is normal
- Decubitus ulcers (bony prominences)
  - **Stage 1** = redness
  - **Stage 2** = break in skin
  - **Stage 3** = visible muscle
  - **Stage 4** = visible bone
  - **Unstageable** = full thickness tissue loss



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❖ Hair

- Even distribution?
- Alopecia – hair loss/thinning
- Hirsutism – abnormal excess

❖ Head

- Size
- Shape
- Symmetry
- Cranial nerve function

❖ Eyes

- Symmetrical
- Color of sclera and conjunctiva
- Peripheral vision
- Acuity
  - Snellen chart (20/20 is normal)

❖ Ears

- Pull **pinna up and back** to examine patient's **3 years of age and greater**
- Pull **pinna down and back** to examine patient's **under 3 years of age**

❖ Nose/Sinuses

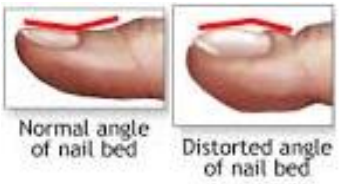
- Alignment (septum)
- Discharge
  - Color
  - Consistency

❖ Mouth

- Mucosa
- Teeth
  - Chips, cavities, missing, dentures
- Tongue
  - Color, hygiene
- Tonsils
- Ability to swallow

❖ Nails

- Color
- Shape
  - **Normal** = angle of nail bed is less than 160 degrees
  - **Clubbing** = angle of nail bed is greater than 180 degrees
    - Due to prolonged decreased oxygenation



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❖ Breasts

- Size
- Shape
- Symmetry
- Masses or lumps
- Gynecomastia – enlarged breasts in males

❖ Abdomen

- Order of abdominal assessment is different than other areas of body
  - **1. Inspect**
  - **2. Auscultate**
  - **3. Percuss**
  - **4. Palpate**
- Symmetry
- Contour
  - Flat
  - Rounded
  - Protuberant
  - Scaphoid
- Palpate for rebound tenderness

❖ Gastrointestinal

- Inspect
  - Flat
  - Rotund
  - Distended
- Auscultate
  - All 4 quadrants
    - Right upper quadrant
    - Left upper quadrant
    - Right lower quadrant
    - Left lower quadrant
  - Bowel sounds
    - **Hypoactive** = <3 sounds per minute
    - **Normoactive**
    - **Hyperactive** = loud and frequent
    - **Absent** = no bowel sounds for at least 5 minutes of ausculating
- Palpate
  - Pain
  - Rebound tenderness
  - Masses
- Percuss
  - Air filled or fluid filled?
- Nausea/vomiting?
- Tubes present
  - Tube feedings
- Stoma present
  - Stoma status
    - Pink (normal)
    - Red
    - Dusky
    - Dark
    - Retracted
    - Infected
- Stool
  - Time of last bowel movement
  - Color
  - Character
  - Consistency

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❖ Musculoskeletal

- Alignment of neck and spine
- Range of motion of neck and spine
- Joint movement
- Muscle strength
- Wheelchair/walker/cane?

❖ Genitourinary

- Urination
  - Amount (<30mL/hr is normal)
  - Color
    - Yellow
    - Amber
    - Orange
    - Pink
    - Red tinged
    - Bloody
  - Characteristics
    - Cloudy
    - Sediment
    - Abnormal odor
  - Burning
  - Frequency
  - Urgency
  - Bladder distention
  - Flank pain
- Continent/incontinent
- Stents?
- Catheter?

❖ IV Assessment

- Type of line
  - Peripheral
  - PICC
  - Central
- Insertion site
  - Location
  - Redness
  - Pain
  - Warmth
  - Swelling
  - Drainage
  - Gauge
- Fluids
  - Rate
  - Lock
    - Saline
    - Heparin

❖Pain

- Scale of 0-10
- Wong-Baker (faces) scale for children

Symptom Analysis: This assists the client in describing the problem.	
P	Provocate/Palliative: What caused it? What makes it better/worse?
Q	Quality/Quantity: How does it feel, sound, look, how much?
R	Region/Radiation: Where is it and does it spread?
S	Severity Scale: Rate on appropriate pain scale. Does it interfere with ADLs?
T	Timing: When did it start? Sudden/gradual? How often? How long does it last?