9.5: Checklist for Cardiovascular Assessment

Use the checklist below to review the steps for completion of a “Cardiovascular Assessment.” [1]

Steps

Disclaimer: Always review and follow agency policy regarding this specific skill.

1. Gather supplies: stethoscope and watch with a second hand.
2. Perform safety steps:
   ◦ Perform hand hygiene.
   ◦ Check the room for transmission-based precautions.
   ◦ Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.
   ◦ Confirm patient ID using two patient identifiers (e.g., name and date of birth).
   ◦ Explain the process to the patient and ask if they have any questions.
   ◦ Be organized and systematic.
   ◦ Use appropriate listening and questioning skills.
   ◦ Listen and attend to patient cues.
   ◦ Ensure the patient's privacy and dignity.
   ◦ Assess ABCs.
3. Conduct a focused interview related to cardiovascular and peripheral vascular disease.
   ◦ Ask relevant focused questions based on patient status. See Tables 9.3.1 and 9.3.2 for example questions.
4. Inspect:
- Face, lips, and extremities for pallor or cyanosis
- Neck for jugular vein distension (JVD) in upright position or with head of bed at 30-45 degree angle
- Chest for deformities and wounds/scars on chest
- Bilateral arms/hands, noting color, warmth, movement, sensation (CWMS), edema, and color of nail beds
- Bilateral legs, noting CWMS, edema to lower legs and feet, presence of superficial distended veins, and color of nail beds

5. Auscultate with both the bell and the diaphragm of the stethoscope over five auscultation areas of the heart. Auscultate the apical pulse at the fifth intercostal space, midclavicular line for one minute. Note the rate and rhythm. Identify the S1 and S2 sounds and follow up on any unexpected findings (e.g., extra sounds or irregular rhythm).

6. Palpate the radial, brachial, dorsalis pedis, and posterior tibialis pulses bilaterally. Palpate the carotid pulse one side at a time. Note presence/amplitude of pulse and any unexpected findings requiring follow-up.

7. Palpate the nail beds for capillary refill. Document the capillary refill time as less than or greater than 2 seconds.

8. Assist the patient to a comfortable position, ask if they have any questions, and thank them for their time.

9. Ensure safety measures when leaving the room:
   - CALL LIGHT: Within reach
   - BED: Low and locked (in lowest position and brakes on)
   - SIDE RAILS: Secured
   - TABLE: Within reach
   - ROOM: Risk-free for falls (scan room and clear any obstacles)


11. Document the assessment findings. Report any concerns according to agency policy.

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1. This work is a derivative of [Clinical Procedures for Safer Patient Care](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Skills_(OpenRN)/09%3A_Cardiovascular_Assessment/9.05%3A_Ch…) by British Columbia Institute of Technology licensed under [CC BY 4.0](https://creativecommons.org/licenses/by/4.0/).