12.5: Checklist for Abdominal Assessment

Use this checklist below to review the steps for completion of an "Abdominal Assessment."[1]

Steps

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

1. Gather stethoscope.
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 gastrointestinal and genitourinary concerns. Ask relevant, focused questions based on patient status. See Tables 12.3.1 and 12.3.2 for sample focused questions.
4. Position the patient in the supine position and drape the patient, exposing only the areas needed for assessment.
5. Inspect the abdomen for shape/contour, symmetry, pigmentation/color, lesions/scars, pulsation, and visible...
6. Auscultate using the diaphragm of the stethoscope to assess for bowel sounds.

7. Lightly palpate the four quadrants of the abdomen to assess for pain or masses. Palpate the suprapubic area for bladder distention. If the patient reports abdominal pain, palpate that area last.

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)
   - SIDERAILS: Secured
   - TABLE: Within reach
   - ROOM: Risk-free for falls (scan room and clear any obstacles)


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

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