C: Head-to-Toe Assessment Checklist

This checklist is intended as a guide for a routine, general, daily assessment performed by an entry-level nurse during inpatient care. Students should use a systematic approach and include these components in their assessment and documentation. Assessment techniques should be modified according to life span considerations. Focused assessments should be performed for abnormal findings and according to specialty unit guidelines. Unanticipated findings should be reported per agency protocol with emergency assistance obtained as indicated.

1. Gather supplies: stethoscope, penlight, watch with second hand, gloves, hand sanitizer, and wound measurement tool.
2. Perform hand hygiene before providing care and clean stethoscope. Check the room for transmission-based precautions.
3. Greet the patient, introduce oneself, explain the task, and provide privacy.
   1. Knock before entering the room.
   2. Greet the patient and others in the room. Ask the patient’s preferred way of being addressed. Ask if the patient is comfortable if others are present in the room during the assessment.
   3. Introduce your name and role.
   4. Explain the planned task and estimate the duration of time to complete it.
   5. Provide for privacy.
   6. During the assessment, listen and attend to patient cues. Use appropriate listening and questioning skills.
4. Identify the patient with two appropriate identifiers.
5. Perform a primary survey to ensure medical stability. Obtain emergency assistance if needed.
   1. **Airway:** Is the airway open? Is suctioning needed?
   2. **Breathing:** Is the patient breathing normally?
   3. **Circulation:** Are there any abnormal findings in the overall color and moisture of the patient’s skin (cyanosis,
diaphoresis)

4. **Mental Status:** Is the patient responsive and alert?

6. Perform a general survey while completing the head-to-toe assessment. Include general appearance, behavior, mood, mobility (i.e., balance and coordination), communication, overall nutritional status, and overall fluid status.

7. Address patient needs before starting assessment (toileting, glasses, hearing aids, etc.).

8. Evaluate chief concern using PQRSTU (i.e., ask the patient their reason for seeking/receiving care). Ask, “Do you have any concerns or questions you’d like to talk about before we begin?”

9. Obtain and/or analyze vital signs. (Initiate emergency assistance as needed.)

10. Evaluate for the presence of pain or other type of discomfort. If pain or discomfort is present, perform comprehensive pain assessment using PQRSTU.

11. Perform a neuromuscular assessment:

   1. Perform a subjective assessment. Ask if headache, dizziness, weakness, numbness, tingling, or tremors are present. Inquire if the patient has experienced loss of balance, decreased coordination, previous falls, or difficulty swallowing. Be aware of previously diagnosed neuromuscular conditions and currently prescribed medications and how these impact your assessment findings.

   2. Assess level of consciousness and orientation to person, place, and time.

   3. Assess PERRLA using penlight.

   4. Assess motor strength and sensation:

      1. Bilateral hand grasps

      2. Upper strength and resistance

      3. Lower strength and resistance

      4. Sensation in extremities

   5. Note unanticipated neurological findings in symmetrical facial expressions, extremity movement, and speech and obtain emergency assistance as needed.

   6. Assess fall assessment risk per agency policy.

   7. Perform a focused assessment if neurological or musculoskeletal condition is present.

12. Perform a basic head, neck, eye, and ear assessment:

   1. Perform a subjective assessment. Be aware of previously diagnosed head, neck, eye, or ear conditions and associated medications and how these impact your assessment findings.

      1. Ask if they are having any problems with their teeth or gums, and if so, has this impacted their ability to eat.

      2. Ask if they use glasses, hearing aids or dentures.

      3. Ask if they have any difficulty seeing or blurred vision.

      4. Ask if they have trouble hearing or experience ringing in their ears.

   2. Inspect the external eye and the external ear. Inspect the oral cavity for lesions, tongue position, moisture, and oral health. Ask the patient to swallow their saliva and note any difficulty swallowing.

   3. Palpate the lymph nodes (per agency policy).

13. Perform a cardiovascular system assessment:

   1. Perform a subjective assessment. Ask if they are having chest pain, shortness of breath, edema, palpitations, calf pain, or pain in their feet or lower legs when exercising. Be aware of previously diagnosed cardiovascular conditions and currently prescribed medications and how these impact your assessment findings.
2. Inspect:
   1. The face, lips, and extremities for pallor or cyanosis.
   2. The neck for JVD in upright position or with head of bed at 30-45 degree angle.
   3. The bilateral upper and lower extremities for color, warmth, and sensation.
   4. The lower extremities for hair distribution, edema, and signs of deep vein thrombosis (DVT)

3. Palpate:
   1. Palpate and compare the radial, brachial, dorsalis pedis, and posterior tibial pulses bilaterally. Note the presence and amplitude of pulses.
   2. Palate the nail beds for capillary refill.

4. Auscultate:
   1. Auscultate with both the bell and the diaphragm of the stethoscope over the five auscultation areas of the heart. Note the rate and rhythm. Identify S1 and S2 and any unexpected findings (i.e., extra sounds or irregular rhythm).
   2. Measure the apical pulse for one minute.

14. Perform a respiratory assessment:
   1. Perform a subjective assessment. Ask if they have shortness of breath or a cough. Ask if the cough is dry or productive. Ask if they smoke, and if so, what products, how many a day, and if they are interested in quitting. Be aware of previously diagnosed respiratory conditions and currently prescribed medications or treatments and how these impact your assessment findings.

   2. Inspect:
      1. Level of consciousness and for signs of irritability, restlessness, anxiety, or confusion
      2. Breathing pattern, including rate, rhythm, effort, and depth of breathing. Note signs of difficulty breathing such as nasal flaring, use of accessory muscles, or pursed-lip breathing.
      3. Skin color of lips, face, hands and feet for cyanosis and pallor
      4. Trachea (midline)
      5. Symmetrical chest movement

   3. Auscultate lung sounds using stethoscope directly on the skin over anterior and posterior auscultation areas. Compare sounds from side to side and note any adventitious sounds such as rhonchi, crackles, wheezing, stridor, or pleural rub.

   4. If oxygen equipment is prescribed:
      1. Note if the patient is using oxygenation devices during the exam or on room air.
      2. If the patient is using an oxygenation device, document the name of device and current flow rate and/or fraction of inspired oxygen (FiO2).
      3. Inspect for signs of skin breakdown due to the use of oxygenation devices.

   5. If a tracheostomy is present, document the condition of the tracheostomy site and characteristics of sputum present.

15. Perform an abdominal assessment:
   1. Perform a subjective assessment:
      1. Ask if the patient is having any abdominal pain, cramping, nausea, vomiting, constipation, loss of appetite, or difficulty swallowing. Inquire about the date of the last bowel movement, if there have been any changes in the pattern or consistency of the stool, and if any blood is present or dark stool. Be aware of previously diagnosed gastrointestinal or genitourinary conditions and currently prescribed
medications and how these impact your assessment findings.

2. Ask if the patient has pain or problems with urination or leakage of urine.

2. Inspect the general contour and symmetry of the abdomen and for distension.

3. Auscultate for bowel sounds over four quadrants for one minute, note any hypoactive, high pitched sounds.

4. Palpate lightly for tenderness and masses.

5. Analyze weight trend and 24-hour input and output, as appropriate for patient status.

6. If enteral tube is present, assess tube insertion site, tube placement, and amount of enteral feeding/fluids administered during your shift per agency policy.

7. If an indwelling urinary catheter is present, assess urine output and urine characteristics. Document continued need for indwelling catheter per agency policy.

8. If an ostomy is present, document the condition of stoma and peristomal skin. Document amount and characteristics of output during your shift.

16. Perform an integumentary assessment:

1. Perform a subjective assessment. Ask if the patient has any skin concerns such as itching, rashes, or an unusual mole or lump. Be aware of previously diagnosed integumentary conditions and currently prescribed medications or treatments and how these impact your assessment findings.

2. Inspect:

   1. Assess overall skin color and note pallor, cyanosis, jaundice, erythema, bruising, moisture, and turgor.

   2. If an intravenous site is present, assess the insertion site for redness, warmth, tenderness, or induration. If intravenous fluids and/or medications are infusing, document the type and amount of fluids during your shift per agency policy.

   3. Assess for skin breakdown in pressure points (behind ears, occipital area, elbows, sacrum, and heels).

   4. If a pressure injury is present, stage from 1 to 4.

   5. If a wound is present, perform a wound assessment.

3. Palpate for temperature, moisture, and texture. If erythema or rashes are present, assess for blanching. If edema is present, document the depth of indentation and the time it takes to rebound to original position and grade on a scale from 1 to 4.

17. When the assessment is completed, assist the patient back to a comfortable position. Thank them and ask if anything is needed before you leave the room.

18. Ensure safety measures before leaving room:

   1. Call light is within reach.

   2. Bed is low and locked.

   3. Side rails are secured.

   4. Table and personal items are within reach.

   5. Room is risk-free for falls.

19. Remove any PPE before leaving the room. Perform hand hygiene and clean stethoscope.

20. Document assessment findings and report unanticipated findings according to agency policy.