The Head-to-Toe Skills test guidelines:

- You have 50 minutes to complete the Head-to-Toe assessment
- Bring a calculator
- THE HEAD-TO-TOE ASSESSMENT NEEDS TO FLOW SMOOTHLY AND SYSTEMATICALLY.
- This test is an assessment of **YOUR ASSESSMENT TECHNIQUES:**
  - **IT IS HEAD TO TOE WITH CONSTANT COMPARISION SIDE TO SIDE**
- **Knowledge is always essential: knowledge of normal ranges in this test is expected.** Example: Normal CRT? Normal bowel sounds? Normal turgor?
- **Pick your own patient – this test is somewhat invasive in areas. We want you to feel as comfortable as possible**
- You can have the Head-to-Toe Assessment sheet that was given to you. No other papers or guidelines that were given to you are allowed. **---NO NOTES ON THE GUIDE**
- **Please understand, we want you to use the guideline to ensure everything is covered, but you need to show us that the Head to Toe has been practiced and you know your assessments systematically.**
- Offer to patient the use of restroom/urinal prior to assessment --- you will be palpating suprapubic and applying pressure ---- prevent accidents and provide comfort to patient
- Vital Signs will be statement – you will not be performing in this test
- Ask 2 questions per region/body part. **Questions for orientation are outside of the 2 questions.**
- For time frame purposes you will not document within the timed test. BUT WHEN THE TEST IS COMPLETED, WE ARE GOING TO HAVE YOU DOCUMENT THE **ASSESSMENT FINDINGS** AS A NARRATIVE NURSE NOTE. **WE KNOW WE HAVE NOT TAUGHT THIS EXTENSIVELY.** WE WANT THE ASSESSMENT FINDINGS ON PAPER IN THE **SAME ORDER OF ASSESSMENT (SYSTEMATIC).** Include date, time, patient initials, and your legible signature with title.
- Assessment begins with observation as soon as you approach the patient –you will have to voice out to instructors what is being observed by you. EXAMPLE: "I am looking at the patient's alignment, skin color, affect (outward emotional appearance)."
- Methods of assessments in all body areas/regions **always begins with observation.** No matter what area you are in make a statement of I am observing appearance of skin, color, rashes, lesions, etc.
- **Remember the correct order of assessment in all body areas is the same except abdomen**
  - and olfaction is a *continuous assessment*
- **Assessment of the abdomen:**
  1.inspection/observation 2.auscultation 3.percussion 4.palpation
- When assessing the abdomen please follow the large intestine:
  - 1 right lower quadrant (RLQ) 3 left upper quadrant (LUQ)
    2 right upper quadrant (RUQ) 4 Left lower quadrant (LLQ)

  this is a systematic approach in assessing the abdomen

  all 4 quadrants are assessed for bowel sounds. RLQ – normal bowel sounds, RUQ normal bowel sounds, LUQ hyperactive bowel sounds, LLQ hyperactive bowel sounds
- make sure you know range for normal bowel sounds to determine your patient's assessment findings
- **When assessing pulses:** * always assess bilaterally - continuous * assesses the pulse for strength and regularity using pulse scale (right brachial, left brachial, right radial, left radial, etc)
- Perform a **full pain assessment.** The patient will create a location of pain with a **pain level < 3.**

- Weight can be done following the video or guideline – if scale is being used you will be instructed to proceed with assessment and instructor will let you know when scale is available
- Walk the patient to the scale – you walk slightly behind and to the side assessing the musculoskeletal system (gait, balance, strength, endurance, etc)
- The **weight will be converted to Kg** by dividing the weight by 2.2
- The **height will be converted to cm** by multiplying the height 2.5 – we talked about aligning with Essentials of Medication in class.
- JVD is assessed with patient supine and head of bed up at 15 – 35 degrees
- Remember when assessing extremities, you're pretty much following a neurovascular assessment and what you do to top extremities – you also do to lower extremities

RUBRIC

A, B, C, D (SKILL) X, Y, Z

PHYSICAL ASSESSMENT

Lung Assessment

Tracheal Breath Sounds: heard over the trachea 1. They are equal in length for inspiration and expiration with a slight pause between them. 2. The sounds are course and loud.

Bronchial Breath Sounds: heard to the upper chest area. 1. Shorter on inspiration than expiration with a pause between them. 2. The sounds are harsh and loud.

Bronchovesicular Breath Sounds: heard over the central chest and back. 1. Equal in lenth during inspiration and expiration with no pause between them. 2. Medium in tonality and loudness.

Vesicular Breath Sounds: heard in the periphery of the lung fields. 1. Longer on inspiration than expiration with no pause between them. 2. Soft, rustling sounds

There are 9 locations to ascultate on posterior lung sounds.

Do not ascultate over boney areas. Place the stethoscope between the scapula, beside the vertebrae, and between the ribs.

Move from side to side for constant comparison between the right and left lung.

There are 5 locations to ascultate on anterior lung sounds.

Listen between the womens breast and mens . Lift the breast when necessary.

Have the patient breath in through their nose and out through their mouth slowly.

Listen to both the inspiration and expiration before moving to the next area to ascultate.

Give the patient rest breaks during the assessment if needed.

Ask the patient if they are feeling lightheaded or dizzy during the assessment as needed.

Keep the deep breathing they will do for you slow to avoid the lightheadedness or dizziness.

Figure 22-9 Sites for auscultation of the lung fields.

PHYSICAL ASSESSMENT

Abdominal Assessment

Bowel sounds are assessed upon admission and once per each shift and prn.

Always follow proper sequence of assessment.

1. Inspection (Do Not touch) 2. Auscultation 3. Percussion 4. Palpation

INSPECTION OF THE ABDOMEN: done by visualization of the entire abdomen without touching.

What are you looking at? The skin for any type of abnormalities (scars, bruising, rashes, lesions etc.). look at size and shape of the abdomen (flat, sunken, large, obese), look for distention of the abdomen (shiny stretch skin, rounded abdomen, a flattened or stretched umbilicus). Look for herniations, pulsations (midline may be a pulsation of the aorta).

AUSCULTATING FOR BOWEL SOUNDS:

Bowel sounds are produced by the wavelike movements or contractions of the small and large intestine. You will hear clicks or gurgles that occur 5 – 30 times per minute normally.

Bowel sounds are usually more active after meals due to the digestion that is occurring.

Before the am meal and / or between meals bowel sounds may be less active.

But to whatever degree of bowel sound activity, bowel sounds should always be present. If bowel sounds are not present, this is a serious condition that may be life – threatening.

NORMAL BOWEL SOUNDS: 5 – 30 bowel sounds per minute or there will be a sound every 5 to 15 seconds.

HYPERACTIVE BOWEL SOUNDS: frequently heard (every 3 seconds or more) More than 30

HYPOACTIVE BOWEL SOUNDS: long periods of silence (1 – 3 sounds every minute) less than 5

✓ ABSENT BOWEL SOUNDS: no sounds for 2 – 5 minutes (verify your findings with another nurse, if verified there are no bowel sounds, place patient NPO and call physician to report immediately)

Count the bowel sounds in each quadrant for 30 seconds and multiply by 2 to determine if bowel sounds are normal, hyperactive, hypoactive. In the case of suspecting no bowel sounds auscultate each quadrant for 2 to 5 minutes.

To divide the abdomen into the four quadrants, use the umbilicus as your landmark. RUQ = right upper quadrant, RLQ = right lower quadrant, LUQ = left upper quadrant, LLQ = left lower quadrant.

PERCUSSION: after auscultation is percussion, if the patient has a G/I problem.

PALPATION: after percussion is palpation. Gentle touching in each quadrant. Palpate for softness or firmness, tenderness, pain, rigidity, guarding, masses, pulsations.

Always assess each quadrant separately.

Document your findings in the same order of assessment.

1. Inspection = abdomen large with surgical scar to the RUQ.
2. Auscultation = normal bowel sounds auscultated to all 4 quadrants.
3. Palpation = abdomen is soft without pain or discomfort with palpation.

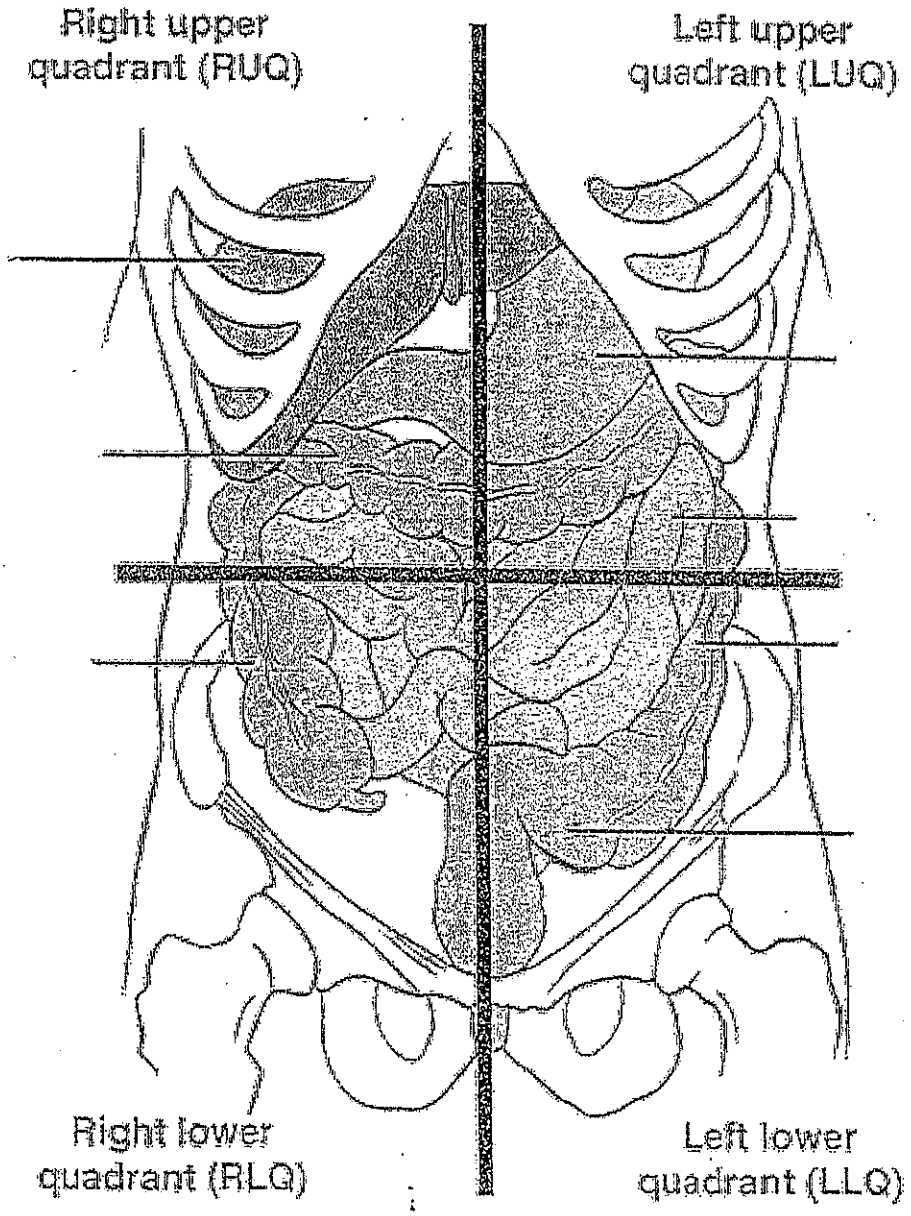

Figure 22-10 Auscultation of bowel sounds; listen in each quadrant.