<table>
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<th>Standard Met/Initials</th>
<th>Competency Areas</th>
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<td><strong>Prerequisite Skills</strong></td>
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<td>Understanding that the head-to-toe assessment is a noninvasive physical examination for obtaining preliminary information on body system function, mental/emotional status, and overall health</td>
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<td>Basic understanding of the anatomy and physiology of the body systems and of the components of the physical assessment</td>
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<td>Understanding of normal vital sign parameters, normal variations in vital signs by patient age and developmental stage, and appropriate intervention(s) if vital sign measurements are outside normal limits</td>
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<td>Familiarity with facility pain assessment tool(s); understanding of applicable facility-wide pain management standards</td>
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<td>Understanding of facility protocol concerning procedure, including frequency with which the assessment should be performed and notification of the treating clinician if abnormalities are detected</td>
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<td><strong>Preparation</strong></td>
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<td>Reviews the facility/unit specific protocol for the procedure, if one is available. Notes unit-specific guidelines for the frequency of the physical assessment and how to notify the treating clinician of abnormalities</td>
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<td>Reviews the treating clinician’s order for the physical assessment, if one exists, although it is generally not necessary to obtain a physician’s order as the head-to-toe assessment is a standard part of nursing duties</td>
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<td>Reviews the manufacturer’s instructions for all equipment to be used, and verifies that the equipment is in good working order</td>
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<td>Verifies completion of facility informed consent documents, if necessary</td>
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Reviews the patient’s history/medical record to assess for:
- any acute or chronic illness or physical impairment
- results of previous assessments for comparison
- any allergies (e.g., to latex or other procedure materials); uses alternative materials, as appropriate

Gathers the necessary supplies, which typically include the following:
- Nonsterile gloves; additional personal protective equipment (PPE; e.g., gown, mask, eye protection) may be needed if exposure to body fluids is anticipated
- Patient gown
- Thermometer (e.g., oral, axillary), depending on facility protocol
- Pulse oximeter
- Stethoscope
- Penlight
- Blood pressure machine with a cuff of appropriate size for the patient
- Floor or bed scale
- Measuring tape
- Facility-approved pain assessment tool
- Additional supplies to be provided for well-patient physical assessment (i.e., more detailed assessment performed by advanced practice nurses, physician assistants, and physicians, often assisted by nurses), such as:
  - otoscope/ophthalmoscope
  - reflex hammer

### Procedure

**Performs hand hygiene and dons PPE**

**Identifies the patient using 2 unique identifiers, according to facility protocol**

**Establishes privacy by closing the door to the patient’s room and/or drawing the curtain surrounding the patient’s bed**

**Introduces self to the patient and family member(s), if present; explains clinical role; assesses the coping ability of the patient/family and for knowledge deficits and anxiety regarding the head-to-toe physical assessment**

- Determines if the patient/family requires special considerations regarding communication (e.g., due to illiteracy, language barriers, deafness); makes arrangements to meet these needs if they are present
- Uses professional certified medical interpreters, either in person or via phone, when language barriers exist

**Explains the procedure for the head-to-toe physical assessment and its purpose; answers any questions and provides emotional support as needed**

**Assists the patient as necessary to don a gown if he/she is not already wearing one**

**Positions the patient for privacy, comfort, and accessibility**
Begins the head-to-toe assessment with inspection to assess the patient’s overall appearance and identify any obvious physical abnormalities, and asks the patient about any unusual symptoms to provide important preliminary information that can guide the physical assessment.

- Asks the patient how he/she feels, about any physical symptoms that have developed or changed recently, and inquires about each of the body systems
- Considers the general appearance of the patient while looking for clues to poor health, noting patient affect and body position, presence of anxiety, presence or absence of self-care measures such as hygiene and grooming, and whether the patient’s age is congruent with his/her appearance

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<td>Measures the patient’s vital signs—temperature, pulse, respiratory rate, and blood pressure. Compares findings with established reference values appropriate to the age of the patient to identify abnormalities.</td>
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<td>Assesses for pain by utilizing the self-report method (i.e., asking the patient directly whether or not he or she has pain, where it is located, the type of pain [e.g., burning, aching], and how severe it is), and/or by utilizing a facility-approved pain rating scale or measurement tool.</td>
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<td>Measures the patient’s height, weight, and waist circumference; does not rely on self-report. Calculates the patient’s body mass index (BMI) and compares with established reference values.</td>
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<td>Verifies that there is adequate lighting to perform the assessment.</td>
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| Assesses the skin as each of the body systems is assessed, exposing only the area of skin to be assessed and keeping the rest of the body covered to promote privacy.
- Asks the patient about any skin lesions, areas of irritation, or other changes in the skin, and any precipitating factors
- Inspects the patient’s skin for scars, lesions, wounds, injuries, rashes, irritation, color, and areas of redness or cyanosis. Takes care to assess within folds of skin, the sclera, mucus membranes, the nailbeds, the scalp, the palms of the hands, and the soles of the feet
- Palpates the patient’s skin to assess for temperature, elasticity/turgor, moisture, edema, and pain. |
Assesses the patient’s neurological status

- Assesses level of wakefulness, consciousness, and orientation, and for sensory deficits
  - If the patient is awake and alert (i.e., responsive to stimuli), assesses the patient’s understanding of person, place, time, and situation, the four spheres of orientation. This can be done through conversation or, more explicitly, by asking the following four questions:
    - “What is your name?”
    - “Can you tell me where you are?”
    - “What day is it?”
    - “Why are you here?”
  - If the patient can answer all four questions, he or she is awake, alert, and oriented to all four spheres of orientation.
  - If the patient knows his or her name, but is unable to answer the other three questions, he or she is considered awake, alert, oriented to person, and disoriented to place, time, and situation

- Inspects pupillary size, symmetry, and reaction to light (using penlight)

- Assesses hand strength (e.g., strength and symmetry of grip)

- Uses the reflex hammer to check for the presence and strength of the patellar reflex and other reflexes as desired

Examines the head (including eyes, ears, nose, and throat)

- Inspects the skin, eyes, sclera, inner and outer ears, mucus membranes, and scalp. Notes the
  - moisture and color of mucous membranes
  - presence of discharge from eyes, ears, or nose
  - texture and distribution of hair

- Inspects and palpates the thyroid gland for enlargement, nodules, or masses

- Assesses breath odor and for poor oral hygiene or tooth decay

- Assesses for problems with speech (e.g., aphasia, or dysphasia) or swallowing

- Palpates for swelling or masses, lesions in the mouth or elsewhere, and for pain or tenderness

- Percusses over the sinuses to assess for pain or tenderness
Assesses the respiratory system
• Uses inspection to note whether the patient is using the normal respiratory muscles or is relying on use of accessory muscles (i.e., sternocleidomastoid, scalene, trapezius, intercostal, and rhomboid muscles) to breathe. Assesses for equal chest expansion, the position of the trachea, and for cyanosis
  – Notes oxygen saturation level. Assesses for any clubbing of the fingertips, which is an indication of chronic respiratory insufficiency
  – Verifies the presence of airway devices/oxygen therapy (e.g., endotracheal tube) and confirms that they are positioned and working correctly
• Auscultates breath sounds over the anterior and posterior chest and all lobes of the lungs. Notes the character and quality of sounds
• Palpates for fremitus and subcutaneous emphysema
• Percusses over the chest wall to assess for areas of consolidation or other changes. Measures lung/diaphragmatic excursion as desired

Assesses the cardiovascular system
• Inspects over the area of the heart for bulging or heaving. Places the patient at a 45° angle and assesses for jugular venous distention (JVD)
• Lightly palpates over the area of the heart for thrills/vibrations
• Assesses the carotid, radial, femoral, posterior tibial, and dorsalis pedis pulses Compares the strength of pulses on each side of the body. Assesses the color of the nail beds and capillary refill time
  – Assesses the carotid pulses one side at a time
• Percusses to determine the borders of the heart
• Auscultates the apical pulse for rate, rhythm, and strength, ideally while the patient is in the sitting position
  – Assesses heart rate by counting the number of heartbeats over the course of one minute; assesses heart rhythm by comparing the intervals between heartbeats, which should be evenly spaced, or regular; assesses the strength of the apical pulse by noting whether heart sounds are easy or difficult to hear
• Auscultates over the carotid arteries to assess for bruits
• Palpates the radial pulse while auscultating the apical pulse and assess for pulse deficit
• Assesses blood pressure in each arm

Assesses the lymphatic system
• Palpates lymph nodes in the neck, supraclavicular, axillary, and inguinal areas for tenderness or swelling. Notes size, shape, motility, and tenderness
Assesses the abdomen
• Inspects the abdomen for color, rashes, scars, distended blood vessel, distention, and obvious areas of swelling (e.g., hernias)
• Auscultates bowel sounds over the four abdominal quadrants: the right lower quadrant (RLQ), right upper quadrant (RUQ), left upper quadrant (LUQ), and left lower quadrant (LLQ). Performs auscultation prior to palpation
• Auscultates over the abdominal aorta for bruits
• Percusses over the four abdominal quadrants, noting any abnormalities; percusses in the RUQ for the borders of the liver and in the LUQ for splenic enlargement
• Palpates over the four quadrants for tenderness, distention, or masses
  – Performs light palpation to assess for tenderness or distention by depressing the skin 0.5–0.75 inches (1–2 cm) with the pads of the fingers
  – Performs deep palpation to assess for the size, shape, and tenderness of internal organs or masses by depressing the skin 1.5–2 inches (4–5 cm) using firm pressure. Places a second hand over the first to provide firmer pressure, as needed, particularly if the patient is obese or muscular
• Palpates the liver, spleen, and kidneys, assessing for tenderness and/or enlargement
• Asks about bowel patterns, verifying that the patient has had a bowel movement within the past three days
• If the patient has a colostomy or ileostomy, assesses the surrounding skin for signs of irritation and assesses the contents of the stoma pouch

Assesses the genitourinary system
• Asks about voiding patterns and urine characteristics
  – Determines whether the patient is continent or incontinent
  – Verifies that the patient has voided sometime within the last 8 hours. If the patient has not, percusses over the bladder to check for distention
  – Inquires about any discomfort during urination and whether the patient has urinary urgency or frequency
• Notes the presence of assistive devices (e.g., indwelling urinary catheter) and confirms that they are working correctly
Assesses the musculoskeletal system
• Inspects for symmetry, deformities (e.g., breaks, contractures), and range of motion (ROM). Observes gait and posture
  – Asks about any leg or calf pain during passive ankle flexion, which could indicate deep vein thrombosis (DVT)
• Assesses strength of the patient’s grip when asked to squeeze the clinician’s hand
• Palpates the lower extremities for edema and, if present, the extent of any pitting by applying pressure over a bony prominence with one fingertip for approximately 2 seconds, releasing the pressure, and noting how long it takes for the indentation to refill
• Palpates the joints for crepitus, which is often present with osteoarthritis

| Assists the patient into a comfortable position in a bed or chair |
| Provides the patient with privacy to redress, or helps the patient to redress, as appropriate |
| Cleans/disinfects and stores reusable equipment according to facility protocol |
| Disposes of PPE and other procedure materials and performs hand hygiene |

**Post-Procedural Responsibilities**

| Notifies the treating clinician of abnormal findings and/or significant changes in previous assessments so that the treatment plan may be established or modified. Assists with referral for further assessment, as indicated and ordered |
| Conducts reassessments once every shift (every 4–12 hours) or per patient condition or facility protocol, and more frequently
  • to evaluate the outcome of interventions
  • if the patient’s condition changes
  • if the patient is medically unstable |
Updates the patient’s plan of care, as appropriate, and document the head-to-toe physical assessment in the patient’s medical record, including the following information:

- Date and time the assessment was completed
- Patient assessment findings from each portion of the assessment, including pain experienced and any deviation from normal
- Patient’s response to the procedure (including pain/discomfort/anxiety during and immediately following the assessment)
- Any unexpected patient events or outcomes, interventions performed, and whether or not the treating clinician was notified
- Patient/family member education, including topics presented, response to education provided/discussed, plan for follow-up education, and details regarding any barriers to communication and/or techniques that promoted successful communication

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<td>Evaluator's Signature</td>
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