### Neurological Assessment

<table>
<thead>
<tr>
<th>Location</th>
<th>Muscle Tone</th>
<th>Muscle Strength</th>
<th>Sensation</th>
<th>Tremor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/ Neck</td>
<td>WNL</td>
<td>Flaccid</td>
<td>WNL</td>
<td>To pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spastic</td>
<td>No response to pain</td>
<td>No</td>
</tr>
<tr>
<td>R hand</td>
<td>WNL</td>
<td>Flaccid</td>
<td>WNL</td>
<td></td>
</tr>
<tr>
<td>L hand</td>
<td>WNL</td>
<td>Flaccid</td>
<td>WNL</td>
<td></td>
</tr>
<tr>
<td>RUE</td>
<td>WNL</td>
<td>Flaccid</td>
<td>WNL</td>
<td></td>
</tr>
<tr>
<td>LUE</td>
<td>WNL</td>
<td>Flaccid</td>
<td>WNL</td>
<td></td>
</tr>
<tr>
<td>RLE</td>
<td>WNL</td>
<td>Flaccid</td>
<td>WNL</td>
<td></td>
</tr>
<tr>
<td>LLE</td>
<td>WNL</td>
<td>Flaccid</td>
<td>WNL</td>
<td></td>
</tr>
</tbody>
</table>

**Muscle Strength:** 5 = WNL  4 = 75% normal  3 = 50% normal  2 = 25% normal  1 = 10% normal  0 = complete paralysis

### Respiratory Assessment

**Pulse ox:** WNL (95-100%)  WNL for this patient at __________

**Cough:** None  Non-productive, dry  Productive  Productive sounding, no sputum

**Sputum:** None  Consistency: Thick  Thin  Foamy  Color: White  Other

**Oxygen:** N/A Room air  liters/ nasal cannula  % per face mask  Mechanical ventilator

**Respiratory rate:** WNL  Tachypnea/ hyperventilation (too fast)  Bradypnea/ hypoventilation (too slow/ shallow)

**Respiratory effort:** Relaxed and regular  Pursed lip breathing  Painful respiration  Labored  Dyspnea at rest  Dyspnea with minimal effort, talking, eating, repositioning in bed, etc.  Dyspnea when walking ____ feet or with exercise

**Respiratory rhythm:** WNL  Regular, tachypneic  Regular, bradypneic  Regular with periods of apnea  Regular, abnormal, rapid and deep respiration (central neurogenic hyperventilation)  Regular, abnormal, prolonged inspiration with a pause or sigh with periods of apnea (apneustic)  Irregularly irregular pattern/ depth (ataxic)  Irregular with periods of apnea (cluster breathing)

**Breath sounds** (auscultate anterior & posterior, R & L upper, mid, lower chest):

- Clear (vesicular) throughout
- Decreased (atelectasis?)
- Crackles: Fine (sounds like hair rubbing)  Coarse/ moist
- Gurgles/ rhonchi (low pitched, moaning, snoring sounds)
- Wheezes: Inspiratory  Expiratory
- Friction rub (sounds like leather rubbing against leather)
- Absent (pneumothorax?)

<table>
<thead>
<tr>
<th>Upper chest</th>
<th>Mid chest</th>
<th>Lower chest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>Left</td>
<td>Left</td>
</tr>
</tbody>
</table>
Cardiovascular Assessment

**Skin:**
- Warm/ dry
- Cool
- Clammy/ diaphoretic

**Skin turgor:**
- WNL
- Tenting

**Weight:**
- kg/ lb

**Capillary refill:**
- WNL
- Delayed > 2 seconds

**Apical pulse rhythm:**
- Regular
- Regularly irregular
- Irregularly irregular

**Apical pulse rate:**
- WNL (60-100)
- Bradycardia
- Tachycardia

**Apical/ radial deficit:**
- No
- Yes

**Heart sounds:**
- Normal S1 S2
- Valve click [artificial heart valve]
- Murmur:
  - Holosystolic
  - Midsystolic
  - Diastolic

**B/P:**
- WNL
- Hypertension
- Hypotension
- R/ L diff.

**Orthostatic systolic drop:**
- < 20 mm Hg
- => 20 mm Hg

**Peripheral Pulses**

- **R radial**
  - Yes
  - Doppler
  - No

- **R femoral**
  - Yes
  - Doppler
  - No

- **R pedal**
  - Yes
  - Doppler
  - No

- **R post tib**
  - Yes
  - Doppler
  - No

- **L radial**
  - Yes
  - Doppler
  - No

- **L femoral**
  - Yes
  - Doppler
  - No

- **L pedal**
  - Yes
  - Doppler
  - No

- **L post tib**
  - Yes
  - Doppler
  - No

**Edema**

- **R hand/ arm**
  - No
  - Non-pitting
  - Pitting

- **R knee to thigh**
  - No
  - Non-pitting
  - Pitting

- **R ankle to knee**
  - No
  - Non-pitting
  - Pitting

- **R foot/ ankle**
  - No
  - Non-pitting
  - Pitting

- **L hand/ arm**
  - No
  - Non-pitting
  - Pitting

- **L knee to thigh**
  - No
  - Non-pitting
  - Pitting

- **L ankle to knee**
  - No
  - Non-pitting
  - Pitting

- **R post tib**
  - No
  - Non-pitting
  - Pitting

- **L post tib**
  - No
  - Non-pitting
  - Pitting

**ECG assessment if applicable, see below**

Genitourinary Assessment

**Genitalia:**
- WNL
- Abnormalities, describe:

**Assessment of urination:**
- WNL
- Burning
- Frequency
- Urgency
- Bladder distention
- Pelvic pain/ discomfort
- Lower back/ flank pain/ discomfort

**Continent:**
- Yes
- Stress incontinence with coughing, etc.
- Rarely incontinent
- Regularly incontinent

**Urine amount:**
- WNL (over 30 mls/ hr, output approximates intake)
- Less than 30 mls/ hr (dehydration? Post-op volume depletion? SIADH?)
- Output greatly exceeds intake (Post-op diuresis? Diabetes insipidus?)

**Urine color:**
- Yellow, WNL
- Amber
- Orange
- Dark amber
- Pink
- Red tinged
- Grossly bloody

**Urine characteristics:**
- Clear, WNL
- Cloudy
- Sediment
- Abnormal odor

**Urostomy:**
- N/A
- Urostomy/ ileal conduit
- Continent maintaining nipple valve ostomy

**Stoma status:**
- Pink, viable
- Red
- Deep red
- Dusky
- Dark
- Retracted below skin
- S/S of infection

**Urinary stents:**
- N/A
- R ureter
- L ureter

**Urinary catheter:**
- N/A
- Foley, short term
- Foley, long term at home
- Suprapubic catheter

**Insertion site:**
- WNL
- S/S of infection
**Gastrointestinal Assessment**

**Oral mucosa:**
- ☐ Intact
- ☐ Moist
- ☐ Dry
- ☐ Pink
- ☐ Pale

**Tongue:**
- ☐ WNL
- ☐ Pink
- ☐ White patches

**Abdomen:**
- ☐ WNL
- ☐ Distended
- ☐ Taut
- ☐ Ascites
- ☐ Abdominal incision

**Abdominal girth:**
- (PRN): cm

**Abdominal pain, see pain assessment**

**Bowel movements:**
- ☐ WNL
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bowel program required
- ☐ Other, ________________

**Last bowel movement:**
- ☐ Today
- ☐ Yesterday
- ☐ Other, ________________

**Continent:**
- ☐ Yes
- ☐ Rarely incontinent
- ☐ Regularly incontinent

**Nausea/ vomiting:**
- ☐ No
- ☐ Yes, describe:

**Nutritional intake:**
- ☐ Adequate
- ☐ Inadequate, address in care planning

**Bowel sounds**

- (all four quadrants):
  - ☐ Active, WNL
  - ☐ Hyperactive
  - ☐ Hypoactive
  - ☐ Absent (listen for 5 full minutes)

**Tubes:**
- ☐ None
- ☐ Salem sump
- ☐ Nasoduodenal feeding tube
- ☐ PEG tube
- ☐ Jejunostomy (J) tube
- ☐ pH aspirate: __________

**Insertion site:**
- ☐ WNL
- ☐ Pressure areas
- ☐ Redness
- ☐ Purulent drainage
- ☐ Tenderness
- ☐ Warmth

**Tube feeding:**
- Type: ________________
- Amount: _______ mls over _______ hours via ☐ Gravity
  - ☐ Pump
  - ☐ Intermittent
  - ☐ Continuous

**Stoma:**
- ☐ N/A
- ☐ Colostomy
- ☐ Ileostomy

**Stoma status:**
- ☐ Pink, viable
- ☐ Red
- ☐ Deep red
- ☐ Dusky
- ☐ Dark
- ☐ Retracted below skin

*PEG tube = percutaneous endoscopic gastrostomy tube*

**Skin Integrity Assessment**

**Skin color:**
- ☐ WNL
- ☐ Pale
- ☐ Jaundice
- ☐ Dusky
- ☐ Cyanotic

**Skin is:**
- ☐ Intact
- ☐ No, see below
- ☐ No, describe: ________________

**Braden Scale Score:**

**Signs/ symptoms of inflammation/ infection:**
- ☐ Redness
- ☐ Tenderness/ pain
- ☐ Warmth
- ☐ Swelling

**Surgical incision:**
- (circle one)

**Wounds**

<table>
<thead>
<tr>
<th>Location</th>
<th>Type</th>
<th>Size</th>
<th>tunneling</th>
<th>undermining</th>
<th>surrounding tissue</th>
<th>drainage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrasion</td>
<td>Length cm</td>
<td>Width cm</td>
<td>Depth cm</td>
<td>Present at</td>
<td>WNL</td>
<td>None</td>
</tr>
<tr>
<td>Avulsion</td>
<td>Incision length cm</td>
<td></td>
<td></td>
<td>o’clock, depth cm</td>
<td>Redness</td>
<td>Present, surrounding tissue is:</td>
</tr>
<tr>
<td>Burn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tenderness</td>
<td>Dusky</td>
</tr>
<tr>
<td>Laceration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pain</td>
<td>Soft</td>
</tr>
<tr>
<td>Puncture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Warmth</td>
<td>Boggy</td>
</tr>
<tr>
<td>Pressure ulcer, Stage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Streaking</td>
<td>Fluid-full</td>
</tr>
<tr>
<td>Stasis ulcer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Excoriation</td>
<td>Other, describe:</td>
</tr>
<tr>
<td>Surgical incision, closed, edges are approximated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Bruising</td>
<td></td>
</tr>
<tr>
<td>Surgical, open areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Discolored</td>
<td></td>
</tr>
<tr>
<td>total wound dehiscence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dusky</td>
<td></td>
</tr>
<tr>
<td>staples/ sutures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WNL</td>
<td>Color/ Characteristics:</td>
</tr>
<tr>
<td>(circle one)</td>
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<td></td>
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<td></td>
<td>Hyperkeratotic</td>
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<td>Serosanguinous</td>
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<td></td>
<td></td>
<td>Bloody</td>
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<td>Yellow</td>
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<td>Brown</td>
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<td></td>
<td></td>
<td></td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>Wound edges</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td>Purulent?</td>
</tr>
<tr>
<td></td>
<td>WNL</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Odor?</td>
</tr>
</tbody>
</table>

*Undermining is due to liquefaction of necrotic tissue or mechanical forces that sheared and separated underlying tissues.*
Blood sugars ranges:

- Acute
- Chronic
- Constant
- Intermittent

**Pain Assessment**

<table>
<thead>
<tr>
<th>Location of pain:</th>
<th>Pain is:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain is affecting:</td>
<td>☐ N/A</td>
<td>☐ Sleep</td>
</tr>
</tbody>
</table>

**Description of pain:** ☐ Sharp | ☐ Stabbing | ☐ Throbbing | ☐ Shooting | ☐ Burning | ☐ Electric-shock like |

**Pain rating on a scale of 0 to 10:** _____

**Highest pain level today:** Best pain level today: Best pain ever gets:

**What makes the pain worse?** ☐ Activity | ☐ Exercises | ☐ Other: |

**What makes the pain decrease?** ☐ Rest/ sleep | ☐ Medication | ☐ Heat | ☐ Cold | ☐ Family presence | ☐ Music | ☐ Reading | ☐ Distraction | ☐ Meditation | ☐ Guided imagery | ☐ Relaxation techniques | ☐ Other: |

**IV Assessment**

**Type of line:** ☐ Peripheral, site __________ | ☐ Triple lumen CVL | ☐ PICC | ☐ Tunneled CVL | ☐ Implanted port | ☐ TPN |

**Insertion site:** ☐ WNL | ☐ Redness | ☐ Tenderness/ pain | ☐ Warmth | ☐ Swelling | ☐ Drainage |

**IV fluids:** ☐ N/A, heplock | ☐ IV fluids: _____ mls/hr | ☐ Continuous | ☐ over ____ hours |

**TPN/ PPN:** ☐ N/A | ☐ TPN | ☐ PPN: _____ mls/hr | ☐ Continuous | ☐ over ____ hours per ____ pump |

**Blood sugars:** ☐ N/A, heplock | ☐ Intermittent | ☐ Continuous | ☐ over ____ hours per ____ pump |

**PCA:** ☐ N/A | ☐ Morphine | ☐ Dilaudid | ☐ Fentanyl via | ☐ IV | ☐ Epidural, dressing: | ☐ D&I | ☐ Other: _______________ |

**Continuous dose:** ___________/hr | **Demand dose:** ___________/hr | **Max doses per hour:** ___________ |

**Blood sugars ranges:** ☐ WNL | ☐ High with coverage needed |

**Does the client have concerns about overusing medications/addiction?** ☐ No | ☐ Yes, describe:_______________ |

**IV Assessment**

**Type of line:** ☐ Peripheral, site __________ | ☐ Triple lumen CVL | ☐ PICC | ☐ Tunneled CVL | ☐ Implanted port |

**Insertion site:** ☐ WNL | ☐ Redness | ☐ Tenderness/ pain | ☐ Warmth | ☐ Swelling | ☐ Drainage |

**IV fluids:** ☐ N/A, heplock | ☐ IV fluids: _____ mls/hr | ☐ Continuous | ☐ over ____ hrs per ________ pump |

**TPN/ PPN:** ☐ N/A | ☐ TPN | ☐ PPN: _____ mls/hr | ☐ Continuous | ☐ over ____ hrs per ____ pump |

**Blood sugars:** ☐ N/A, heplock | ☐ High with coverage needed |

**PCA:** ☐ N/A | ☐ Morphine | ☐ Dilaudid | ☐ Fentanyl via | ☐ IV | ☐ Epidural, dressing: | ☐ D&I | ☐ Other: _______________ |

**Continuous dose:** ___________/hr | **Demand dose:** ___________/hr | **Max doses per hour:** ___________ |

**Cast/ Extremity Assessment**

**Hot spots over cast?** ☐ No | ☐ Yes, describe:_______________ |

**Cast intact:** ☐ Yes | ☐ No, describe:_______________ |

**Drainage:** ☐ None | ☐ Yes, describe:_______________ |

**Extremity check**

<table>
<thead>
<tr>
<th>Color:</th>
<th>☐ WNL</th>
<th>☐ Pale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature:</td>
<td>☐ Warm</td>
<td>☐ Cool</td>
</tr>
<tr>
<td>Sensation:</td>
<td>☐ WNL</td>
<td>☐ Loss of sensation</td>
</tr>
<tr>
<td>Pain increasing?</td>
<td>☐ No</td>
<td>☐ Yes, describe:_______________</td>
</tr>
<tr>
<td>Swelling increasing?</td>
<td>☐ No</td>
<td>☐ Yes, describe:_______________</td>
</tr>
</tbody>
</table>

**TYPES OF APHASIA:**

- **Dysarthria** – patient has problems with speech due to muscular control.
- **Expressive aphasia (Broca’s)** – patient understands, can respond w/ great difficulty in short abbreviated, phrases. Aware and frustrated. Often frontal lobe damage.
- **Receptive aphasia (Wernicke’s)** – patient cannot understand spoken and sometimes written words, speaks fluently, long sentences that do not make sense. Patient may not be aware of deficits. Often secondary to L-temporal lobe damage.
- **Global or mixed aphasia** – patient has difficulty in understanding and speaking/ communicating. Often secondary to extensive damage of the language areas of the brain.

**ASSESSMENT FOLLOW UP:**

- **Notify** the physician of all abnormal findings!!
- **Use the nursing process to:**
  - Analyze subjective and objective findings.
  - Make a nursing diagnosis.
  - Plan and implement appropriate interventions.
  - Evaluate the effectiveness of the plan and revise as needed.
### Putting it All Together

#### As you walk into the room assess:
- Awake/alert, asleep?
- Skin color
- Respiratory effort

#### As you converse with the patient assess:
- Orientation to person, place, time
- Communication/speech
- Respiratory effort and rhythm
- On/off O₂
- Glasgow coma score
- Pain

#### At the head assess:
- Skin color, temp, moisture and integrity
- Incisions and dressings
- Oral mucosa/tongue
- Skin tenting on forehead
- Tremors
- Pupils
- Jugular/subclavian CVL
- NG/Nasoduodenal tube

#### At the chest/back assess:
- Skin color, temp, moisture and integrity
- Incisions and dressings
- Respiratory rate, depth, rhythm and effort
- Oxygen settings
- Apical pulse
- Apical/radial deficit
- Heart sounds

#### At the upper extremities assess:
- Skin color, temp, moisture and integrity
- Incisions and dressings
- Capillary refill
- Radial pulses
- Skin tenting on forearm
- Edema
- Periph IV/PICC insertion sites
- Tremors
- Hand grasps
- Muscle tone and strength
- Casts

#### At the abdomen assess:
- Skin color, temp, moisture and integrity
- Incisions and dressings
- Nutritional intake
- Nausea/vomiting
- Bowel movements
- Distention/ascites
- Bowel sounds
- PEG/J tube site
- Tube feedings
- Stomas
- Constipation
- Abdominal/flank pain
- Bladder distention, s/s of UTI
- Urine output, color, characteristics
- Urinary catheter

#### At the genitalia/buttocks:
- Skin color, temp, moisture and integrity
- Incisions and dressings
- Femoral pulses
- Sacral edema

#### At the lower extremities assess:
- Skin color, temp, moisture and integrity
- Incisions and dressings
- Pedal and posterior tibial pulses
- Edema
- Muscle tone and strength

- Notify the Physician of abnormal findings of concern
- Implement the nursing process
- Analyze the data
- Identify the appropriate nursing diagnoses
- Develop and implement a plan
- Evaluate the outcomes
An Easy Guide to Head to Toe Assessment
© Mary C. Vrtis, Ph.D., RN, 2011 available from www.aperiomlc.com

Cardiac Rhythm Assessment by ECG

Sinus rhythm:
- Normal sinus rhythm (NSR) [P wave before every QRS, P-R interval < 0.20, rate is between 60 to 100]
- Sinus tachycardia [rate => 101]
- Sinus bradycardia [rate <= 59]
- Sinus arrhythmia [P wave before every QRS, but rate varies with respiration]

Atrial dysrhythmias:
- Atrial fibrillation [atria of heart is fibrillating, ECG shows wavy line, conduct ion thru A-V node to ventricles is erratic]
- Atrial flutter with __:1 conduction block [atrial rate approx 300, ventricular (heart) rate 150 = 2:1, HR 75 = 4:1]
- Atrial fibrillation [atria mixture of flutter and fibrillation]
- Paroxysmal supraventricular tachycardia (PSVT) [sudden onset, very fast rates, narrow QRS, P wave absent or behind QRST]

A-V Heart Blocks:
- First degree heart block [delayed conduction thru AV node, P-R interval > 0.20]
- Second degree A-V block, Mobitz I* [P-R interval lengthens until a QRS is absent, cyclic pattern with every X beat dropped]
- Second degree A-V block, Mobitz II** [P-R interval is stable, no QRS after some P waves due to intermittent AV block]
- Third degree A-V block*** [no relationship between P waves and QRS complexes due to complete block at AV node]

Paced Rhythms:
- Atrial-ventricular (AV) sequential pacing [spike before the P wave and spike before the QRS] 1:1? Yes No
- Ventricular pacing [pacing spike before the QRS only] 1:1? Yes No
- Demand pacing [heart rate is higher, pacemaker fires only if there is a delay in spontaneous activity]? Yes No
- Automatic internal defibrillator (IAD)? No Yes Has client felt it fire? No Yes, when

Ectopic Beats:
- Ventricular premature beats (VPB, PVC) [an early, wide QRS, extra beat originating in the ventricle]
- Bigeminy [every other beat is a VPB]
- Trigeminy [every 3rd beat is a VPB]
- Quadrigeminy [every 4th beat is a VPB]
- Premature atrial beats (PAB, PAC) [an early, narrow QRS, extra beat originating in the atria, P wave shape may be different]
- Premature junctional beats (PJ) [an early, narrow QRS, extra beat originating above the A-V node, no P wave]

Lethal dysrhythmias:
- Ventricular escape rhythm (also called idioventricular) [wide QRS complexes, HR @ ventricular intrinsic rate, 30-40]
- Ventricular tachycardia [wide QRS, tachycardi rates, minimal cardiac output due to ineffective pumping, cannot sustain life]
- Ventricular fibrillation [eratic line, ventricles are quivering, no pumping action, cardiac output is 0]

*A fib with rapid response (HR > 100) increases myocardial oxygen needs and risk of LV failure is high, also high risk for PE.
**Previously called Wenckebach. ***Mobitz II second degree and third degree block can result in life threatening bradycardia.