**Change of Condition Competency**

Appendix A – Head to Toe Assessment

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**Head to Toe Assessment Standard**

**Standard**

A head to toe assessment is a systematic process of gathering information through a physical examination that is able to differentiate between normal and abnormal changes in a resident/client physical, mental and or psychosocial status.

**Purpose**

The components of a head to toe assessment include:

1. Differentiate between normal and abnormal vital sign parameters.
2. Identify key components of the neurological exam.
3. Identify key components of heart assessment.
4. Identify key components of respiratory assessment.

**Components**

* Vital Signs
* Neurological Assessment
* Heart Assessment
* Respiratory Assessment
* Mental Status Exam
* Assessment Check List
* Sample Narrative Charting
* Head to Toe Assessment Template

**Infection Control**

* Perform hand hygiene between each Individual
* Use Standard Precautions in assessing the client/resident.

**Introduction to the Client/Resident**

* Introduce yourself to the client/resident
* Explain the purpose of the head to toe assessment
* Explain to the Individual the need for the assessment to identify changes in condition to allay possible anxiety.
* Be sure that the resident/client is comfortable before beginning the assessment.

**General Observation**

* Look at the client/resident for eye contact, appearance, hygiene and cooperation

**Head to Toe Assessment Guidelines**

**Head and Neck**

* Palpate the head for tenderness, bumps, and abrasions.
* Observe for head lice.
* Observe the ears for signs of skin breakdown, abrasions, earwax build-up, and use of adaptive hearing devices.

**Vital Signs**

* Measure and record the temperature, pulse, respiration, and orthostatic blood pressures.

**Orientation**

* Check orientation by determining if the resident/client can state their name, the day or date, where they are, and the reason they are in the facility or receiving nursing care.
* Use open-ended statements, such as, "Tell me your name", " What year is this?", "Tell me where you are." “Tell me why you are here.”
  + Yes/no questions may not be an accurate measure of orientation.

**Pupil Check PERRLA (P**upil**s E**qual**, R**ound**, R**eactto **L**ight**, A**ccommodation**)**

* Check pupils checked by shining a light in from the side.
* View each pupil and note equality of size.
* Note when the light is shone whether pupils react equally by constricting
* Note if the reaction is sluggish, normal, or brisk
* Note if there no change in pupil size when the light is shone
  + A millimeter scale is often used to check pupil size. For example, the pupils may change from 4 mm to 3 mm with the light. Accommodation tests the ability of the pupils to constrict to a closer moving object.
  + Have the resident/client follow a pen or your finger. The pupils will constrict as the object comes closer.
  + Accommodation cannot be checked if the resident/client is confused, blind, comatose, or unable to follow the object. In that case, chart **PERRL**, and leave the **'A'** off.

**Neck Veins**

* Check neck veins by having the client/resident sit at a 45-degree angle. The jugular veins should be flat. Distended neck veins at 45 degrees are an indicator of over hydration or fluid overload.

**Heart Tones**

* Check heart tones by listening to the apical pulse.
* Listen with the diaphragm and the bell of the stethoscope placed over the heart just below the left nipple between the 5th and 6th ribs.
* The apical pulse is counted for a full minute.
* Check the apical pulse for rate, rhythm, and clarity of the sounds of the S1 and S2 otherwise known as "lub and dub".
* Report any abnormalities.

**Bilateral Checks**

Compare measurements on each side of the body for:

* Radial pulses - check rate, strength, and regularity
  + Hand strength - have resident/client grip two of your fingers at the same time. Check for equality in strength.
    - Never offer the resident/client your entire hand to grasp. A resident/client with a strong grip can injure your hand, but is less likely to hurt two fingers
* Leg strength - place your hands on the resident/client thighs. Have the resident/client push legs against the resistance of your hands.
  + - Check for equality in strength.
* Pedal pulses located on the top of the foot.
  + - Check rate, strength, and regularity
* Capillary refill - can be done on the fingers or toes.
  + - Press down on the nail bed. The color will blanch. Record the time for the color to return.
    - Capillary refill should return in 3 seconds or less. A delay in capillary refill may indicate impaired circulation.

**Skin**

**Turgor-an indicator of hydration status**

* + Check skin turgor by gently pulling up skin on the sternum – the pulled skin should return to the baseline flat state within 1 to 3 seconds.
  + Do not check for skin turgor on the hands; the sternum is not as affected by aging changes and is a better reflection of hydration status.

**Mucous Membrane Color-an indicator of oxygenation status**

* + Check skin color by observing mucous membranes on the inside of the lip or the conjunctiva.
  + Color can generally be described as pink, pale, jaundiced, or cyanotic.

**Temperature**

* + Check by using the back of the clinician’s hand placed on the client/resident skin.
    - Skin may be hot, warm, clammy or cool.

**Skin Breakdown Check**

* + Check the entire body for redness or skin breakdown including bony prominences.

**Breath Sounds**

* Use the bell and the diaphragm for assessing breath sounds.
* The apices of the lungs are very high, extending above the clavicles.
* Assess anterior and posterior breath sounds listening for side to side comparisons.
* The right middle lobe is assessed by listening on the client/resident t's right side and instructing to take deep breaths in and out of their mouth.
* Be careful not to move the stethoscope too rapidly to avoid hyperventilating the client/resident.
* Nose breathing can create air turbulence that may alter the sounds. Breath sounds should be clear bilaterally with good air flow.

**Bowel Sounds**

The abdomen is divided into four quadrants.

* To assess bowel sounds, using the umbilicus as the mid-point, it is very important to auscultate the abdomen before touching.
* Palpation of the abdomen prior to auscultation may disrupt normal sounds.
* If the client/resident is on nasogastric suction, turn the machine off prior to listening for bowel sounds.
* Bowel sounds can be described as hypoactive, active, hyperactive, or absent.
* To chart absent bowel sounds, each quadrant must be assessed for 5 minutes. In other words, absent bowel sounds infer a 20-minute assessment.

**Peripheral Edema**

Edema or fluid in the tissues tends to go to dependent areas of the body. This may be the hands, arms, legs, feet or sacrum. Client/resident that requires bed rest, the dependent area is most often the sacrum. Check for edema push your finger down on the feet, hands, and sacrum and observe for indentation or pitting.

**Assessing for Pain - Pain is the 5th Vital Sign**

* Ask the client/resident if they are having any pain. Assess for location, duration, radiation, alleviating factors, precipitating factors, quality and intensity.
* Where is the pain, how long has it lasted?
* Does the pain travel anywhere?
* What makes the pain feel better, what makes the pain worse?
* Describe how the pain feels. Is it sharp, dull, pressure, stabbing?
* On a scale of 1 to 10, with 10 being the worst pain you could possibly have, tell me the level of pain you are experiencing."

**Closure**

Let the client/resident know you are finished and when you will be back. Leave the bed in the appropriate position and height for the client/resident. Ask if they need anything else and leave them comfortable and oriented to the new environment. Place the call light in reach and ensure they know how to use it. If the client/resident is unable to demonstrate or verbalize use of the call light, coordinate frequent checks and oversight.