Nurses International

Clinical Skills

Name of the Procedure/Rubric/*Rationale*: Head to Toe Physical Assessment (Older Adult)

Step	Procedure	Yes	No	Remarks
1.	Perform hand hygiene.			
2.	Collect necessary equipment for physical assessment in a clean tray: a. Clean gloves b. Stethoscope c. Sphygmomanometer d. Tongue depressor e. Penlight			
3.	Greet the client kindly, and identify the client using two client identifiers i.e name and date of birth.			
4.	Inform them what, why, and how of the physical assessment procedure. Obtain their verbal consent for the procedure. *Reduces the anxiety related to the procedure and promotes client's co-operation.*			
5.	Ensure client's privacy by pulling curtain, closing door as per client's comfort			
6.	Maintain a warm temperature in the room if possible.			
7.	Perform hand hygiene.			
8.	If the client is in bed, raise the level of the bed to appropriate height. *To ensure proper body mechanics and prevent injuries.*			
9.	Lower the side-rail on your side, and position the client in a comfortable position.			
General Appearance				
10.	Assess speech pattern/articulation when talking			
11.	Assess affect/behaviour: - comfortable? restless? inattentive?			
12.	Assess level of hygiene			
13.	Assess if the client looks undernourished, pale.			

Nurses International

Clinical Skills

Name of the Procedure/Rubric/*Rationale*: Head to Toe Physical Assessment (Older Adult)

14.	Assess if the client is dyspneic or cyanotic.			
Head and Face and Neck Examination				
15.	Inspect client's head and face - Hair long/ short? hair loss /bald? beard/mustache? - color of the hair - lesions? bruising? rashes? edema - facial symmetry?			
16.	Palpate head and face for - any mass, moles, or other growth?			
17.	Palpate temporal arteries for tenderness and thickening. *May indicate giant cell arteritis which requires immediate evaluation/treatment.*			
18.	Inspect eyes for : - drainage? - Redness?			
19.	Inspect conjunctiva by pulling down on the lower lids of the eyes - Are they pink/pale/red? - Moist, dry?			
20.	a. Test pupillary reaction to light using pen light 1- Instruct the client to focus on a far away object straight ahead to cause dilation of the pupils. 2- Hold the penlight at an outer corner of an eye and slowly bring it to the pupil of that eye. 3- Check for the pupillary reaction when the penlight falls on the pupil. (Normal reaction- pupil constricts and become smaller) 4- Repeat the process for the other eye. 5- Compare for symmetrical /asymmetrical reactions between b. Test visual acuity using Snellen's chart			
21.	Standing in front of the client, inspect the client's ears for: - Asymmetry, prominence - Scars, masses, edema - Erythema, discoloration of skins - Exudate, discharge - Displacement of pinna			
21.	Palpate ears for tenderness.			

Nurses International

Clinical Skills

Name of the Procedure/Rubric/*Rationale*: Head to Toe Physical Assessment (Older Adult)

22.	Inspect nose - Are both sides of the nose symmetrical? - Lesions, redness, swelling, or discharge present? Progressive descent of the nasal tip is a normal age-related finding.			
23.	Gently block one of the nares and instruct the client to inhale with the mouth closed to check for patency. Repeat procedure on the other side.			
24.	Inspect the nose by gently tilting the client's head backwards, lifting the chin. - Observe for symmetry - Observe nostrils for masses/growths, discharge			
25.	Observe the lips for - Color blue/pale? - Dryness, scaling? - Lesions, swelling around lips			
26.	Don clean gloves. Instruct the client to open the mouth to assess oral cavity using a penlight. Observe for - Dryness/moisture. - Lesions/wounds. - Cleft palate. - White patches, lesions. - Swollen, bleeding gums. - Dental caries.			
27.	Instruct the client to lift the tongue to check for the tongue tie.			
28.	Use the tongue depressor to check if the tonsils are enlarged, red, or have discharge.			
29.	Dispose of the tongue depressor and the gloves, and inspect the neck for - asymmetry, scars, or other lesions.			
30.	Assess if both sides of the neck under the chin are asymmetrical, swollen.			
31.	Palpate the neck to detect areas of tenderness, deformity, or masses.			
32.	Palpate lymph nodes in the neck using pads of the index and middle fingers.			

Nurses International

Clinical Skills

Name of the Procedure/Rubric/*Rationale*: Head to Toe Physical Assessment (Older Adult)

Chest Examination				
33.	Instruct the client to remove the clothing from the upper part of the client's body.			

34.	Inspect the chest for
	- the symmetry of both sides of the chest with respect to
	  - Location of the nipples
	  - Rise and fall with each respiration
	- Shape of the chest - pigeon chest/Barrel chest?
	- Moles, masses, discoloration of skin, open skin?			

35.	Observe if - accessory muscles are used for breathing (i.e., scalenes, sternocleidomastoid muscle, intercostal muscles) - Labored breathing?			
	Auscultate breath sounds using a stethoscope			
36.	Warm up the stethoscope by rubbing the diaphragm piece in your hands before placing it on the client's body. (Auscultation should never be done through the clothing.)			
37.	Instruct the client to take deep breaths through the open mouth. Then using the diaphragm of the stethoscope, start auscultation anteriorly at the apices, and move downward side to side until no breath sound is appreciated on both sides. - At least one complete respiratory cycle should be heard at each site. - Always compare symmetrical points on each side. - Listen for the quality of the breath sounds, the intensity of the breath sounds, and the presence of adventitious sounds like crackles, wheezing, rhonchi.			
38.	Next, listen to the back, starting at the apices and moving downward. Avoid areas covered by scapulae.			
39.	Count the respiratory rate for one whole minute.			
40.	Auscultate apical heart beat by placing diaphragm of the stethoscope on the midclavicular point of fifth intercostal space in the left side of the chest. Rarely, the heart presents towards the right side of the chest. Count the rate and rhythm of the heart beat for one whole			

Nurses International

Clinical Skills

Name of the Procedure/Rubric/*Rationale*: Head to Toe Physical Assessment (Older Adult)

	minute.			
41.	Cover the client's chest with clothing.			
Abdomen Examination				
42.	Expose the abdominal area of the client.			
43.	Inspect the abdomen for, - Asymmetry or distention - Condition of the skin			
44.	Rub the diaphragm of the stethoscope to make it warm, and auscultate all four quadrants of the abdomen for bowel sounds. Allow 1 minute for each quadrant to detect bowel sounds)			
45.	Percuss all four quadrants of the abdomen.			
46.	Rub your hands together to warm your hands and palpate all four quadrants of the abdomen for, - Tenderness, guarding - Unusual masses.			
47.	Cover the abdomen with clothing.			
Upper Extremities and Musculoskeletal Examination				
48.	Inspect upper extremities for - Condition of skin, nails - Deformities? - Wounds, edema, erythema?			
49.	Palpate the nail bed for capillary refill 1- Press on the nail of the client's digit until it loses its colour,i.e typically for 5 seconds 2- Then relieve the pressure on the nail bed and time the return of pale nail bed color to pink.			
50.	Palpate both upper extremities for bilateral brachial pulse 1- Feel the bicep tendon in the area of antecubital fossa. 2- Move the pads of your three fingers medial (about 2 cm) from the tendon and about 2-3 cm above the antecubital fossa to locate the pulse. 3- Once you feel the pulse count for one whole minute for rate and rhythm.			

Nurses International

Clinical Skills

Name of the Procedure/Rubric/*Rationale*: Head to Toe Physical Assessment (Older Adult)

	4- Make bilateral comparison for symmetry in rate and rhythm			
51.	Palpate both upper extremities for bilateral radial pulse 1- Place pads of your first three fingers along the radius bone which is on the lateral side (the thumb side) of the client's wrist 2- Move the fingers closer to the flexor aspect of the wrist (where the wrist meets the hand) and press your fingers gently to palpate for radial pulse. 4- Count pulse rate and rhythm for one whole minute 5- Make bilateral comparison for symmetry in rate and rhythm			
52.	Assess and compare bilateral muscle strength of upper extremities by 1- Instructing the client to grip your hands 2- Instructing the client to push and pull against the resistance of your hands.			
53.	Assess and compare bilateral range of motion of the shoulders, arms, and wrists Shoulders: Forward flexion 180 degrees (arms at side, move arms up in arc to top of head) Hyperextension 50 degrees (hyperextend extended arms behind shoulders) 1- Instruct the client to raise both arms straight in front of the chest, to the side, towards the back, and above the head. 2- Instruct the client to lower both arms, assess if the client's arms fall rapidly or with control. 3- Instruct the client to bend the elbows and wrists in turns. 4- Instruct the client to rotate arms at shoulders inwards and outwards. 5- Instruct the client to rotate wrists inwards and outwards. Assess for stiffness and speed in which the client perform the above activities.			
	Assessment of the lower extremities			
54.	Instruct the client to remove her/his clothing below the hip			

Nurses International

Clinical Skills

Name of the Procedure/Rubric/*Rationale*: Head to Toe Physical Assessment (Older Adult)

	region. Assist if the client is unable to do so on her/his own.			
55.	Observe the sacral and buttock area for skin integrity - Pressure sores? - Color - blue/erythema?			
56.	Inspect lower extremities for - Symmetry, deformities - Edema, wounds - Skin discoloration, masses, growths - Nail integrity			
57.	Put the clothes back on the client.			
58.	Palpate the pedal pulse (dorsalis pedis artery pulsation) 1- Locate the dorsal most prominence of the navicular bone of the feet, and place index and middle finger 2- Palpate for the dorsalis pedis artery pulsation 3- Assess the bilateral rate and rhythm of the pedal pulse for one whole minute.			
59.	Assess for dorsiflexion and plantar flexion of both feet 1- Instruct the client to flex the feet upward for dorsiflexion 2- Instruct the client to flex feet downward for dorsiflexion			
60.	Tests for bilateral leg strength by instructing client to raise the leg against counter pressure (preferably with client sitting). Alternate method: instruct the client to push and pull feet against resistance.			
61.	Assess for Babinski reflex, 1- Run the tongue depressor up the lateral plantar side of the foot from the heel to the toes, and across the metatarsal pads to the base of the big toe 2- Assess for the normal reaction where the toes deviate downward. (Babinski reflex is present if dorsiflexion of the big toe and fanning of the other toe occur. It indicates damage to the corticospinal tract)			
62.	Ask the client for any discomforts, ensure the call bell is within the client's reach, lower and lock the bed, and assess to determine the need for side rails before you leave.			

63.	Dispose of the equipment appropriately as per institutional protocol/policy.			
64.	Perform hand hygiene.			
65.	Document the assessment findings in the client's medical record as per institutional policy.			

Reference:
Doyle. G. R., & McCutcheon. J. A. (2015). *Clinical Procedures for Safer Patient Care.* BCcampus. Retrieved on 16th of December, 2020 from https://opentextbc.ca/clinicalskills/