Nurses International

Clinical Skills

Name of the Procedure/Rubric/*Rationale*: Brief Bedside Assessment

Step	Procedure	Yes	No	Remark
1.	Perform hand hygiene and collect equipment in a clean tray: - Blood pressure machine - Stethoscope - Penlight - Tongue depressor - Pulse oximeter			
2.	Greet and identify the client using two identifiers (name and date of birth).			
3.	Explain the procedure and obtain informed consent			
4.	Perform hand hygiene.			
5.	Provide privacy.			
6.	Check for orientation**:** person, place and time			
7.	Observe client's general appearance and signs of distress			
Measure Vital Signs				
8.	Raise the bed to the working height, and lower the side rail (if present).			
9.	Measure temperature, apical pulse, respirations, blood pressure, and pulse oximetry			
10.	Assess all body systems using a systematic approach			
Assesses Integument (Hair, Nails, and Skin)				
11.	a. When examining each area of the body: 1) Note skin color, rashes, and lesions 2) Palpate for temperature, turgor, and texture 3) Inspect hair and nails in the area b. Assesses wounds (appearance, size, drainage, dressings, drains)			
Assesses the head and neck areas				
12.	Eyes: Observe pupil reaction, accommodation, cardinal fields of gaze, color of conjunctiva			
13.	External observe ears for symmetry, lesions/wounds, masses/growth, drainage/discharge, color of discharge if present			
14.	Observe nares for symmetry and patency			
15.	Lips: Observe color, mucous membranes.			
16.	Tongue and oropharynx: Observe hydration, color, lesions, dentation			
17.	Carotid pulse, palpate lightly, one side at a time			

Brief Bedside Assessment (continued)

Step	Procedure	Yes	No	Remark
Assess Chest and the Back				
18.	Assist the client to a sitting position (if not already sitting up)			
19.	Inspect skin for lesions, lumps, growth, color			
20.	**Auscultate breath sounds**, side to side and apex to base. Four locations (the front upper and lower lobes) and four locations in the back (upper and lower lobes, one lobe on the right side			
Assess Abdomen				
21.	Assist the client to supine position.			
22.	Inspect for size, shape, symmetry, distention, and condition of skin.			
23.	Auscultate bowel sounds in all four quadrants.			
24.	Percuss abdomen in all four quadrants			
25.	Gently palpate all four quadrants for: tenderness, and guarding			
26.	Determine the time of last bowel movement, and pattern of bowel movements.			
27.	Assess urinary status: a. Review voiding pattern including frequency and dysuria b. Observe for distention (over pubic area)			
Assess Upper Extremities				
25.	Inspect the condition of the skin and nails.			
26.	Palpate skin temperature.			
27.	Palpate bilateral brachial and radial pulses.			
28.	Check capillary refill.			
29.	Check the range of motion and symmetry. Note any stiffness or limited range of motion of the hands and arms.			
30.	Test muscle strength by instructing the client to grip your two fingers, and pushing and pulling against the resistance you provide.			
31.	Observe sacral and buttock area for skin integrity.			

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Name of the Procedure/Rubric/*Rationale*: Brief Bedside Assessment

Step	Procedure	Yes	No	Remark
Assesses Lower Extremities				
32	Observe range of motion and symmetry			
33	Inspect the condition of the skin and nails			
34	Palpate skin temperature and pedal pulses.			
35	Test for leg strength by instructing the client to raise the leg against counter pressure (preferably with client sitting). Alternate method: instruct client to push and pull feet against resistance.			
36	Check sensation through light touch, proceeding to pain as needed. Check for calf pain, tenderness, or warmth			
37	Observe for edema.			
38	Check capillary refill.			
39	Check for: Babinski reflex			
40	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.			
41	Perform hand hygiene.			
42	Document the findings from the assessment as per agency protocol.			

Reference:

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