HERZING UNIVERSITY | SCHOOL of NURSING

HEAD-TO-TOE ASSESSMENT SKILL VALIDATION

Student Name: _____ Date: _____

*The purpose of this check-off is to help you prepare for the type of assessment you will perform in a hospital setting. To ensure proficiency and efficiency, practice this assessment before the check-off so you can complete it in **within 30 minutes.** Use the person's body as your guide, starting at the top of the head and systematically working your way downward to assess the eyes, nose, mouth, neck, etc. As part of the check-off, you are required to verbalize your findings after each assessment step using appropriate medical terminology.*

	Points Allowed	1st Attempt	2nd Attempt
Preparation			
Perform I-CHECK: introduce yourself, **check armband (two patient identifiers),** hand hygiene, explain procedure, check order, and keep privacy	+1		
Perform patient interview • Chief complaint • Past medical history • Family history • Past surgical history • Allergies • Medications • Social history (drugs, alcohol, smoking, sex & safety) • Social determinants of health (insurance & flu/pneumonia vaccines)	+8		
Assess patient for alert and awake or stupor and non-arousable	+1		
Assess the patient's **orientation** to person, place, time, and situation	+1		
Verbalize that all assessment will be done on bare skin	+1		
Vital Signs & Pain			
Assess vital signs: • Heart rate (count radial pulse for 30 seconds if regular then multiply by 2) • Respiratory rate (count for 30 seconds if regular then multiply by 2) • Blood pressure • Temperature (oral) • Pulse ox	See VS/Pain Form		
Assess pain using the OPQRST method: • Are you having any pain? • Onset: When did the pain begin? • Provocation: What makes the pain worse? • Quality: How do you describe the pain? • Radiation: Does the pain spread elsewhere? • Severity: Explain and use 0-10 scale to assess intensity • Timing: Is the pain constant or intermittent? How long does it last?	See VS/Pain Form		
Head, Eyes, Ears, Nose, Mouth, Throat (HEENT)			
Examine the eyes: • Inspect the sclera, conjunctivae, and pupil size • Check pupillary light reflex by shining a light in each eye and observing for direct and consensual responses	+2		
Assess nares for patency, congestion, and drainage	+1		

Inspect the oral mucous membranes for smoothness, moisture, and color	+1		
Inspect ears for any drainage	+1		
Chest			
Inspect the chest configuration (AP to Transverse diameter), noting any abnormalities	+1		
Note any lesions on the chest and back	+1		

Auscultate lung fields anteriorly & posteriorly and from the axillae:
• Place stethoscope diaphragm on the anterior chest (6) (ask the patient to breathe deeply, moving the stethoscope to the next spot after exhalation)
  ○ Posterior (8)
  ○ Lateral (2)
• Identify breath sounds in each lobe as normal (bronchovesicular) or adventitious (e.g., wheeze, crackles, rhonchi, friction rub)
	+4		

Auscultate the heart (using the bell and diaphragm of the stethoscope, noting the presence of S1 and S2, any additional cardiac sounds, and the regularity of the rhythm) • Aortic • Pulmonic • Tricuspid • Mitral	+4		
Upper Extremities			
Assess the color, warmth, and moisture of upper extremities	+1		
Note any lesions on the upper extremities	+1		
Palpate the pulses bilaterally, grading the force (0-4+) • Brachial • Radial	+2		
Assess capillary refill on both hands	+1		
Assess upper arms strength by having client squeeze two fingers (0-5)	+1		
Abdomen			
Assess abdominal contour by having client lie supine, uncovering the abdomen	+1		
Assess skin for any lesions	+1		
Auscultate the abdomen first with the diaphragm of the stethoscope for approximately 30 seconds, or up to five minutes if no bowel sounds are heard	+1		
Lightly palpate the abdomen to assess for tenderness	+1		
Ask the client when the last bowel movement occurred • Describe color, consistency, frequency, or any changes	+2		
Ask if the client is having any difficulties or abnormalities with urinating, such as changes in color, clarity, frequency, urgency, pain, or any presence of blood	+1		
Lower Extremities			
Assess the color, warmth, and moisture of lower extremities	+1		
Note any lesions on the lower extremities	+1		
Assess for edema and grade it (0 to 4+)	+1		
Palpate the pulses bilaterally and grade the force of each pulse (0-4) • Posterior tibial • Dorsalis pedis	+2		
Assess capillary refill on both feet	+1		
Assess lower extremity strength by having the client dorsiflex and plantar flex feet against resistance. (0 to 5)	+1		

Focused Assessment			
Assess beyond the basic questions for a head-to-toe (assess in more detail) • Asks 2 more questions about their chief complaint • Assess that specific body system in more detail, performing 2 additional assessments • Verbalizes if any tests need to be ordered	+5		
Total Points (successful/unsuccessful) 43 out of 52 needed to be successful			
Comments **1st Attempt:** **2nd Attempt:**			

Evaluator Initials or Signature: _____ Date: _____

1ST Attempt Pass _____**/ Needs Remediation**_____

Evaluator Initials or Signature: _____ Date: _____

2nd Attempt Pass _____**/ Lab Fail**_____