Assessment Process

August 3, 2015

Outside Room

- Start of the shift
- Gather resources from outside patient room
- To patient room
- Verify markers/flags in the doorway
- Additional supplies needed?
  - no
  - yes
    - Collect supplies

Computer in Room

- Place resources in available space
- Hand Hygiene
- Greet/introduce yourself to the patient. Ask about how he/she is doing.
- Assist patient into bed if needed
- Note movement ability
- Assess for pain using institution approved scale
- Check patient controlled analgesia pump settings; rate and type of solution

Inside Room

Comments
Evaluate Vital Signs.

Document V.S. abnormal findings.

Reassess pain level if needed.

Check Oxygen, FiO₂ and respiratory effort.

Measure blood pressure.

Measure respirations.

Measure pulse.

Measure temperature.

Record abnormal findings.

Offer water and assess hearing, following directions, crossing midline, swallow.

Supply additional dose.

Contact physician.

Is there an order? yes

Further dosing needed? no

no

Document in piece of paper before inputting data in computer.
Evaluate Neurologic system

Document Neurologic System abnormal findings

Check fitting of oxygen mask/nasal prongs, if needed

Auscultate breath sounds

Have patient cough and check for mucus color/amount

Check incentive spirometer, if ordered. Educate/remind patient on its use.

Remove gown and auscultate rhythm at apex

Check apical pulse against radial pulse

Asses heart sounds in all auscultatory areas with diaphragm

Asses heart sounds in all auscultatory areas with bell

Check capillary refill

Document in piece of paper before inputting data in computer.
Check pretibial edema using institution approved scale

Palpate posterior tibial or dorsalis pedis pulse, right and left

Could find by palpation? 

- **No** Assess by Doppler imaging
- **Yes** Verify IV solution rate and type are consistent with physician orders AND your own assessment

- Note skin color
- Palpate skin temperature
- Pinch skin to note mobility and turgor
- Note skin/dressings integrity

Date IV site, note surrounding skin

Assess skin measures

Complete standard skin assessment tool if abnormal
Assess oral intake

Inquire whether passing flatus or stool

Inquire if voiding regularly

Assess ABDOMEN contour

Listen to bowel sounds

Check and correct drainage tube

Foley catheter in place? no

Has patient void?

Check urine for color, quantity and clarity and amount

Needs to know diet orders. Do they check it right before this step or they are supposed to know this before coming to the room?
Ambulatory?

Evaluate risk of skin breakdown with appropriate tool

Check SCDs, TED hose, foot pumps are hooked up and turned on.

Complete patient fall assessment tool

Initiate or continue appropriate Plan of Care

Note findings requiring attention

Document in computer

Bed in low position

Place call bell within reach from patient

Bed rails x 1 side only

Activate bed alarm if needed

End

Needs to know activity orders. Do they check it right before this step or they are supposed to know this before coming to the room?

Safety precautions before leaving the room

a) Start/end
b) Process
c) Decision
d) Documentation
e) Storage in database system
f) Movement
g) Manual operation
h) Inspection
i) Critical Thinking

Evaluate the quality of the output compared to a standard, often using a measuring device.

Using information from the process to make a decision or determine future actions. Often followed by a decision or by a documentation.