Physical Assessment: Adult Inpatient

Site Applicability

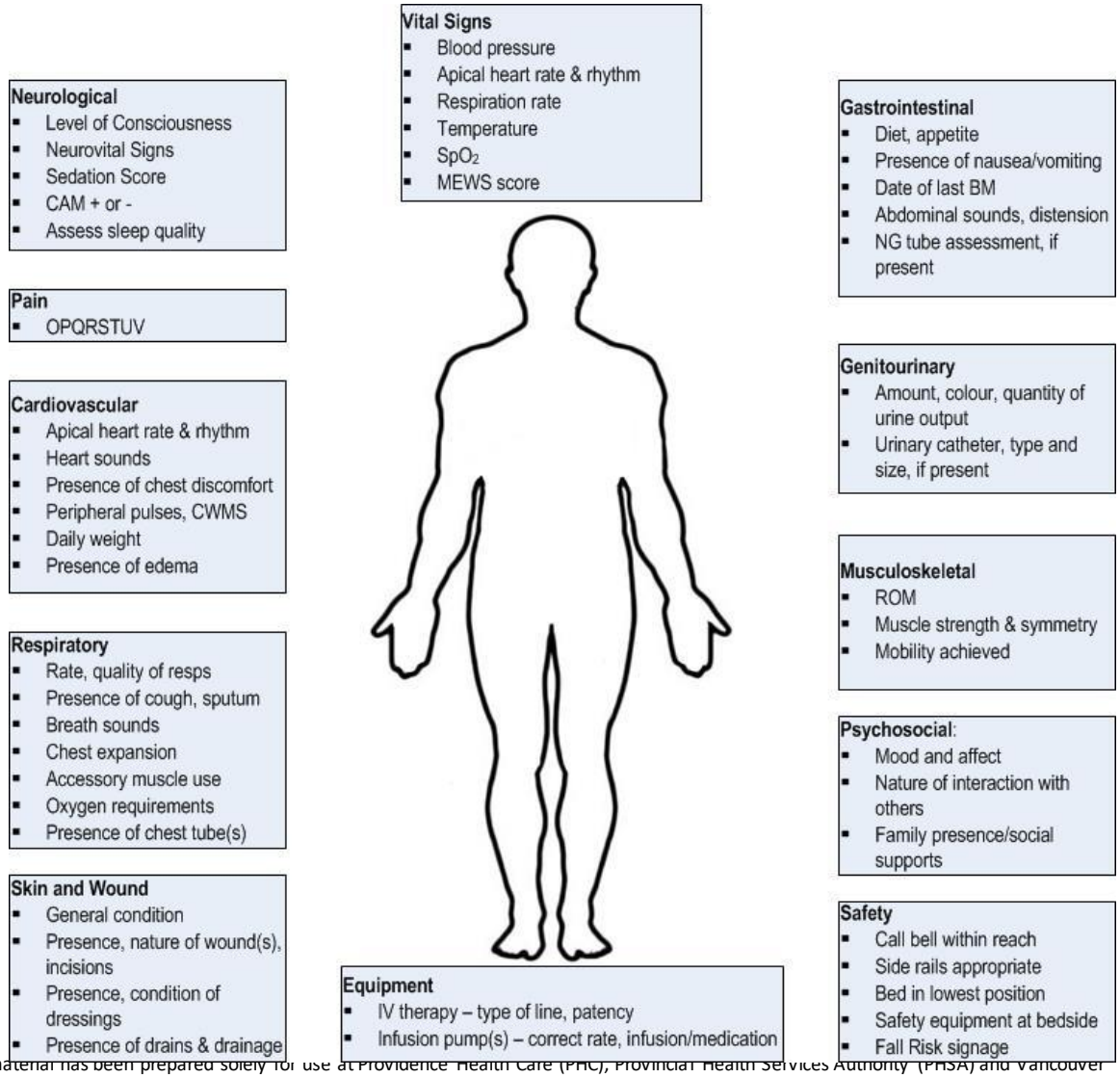
VCH Coastal CoC: Acute Care

Exceptions: *Critical Care Units, Emergency/Urgent Care Departments, Ambulatory Care, and Medicine Units live on CST Cerner*

Practice Level

Basic skills for the following professions within their scope of practice:

- RN, RPN, LPN, NP



Need to Know

Comprehensive physical assessment, as outlined in this protocol, is the responsibility of all nurses. By recording and comparing physical observations a nurse is able to identify problems early and reduce the likelihood of a critical event. During assessments staff will introduce themselves to the patient, explain the procedure, follow principles of asepsis and safety, and finally ensure patient's privacy and dignity

Alternate Level of Care (ALC) patients require head to toe assessments at the beginning of each shift and with any change in the patient's status.

Exception: Palliative Care/actively dying patients should have VS and assessments completed in line with their goals of care (e.g. pain management). Exceptions to assessment and care should be documented in the patient health record.

Guideline

Assessment

Vital Signs (Blood pressure, heart rate, temperature, respiratory rate, oxygen saturation, oxygen therapy and Glasgow Coma Scale).

Note: MEWS score is to be completed with EACH set of vital signs.

On admission or transfer to ward

- Minimum at the beginning of each shift and PRN
- Q shift and/or as per specific orders or as outlined in related/site specific guidelines and policies
- With any change in the patient's status
- After administering medications requiring VS monitoring

Head to Toe Assessment frequency

- On admission/transfer to the ward
- At the beginning of each shift
- With any change in patient status
- As outlined in related/site specific guidelines and policies

Head to Toe Assessment

Complete a head to toe assessment. For information search Mosby's/Elsevier under Assessment: Focused (Mosby's/Elsevier). Include:

System	Not in Mosby's/Elsevier

Safety	• Universal Falls Precautions (SAFE step/ SAFE)
	• Call bell within reach
	• Bed brakes on
	• Side rails in appropriate position
	• Bed in lowest position
	• Bed/chair alarm on, if appropriate
	• Falls risk signage at the beside, if appropriate
	• Suction- Working suction, suction flow meter, suction canister lining with lid and connector tubing, Yankauer suction.
	  ○ Air flow meter
	  ○ Oxygen - Oxygen flow meter with nipple adaptor, Nasal prongs, Simple mask, Oxygen extension tubing

Neurological System	Complete *Confusion Assessment Method* (CAM) screen as outlined in Delirium Guideline VCH or PHC. Assess sleep quality.
Pain	For a more in depth pain assessment search: pain assessment and management • Presence and location of non-cardiac pain • For self reporting of severity of pain use a standardized pain assessment tool – e.g. Numeric Rating Scale, Verbal Descriptor Scale, Wong-Baker FACEs pain scale. When self report is limited or not possible, use the Pain Assessment in Advanced Dementia (PAINAD) tool to assess presence of pain and to evaluate effectiveness of interventions • Assess pain using OPQRSTUV pain assessment mnemonic • Sedation level if on opioids for pain (use Pasero Opioid-Induced Sedation Scale, see Appendix A)

Cardiovascular System	• Daily weight – A.M. as per physician/NP orders, following first morning void
	• Presence of chest discomfort or other symptoms suggesting cardiac ischemia (determine patient's usual symptoms of ischemia if applicable), as per:
	  ○ PHC: Chest Pain (Outside Critical Care): Care of Patient Protocol.
	  ○ VCH/PHC: Chest pain: Management (Adult 17 years and older)

Respiratory System	Assess oxygen saturation (SpO_2) status, oxygen requirements and delivery method VCH/PHC Presence and location of pleural chest tube; assess for air leak, amount and nature of drainage. See VCH/PHC: Chest Tubes: Patient Assessment and Interventions) for management of chest tube.

System	Not in Mosby's/Elsevier
Gastrointestinal System	• Diet type and appetite • Abdominal girth if ordered and PRN • Nasogastric (NG) tube assessment, if present, – assess for migration, note type and rate of feed. Refer to NCS6255 Tube Feeding: Small Bore Enteral Feeding (Enteroflex), ACUTE CARE ONLY for further instructions on assessment. For Coastal refer to Elsevier. • Ostomy pouch, if present, assess for skin integrity, output, consistency and amount • Intake and output, if appropriate
Genitourinary System	• Assess for urinary retention, signs and symptoms of a UTI • Urinary catheter – type and size of catheter • Assess need for catheter and remove promptly, see PHC NCS6405: Urinary Catheters: Management for Prevention of UTI, VCH Urinary Retention, VCH Intermittent Urinary Catheter-Procedure • Urostomy pouch, if present, -assess for skin integrity, leakage, and amount of output • Assess genital area for edema, bleeding or discharge
Integumentary System	• Braden Scale completion within 24 hours of admission and with any change in patient condition. • Presence and nature of wounds, lesions, or incisions. Complete Wound assessment/Intervention Flowsheet • Presence of staples or sutures • Dressings – location and integrity • Presence of drains and drainage - amount, colour, consistency, odour (if applicable)
Musculoskeletal System	• Inspect - any obvious signs of musculoskeletal abnormalities (e.g. posture, gait, etc.) • Assess patient's ability to participate in ADLs e.g mouth care, peri-care; tub/sponge bath or shower • Range of motion (ROM) – any abnormalities noted during normal care activities • Muscle strength and symmetry • Mobility –prior to transferring patient; assess type of assist required (e.g. no assist required or type of mobility aid required). • PT/OT referral, as needed. • VCH Falls and Injury Prevention Guideline in Acute Care
Psychosocial	• Nature of interactions with others • Mood & affect • Family/social support

System	Not in Mosby's/Elsevier

Equipment	• IV Therapy
	  ○ Type and location of line (e.g. PIV, CVC/PICC). Note external length, IV line saline locked or TKVO
	  ○ Dressing, Patency, swelling or redness, drainage around site
	  ○ IV tubing dated and not expired
	  ○ Correct medication infusing: drug, concentration, dose and rate
	• Assess all other patient specific equipment.

Interventions

- Plan and implement nursing interventions for identified problems, e.g. regular toileting, encouraging fluids for prevention of UTI; Dysphagia screening, regular mouth care, proper positioning for prevention of aspiration pneumonia; use of universal falls precautions and other interventions for prevention of falls; regular turning, proper hydration and nutrition; and regular mobilization for prevention of pressure injuries.
- Report and document any significant changes in condition or any deviation from written parameters to the responsible member of the health care team.
- Refer to specific protocols (e.g. Sepsis, Stroke, COPD, CHF, chest tube) for specific interventions
- Evaluate and document effectiveness of interventions according to identified goals or expected outcomes.

Site Specific Practices

PHC

Unless clinical indication warrants more frequent assessment or further investigation, patients are to be assessed at least every hour by conducting Intentional Rounding. Assess for Pain, Personal needs, Proximity, and positioning during intentional hourly rounding.

Four Ps for Hourly Rounding/Intentional Rounding	
Pain	How is your pain?
Personal Needs	Do you need to use the toilet?
Proximity	Do you have everything you need close by? (e. g. water, mobility aide, call bell, etc.)
Positioning	Are you comfortable?
Always inform your patient when you will return	

Documentation

Document all assessment findings and interventions in the patient record (EHR or paper) as per unit/program standards and VPP Documentation policy

Patient and Family Education

Explain the purpose and timing of assessments and interventions required with the patient. Provide patient and family with relevant educational materials as appropriate. Ensure patients and families understand information provided to them and have had an opportunity to ask questions. Documentation of education provided to patients and families is important.

References

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Appendix A: Pasero Opioid Induced Sedation Scale

Pasero Opioid-Induced Sedation Scale (POSS)		
Score	**Meaning of Score**	
S	Sleep, easy to rouse	**Acceptable**; no action necessary; may increase opioid dose if needed
1	Awake and alert	**Acceptable**; no action necessary; may increase opioid dose if needed
2	Slightly drowsy, easily roused	**Acceptable**; no action necessary; may increase opioid dose if needed
3	Frequently drowsy, rousable, drifts off to sleep during conversation	**Unacceptable;** • hold next oral dose of opioid **and** NOTIFY prescriber /MD for adjustment of opioid orders • monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory • consider administering a non-sedating, non-opioid analgesic for pain i.e. acetaminophen or NSAID • remove PCA button if in use
4	Somnolent, minimal or no response to verbal and physical stimulation (use trapezius muscle squeeze for physical stimulation - do not use sternal rub)	**Unacceptable;** • stop opioid • oxygen by mask 10 L/min (if not COPD) and monitor vital signs • administer naloxone as per order • IMMEDIATELY page MD/ Prescribing Service physician STAT • **PROVIDE AIRWAY and BREATHING SUPPORT** • **DO NOT re-commence opioid therapy prior to patient being seen by the prescribing service physician**

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