Physical Assessment of Patients (Acute Medicine)

Site Applicability

SPH and MSJ Medicine Inpatient Units, Medicine patients on off-service units

Practice Level

Basic: Within the scope of practice of every RN/RPN/LPN.

Requirements

Consent must be obtained prior to physical assessment in accordance with the British Columbian Health Care (Consent) and Care Facility (Admission) Act.

Need To Know:

Professional Standards require nurses to document timely and appropriate reports of their assessments, decisions about patient status, plans, interventions and outcomes.

Documentation is any written or electronically generated information about a patient that describes the care or service provided to that patient. It is an essential part of nursing practice.

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, chest tube) for specific interventions

Evaluate and document effectiveness of interventions according to identified goals or expected outcomes.

The components of comprehensive physical assessment include vital signs and head to toe assessment. Comprehensive physical assessment, as outlined in this document, is the responsibility of all nurses on the medicine wards. By recording and comparing physical observations a nurse is able to identify problems 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.

Head to Toe assessment is required as follows (See Appendix B, Cerner iView):

- On admission/transfer to the ward
- At the beginning of each shift and in alignment with patient's goals of care e.g., in some patient populations, the promotion of sleep hygiene outweighs waking a patient for full head to toe assessment when starting shift at 2300.
- With any change in the patient's status
- As outlined in related Providence Health Care Decision Support Tools (DST's)

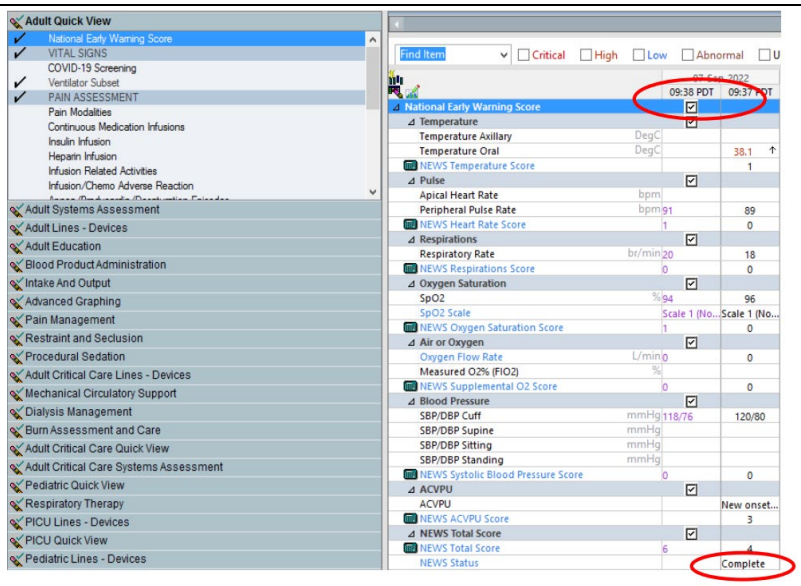
Exception: Palliative Care/actively dying patients should have VS and assessments completed in line with their goals of care (e.g. pain management). Exceptions to assessment and care should be documented in the appropriate sections in the health record.

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 **P**ain, **P**ersonal needs, **P**roximity, and **P**ositioning 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	

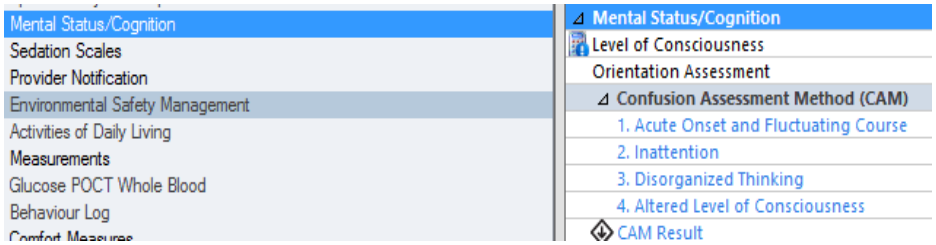
Protocol - Head to Toe Assessment

This is a guide only, and should be used in conjunction with clinical judgment

Category	Assessments and Documentation
Vital Signs & - NEWS	• Temperature • Heart rate (HR) • Respiratory rate (RR) • Oxygen saturation (Scale 1 (majority of patients), Scale 2 (with provider order for patients with hypercapnic respiratory failure and a lower target SpO_2) • Oxygen therapy / Oxygen flow rate • Blood pressure (BP) • CNS response (ACVPU - Alert, Confusion (new onset), Voice, Pain and Unresponsive). **General criteria for monitoring vital signs** • On admission/arrival or transfer onto the ward • At the beginning of each shift • Routine vital signs (Q8H) or as ordered by the physician/NP • With any change in the patient's status • When administering medications requiring VS monitoring (See PDTM) • As outlined in related Providence Health Care Decision Support Tools (DST's) **Note**: A National Early Warning Score (NEWS) is to be completed with EACH set of vital signs. A MEWS Total Score is automatically calculated by Cerner by double clicking on the blue band under the current time column before inputting values. The NEWS calculation will display as "complete" if all parameters are entered, otherwise it will display as "incomplete"in iView. For more information about MEWS and Situational Awareness Criteria see the National Early Warning Score (NEWS 2) for Clinical Deterioration in Adults.
	

Category	Assessments and Documentation

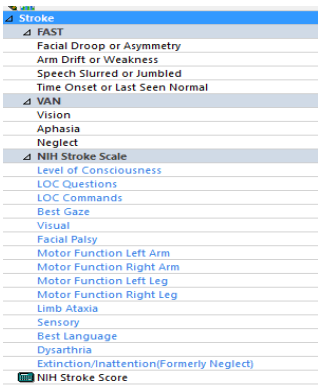
Pain	• Assess for actual or suspected pain and document:
	  ○ Onset
	  ○ Location
	  ○ Laterality
	  ○ Quality
	  ○ Provoking
	  ○ Palliating
	  ○ Radiation Characteristics
	  ○ Pain tool used
	
	For self-reporting of severity of pain, use a standardized pain assessment tool. Validated pain rating scales for use in PHC include Numeric Rating Scale, Verbal Descriptor Scale, and Wong-Baker FACES pain scale.
	
	When a patient's ability to 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 sedation using the Passero Sedation Scale, if receiving opioids. see Appendix A). Document POSS under Adult Quick View.

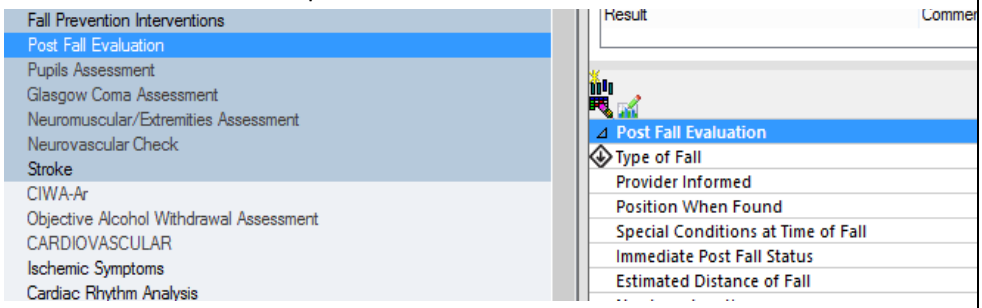
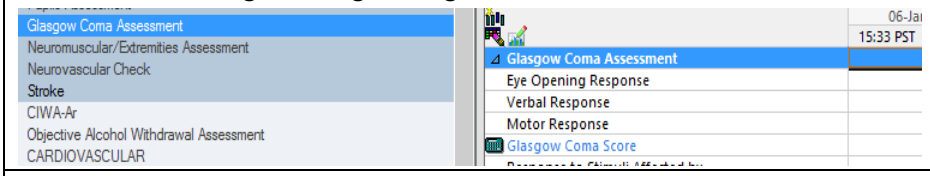
Mental Status/Cognition	Assess: • Level of Consciousness • Orientation • Confusion Assessment Method (CAM) - On admission a patient is screened for delirium risk factors as part of the Adult Admission History. If a patient has three or more risk factors, the CAM delirium assessment will be tasked BID. • If patient score is CAM +, initiate PRISME interventions and document.  Refer to: • B-00-13-10065 Delirium Assessment and Care Protocol • B-00-10-10001 Delirium Risk Care Plan

Category	Assessments and Documentation

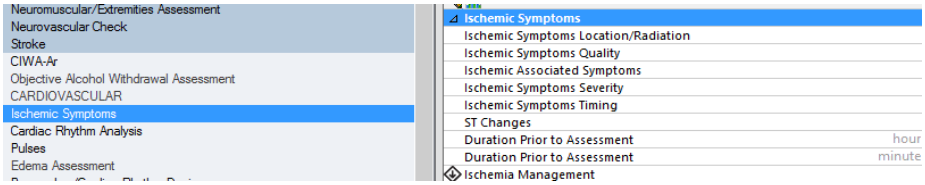
Environmental Safety Management	• Universal Falls Precautions (SAFE step) in place for all patients
	• Falls risk signage at the beside, if appropriate. Refer to Falls Injury Prevention guideline
	• Suction – Working suction flow meter, suction canister lining with lid and connector tubing, Yankauer suction
	• Air flow meter
	• Oxygen – Oxygen flow meter with nipple adaptor, nasal prongs, simple mask, oxygen extension tubing, and two tubing connectors
	• If applicable: Communication devices in place
	• Ensure Process alerts are up to date in Cerner:
	  ○ Hazardous Drugs precaution signage and equipment
	  ○ Violence risk alert and care plan
	  ○ Falls
	  ○ Unsafe sharps risk
	  ○ Infection Control precautions signage and equipment

Activities of Daily Living	• Mobility – perform 'Quick Mobility Screen' (e.g. patient's ability to bridge and roll) prior to transferring patient and assess type of assistance required (e.g. no assist required or type of mobility aid required).
	• Request PT/OT referral, as needed
	
	• **Functional Assessment**
	  ○ Bathing
	  ○ Personal hygiene
	  ○ Walking
	  ○ Toilet use
	  ○ Bed Mobility, if applicable
	  ○ Dressing
	  ○ Eating
	  ○ Sleeping behaviour
	  ▪ Assess sleep quality
	  ▪ Record Sleep Log (Ad Hoc form) as ordered
	
	• **Activity**
	  ○ Use of assistive device
	  ○ Weight bearing performance, as applicable
	  ○ Activity status ADL (e.g. patients who require turning Q2H)
	  ○ Bed Angle, if applicable
	  ○ Anti-embolism device/ Sequential Compression Devices, as needed

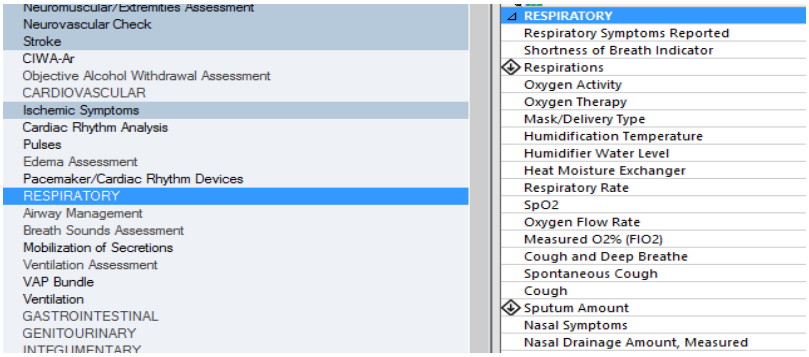
Category	Assessments and Documentation
Activities of Daily Living (Cont.)	**Nutrition ADLs** • Diet type, if applicable • For calorie count, use the '24 Hour Calorie Count Worksheet' printable from FormFast **Hygiene ADLs** • Personal care provided and routine oral care
Measurement	• On admission enter admission weight as dosing weight • Measure and record weight at frequency ordered • Indicate the type of scale used
Glucose POCT Whole Blood	• Point of Care (POC) Glucose result, as ordered • Complete task through Care Compass
Behaviour Log	• As applicable for close or constant care. It may be completed by patient care aides
Neurological System	• For patients with neurological diagnoses, with stroke, or if neurological symptoms are reported, complete neurological assessment including: ○ Nystagmus ○ Diplopia ○ Characteristics of Communication ○ Characteristics of Speech ○ Characteristics of Expression ○ Characteristics of Comprehension ○ Ability to follow command ○ Aspiration risk – complete field for patients with dysphagia ○ Facial symmetry ○ Brainstem reflexes For patients who have had a stroke assessed: • Post stroke NIHSS (completed only by certified nurses) • For suspected acute stroke or stroke like symptoms complete FAST Refer to Hot Stroke Protocol ED and In-patient (SPH and MSJ) 

Category	Assessments and Documentation
Falls	**MORSE Fall Scale** • Completed within 24 hours of admission or transfer, with a significant change in status, or following a fall • All patients who are identified as being at high risk for falls will have a care plan to prevent falls and fall- related injuries. Refer to Fall Injury Prevention **Fall Prevention Interventions** • Document fall interverventions for mobility, and fall preventions for the environment and elimination **Post Fall Evaluation –** complete after a fall  Refer to: Falls: Assisting Patient Post Fall in Acute/Sub Acute Care
Glasgow Coma Assessment	**Pupil Assessment** Assess PERRLA. Provide pupil description, reaction and size.
	Assess Level of consciousness (LOC), using Glasgow Coma Scale (GCS) when: • The ACVPU is anything but 'Alert' • Completing neurovital signs (includes following post-fall guideline) • For monitoring neurologic change 
	Neuromuscular/ Extremities Assessment For all patients: • Inspect for any obvious signs of musculoskeletal abnormalities (e.g. posture, gait, etc.) • Range of motion (ROM) – any abnormalities noted during normal care Patients who have had a stroke: • Grip strength

Category	Assessments and Documentation

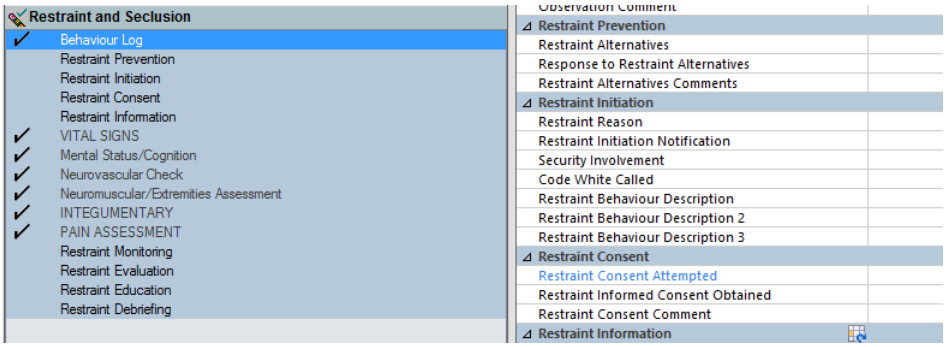
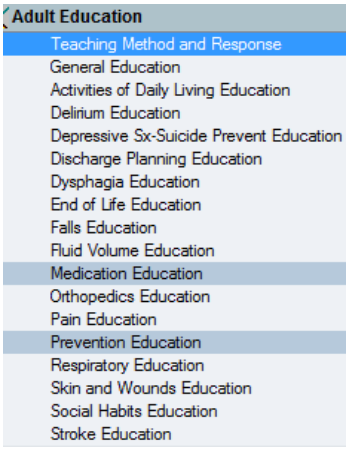
Cardiovascular System	• Cardiovascular symptoms reported
	  ○ Heart rhythm
	  ○ Heart sounds
	  ○ Nail bed color
	  ○ Capillary refill peripheral
	• Pulses – note anatomical location
	
	• At MSJ, if a patient is on telemetry, refer to the standard on Telemetry Remote Monitoring
	• Document ischemic symptoms, if applicable. Refer to: Chest Pain (Outside Critical Care): Care of Patient Protocol
	
	 

	Edema Assessment
	• If edema present, assess:
	  ○ location
	  ○ degree of edema

Respiratory System	• Assess for presence of respiratory symptoms including rate, depth, dyspnea, cough or presence of sputum. Document abnormalities under 'Respirations' • If no symptoms are reported, document respirations as 'regular'  • For patients with COPD, Refer to: COPD Clinical Pathway. Breath Sounds Assessment • Auscultate anterior and posterior lung fields for quality and location of any adventitious sounds

Category	Assessments and Documentation
Gastrointestinal System	Assess: • GI symptoms reported • Abdomen Description & Palpation • Presence and Quality of bowel sounds • Presence of nausea or vomiting/emesis • Appetite • On admission document last date of bowel movement • At a minimum, document stool count per bowel movement. Include amount, color, description, and Bristol Stool Form Scale if stool observed • Document '0' if no bowel movements observed/reported on the current shift • Bowel elimination – continent, incontinent **Ostomies**: add Wound Ostomy navigator band, if present and assess ○ Skin integrity ○ Output, consistency ○ Amount. Document GI Ostomy output under GI Ostomy section only
Genitourinary System	Assess: • Urinary symptoms reported or changes in elimination pattern • Colour and quality of urine output • Urinary retention, signs and symptoms of a UTI • Assess need for catheter and remove promptly, see Urinary Catheters: Management for Prevention of UTI. If assessing for urinary retentation or post-void residual add Bladder Scan/Post Void Residual section to documentation. Document intermittent urinary catheterization, if applicable
Integumentary System	• Skin colour general – if unusual for ethnicity inspect, ○ Skin temperature ○ Skin Moisture ○ Skin Integrity General ○ Skin turgor
Braden Assessment	• Complete Braden Scale within 24 hours of admission and with any change in patient condition • Complete Braden assessment daily for a score of 18 or less • If patient requires an Advanced Support Surface (including AtmosAir 9000A + pump or AtmosAir Velaris + Pump) document under: Activities of Daily Living → Specialty Bed/Surface

Category	Assessments and Documentation
Incision/Wound/ Skin/Pin Site	• Check for presence of a wound care plan • Check for presence of "Refer to Wound Care Plan" order. • For VAC Therapy refer to Negative Pressure Wound Therapy Guideline • Create dynamic group for each incision/wound • Note: presence of staples or sutures, date to be removed, peri-wound skin assessment, document under dressing activity • If urostomy present assess for skin integrity, leakage, and amount of output. Document under wound and ostomy
Musculoskeletal	• Create a dynamic group for specific location, e.g. for fractured limb, spine injury, and document assessment appropriate to that anatomy
Psychosocial	• Affect • Behaviour during interaction • Family/social support • Aggression. If aggression present, refer to Violence Risk Alert policy
Adult Lines and Devices Create dynamic group for any parenteral lines/devices (ie. surgical drains).	**Peripheral IV Central Lines & Subcutaneous Catheters**: • Note type and location of line (e.g. PIV, CVC/PICC). Note external length • IV lines should be saline locked or TKVO. Extra lines should be removed as needed and when they aren't working. • Note line's dressing, patency, and any swelling, redness, or drainage around the site • Note the expiry date of the tubing • Confirm correct medication infusing: drug, concentration, dose and rate **Urinary Catheter**: • Document type and size of catheter, activity management & site condition **Chest Tube(s)**: • Assess for activity, drainage device, air leak, dressing, amount and type of drainage. See (Chest Tubes: Patient Assessment and Interventions) for management of chest tubes **GI Tubes (G-Tubes, J-tubes and NG-tube):** • Assess for position, signs of migration. Note type and rate of feed. Refer to Tube Feeding: Small Bore (Entriflex) for further instructions on assessment **Warming/Cooling** Document if a Bair Hugger is applied. See (Warming Patient using Forcer Air Warmer) for further instructions on assessments

Category	Assessments and Documentation
Intake and output	• Document all parenteral intake • Document output from all tubes and drains • Document intake and output as ordered or clinically indicated
Restraints	(Find under Restraints and Seclusion Navigator Band) Mandatory for all patients who have physical restraints insitu • Create a dynamic group for each restraint device • Document the initiation and removal of any restraint device, ongoing care and assessment of the patient, and the need for the device • Document patient/family debriefing when appropriate • Document the situation that led to application of restraints as a nursing narrative note with the title “restraint” • Refer to: Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care) 
Patient Education and Resources	• Explain the purpose and timing of assessments/interventions required with the patient and or substitute decision maker. Provide relevant educational materials as appropriate. Ensure patients and families understand information provided to them and had an opportunity to ask questions • Document education provided to patients and families under Adult Education • Access educational materials from http://phc.eduhealth.ca, Lexicomp, Elsevier Clinical Skills and Patient Health Education Materials (PHEM) 

Documentation

1. Use IView to document vital signs, NEWS score, situational awareness criteria, physical assessment, intake and output, and lines and devices. Document on medication administration using the Medication Administration Wizard and Medication Administration Record (MAR).
2. Use a **nursing narrative note** to expand upon pertinent events, patient/family concerns, ensuring nursing narrative note uses structured format such as DAR (data-action-response) or SOAP (subjective-objective-assessment-plan) and is **titled** to the focus of that note. Refer to Documentation Policy for more information.
3. Narrative Documentation:
    - Used to provide details about behaviour, an event, or care provided.
    - Title note to help easily identify the event
    - The use of a documentation framework such as DAR (Data, Action Response) or SOAP (subjective, objective, assessment, plan) can be helpful to organise information in a structured and organized way.
    - End of shift documentation and shift summary documentation of patient care over a few hours is contrary to the general principles and should be avoided. Our goal is to ensure timely communication in order to facilitate early intervention

Related Standards & Resources:

1. B-00-13-10013 – Alcohol Withdrawal Protocol
2. B-00-12-10065 – Blood/Blood Product Administration
3. BD-00-12-40067 – CVC: Tunneled Central Venous Catheter (T-CVC) – Basic Care and Maintenance
4. BD-00-07-40011 – Chest Tubes: Patient Assessment and Interventions
5. B-00-13-10065 – Delirium: Assessment and Care Protocol
6. B-00-07-10008 – Documentation
7. B-00-12-10022 – Falls: Assisting Patient Post-Fall in Acute/Sub-Acute Care
8. B-00-07-10011 – Falls Injury Prevention (Acute and Sub Acute Care)
9. B-00-13-10159 – Hot Stroke Protocol ED and In-Patient (SPH and MSJ)
10. BD-00-12-40080 – IV Therapy Peripheral: Insertion Care and Maintenance
11. B-00-13-10059 – Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care)
12. BCD-11-13-41001 – National Early Warning Score (NEWS 2) for Clinical Deterioration in Adults
13. BD-00-07-40050 – Ostomy, Assessment and Management
14. B-00-13-10019 – Oxygen Therapy, Acute Care
15. B-00-12-10015 – Warming Blanket
16. BD-00-12-40054 – Peripherally Inserted Central Catheter (PICC) – Basic Care and Maintenance
17. B-00-13-10010 – Postoperative Pain Management Protocol
18. BD-00-12-40079 – Pressure Injury: Prevention in Adults and Children (Summary)

19. B-00-13-10163 – Sepsis: Early Identification and Treatment using Cerner EHR Protocol
20. BD-00-07-40059 – Seizure Management (Adult/Pediatric)
21. B-00-13-10079 – Telemetry: Remote Monitoring (MSJ)
22. B-00-07-10034 – Tracheostomy Care: Nursing and Respiratory Therapy
23. B-00-13-10045 – Tube Feeding: Small Bore Enteral Feeding (Enteroflex), ACUTE CARE ONLY
24. B-00-13-10121 – Urinary Catheters: Management for the Prevention of UTI

References:

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3. British Columbia College of Nurses & Midwives (BCCNM) (May 2023) Documentation Standard. Retrieved May 9, 2023, at: https://www.bccnm.ca/
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5. Fraser Health Authority. (2015) Acute Care Standard: Nursing – Medicine.
6. Jarvis, C. (2016). Physical Examination & Health Assessment (7th ed.). St. Louis, MO: Elsevier.
7. Liu, V. X., Lu, Y., Carey, K. A., Gilbert, E. R., Afshar, M., Akel, M., Shah, N. S., Dolan, J., Winslow, C., Kipnis, P., Edelson, D. P., Escobar, G. J., & Churpek, M. M. (2020). Comparison of Early Warning Scoring Systems for Hospitalized Patients With and Without Infection at Risk for In-Hospital Mortality and Transfer to the Intensive Care Unit. *JAMA Network Open, 3*(5)https://doi.org/10.1001/jamanetworkopen.2020.5191

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**

Appendix B: National Early Warning Score (NEWS) Criteria

National Early Warning Score Criteria							
Physiological Parameter	Score						
	3	2	1	0	1	2	3
Respiratory Rate (per minute)	8 or less		9 to 11	12 to 20		21 to 24	25 or more
SpO_2 Scale 1 (%)	91 or less	92 to 93	94 to 95	96 or more			
SpO_2 Scale 2 (%)	83 or less	84 to 85	86 to 87	88 to 92 More than 93 on air	93 to 94 on oxygen	95 to 96 on oxygen	97 or more on oxygen
Air or oxygen?		oxygen		air			
Systolic Blood Pressure (mmHg)	90 or less	91 to 100	101 to 110	111 to 219			220 or more
Pulse (HR) (per minute)	40 or less		41 to 50	51 to 90	91 to 110	111 to 130	131 or more
Consciousness				alert			CVPU
Temperature (C°)	35 or less		35.1 to 36	36.1 to 38	38.1 to 39	39.1 or more	

Appendix C: National Early Warning Score (NEWS) Escalation Aid

National Early Warning Score	NEWS Score	Response	Frequency of Monitoring	Clinical Response
	Total Score 0	No alert, no task	Minimum 12 hourly	• Continue NEWS monitoring and documentation
	Total Score 1 to 4	Ward-based response	Minimum 4 to 6 hourly	• Discuss with nursing leader • Decide whether increased frequency of monitoring and/or escalation of care is required
	Single Parameter 3	Urgent ward-based response	Minimum 1 hourly	• Discuss with nursing leader • Inform Most Responsible Provider or delegate, who will review and decide whether escalation of care is necessary. • Consider consulting Rapid Response Team or Clinical Resource Team (e.g. CCOT/NAR)

	Total Score 5 or more	Urgent Response	Minimum 1 hourly	• Inform the Most Responsible Provider for urgent assessment
				• Activate Rapid Response Team or Clinical Resource Team (e.g. CCOT/NAR)
				• Discuss with nursing leader:
				  ◦ Nurse / Patient ratio
				  ◦ Location
				  ◦ Care provider skill mix
				  ◦ Equipment
				  ◦ Medications
				  ◦ Resources available
				  ◦ Consideration of internal or external transfer to higher level of care

	Total Score 7 or more	Urgent or Emergency Response	Continuous Monitoring of Vital Signs	• Immediately Inform Most Responsible Provider for emergency assessment • Activate Rapid Response Team or Clinical Resource Team (E.g. CCOT/NAR) • Discuss with nursing leader: • Increase nursing (1:1) • Internal or external transfer to higher level of care

CCOT = Critical Care Outreach Team

Appendix D: Cerner iView

Adult Quick View

- **National Early Warning System**
  - (Double click blue banner to activate)
- **Vital Signs**
  - Temperature / Pulse / Respiratory Rate / Oxygen Saturation & Therapy / Blood Pressure / ACVPU
- **Pain Assessment**
  - Pain Present (if yes, complete: Onset / Location / Laterality / Quality / Provoking / Palliating / Radiation Characteristics / Pain Tool Used)
- **Pain Modalities (if required)**
- **Mental Status / Cognition**
  - LOC / Depth of Consciousness / Orientation Assessment / CAM (if required)
- **Sedation Scale (if required)**
- **Environmental Safety Management**
- **Activities of Daily Living**
  - All Functional Assessments
  - Activity: Assistive Device / Weight Bearing Performance / Lifting Equipment / Activity Status / Patient Position / Bed Angle / Positioning & Pressure Reducing Devices
  - Nutrition: % of meals (if needed), Oral Intake
  - Hygiene: Personal Care Provided / Routine Oral Care / Elimination Assistance Offered
- **Measurements**
  - Height/length Measure (if required) / Weight Measured / Scale Type
- **Behaviour Log**
  - Patient Location & Activity / Affect / Motor Activity / Behaviour during Interaction / Observation Comment
- **Shift Report / Handoff**

Adult Lines - Devices

- If applicable:
  - Peripheral IV / Subcutaneous Catheter / Central Line / Urinary Catheter / Surgical Drains & Tubes / Gastrointestinal Tube (G tube, J tube, NG tube) / Chest Tubes

Other Bands

- **Intake and Output**
  - Continuous Infusions / Flush Volumes / Tube Feeds / Oral Intake
- **Restraints**
  - Restraint Prevention / Initiation / Consent / Activity & Release Reason / Monitoring / Evaluation / Education / Debriefing

Adult Systems Assessment

- **Neurological**
  - Neurological Symptoms Reported (Ptosis / Nystagmus / Diplopia / Characteristics of Communication, Speech, Expression & Comprehension / Ability to Follow Command / Facial Symmetry / Aspiration Risk (if Dysphagic) / Facial Symmetry
- **Morse Fall Scale / Fall Prevention Interventions / Post Fall Evaluation (required after a fall)**
- **Pupils Assessment**
  - PERRLA / Pupil Description, Reaction & Size
- **Glasgow Coma Assessment**
- **Neuromuscular/Extremities Assessment**
  - Grip Strength / Tone / Spasticity / Contracture / Strength / Sensation / Movement / ROM / Head Control
  - Neurovascular Check Upper & Lower
- **Stroke / CIWA / OAWS (if required)**
- **Cardiovascular**
  - Cardiovascular Symptoms Reported / Heart Rhythm / Heart Sounds / Nail Bed Colour / Capillary Refill Peripheral
- **Pulses**
- **Edema Assessment (if present)**
- **Respiratory**
  - Respiratory Symptoms Reported / SOB Indicator / Respirations / Patient Position / Cough (if present)
  - Breath Sounds Assessment
- **Gastrointestinal**
  - GI Symptoms Reported / Abdo Description & Palpitation
  - Bowel Sounds Assessment / Nausea / Appetite / Emesis (if present) / Passing Flatus
  - LBM (If BM, include: Amount / Colour / Description & Bowel Elimination / Bristol Stool Form Scale
- **Genitourinary**
  - Urinary Symptoms Reported / Urinary Elimination / Urine Voided, Urine Amount Unmeasured or Patient Voided (unknown amount) / Episodes of Bladder Accident / Brief Check / Urine Colour/Characteristics & Odour / Bladder Distention
- **Bladder Scan / Post Void Residual (if required)**
- **Integumentary**
  - Head-to-toe Pressure Injury Skin Check / Skin Colour General / Temperature / Moisture / Integrity / Turgor / Mucous Membrane Location, Colour & Description / Bruising Status, Petechiae or Rash (if applicable)
  - Braden Assessment & Prevention Interventions
  - Incision / Wound / Skin / Pin Site
- **Psychosocial**
  - Affect / Behaviour During Interaction / Aggression (if applicable)

Persons/Groups Consulted:

Medicine Nurses, PHC

Nurse Educators, Medicine, PHC

Clinical Nurse Leaders, Medicine, PHC

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