AULTMAN College
OF NURSING AND HEALTH SCIENCES

NRS 101 FOUNDATIONS I
Clinical Skills Evaluation Performance Checklist
Modified Head to Toe Assessment

Name of Student_____ Date_____

Name of Evaluator_____

Name of Lab Instructor_____

Attempt Number_____ S_____ U_____

Number of Points Awarded_____

First attempt = 10 points, second attempt = 5 points, three or more attempts = 0 points. Competency still must be complete to be satisfactory in course.

Check (√) S (Satisfactory) or U (Unsatisfactory)
* Indicates must be performed in order to be Satisfactory

PROCEDURE STEPS	S	U	COMMENTS
*1. **K**: Knocks on door			
*2. **I**: Introduces self			
*3. **T**: Tells patient what is being done			
*4. **E**: Eliminates germs			
*5. **S**: Safety checks (**MUST** check ID band)			
*6. Addresses patient by proper name and conversation is therapeutic all the time.			
7. Uses good body mechanics: positions bed or overbed table to a working level.			
Specific Skill: Modified Head to Toe Assessment:			
1.Assesses vital signs (T, P [radial or apical], R, B/P, pain)			
2. Pupil assessment for PERRLA			
3. Assesses level of orientation by asking questions to determine mental status (Name, day of week, month, season, situation, president, etc.)			
4. Skin:			

PROCEDURE STEPS	S	U	COMMENTS
a. Health history questions b. Assesses condition of skin (Color, intactness, rashes, lesions, scars, tatooes)			
5. Thoracic a. History questions b. Assesses lung sounds anterior, posterior, and lateral (8 areas on the anterior and 10 areas on the posterior) c. Assesses heart sounds over the skin (5 areas). d. Names the 5 sites and locates landmarks. e. Listens to apical for one minute.			
7. Abdominal assessment (proper sequence) a. History questions b Inspection c. Auscultation in all four quadrants d Light palpation for tenderness or lumps e. Palpate the bladder e. Ask about elimination patterns (voiding/BM) f. Ask about intake and appetite			
8. Assessment of extremities a. History questions b. Assess for temperature and capillary refill c. Palpate pulses: dorsalis pedis, posterior tibial d. Note any edema, lesions, lumps, pain e. Feet and hand pushes and pulls			
After the procedure: a. Evaluates patient's response to the procedure. b. Leaves patient in a comfortable, safe position (safety checks) with call light within reach. c. Hand hygiene before leaving the room.			
Completes skill in allotted time (30 minutes).			

Documentation of findings in an organized format (does not count in allotted time). Use back of page if necessary.