# Rapid Head-To-Toe Assessment of the Hospitalized Patient

Mastering an efficient head to toe assessment is a key skill for inpatient nurses. In general, the head-to-toe assessment is performed when the patient is admitted to an inpatient unit and at the start of every shift thereafter. Additional focused patient checks can occur when the nurse is in the room for prescribed interventions. Different units have different policies and expectations depending on acuity. For the majority of emergency department (ED) patients, nurses perform a focused assessment based on the chief complaint.

While a full physical exam from a textbook takes 30 minutes, a bedside head-to-toe assessment should take 5 to 10 minutes. The goal is to identify deviations from the patient's baseline and catch "red flags" early, so that clinical deterioration or adverse reactions to the treatment are addressed promptly.

Before examining the patient, scan the room:

| **Environment Assessment** | ✓ |
|---|---|
| **Safety:** Bed low/locked? Side rails up? Is the call light within reach? Are there any fall risks (clutter)? Ambu-bag and suction set up? | |
| **Equipment:** IV pumps (rates/fluids), oxygen (Liters/delivery device), chest tubes/drains, intracranial pressure monitors, intra-aortic balloon pumps, continuous dialysis machines. | |
| **General Survey:** Does the patient look "sick"? Are they in distress? Tracking you as you enter? | |

After this initial step of safety checks and general observations, ensure patient privacy and practice hand hygiene. Gather exam gloves, a stethoscope and pen light. Start by measuring vital signs and initiating emergency assistance if needed.

The following table outlines a concise approach to the head-to-toe assessment of the hospitalized patient.

| System | What to Check | ✓ | Red Flags |
|---|---|---|---|
| **Neurological** | **Level of Consciousness:**<br>• Are they awake, lethargic, or obtunded?<br>• Are they oriented in the 4 domains of person, place, time, and situation (“A&O x4”)?<br><br>**Pupils:** Size, symmetry, and reactivity.<br><br>**Motor Strength:** Bilateral hand grips and pedal pushes/pulls. Rate on a 0–5 scale. | | • Sudden confusion<br>• Inability to follow commands<br>• Slurred speech<br>• Aphasia<br>• Facial droop<br>• Unilateral weakness (drift)<br>• Unequal pupils. |

| | | | |
|---|---|---|---|
| | **Motor Drift**: Can they hold arms/legs up against gravity?<br><br>**Speech Clarity & Content:** Is speech slurred? Can they find the right words? | | |
| **Head/Eyes/Ears**<br><br>**Nose/Throat (HEENT)** | **Head:** Assess scalp (trauma patients and falls)<br><br>**Eyes:** Sclera (white) and conjunctiva (pink)<br><br>**Ears/nose:** Assess for drainage<br><br>**Mouth:** Lips, mucous membranes, dentition<br><br>**Glasses or hearing aids present?** | | • Dry membranes (dehydration)<br>• Yellow sclera (jaundice)<br>• Oral white patches (thrush)<br>• Scalp lacerations or contusions |
| **Neck** | **Trachea:** is it midline?<br><br>**Neck veins:** Distended? Presence of central venous lines? | | • Deviated trachea (pneumothorax)<br>• Distended neck veins (fluid overload, heart failure) |
| **Cardiac** | **Heart Sounds:** S1, S2 (apical).<br><br>**Periphery:**<br>**Perfusion:** Capillary refill time, temperature of extremities.<br>**Pulses:** Radial & Pedal (strength 0-4+).<br><br>**Edema**: Pitting or non-pitting, rate 0 to +4. | | • Irregular rhythm<br>• "Thready" pulses<br>• Cold/dusky extremities<br>• New or increased pitting edema |
| **Respiratory** | **Breath Sounds:** Anterior and posterior.<br><br>**Effort:** Rate, rhythm, use of accessory muscles.<br><br>**Oxygen:** Flow rate and oxygen saturation. | | • Crackles (fluid)<br>• Wheezing (constriction)<br>• Tachypnea<br>• Hypoxia<br>• Increasing oxygen requirement |
| **Gastrointestinal** | **Inspection:** Scars, feeding tubes, drains.<br><br>**Bowel Sounds:** Check 4 quadrants.<br><br>**Palpation:** Note areas of tenderness, masses. | | • Distention<br>• Rigidity (board-like)<br>• Tenderness, guarding<br>• Absent bowel sounds for 5 full minutes<br>• Diarrhea |

| | | | |
|---|---|---|---|
| | **Stool characteristics:** Color, consistency, frequency. | | • Bloody stools |
| **Genitourinary** | **Output:** Voiding vs. indwelling catheter.<br><br>**Quality:** Color, clarity, odor, sediment.<br><br>**Inspection:** Discharge, rash, vaginal bleeding | | • Output less than 30 mL/hr<br>• Frank blood<br>• Tea-colored urine<br>• Sediment |
| **Skin** | **Color and Integrity**: Turgor, moisture, erythema, lesions, rashes, wounds.<br><br>**IV Site**: Redness, edema, infiltration. | | • Diaphoresis<br>• Pressure ulcers<br>• New rash<br>• Tenting (dehydration)<br>• Jaundice<br>• Pallor<br>• Flushing |
| **Musculoskeletal** | **Structure**: Joint swelling, tenderness, redness, or heat.<br><br>**Symmetry**: Gross bony deformities or misalignments.<br><br>**Mobility**: Range of motion (ROM) and gait (if applicable). | | • Joint crepitus (crunching)<br>• Swelling<br>• Limited ROM or tenderness<br>• Shortened and externally rotated leg |

## Pearls and Pitfalls

**Assess during the interview:** For example, while asking orientation questions, observe their overall status, listen for speech abnormalities, and check their pupils. Doing this saves time.

**Assess posteriorly**: If the patient is bedbound, they should be turned to assess posterior breath sounds as well as for pressure ulcers or sacral edema. While doing so, assess the patient's ability to cooperate and assist with the turn, which gives insight into their neurological and motor status.

**Further explore new abnormal findings:** The detection of red flags or changes in the patient's baseline warrants a more in-depth examination of relevant body systems. For example, in patients with new lung crackles, a complete cardiopulmonary examination must be performed.

**Subtle changes of mental status decline:** When a patient begins to decline neurologically, there is a hierarchy of loss of the four spheres of orientation. They typically lose these in a specific order: Situation goes first, then Time, then Place, and Person is almost always the last to go.

**Where does motor strength belong?** Motor strength overlaps the neurological and musculoskeletal systems, but it's generally documented as part of the neurological assessment. Think of it this way:

- Neuro (the software): Can the brain *tell* the muscle to move? (Assessed via hand grips, pedal pushes, and arm/leg raises, noting asymmetry).

- Musculoskeletal (the hardware): Is the limb *physically capable* of moving? (Assessed via joint flexibility, bone alignment, and absence of swelling/pain).

**Specialty Units**: In highly specialized units, the rapid head-to-toe assessment remains the foundation, but the nurse layers on high-acuity assessments that focus on specific organ systems or life-support technology. For example, an ICU nurse assesses for ventilator dyssynchrony, looking for "bucking" the vent or increased peak inspiratory pressures. In oncology units, nurses assess for mucositis, stomatitis and radiation skin burns.

**Before You Leave:**

- Address safety risks (falls, alarms, alerts).
- Address the “5 Ps” (pain, potty, position, possessions, personal needs).
- Make sure that the bed is low, locked and the call bell is within reach.

**Documentation tips:**

- Charting by Exception: Most Electronic Medical Records (EMRs) use "Within Normal Limits" (WNL) checkboxes. Use the narrative note for deviations.
- Use descriptors for clarity:
    - Instead of "Normal": Use *Symmetrical, Patent, Resonant, Supple, Crisp.*
    - Instead of "Abnormal": Use *Asymmetrical, Labored, Dusky, Guarding, Lethargic.*
    - When available, use rating scales for findings such as edema, motor strength, and pulse quality, to objectively quantify clinical trends.
- Avoid subjective “opinion” words. For example, instead of stating “breathing seems better”, write that the respiratory rate is down to 18 and the lungs are clear.
- Avoid vague terminology such as "Vitals stable." Instead, chart: *"Vitals remain within patient’s baseline parameters."*
- Do not copy and paste the same note from the previous shift. Note copying is an audit trigger because it suggests cloning and that the nurse did not actually do their own assessment. Even if nothing changed, re-wording findings slightly will show it was an updated evaluation.

## References

Hogan-Quigley, B., & Palm, M. L. (2022). *Bates' nursing guide to physical examination and history taking* (3rd ed.). Wolters Kluwer.

Toney-Butler TJ, Unison-Pace WJ. (2023, August 28). Nursing Admission Assessment and Examination. In: *StatPearls [Internet]*. Treasure Island (FL): StatPearls Publishing. Available from: https://www.ncbi.nlm.nih.gov/books/NBK493211/