

PROCEDURE FOR: Assessment: Scope of Nursing Physical Assessment: Adult Inpatient - DRAFT

- POLICY:**
1. The scope of nursing care as well as the process utilized at John Dempsey Hospital is defined within the parameters of the State of Connecticut Nurse Practice Act.
 2. All patients are assessed by an RN within 24 hours of admission. LPN's may collect, report and record objective and subjective data under the direction of the RN.
 3. Frequency of assessment is defined in departmental and unit specific protocols, procedures, and structure standards, with a minimum assessment frequency of three times a day, approximately 8 hours apart.
 4. The scope of adult physical assessment is outlined as follows (unit specific standards protocols and procedures may further define the physical assessment): Temperature, heart rate, blood pressure, respiratory rate, pain, pulses of the upper and lower extremities (one set of each), weight (on admission, then as ordered), neurological assessment (on admission and then per neurological assessment protocol), breath sounds, bowel sounds, edema and skin (per skin care protocol).
 5. The standardized scale for documentation of pulse volume/force/amplitude is:
 - 0 = absent, not palpable
 - 1 = diminished, weak or thready
 - 2 = as expected
 - 3 = full, increased
 - 4 = bounding
 6. The standardized scale for documentation of edema is:
 - 0 = absent; no edema
 - TR = trace, no pitting
 - 1+ = 0 to ¼ inch indentation, disappears rapidly
 - 2+ = ¼ to ½ inch indentation, duration 10 to 15 seconds
 - 3+ = ½ inch to 1 inch indentation, duration 1 to 2 minutes
 - 4+ = over 1 inch indentation, duration 2 to 5 minutes

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 1/98

REVISION DATES: 11/02, 4/03, 10/06, 2/07, 7/09