THE 5-MINUTE ASSESSMENT

When you have 5 patients, you can't take 30 minutes per patient to do your assessment! This is what a REAL shift assessment looks like in practice. And you can do it in 5 minutes! It's all about multi-tasking.

Action You Take *This is what you actually DO*	**Gets Assessed Simultaneously** *This is the information you can gather just by doing it!*
Walk in. Introduce yourself to the patient.	General level of consciousness, general appearance, affect, verbal response, speech quality
Orientation questions (person, place, time, situation)	Further idea of affect, emotions, LOC, verbal response, speech quality, etc.
Tell the patient: "If anything causes pain, just let me know".	Allows you to be constantly assessing for pain throughout assessment
Use your Pen Light to: • Check PERRLA • Look in nose, mouth, and ears (pt turns head) • EOM - 6 cardinal movements	Facial symmetry, conjunctiva color/drainage, sclera color/moisture, ability to follow commands, neck ROM (they should also tell you if it hurts)
Ask the patient: "Any issues or pain in your head, neck, jaw, or ears?"	If NO - move on! If yes, assess further. Allows you to move quickly past less important assessments
Auscultate Heart and Lung sounds (Inspect chest simultaneously!)	Palpate for crepitus (SubQ air), chest symmetry, chest expansion, retractions/accessory muscle use, SKIN on Thorax (including TURGOR)
Auscultate Bowel Sounds (Inspect abdomen simultaneously!)	Skin color and character, symmetry, wounds/lesions, distention, hernias
Palpate Abdomen → ONLY Percuss if abnormal findings	Masses or tenderness, watch for grimacing or guarding that may indicate pain. Feel for tight, firm, or distended abdomen.
Upper Extremities: 1. Squeeze hands 2. Radial pulses & cap refill 3. Strength 4. ROM - sides, front, over head	1. Gets their hands in front of them for other tests 2. Skin color, nail color/condition, edema, temp, moisture 3. ROM, command following 4. Pt should report pain, can palpate joint for crepitus during ROM
Lower Extremities: 1. Pedal pulses & cap refill 2. Strength - push, pull, lift, lower 3. ROM - bend knees (leave bent!)	1. Skin color, nail color/condition, edema, temp, moisture 2. ROM, command following 3. Pt should report pain, palpate joint for crepitus - leave knees bent for next step!
Have patient turn to one side	Strength, ability to turn, command following **Note - plan ahead if you need help turning patient*
Auscultate lungs on back	Skin, continence, pressure areas **Alternatively - can do this first during bedside report because you and the offgoing RN will be turning the patient to check skin anyways! — Make the most of your time!*
Ask your patient: "Any issues with pain or burning with urination?"	Reserve GU assessment for perineal care or bed bath. If NO issues and NO primary GU complaint, this assessment is usually deferred.

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