PROCEDURE CHECKLIST

Chapter 21: Assessing the Abdomen

PROCEDURE STEPS		
Identifies patient using two identifiers and according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics. Tools: stethoscope, pen		
1. Have the client void prior to the exam.	YES	NO
2. Data Collection: a. Ask Client about continence and frequency of urination and bowel movement and/or passing of flatus. b. Bowel: Ask if bowel movement was normal for them. Have them describe! c. Urine: Ask or note amount, color, presents of sediment, and any pain when voiding. Note: If incontinent, you must assess perineal area!		
3. Positions the client supine with the knees slightly flexed.		
4. Examines abdomen in this order: inspection, auscultation, percussion, palpation.		
5. Inspects the abdomen for: a. Size, symmetry, and contour. (If distention is present, measures girth at umbilicus with tape measure) b. Have client raise his head to check for bulges. (Why?) c. Observes the condition of skin and skin color; lesions, scars, striae, superficial veins, and hair distribution. d. Notes abdominal movements. e. Notes position, contour, and color of the umbilicus.		
6. Auscultates the abdomen for bowel sounds, using diaphragm of stethoscope. a. Asks clients when he last ate. b. Listens for up to 5 min in all 4 quadrants before concluding that bowel sounds are absent.		
7. Percusses abdomen: a. indirect percussion to assess at multiple sites in all four quadrants b. Uses fist or blunt percussion to percuss the costovertebral angle for tenderness.		
8. **Verbalize: You would use deep palpation to palpate organs and masses.**		
9. Document on the back: a. Document the information from Data Collection: Client states…. b. Note the color of the skin over the abdomen, and any scars, rashes, lesions, or striae. c. Describe the abdominal contour and symmetry and the status of the umbilicus. d. Document bowel sounds in all quadrants. e. If you percussed the abdomen, document the tone generated. f. Document your palpation findings: whether the abdomen is soft, firm, or distended, and any tenderness, rebound or otherwise, and any masses.		

Recommendation: Pass _____ Needs more practice _____

Student: _____ Date: _____

Instructor: _____ Date: _____

Your Documentation:

Sample:

9/25/18 1320: Abdomen soft, nondistended with umbilicus noted midline. Noted no open areas, incisions, wounds, rashes, or lesions to abd. Noted skin color pink and smooth upon inspection Normoactive bowel sounds present x 4. Client stated last BM was a soft formed stool 9/26/18. Client stated voiding clear, yellow urine x 2 this morning. No pain, urgency, frequency or tenderness with voiding reported. No bladder distention noted. Client denies discomfort upon assessment.----------B. Ready, SSCC NS