10 Minute Assessment Rubric

Knock on Patient's Door: Respectfully enter the patient's room.
Hand Hygiene: Perform proper hand hygiene before caring for patient and as needed.
Introduce Self: full name and role to the patient, family and/or other health care providers.
Patient Identification:

Check the patient's name, date of birth (DOB), and medical number to make sure that Must look at ID band and ask patient to state his name and DOB.

Allergies: Ask patient about allergies and check for the correct allergy band.
Assess the following 3 areas as you ascertain the patient's proper name and DOB on their ID band:

Airway and Breathing: Is airway open and is the patient breathing?
Circulation (skin warmth and pulse strength): Gently touch patient's wrist to feel pulse as checking ID Band.
Level of Consciousness and Facial Symmetry: Does patient correctly state name and DOB properly? Can patient correctly state where they are?

Vital Signs/Oxygen (O2) Saturation: Assesses initial and previous vital signs/O2 Saturation. Identifies patient's normal and/or abnormal values as scenario evolves.
Pain: If patient states yes to pain do a thorough assessment using OLDCART & pain scale 0 - 10: (0 = no pain, 10= worse pain ever felt or could ever imagine)
Tubes and Equipment: Check tubes and equipment from their source to their connection with the patient.
Example: Check IV for proper solution, rate, presence of air in tubing, all connections. Check IV site for patency, erythema and pain.
Chest: Inspect for symmetry of movement, auscultated heart sounds and lung sounds anterior and posterior. Ask the patient about breathing and chest pain.
Abdomen: Inspect for contour and distention, dressings, drainage and/or suture lines. Auscultate bowel sounds and assess for frequency of sounds. Palpate for tenderness and firmness. Ask the patient about voiding, last bowel movement, nausea and vomiting.
Upper Extremities: Assess both sides for color, cyanosis, temperature, motion (ability to lift and hold), sensation, skin turgor, decubitus ulcer, lesions, edema, presence and strength of radial pulses.
Lower Extremities: Assess both sides for color, cyanosis, temperature, motion (ability to lift and hold), sensation, skin turgor, decubitus ulcer, lesions, edema, presence and strength of pedal pulses.
Skin Integrity: Assess overall skin integrity; assess skin of back, buttocks, heels and any other pressure point including scalp.

Patient Comfort: Is call light within reach? Does patient know how to use call light? Is phone within reach? Does the patient need extra covers, fresh water if permitted, etc.?

Before leaving room ask if there is anything else you can do for the patient.

(What does your facial expression, body language & tone of voice communicate to the patient?)

Adapted from:
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