Abdominal Student Checklist

Abdominal	
Assessment	**Knowledge Indicators – verbalizes and demonstrates**
Client comfort assessed: • empty bladder • abdomen fully exposed • symphysis pubis draped Inspect • right side of client	Notes: • condition of skin • umbilicus • contour & symmetry • peristalsis • pulsations
Auscultate: • auscultate all quadrants & epigastrium • auscultate vascular sounds	• States rationale for auscultating before palpating/percussing • Starts RLQ • Notes bowel sounds Names and notes any bruits in: • aorta • renal arteries • iliac arteries • femoral arteries
Percuss • lightly - all quadrants, epigastric and suprapubic region	• Starts RLQ • Determines areas of tympany and dullness and describes significance
Palpate all 4 quadrants: • Client relaxation methods if needed • Light palpation / Deep palpation • Observes client facial expressions	Identifies: • Starts RLQ • Describes rationale for light vs. deep palpation • Identifies any masses or areas of tenderness – describe location and characteristics
Percuss liver • Measure liver span in mid-clavicular line	• Identify lower border from umbilicus • Identify upper border from lung resonance • Measure span in cm
Palpate liver	• Identifies liver edge • Notes any firmness or tenderness
Percuss spleen • Right side of patient with knees slightly flexed • Splenic percussion sign	• Describe sounds, noting significance
Palpate spleen • Client supine	• States if able to feel tip of spleen noting any tenderness
Palpate kidneys • Standing on patient's right side to examine right kidney • Blunt percussion of costovertebral angle (CVA)	• Demonstrates palpation of right kidney • states right is sometime palpable and left not often palpable • Notes any CVA tenderness
Palpate aorta	• Identifies pulsations • Demonstrates technique for determining aortic width