Date:

Lung Sounds Assessment Evaluation Checklist

Objective: Learner will be complete a respiratory assessment and identify normal and abnormal finings, including lung sounds. Inspect first, auscultate and if appropriate per your facility and your scope percuss and then palpate.

Steps	our scope percuss and men parpate.	Completed	Comments
Respiratory	Assessment		
1.	Review nursing respiratory assessment procedure document and facilities policies		
2.	Identification of appropriate PPE & gather supplies: Nonsterile gloves, stethoscope, alcohol wipes		
	Identify resident with 2 identifiers and explain procedure. Introduce yourself.		
4.	Perform hand hygiene and apply PPE		
5.	Perform visual inspection to identify symmetry, contour, scars, rashes, bruises, artificial openings or devices, skin color, edema, central cyanosis		
6.	Assess cough, sputum, chest pain, and shortness of breath, orthopnea, dyspnea during exertion, activity intolerance or recurrent attacks of pneumonia or bronchitis.		
7.	Observe for any pursed lip breathing, energy conservation techniques, diaphoresis		
8.	Note quality of respirations: depth, retractions, symmetry, audible breath sounds, positioning, regularity, chest rise, use of accessory muscles		
	Assess history/triggers: activity prior to distress, duration, triggers such as pollen or dust.		
10	. Assess capillary refill.		
	. Assess for fremitus or subcutaneous emphysema.		
12	. Check vital signs, including pulse- oximetry.		
Auscultating	Lung Sounds		
	. Position resident for examination, sitting		

Source: Clinical Nursing Skills & Techniques. Perry and Potter 9th edition. Revised 6.25.2018

Facility Name:	
upright. For bedridden residents, elevate	
head of bed 45-90 degrees. If unable to	
tolerate sitting, use supine and side-lying	
positions.	
14. Remove gown or drape first from	
posterior chest. Providing privacy	
15. If possible, stand behind resident.	
Inspect thorax for shape and symmetry.	
Note deformities or audible lung sounds.	
16. Using stethoscope, auscultate breath	
sounds. Instruct resident to take slow,	
deep breaths with mouth slightly open.	
Place stethoscope firmly on chest wall	
over intercostal spaces. Listen to an	
entire inspiration and expiration at each	
stethoscope position. Systematically	
compare breath sounds over right and	
left sides.	
17. Next auscultate over the lateral thorax	
followed by anterior thorax.	
18. Auscultate anterior thorax following the	
same right to left pattern. Begin above	
clavicles, move across then down. Give	
special attention to lower lobes, where	
mucus commonly gathers.	
19. Note the following normal breath	
sounds:	
Bronchial- loud, high pitched sounds best heard over	
the trachea. Expiration lasts longer than inspiration (3:2	
ratio)	
Bronchovesicular- medium- pitched and blowing	
sounds of medium intensity, best heard posteriorly	
between scapulae and anteriorly over bronchioles lateral	
to sternum at first and second intercostal spaces.	
Inspiratory equal to expiratory phase	
Vesicular- soft, breezy and low pitched sounds. Best	
heard over periphery of lung. Inspiratory phase 3 times	
longer than expiratory phase.	
20. Assist resident into a comfortable	
position with call bell in hand. Remove	
PPE and perform hand hygiene.	
Document all findings and report all	
concerns.	

Facility Name: ____

□Experienced	□Verbal	□Beginner	□Orientation	
□Need practice	Demonstration/observation			
□Never done	□Practical exercise	□Expert	□Other	
□Not applicable (based	□Interactive class			
on scope of practice)				

Employee signature

Observer signature

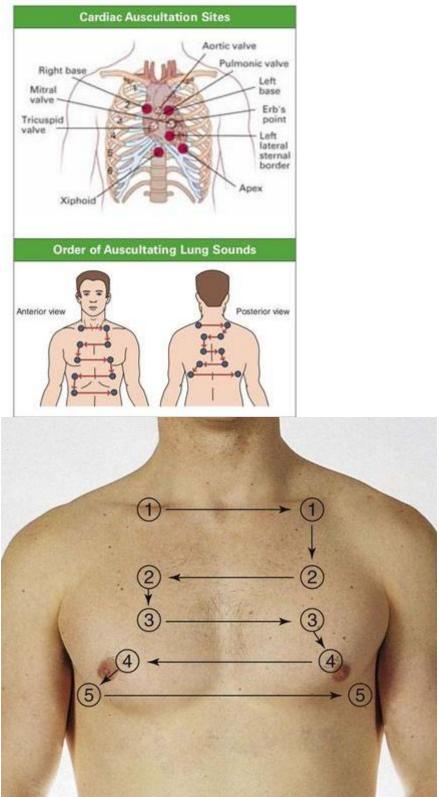
____Facilitator recommends that staff review facility-specific procedures around physical assessment and lung sounds.

References:

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Perry; P. Potter; Ostendorf, W. (2014) *Clinical Nursing Skills & Techniques*. (9th Ed.) Elsevier/Mosby: St Louis, Missouri.

Facility Name: ____



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