Abdominal Auscultation & Inspection

Prepare yourself and the resident:

1. Perform hand hygiene.
2. Keep the resident warm and as covered as possible, with privacy. If possible, have the resident lie on their back with knees bent.
3. Tell the resident what you are going to do, and with their consent, expose and inspect their abdomen.

Auscultate the abdomen:

4. Using the diaphragm of the stethoscope, listen to each of the 4 quadrants, starting in the right lower quadrant and moving clockwise.
5. Be able to describe the sounds by their intensity (soft or strong), and their frequency (normal, hyperactive, hypoactive or absent – listen for 5 minutes before considering sounds to be absent)
6. Using the bell of the stethoscope, listen for bruits. (Aorta, renal artery, iliac artery, femoral artery).

Palpate the abdomen:

7. Starting with light palpation (~2cm), feel for masses, tenderness, rigidity.
8. Use deep palpation (4-5cm) next. If there is a known tender area, palpate there last.
9. Look for rebound tenderness. (pain when deep palpation is released)

An experienced clinician may also palpate for specific organs and use percussion to assess for organs and tympany. This is not an expectation of the typical nursing assessment.

Complete Procedure:

10. Replace the resident's clothing and make them comfortable.
11. Perform hand hygiene.
12. Record findings and report findings when required.