Auscultating Heart Sounds in Adults



identification of abnormal heart sounds that alert the clinician to the possibility of a cardiac abnormality. Because of its regularity of occurrence and importance to providing exceptional patient care, this is a skill that all nurses should keep sharp. Check out the *Dynamic Health*™ competency checklist below to see if your nurses are checking all the boxes

Cardiac auscultation is something that happens

frequently during patient care and allows for the

when it comes to auscultating heart sounds in adults.



how frequently the cardiac assessment should be conducted

6.

Review the treating clinician's orders 2. Review the patient's medical history/medical record 3.

Review the facility/unit-specific protocol for cardiac

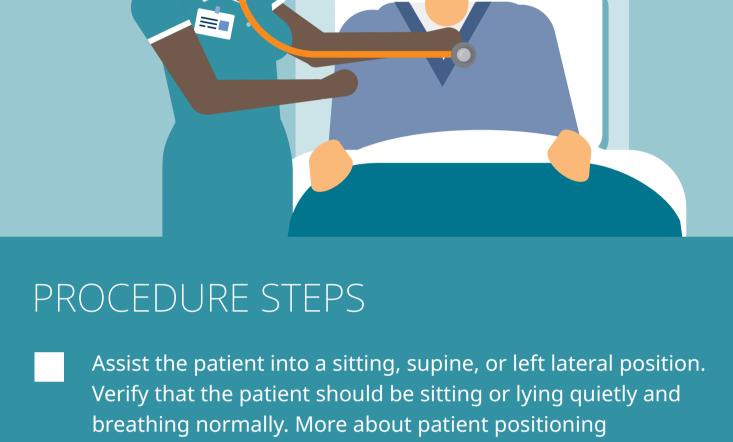
auscultation, noting if there are unit-specific guidelines for

Verify that the environment is quiet enough to properly 5. hear heart sounds

Follow standard pre-procedure steps

equipment, if necessary

Close the door, turn off the television, or silence nearby



chest through the pulmonic, tricuspid, and mitral areas

during expiration

"lub-dub" as one beat

a full minute

Listen for S4

Listen for S1 at each auscultation point Listen for S2 at each auscultation point. Note whether the sound splits during inspiration and appears as a single sound

Auscultate heart sounds in a systematic fashion, beginning

at the aortic landmark and moving across and down the

Assess the heart rhythm by auscultating the apical pulse Locate the point of maximal impulse (PMI) by palpating to the fifth intercostal space at the left midclavicular line and place

the diaphragm of the stethoscope over this area

Count the apical pulse for one minute

Identify the "lub-dub" sounds of S1 and S2 and count each

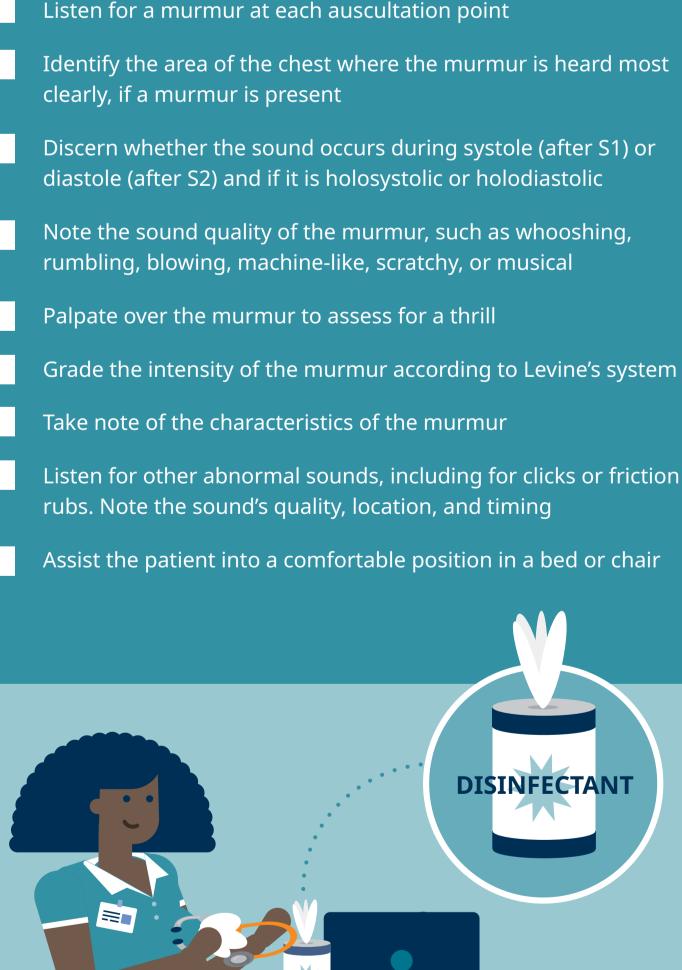
Compare the apical and radial pulses if the heart rate is irregular

Have a second nurse palpate the patient's radial pulse

simultaneously while auscultating the apical pulse for

Note whether the rhythm is regular or irregular

- Compare the beats per minute for each site to determine if the patient has a pulse deficit Listen for S3



Follow standard post-procedure steps 1. 2.

POST-PROCEDURE STEPS

- Reassess the patient according to facility protocol, usually 4.

Clean and disinfect the stethoscope using a disinfectant pad

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Notify the treating clinician of abnormal findings and/or significant changes from previous cardiac assessments so that the treatment plan can be established or modified once every nursing shift Facilitate completion of an electrocardiogram or echocardiogram and/or request referral to a cardiologist for further evaluation, if a cardiac abnormality is suspected Like what you saw?

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