KING SAUD UNIVERSITY
COLLEGE OF NURSING
MEDICAL SURGICAL DEPARTMENT

NURS 221 HEALTH ASSESSMENT (PRACTICAL) PROCEDURE GUIDE AND PERFORMANCE CHECKLIST

MODULE 3

PHYSICAL EXAMINATION OF THE HEAD, NECK AND RELATED LYMPHATIC

A. Prepare all the necessary equipment
    - Examination gown
    - Clean, non-sterile examination gloves
    - Glass of water
    - Penlight
    - Otoscope
    - Cotton wisp
    - Wooden tongue blade

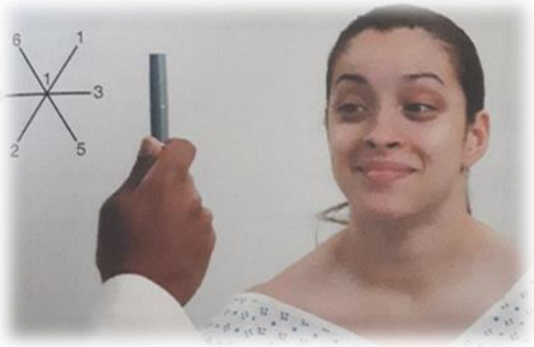
B. Prepare the patient and the environment.
    - Explain the procedure to the patient.
    - Position the client appropriately.
    - Ensure patient privacy.
    - Instruct patient to drape himself/herself appropriately.
    - Make sure environment is with adequate light and room temperature regulated.
    - Wash hands.

C. Obtain comprehensive health history.
    - Using focused interview, ask the patients questions related to:
        - Pain
        - Safety precautions used at home, when driving or away from home
        - Substance and irritants found in the physical environment of the patient including home, workplace and those encountered during the travel.

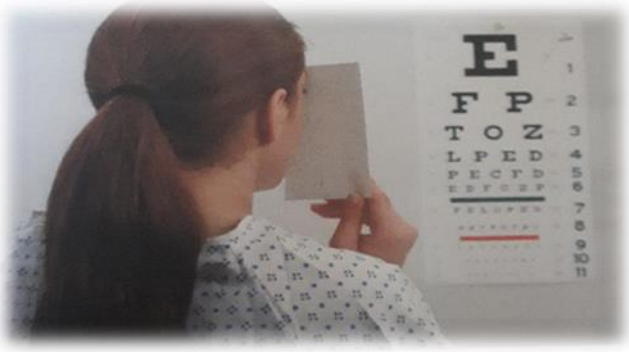
D. Conduct physical examination
    - Physical examination of the head and neck requires the use of inspection, palpation and auscultation.

PROCEDURE GUIDE

PROCEDURE AND RATIONALE	NORMAL FINDINGS
THE HEAD	
1. POSITION THE PATIENT. ➢ Ask the patient to sit comfortably on the examination table.	
2. INSTRUCT THE PATIENT. ➢ Explain that you will be looking at the patient and touching the head, hair and face. Explain that no discomfort should occur, but if the patient experiences pain or discomfort you will stop that part of the examination.	
3. INSPECT and PALPATE THE HEAD AND SCALP. ➢ Note the size, shape, symmetry and integrity of the head and scalp. ➢ Identify the prominences- frontal, parietal and occipital that determine the shape and symmetry of the head. ➢ Part the hair and look for scaliness of the scalp, lesions or foreign bodies. ➢ Check hair distribution and hygiene. ➢ Note the texture of the scalp and the contour and size of the head. Ask the patient to report any tenderness as you palpate.	• Normocephalic. • Feels smooth and symmetric. • No tenderness with palpation.
4. Palpate the temporal artery. ➢ Palpate between the eye and the top of the ear.	• The artery should feel smooth.
The Face	
1. INSPECT THE FACE. ➢ Note the facial expression and symmetry of structures. ➢ Inspect the symmetry of the lips at rest and when speaking**.**	• Eyes, ears, nose and mouth should be symmetrically placed. • Nasolabial folds should be equal. • Palpebral fissures should be equal. • The top of the pinnae of the ear should be at the level of the outer canthi of the eyes.
THE EYES	
ASSESSSING THE EYE	
1. Stand directly in front of the patient and focus on the external structures of the eye.	• The eyebrows should be symmetric in shape and the eyelashes similar in

	quantity and distribution. • The eyebrows and lashes should be free from flakes and drainage.
2. Ask the patient to open the eyes.	• The distances between the palpebral fissures should be equal.
3. Ask the patient to close the eyes.	• The eyelids should symmetrically cover the eyeballs when closed. • The eyeball should be neither protruding nor sunken.
4. **Gently separate the eyelids and ask the patient to look up, down and to each side.**	• Conjunctiva should be moist and clear, with no redness or drainage and with small blood vessels visible beneath the conjunctival surface. • The lens should be clear and the sclera white. • The irises should be round and both of the same color, although irises of different colors can be a normal finding.
5. TESTING THE SIX FIELDS OF CARDINAL GAZE ➢ Stand about 2 ft (0.6 m) in front of the patient. ➢ Starting at the midline, move the pen or light in the direction to form a star or wagon wheel. (Wagon wheel method). ➢ Use random direction pattern to create the movement. ➢ Always return the light or pen to the center before changing direction.  	• Patient is able to follow movements.
6. Inspect the cornea by shining a penlight from the side across the cornea.	• The cornea should be clear with no irregularities. • Pupils should be round and equal in

	size.
7. Observe the constriction in the illuminated pupil. ➢ Observe the simultaneous reaction (**consensual constriction**) of the other pupil. 	• The direct reaction should be faster and greater than the consensual reaction.
8. ASSESSING CORNEAL LIGHT REFLEX ➢ **Shine the light into the eyes from a distance of 12 inches.**  ➢ **Testing corneal reflex (blinking reflex)** **By lightly touching the cornea with a wisp of cotton.**	• The reflection of light should appear in the same spot on both pupils. This appears as a “twinkle” in the eye. **Blinking is normal reaction.**
9. TESTING CENTRAL VISUAL ACUITY (Snellen Eye Chart) ➢ Ask the patient to cover one eye with the opaque card or eye cover. ➢ Tell the patient to read, left to right, from the top of the chart down to the smallest line of letter that the patient can see. ➢ Do the same with the other eye. ➢ If the patient uses corrective lenses for distance vision, test first with eyeglasses or contact lenses. Then test	• Normal vision is 20/20, therefore, at 20 ft the patient can read the line numbered 20. If a patient’s vision is 20/30, the patient reads at 20 ft. what a person with normal vision reads at 30 ft.

without glasses or contact lenses. ➢ Results are recorded as a fraction. The numerator indicates the distance from the chart (20 ft). The denominator indicates the distance at which a person with normal vision can read the last line. ➢ Observe while the patient is reading the chart. ➢ If the patient is unable to read more than one half of the letters on a line, record the number of the line above. 	
10. TESTING THE PERIPHERAL VISION • **Instruct the patient.** • In this test, the patient's peripheral visual fields are compared to that of the examiner. • The patient will alternately cover an eye and must look directly into your open eye. • A pen or penlight will be moved into the patient's field of vision, sequentially from four directions. • The patient is to indicate by saying "now" or "yes" when the object is first seen. • **Ask the patient to cover one eye with a card while you cover your opposite eye with a card.** • **Holding a penlight in one hand, extend your arm upward, and advance it in from the periphery to the midline point.** • **Make sure to keep the penlight**	

equidistant between the patient and yourself. • **Ask the patient to report when the object is first seen. Repeat the procedure upward, toward the nose, and downward. Then repeat the procedure with the other eye covered. This test assumes that the examiner has a normal peripheral vision.** 	
THE EAR	
1. Inspect the external ear for symmetry, position, color and integrity.	• External auditory meatus has no drainage. • Color of the ear should match that of the surrounding area and the fa e, with no redness, nodules, swelling or lesions.
2. Palpate the auricle and push on the tragus. 	• No hard nodules or swelling. • Tragus should be movable. • No pain using this technique.
3. Palpate the mastoid process lying directly behind the ear.	• There is no lesions, pain or swelling.
4. Inspect the auditory canal using the otoscope. ➢ Use the largest speculum that will fit into the auditory canal for best visualization.	• The external canal should be open and without tenderness,

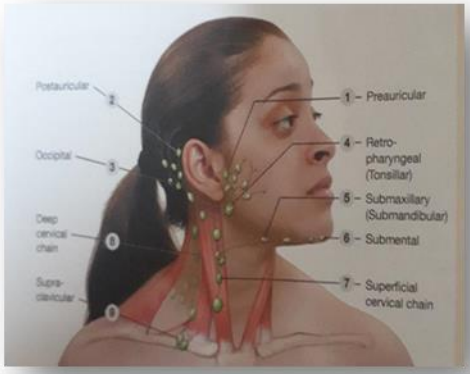
➢ Ask the patient to tilt the head away from you toward the opposite shoulder. ➢ Hold the otoscope between the palm and first two fingers of the dominant hand. The handle may be positioned upward or downward. ➢ Use your other hand to straighten the canal. ➢ In the adult patient, pull the pinna up, back, and out to straighten the canal. ➢ Be sure to maintain this position until the speculum is removed. ➢ Instruct the patient to tell you if any discomfort is experienced but not to move the head or suddenly pull away. ➢ With the light on, use the upward or downward position of the handle to insert the speculum into the ear. Brace the otoscope with the dorsal surface of the fingers or hand.	inflammation, lesions, growths, discharge or foreign substances. • Note the amount, color and texture of the cerumen that is present.
5. PERFORM THE WHISPER TEST ➢ **This test evaluates hearing acuity of high-frequency sounds.** ➢ Ask the patient to occlude the left ear or the ear may be occluded by the nurse. ➢ Cover your mouth so that the patient cannot see your lips. ➢ Standing at the patient's side at a distance of 1 to 2 ft. (approximately 0.3 to 0.6 m), whisper a simple phrase such as, "the weather is not today". Ask the patient to repeat the phrase. Then do the same procedure to test the right ear using a different phrase.	• The patient should be able to repeat the phrases correctly.
THE NOSE AND SINUSES	
1. Inspect the nose for size, symmetry, shape, skin lesions, or signs of infection in frontal and lateral views.	• The nose is straight, in proportion to the other facial structures, midline without deformities, the nares are equal in size, the skin is intact, and no drainage or inflammation is present.
2. Test for patency. ➢ Press your finger on the patient's nostril to occlude one naris, and ask	• The patient should be able to breathe through each naris.

the patient to breathe through the opposite side with the mouth closed. ➢ Repeat with the other nostril.	
3. Palpate the external nose for tenderness, swelling and stability. ➢ Using two fingers, palpate the nose from the bridge to the tip and along the entire lateral surfaces, around the nares and along the columella.	• Note smoothness and stability of the underlying soft tissue and cartilage.
4. Inspect the nasal cavity using an otoscope. ➢ Apply a disposable cover to the tip of the otoscope. ➢ With your nondominant hand, stabilize the patient's head. ➢ With the otoscope in your dominant hand, gently insert the speculum horizontally into the naris. ➢ The speculum should be in the dominant hand for better control at the time of insertion to avoid hitting the sensitive septum. ➢ With the patient's head erect, inspect the vestibule and then the inferior turbinates. ➢ With the patient's head tilted back, inspect the middle meatus and middle turbinates. ➢ When finished with inspection, gently remove the speculum. Again do not hit the sensitive septum. ➢ Repeat on the other side.	• Mucosa should be dark pink and smooth without swelling, discharge, bleeding or foreign bodies. • The septum should be midline, straight and intact.
5. Palpate the sinuses. ➢ Begin by pressing your thumbs over the frontal sinuses below the superior orbital ridge. ➢ Palpate the maxillary sinuses below the zygomatic arches of the cheekbones. ➢ Observe the patient for signs of discomfort. Ask the patient to inform you of pain.	• No tenderness and pain upon palpation.
6. <u>Test Olfactory nerve</u> ➢ Ask patient to close his eyes and block one nostril and inhale a familiar aromatic substance through the other nostril.	
THE MOUTH AND THROAT	
1. Inspect and palpate the lips.	• Lips are symmetric, smooth, pink,

Make up and lipstick should be removed.	moist and without lesions.
2. Inspect the teeth. ➢ Observe patient's dental hygiene. Ask the patient to clench the teeth and smile while you observe occlusion. ➢ Note dentures and caps at this time.	• The teeth should be white, with smooth edges, and free of debris. Adults should have 32 permanent teeth, if wisdom teeth are intact.
3. Inspect and palpate the buccal mucosa, gums and tongue. ➢ **Look into the patient's mouth under a strong light.** ➢ **Ask the patient to touch the roof of the mouth with the tip of the tongue.** ➢ **Palpate the area under the tongue. Check for lesions or nodules. Using a gauze pad, grasp the patient's tongue and inspect for any lumps or nodules.** ➢ **Use a tongue blade to hold the tongue aside while you inspect the mucous lining of the mouth and the gums.** ➢ **Inspect the frenula of the tongue, upper lip and lower lip. The frenulum is the small flap of tissue connecting the protruding portion of the lip or tongue to the rest of the mouth.**	• Tongue is pink and moist with papillae on the dorsal surface. • The ventral surface should be smooth and pink. • The tissue should be smooth. • These areas should be pink, moist smooth and free of lesions. Confirm integrity of both the soft and the hard palate.
4. Inspect the throat. ➢ Use a tongue blade and penlight to inspect the throat. ➢ Ask the patient to open the mouth wide, tilt the head back and say "aah". ➢ Use the tongue blade to depress the middle of the arched tongue enough so that you can clearly visualize the throat but not so much that the patient gags. Ask the patient to say "aah" again. Confirm the rising of the soft palate (test for cranial nerve X). ➢ Observe the tonsils behind the anterior tonsillar pillar. ➢ As you inspect the throat, note any mouth odors. ➢ Discard the tongue blade when finished.	• The uvula should rise in the midline. • Tonsils, uvula and posterior pharynx are pink and are without inflammation, swelling or lesions. • The color should be pink with slight vascularity present. Tonsils may be partially or totally absent.

Visualization of tonsils may be described based on size: **Grade O**: Absent **Grade 1(normal):** Tonsils are hidden behind the tonsillar pillars. **Grade 2**: Tonsils extend to the edges of the tonsillar pillars. **Grade 3**: Tonsils extend beyond the edges of the tonsillar pillars but not to the midline. **Grade 4**: Tonsils extend to the midline.	
THE NECK	
1. Inspect the neck for skin color, integrity, shape and symmetry. ➢ Observe for any swelling of the lymph nodes below the angle of the jaw and along the sternocleidomastoid muscle. ➢ The head should be held erect with no tremors.	
2. Test the range of motion of the neck. ➢ Ask the patient to slowly move the chin to the chest, turn the head right and left, then touch the left ear to left shoulder and the right ear to right shoulder (without raising the shoulder). Then ask the patient to extend the head back.	• There should be no pain and no limitation of movement.
3. Observe the carotid arteries and jugular veins. ➢ The carotid artery runs just below the angle of the jaw, and its pulsations can frequently be seen.	
4. Palpate the trachea. ➢ **Palpate the sternal notch. Move the f**inger pad of the palpating finger off the notch to the midline of the neck. Lightly palpate the area. ➢ Move the finger laterally, first to the right and then to the left. You have now identified the lateral borders of the trachea. ➢ Place the thumb and index finger on each side of the trachea and slide them upward. As the trachea begins to wide, you have now identified the thyroid cartilage. Continue to slide your thumb and index finger high into	• You will feel the C rings (cricoid cartilage) of the trachea. • The trachea should be midline, and the distance to the sternocleidomastoid muscles on each side should be equal. • Hyoid bone and tracheal cartilages move when the patient swallows.

the neck. Palpate the hyoid bone. The greater horns of the hyoid bone are most prominent.	
5. Inspect the thyroid gland. ➢ The thyroid is not observable normally until the patient swallows. Give the patient a cup of water. ➢ Distinguish the thyroid from other structures in the neck by asking the patient to drink a sip of water.	• As the patient swallows, it moves superiorly because the thyroid tissue is attached to the trachea.
6. Palpate the thyroid gland from behind the patient. ➢ Stand behind the patient. ➢ Ask the patient to sit up straight, lower the chin, and turn the head slightly to the right. This position causes the patient's neck muscles to relax. ➢ Using the fingers of your left hand, push the trachea to the right. Use light pressure during palpation to avoid obliterating findings. ➢ With the fingers of the right hand, palpate the area between the trachea and the sternocleidomastoid muscle. ➢ Slowly and gently retract the sternocleidomastoid muscle and then ask the patient to drink a sip of water. ➢ Palpate as the thyroid gland moves up during swallowing. ➢ Reverse the procedure for the left side. **<u>If thyroid gland is enlarged:</u>** ➢ Auscultate the area over the thyroid to detect any bruits. In an enlarged thyroid, blood flows through the arteries at an accelerated rate producing a soft, rushing sound. This sound can best be detected with the bell of the stethoscope.	• Normally you will not feel the thyroid gland, although in some patients with long, thin necks, you may be able to feel the isthmus. You may be able to feel the fullness of the thyroid as it moves up upon swallowing.
7. Palpate the lymph nodes of the head and neck. ➢ Palpate the lymph nodes by exerting gentle circular pressure with the finger pads of two or three fingers of both hands. It is important to avoid	•

strong pressure, which can push the nodes into the muscle and underlying structures, making them difficult to find. ➢ Ask the patient to relax the muscles of the neck to make the nodes easier to palpate. If lymph nodes are palpable, make a note of their location, size, shape, fixation or mobility and tenderness. ➢ The following is one suggested order of assessment:  	

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- **Jarvis C. Physical Examination and Health Assessment. St. Louis 7th Ed. (2015). Missouri, Saunders Elsevier.**

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NURS 221 HEALTH ASSESSMENT (PRACTICAL)
PHYSICAL EXAMINATION OF THE HEAD, NECK AND RELATED LYMPHATICS

STUDENT'S NAME: _____ **RATING: _____**
STUDENT'S NUMBER: _____ **Date performed: _____**

Performance Criteria	COMPETENCY LEVEL			
	DONE CORRECTLY	DONE WITH ASSISTANCE	NOT DONE	COMMENTS
Preparation				
• Explain the procedure to the patient.				
• Position the client appropriately.				
• Ensure patient privacy.				
• Instruct patient to drape himself/herself appropriately.				
• Make sure environment is with adequate light and room temperature regulated.				
• Wash hands.				
THE HEAD				
1. Position the patient.				
2. Inspect and palpate the head and scalp • size • shape • symmetry • integrity				

• hair distribution and hygiene • texture				
3. Palpate the temporal artery.				
THE FACE				
1. Inspect the face. ➢ Note the facial expression and symmetry of structures.				
➢ Inspect the symmetry of the lips at rest and when speaking**.**				
THE EYES				
1. Stand directly in front of the patient and focus on the external structures of the eye.				
2. Ask the patient to open the eyes.				
3. Ask the patient to close the eyes.				
4. Gently separate the eyelids and ask the patient to look up, down and to each side.				
5. Testing the six fields of cardinal gaze.				
6. Inspect the cornea by shining a penlight from the side across the cornea.				
7. Observe the constriction in the illuminated pupil. (consensual constriction)				
8. Assess the corneal light reflex.				
9. Test corneal reflex (blinking reflex)				
10. Test central visual acuity. (Snellen's Chart).				
11. Test the peripheral vision.				
THE EAR				
1. Inspect the external ear: • **symmetry** • **position** • **color** • **integrity**				
2. Palpate the auricle and push on the tragus				
3. Palpate the mastoid process				

lying directly behind the ear.				
4. Inspect the auditory canal using the otoscope				
5. Perform the Whisper Test				
THE NOSE AND SINUSES				
1. Inspect the nose: • Size • Symmetry • Shape • Skin lesions, or signs of infection in frontal and lateral views.				
2. Test for patency.				
3. Palpate the external nose for tenderness, swelling and stability.				
4. Inspect the nasal cavity using an otoscope.				
5. Palpate the sinuses.				
6. Test Olfactory nerve				
THE MOUTH AND THROAT				
1. Inspect and palpate the lips.				
2. Inspect the teeth.				
3. Inspect and palpate the buccal mucosa, gums and tongue.				
4. Inspect the throat.				
THE NECK				
1. Inspect the neck for skin color, integrity, shape and symmetry.				
2. Test the range of motion of the neck.				
3. Observe the carotid arteries and jugular veins.				
4. Palpate the trachea.				
5. Inspect the thyroid gland.				
6. Palpate the thyroid gland from behind the patient. **<u>If thyroid gland is enlarged:</u>** • Auscultate the area over the thyroid				
7. Palpate the lymph nodes of the head and neck.				
Document your findings.				

Evaluated by: _____
Date of Evaluation: _____