King Saud University

Collage of Nursing

Medical Surgical Nursing depart

Application of Health Assessment

NUR 225

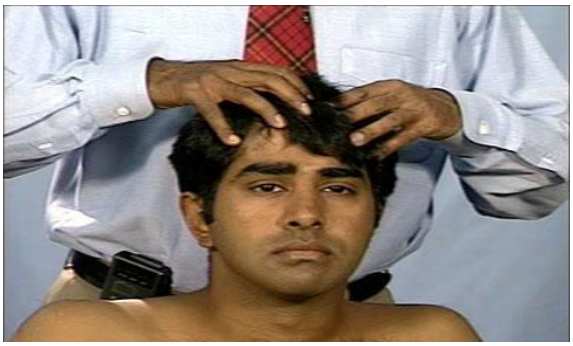
Module Three

Physical examination of Head and Neck

Physical Examination techniques for head and neck

1- Prepare patient and environment
2- Obtain health history
3- Prepare equipment needed as listed in the lecture

1- Assessment technique: The Head

Objective data normal range of findings	Abnormal findings
Inspect and Palpate the Skull General size and shape **Size** Note the general size and shape. Normocephalic is the term that denotes a round symmetric skull that is appropriately related to body size. **Shape** To assess shape, place your fingers in the person's hair and palpate the scalp. The scalp normally feels symmetric and smooth. There is no tenderness to palpation. Use a gentile rotating motion with finger tips. Begin at the front and palpate down the midline. Palpate each side of the head then occipital region for occipital lymph. **Inspect the Face:** Note facial expression and its appropriateness to behavior or reported mood. Anxiety is common in the hospitalized or ill person. Although shape of facial structures may vary among races, they should always be symmetric, eyebrows, palpebral fissures, nasolabial folds, and the creases extending from the nose to each corner of the mouth. Note any abnormal facial structures (coarse facial features, exophthalmos, changes in skin color or pigmentation), or any abnormal swelling. Note any involuntary movements (tics) in the facial muscles, normally none occur.	**Deformities:** Microcephaly (abnormally small head) Macrocephaly (abnormally large head) 

Inspect External Ocular Structures (The Eye) Size, placement, alignment All three should be symmetrical **Eyebrows** Normally eyebrows are present bilaterally, move symmetrically as the facial expression changes, and have no scaling or lesions.	Unequal or absent movement with nerve damage.
Inspect lashes for hair distribution and growth Short Evenly spaced upper lashes curl upward and lower lashes curve downward and away from eye	
Eyelids When eye is open the upper lid should fall between the upper iris and top portion of pupil. The skin is intact without redness, swelling, discharge, or lesions.	Ptosis – drooping of upper eye lid
Conjunctiva and sclera should be white and free from nodules or swelling	Yellow sclera (Jaundice) Pale palpebral conjunctiva (anemia) Increased number of blood vessels (inflammation)
Eyeballs The eyeballs are aligned normally in their sockets with no protrusion or sunken appearance. Blacks normally may have a slight protrusion of the eyeball beyond the supraorbital ridge. Eyeballs look moist and glossy. Explain procedure to the patient then put on examination gloves and keep his eyes closed , gently palpate eyelids for tenderness, mass & swelling, Eye ball firm Feeling touch sensation	

Pupil Note size, shape and equality of pupils Round, clear and equal Test pupillary light reflex, darken the room and ask the person to gaze into the distance. (This dilates pupils)	Changes in pupils can indicate central nervous system injury
Test for accommodation by asking the person to focus on a distant object. This process dilates the pupils. Then have the person shift the gaze to near object, such as your finger held about 7-8 cm from the nose, a normal response is papillary constriction. Record normal response to these maneuvers s **PERRLA**, or Pupils Equal, Round, React to Light and Accommodation.	Absence of constriction or convergence.
Testing visual field This test is used to evaluate the peripheral extent of visual field.	Hemianopia (loss half of visual field)
Testing visual acuity Ask patient to sit or stand 4-6m from Sellen-chart and cover the left eye with opaque card .Ask patient to read the letters on one line of the chart and then to move downward to increasingly smaller lines until he can no longer discern all of the letters Repeat the test with the other eye.	Blindness Myopia (impaired distant vision) Presbyopia (Impaired Near vision).
Testing corneal reflex By lightly touching the cornea with wisp of cotton. **Blinking is normal reaction**	No reaction
Testing eye ball movement Ask patient to follow the object with his eyes Without moving his head. Nurse moves the object to each of the six cardinal positions, returning to the midpoint after each movement.	

Inspection of the Ear

Location / Alignment hygiene
The top of the ear should be in a straight line with the corner of the eye

No swelling or thickening

Discharge or odor
May be caused by a perforated tympanic membrane, foreign body, exudates or wax .

Inspect ear canal (external auditory canal &tympanic membrane) by using otoscope .The auricle is gently pulled upward and backward to straight the ear canal.

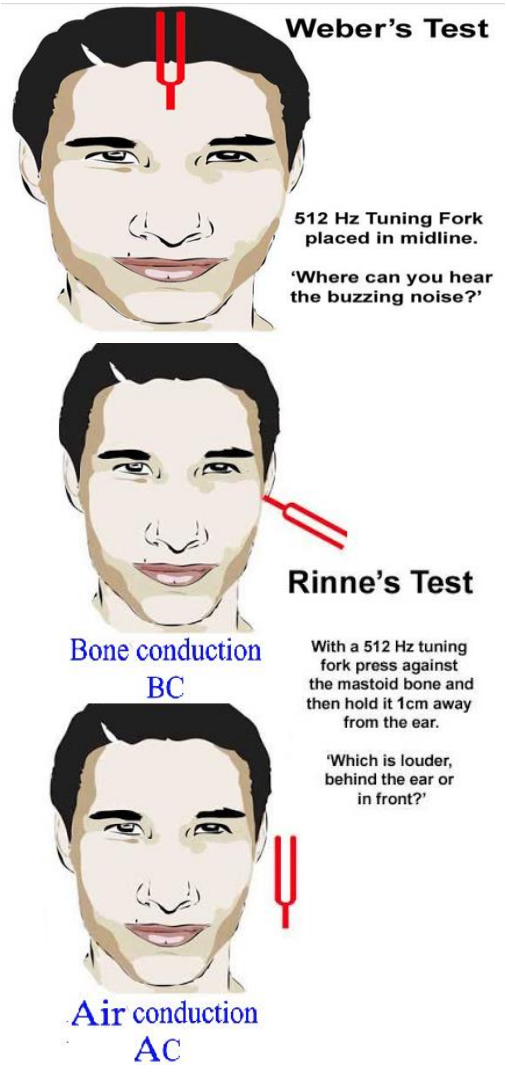
Palpate auricle for texture and pain sensation on movement. Moveable without pain. The auricle is firm in texture

Palpate mastoid area behind ear for tenderness. No tenderness

Hearing acuity tests

A- Weber's test:
Uses to evaluate bone conduction.

B- Rinnes Test:
Uses to evaluate air conduction of the sound

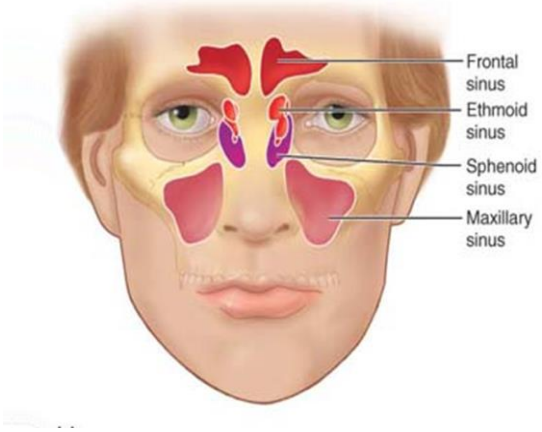


Inspection of the Nose

Shape
Symmetry
Patency
Mucosal Integrity
Should be pink and moist
Septum should be straight

Palpate frontal and maxillary **Sinus** for tenderness.

***Frontal**
Place your thumbs above the patient eyes just under the bony ridges of the upper orbits and place your fingertips on his forehead
*** Maxillary**
Gently press your thumb on each side of the nose just below cheek bones



Test Olfactory nerve
Ask patient to close his eyes and block one nostril and inhale a familiar aromatic substance through the other nostril

Inspect and Palpate the Mouth

Lips
Integrity
Symmetry
Color
Moist, soft and pink

Gum- color ,lesion

Teeth – should be in good condition

Mucous Membrane – colour, texture, discharge, swelling

Tongue – size, colour, thickness, lesions, moisture, symmetry
Palpate the tongue and floor
of mouth with a gloved finger.
Pink ,free from ulcer, nodules

Pharynx – inflammation, exudates, masses . press a tongue blade firmly upon the-tongue-for visualization-of-the pharynx

roof of mouth for color and architecture of hard palate

Inspect and palpate the NECK

Symmetry

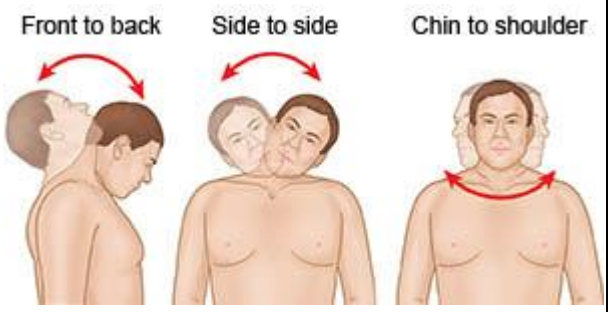
Head position is centered in the midline, and the accessory neck muscles should be symmetrical. The head should be held erect and still.

Range of Motion

Note any limitation of movement during active motion, ask the person to touch the chin to the chest, turn the head to the right and left, try to touch each ear to the shoulder (without elevating shoulders), and to extend the head backward. When the neck is supple, motion is smooth and controlled.

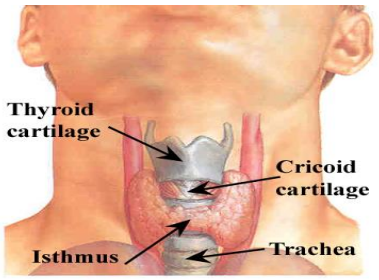
Test muscle strength and the status of cranial nerve XI by trying to resist the person's movements with your hands, as the person shrugs the shoulders and turns the head to each side.

Note pain or limitation at any particular movement.



***Inspect thyroid gland** for symmetry, visible mass.

You should stand in front of the client & Ask client to sip some water and swallow. Symmetrical, no mass. Thyroid gland ascends normally during swallowing & not visible, Except in extremely thin person



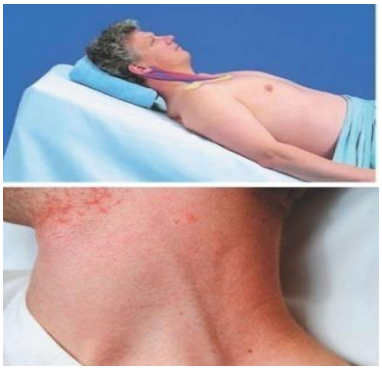
***Palpate thyroid** by standing behind the client. Put your hands around his neck with your finger tips on the lower half of the neck over the-trachea.

Inspect External jugular veins

Observe with patient sitting and then lying at 30-45 angle.

Normal finding: Jugular veins should be flat, without sign of distention

Distention Heart failure



Lymph Nodes

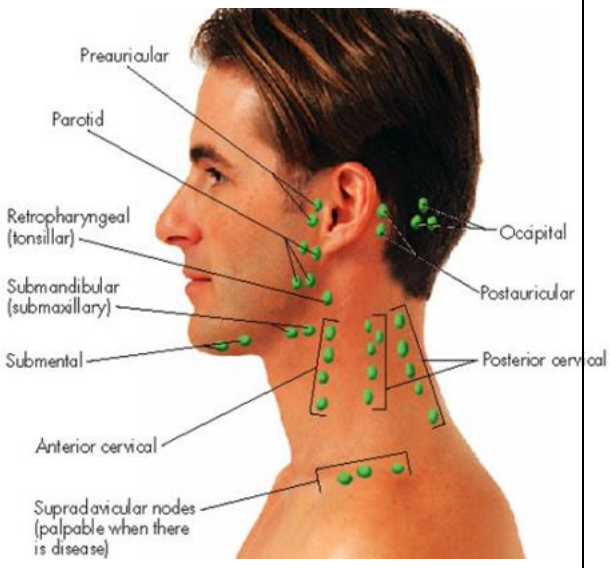
Using gentle circular motion of your finger pads, palpate the lymph nodes.
Use gentle pressure because strong pressure could push the nodes into the neck muscles.

If any nodes are palpable, note their location, size, shape, delimitation (discrete or matted together), mobility, consistency, and tenderness.

Cervical nodes are often palpable in healthy persons, although, this palpability decreases with age. Normal nodes feel movable, discrete, soft, and non tender.

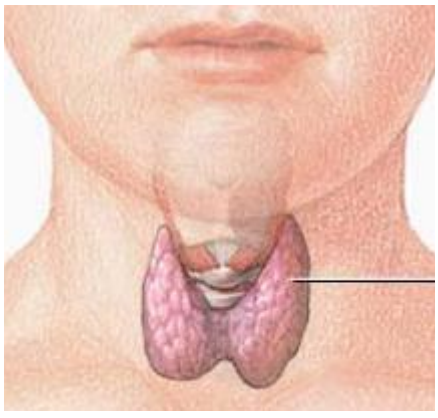
Preauricular - In front of the ear
Postauricular - Behind the ear
Occipital - At the base of the skull
Tonsillar - At the angle of the jaw
Submandibular - Under the jaw on the side
Submental - Under the jaw in the midline
Superficial (Anterior) Cervical over and in front of the sternomastoid muscle
Supraclavicular - In the angle of the sternomastoid and the clavicle

Lympadenopathy is enlargement of the lymph nodes (› 1 cm) due to infection, allergy, or neoplasm.



Trachea

Normally, trachea is midline, palpate for tracheal shift. The space should be symmetric on both sides. Note any deviation from the midline.



Appendix I

Number	Name	Function	Test
I	Olfactory Nerve	Smell	**Test Olfactory nerve** Ask patient to close his eyes and block one nostril and inhale a familiar aromatic substance through the other nostril Such as (coffee, vanilla, lemon)
II	Optic Nerve	Vision	**Testing visual acuity** Ask patient to sit or stand 4-6m from Sellen-chart and cover the left eye with opaque card .Ask patient to read the letters on one line of the chart and then to move downward to increasingly smaller lines until he can no longer discern all of the letters Repeat the test with the other eye.
III	Oculomotor Nerve	pupil constriction Eye movement;	Test pupillary light reflex, darken the room and ask the person to gaze into the distance. (This dilates pupils) **Test for accommodation** by asking the person to focus on a distant object. This process dilates the pupils. Then have the person shift the gaze to near object, such as your finger held about 7-8 cm from the nose, a normal response is papillary constriction. Record normal response to these maneuvers s PERRLA, or Pupils Equal, Round, React to Light and Accommodation. **Testing eye ball movement** Ask patient to follow the object with his eyes Without moving his head. Nurse moves the object to each of the six cardinal positions, returning to the midpoint after each movement.
IV	Trochlear Nerve	Eye movement	
VI	Abducens Nerve	Eye movement	
XI	Spinal Accessory Nerve	Controls muscles used in head movement.	**Test muscle strength** and the status of cranial nerve XI by trying to resist the person's movements with your hands, as the person shrugs the shoulders and turns the head to each side.

Nursing health assessment documentation format

Head &neck *(adapted from KFSH &RC)*

Instructions: Circle or fill in the blanks with actual physical assessment findings. WNL=Within Normal Limits for age. Mark items which require additional documentation with an asterisk (*) and document in the Nurse's Notes sections of the Daily Nurses Record.

Pt. Identification data

Name---------- Age----- Sex----- occupation ---------- Marital status----------

Tel/Address---------- Known Allergies----------

General Survey

Physical appearance _ WNL, abnormality---------- Body structure _WNL, abnormality----------

Mobility _WNL, abnormality---------- Behavior _ WNL, abnormality----------

Present history

Chief complaint: P---------- P ----------

Q---------- R---------- R----------

S---------- T---------- T----------

T---------- Associated symptoms ----------

Medication ----------

Past history----------

Familyhistory----------

Physical examination

Head

Hair: - Equal in distribution Fine Coarse

Scalp: - Intact / Injury Dandruff Nits

Skull: - Intact / Injury Enlarged /smaller

Eye and vision

Sclera: - Clear Yellow Red

Pupil: - Equal /Unequal

Visual acuity: - WNL impaired distant /near vision

Ear and hearing

Auricle: - Firm Tenderness

Ear opening: -Discharge

Hearing field; - WNL Hearing problem

Nose

Mucous membrane; - Pink /Moist Red Swelling

Discharge

Mouth

Lips:- Pink/Moist Red Bleeding

Gums Pink/Moist Red Bleeding

Neck

Thyroid gland; Mass Visible

Lymph node: Normal Enlargement

COMMENTS:-

_____
_____
_____
_____

Signature:-

Date:-

King Saud University Application of Health Assessment
Collage of Nursing NURS 225
Medical-Surgical Nursing

Head &Neck Performance checklist

The student nurse should be able to:

Performance criteria	Competency Level						Comment
	Trial 1			Trial 2			
	Done correctly	Done with assistance	Not Done	Done correctly	Done with assistance	Not Done	
-Collect appropriate objective data about head and neck related to general survey. -Collect appropriate subjective data related to about head and neck.							
Physical examination							
HEAD							
Inspection							
1-Inspect hair for quantity, distribution and texture. 2-Observe face for skin color, hair distribution.							
Palpation							
3-Palpate scalp for tenderness and mass 4-Palpate the skull for nodules or mass.							
EYE AND VISION							
Inspection							
1-Inspect eyebrows and lashes for symmetry, distribution of hair. 2-Inspect lid margins for color, scaling, erythema. 3-Inspect sclera for color. 4--Inspect pupils for size, shape and symmetry 5-Test pupil for accommodation. 6-Test visual acuity 7- Corneal reflex 8- Pupil react to light 9- Eyeball movement 10- Peripheral field acuity							
Palpation							
- Palpate eyeball for tender and feeling sensation.							

EAR AND HEARNING							
Inspection							
1-Note auricle for **texture, lesion.** 2-Inspect opening of the ear canal for discharge, redness or odor.							
Palpation							
3-Palpate auricle and mastoid area for pain sensation.							
4-Hearing field tests Webers test Rinnes test							
NOSE AND SINUSES							
1-Inspect the nose for position, symmetry, and color, discharge, deformity. 2-Inspect for nasal obstruction and air way patency							
Palpation							
3-Palpate frontal and maxillary sinus for tenderness.							
MOUTH							
Inspection							
1-Inspect lips and gums, for Color, swelling ,tenderness and ulcer. 2- Inspect the teeth for number and condition. 3- Inspect tongue for size, color, surface and mid-line protrusion.							
Palpation							
4-Palpate the tongue and floor of mouth with a gloved finger for redness, ulceration, nodules, white.							
PHARYNX							
Inspection							
5–Inspect uvula and pharynx for color and moisture. 6–Note tonsils for size, inflammation, swelling, discharge.							

NECK							
Inspection							
1-Inspect the neck for symmetry, scars, or other lesions 2-Inspectthyroid gland and lymph node for size and visible mass. 3-External jugular vein 4-Trachea shift							
Palpation							
Palpate thyroid Palpation of lymph nodes							
Document findings following designated format							

Evaluated by: _____Date Evaluated: _____

Name and Signature of Faculty_____Total grade _____