

IDA V. MOFFETT SCHOOL OF NURSING
Samford University

NURS 241: Physical Assessment Validation

Requirements: The student must satisfactorily complete the validation exam with a grade of 75 or above in order to be successful in the course and to receive a passing grade. It is expected that the student will be able to describe expected normal and abnormal findings during the process of the validation, as well as answer questions correctly concerning the physical assessment. You will have 40 minutes to complete a full head to toe assessment. At the end of 40 minutes the physical assessment should stop, and you will receive the score you have earned up to that point. Points will be deducted from the overall exam score for items not yet completed or completed incorrectly during the 40 minute exam. It is also expected that you dress appropriately for the physical assessment. You must be able to assess extremities, abdomen, feet, pulses, etc. Shorts and a t-shirt would be acceptable dress.

General Information:

- If student performs a test correctly but does not identify it by the correct name, credit will not be given for the item.
- If student describes a test, but does not perform the test, credit will not be given for the item.
- The number located next to each heading indicates the total number of possible points that may be earned on that section of the validation exam.
- If student makes more than 3 technique errors, an additional 1 point will be lost at the end of the exam under General Examination (technique).

Student Name _____ Date _____ Validation Attempt _____

General Survey (4)

Perform a general survey noting the following areas:

Physical Appearance:

Age (0.2) (appears to be stated age), **sex (0.2)**, **level of consciousness (0.2)** (alert and oriented x 3, listens to questions and responds appropriately), **skin color (0.2)** (color tone is even, skin intact with no obvious lesions), **facial features (0.2)** (should be symmetric)

Body Structure:

Stature (0.2) (height appears within normal range), **nutrition (0.2)** (weight appears within normal range for height and body build), **symmetry (0.2)** (body parts look equal bilaterally and in proportion to each other), **posture (0.2)** (should be erect as appropriate for age), **position (0.2)** (sits comfortably in chair or examination table, arms relaxed at sides)

Mobility:

Gait (0.5) (should be smooth, even, well-balanced), **use of assistive devices (0.5)**

Behavior:

Facial expression (0.2) (expression appropriate for situation, maintains eye contact), **mood and affect (0.2)** (comfortable and cooperative, interacts pleasantly), **speech (0.2)** (articulation, content appropriate), **dress (0.2)** (appropriate for season, clean), **personal hygiene (0.2)** (clean and well-groomed)

Cranial Nerves (12)

Perform an assessment of all 12 Cranial Nerves. Cranial nerves are **1 point** each. Student must know name, number, sensory/motor, and complete associated test correctly in order to receive total point.

CN I: Olfactory

Sensory – Test Smell

***Student should check nasal patency prior to assessing smell**

CN II: Optic

Sensory – Visual acuity (Snellen chart, should state results of test previously completed in the lab), **visual fields** (confrontation test, student should know this assesses peripheral vision)

CN III: Oculomotor

***Note – CN III, IV, VI tested together**

Motor – EOM (Assess CN III, IV, and VI together – note nystagmus in 6 cardinal fields of gaze [diagnostic positions test] and perform corneal light reflex, and cover/uncover test, (student can state that the cover/uncover test would be performed if the corneal light reflex were abnormal); PERRLA (Assess pupils, direct and consensual response to light, and assess accommodation, Pupils Equal Round Reactive to Light and Accommodate

CN IV: Trochlear

Motor – Inferior medial eye movements [the Superior Oblique muscle] assessed with EOM assessment

CN V: Trigeminal

Sensory – light touch sensation of face (forehead, cheeks, chin) using cotton ball

Motor – clench teeth and palpate temporal and masseter muscles, try to **separate jaw** by pushing down on chin, normally cannot separate

CN VI: Abducens

Motor – Lateral eye movements [the Lateral Rectus muscle], assessed with EOM

CN VII: Facial

Sensory – Taste on the anterior 2/3 of the tongue

Motor – Movement of forehead and mouth [raise eyebrows, show teeth, smile, puff cheeks, close eyes tightly]

CN VIII: Acoustic

Sensory – Hearing (**Whisper test** – test one ear at a time, move behind patient and whisper 3 unrelated words; **Weber test** – does the tone sound the same in both ears?; **Rinne test** – compare air conduction and bone conduction, place tuning fork on mastoid process and ask patient to signal when sounds goes away, move tuning fork in front of ear canal and signal when sound goes away, **normal response is AC > BC**, test both ears)

CN IX: Glossopharyngeal

**Note – CN IX, X tested together*

Motor – **Swallowing and phonation** (observe uvula rise and fall symmetrically; “Say ahh”)

CN: Vagus

Sensory – **Sensations of posterior 1/3 of tongue and throat** (student should state this)

Motor – **Gag reflex** (touch posterior pharyngeal wall with a tongue blade, does not have to perform on validation partner but should be able to describe how to test gag reflex)

CN XI: Spinal Accessory

Motor – Shoulder movement and **shrug against resistance** and **rotate head against resistance** (Assesses muscle strength of sternocleidomastoid and trapezius muscles, 5/5 is normal)

CN XII: Hypoglossal

Motor – **Tongue movement** (protrude tongue, push tongue into cheek)

Comments _____

Head/Face (2)

Inspect and palpate: **Hair (0.3)** (color, texture, distribution), **scalp (0.2)** (free of lesions and pest inhabitants), **skull (0.3)** (size and shape, normocephalic, should feel symmetric and smooth), **face (0.2)** (for symmetry)

Palpate: **Frontal (0.25)** (below the eyebrows) and **maxillary sinuses (0.25)** (below the cheekbones), should feel firm pressure but no pain, **Temporal artery (0.1)** (palpate pulsation anterior to ear, should not feel hardened or tender), **TMJ (0.4)** (palpate joint while patient opens and closes mouth, should feel smooth movement, no crepitus)

Comments _____

Eyes (2)

Inspect and palpate:

External structures of eye – **eyebrows (0.5)** (present bilaterally and move symmetrically), **eyelids and lashes (0.5)** (note any ptosis, lid lag, eyelashes evenly distributed)

Conjunctiva and sclera – should look moist and glossy (0.5), small blood vessels normally show through (0.25), note any pallor or jaundice (0.25)

Comments _____

Ears (4)

Inspect: **External ear** (size/position (0.25), skin color (0.25), discharge (0.25), lesions (0.25))

Palpate: **Auricle/Pinna, tragus, mastoid process** (note any tenderness) (1 point)

Perform: **Otoscopic exam** (describe external auditory canal (1 point), tympanic membrane (1 point))

Comments _____

Nose (2)

Inspect: **External nose** (symmetric (0.25), midline (0.25), in proportion to other facial features (0.25), nasal septum for deviation (0.25))

Inspect and palpate: **Mucosa and turbinates** (should appear moist (0.2), note color (0.2), any swelling (0.2), discharge (0.2), lesions (0.2), *note:* can only visualize inferior and medial turbinates, superior is not visible)

Comments _____

Mouth/Throat (5)

Inspect: **Lips** (0.5) (color, moisture, cracking, lesions), **buccal mucosa** (0.5) (color, moisture, lesions), **teeth** (0.5) (should be clean and free of decay, note any diseased, absent, loose teeth), **gums** (0.5) (color, gum margins, note any bleeding or discolored gums), **floor of mouth** (0.5) (note any lesions), **palate** (0.5) (note hard and soft palate, color, lesions), **tonsils** (0.5) (presence, color, grade if visible on 1-4+ scale), **tongue** (0.5) (color, moisture), **posterior pharyngeal wall** (0.5) (color, exudate, lesions)

**Note:* Student should wear gloves and should use light when examining the mouth (0.5)

Comments _____

Neck (8)

Inspect: **Symmetry** (0.5) (head position centered in midline, accessory muscles symmetrical, head erect and still)

Palpate:

Trachea (0.5) (note any deviation, place 1 finger in sternal notch, slip finger off to each side and note any deviation from midline)

Thyroid (0.5) (for any enlargement or nodules, stand facing patient, ask patient to turn head to right side and tip head slightly forward, displace thyroid to right and palpate thyroid with left hand while patient swallows, then assess left side), if any thyroid enlargement noted should listen for a **bruit** with bell of stethoscope

Note: If thyroid not enlarged, should still describe when and how to listen to a bruit (0.5)

Lymph Nodes (palpate and identify lymph nodes, if any nodes are palpable then note, location, size, mobility, tenderness) Normal nodes feel moveable, soft, non-tender. Lymphadenopathy is enlargement of a node > 1cm (could be from infection, allergy, neoplasm) **(1 point – should be able to describe all of above)**

Pre-auricular (in front of ear) **(0.5)**

Posterior auricular (behind ear) **(0.5)**

Occipital (base of skull) **(0.5)**

Tonsillar (first nodes under jaw, under angle of mandible) **(0.5)**

Submandibular (halfway between angle of mandible and tip of jaw) **(0.5)**

Submental (below chin) **(0.5)**

Superficial or anterior cervical (anterior neck overlying sternocleidomastoid muscle) **(0.5)**

Deep cervical chain (down sternocleidomastoid muscle) **(0.5)**

Posterior cervical (in posterior triangle at edge of trapezius muscle) **(0.5)**

Supraclavicular (above clavicle) **(0.5)**

Comments _____

Thorax/Anterior and Posterior (20)

Posterior chest (10)

Inspect: **Symmetry and shape of chest (0.4)** (spinous processes should appear straight, thorax symmetric, downward sloping ribs, scapula symmetric, note AP to transverse diameter which should be 2:1, any skeletal deformities: barrel chest, kyphosis, lordosis, scoliosis), **skin characteristics (0.2)** (note lesions, scars, nevi), **posture (0.2)** (patient takes to breathe, should be relaxed), **chest expansion (0.2)** (symmetrical).

Palpate: **Respiratory excursion (0.5):** Symmetric chest expansion (at level of T9 or T10), **tactile fremitus (0.5)** (use palm of hand to assess fremitus while patient says ninety-nine; tactile fremitus is increased over areas of consolidation and decreased when anything obstructs)

transmission of sound, i.e. pleural effusion, pneumothorax, obstructed bronchus (0.5 for describing), tenderness (0.5), masses (0.5)

Auscultate: (5 points) Systematically for **breath sounds** (all locations) and any **adventitious sounds**. Student should be able to describe **normal breath sounds and locations** (see below). Student should listen to one full respiratory cycle (inspiration and expiration) and compare bilaterally. *Note – student must listen to a full inspiration and expiration in all locations and compare bilaterally or all 5 points will be lost*

Bronchovesicular – over major bronchi, moderate pitch, moderate amplitude, I=E (0.5)

Vesicular – over peripheral lung fields, low pitch, soft amplitude, I>E (0.5)

**Note – student should be able to describe and give an example of adventitious lung sounds (0.5)*

Comments

Anterior Chest (10)

Inspect: **Symmetry and shape of chest** (0.5) (ribs downward sloping, symmetric interspaces, note any retraction or bulging of interspaces, costal angle should be 90 degrees), **facial expression** (0.25) (should be relaxed), **skin characteristics** (0.25) (color, lesions, scars, nevi, any cyanosis or pallor), **respiratory rate and rhythm** (0.25) (do not have to actually count but must speak to it being assessed, quality of respirations, should be regular and even), **abnormal breathing patterns** (0.25) (tachypnea, bradypnea, hyper/hypoventilation, cheyne stokes, biots, agonal, apnea)

Palpate: **Respiratory excursion** (0.5): Symmetric chest expansion (place hands at costal margins), **tactile fremitus** (0.5) (use palm of hand to assess fremitus while patient says ninety-nine, tactile fremitus is increased over areas of consolidation and decreased when anything obstructs transmission of sound, i.e. pleural effusion, pneumothorax, obstructed bronchus; should compare fremitus bilaterally, do not palpate over female breast tissue), **tenderness** (0.25), **masses** (0.25)

Auscultate: (5 points) Systematically for **breath sounds** (all locations) and any **adventitious sounds** (crackles/rales, rhonchi, wheeze, friction rub). Student should be able to describe **normal breath sounds and locations** (see below). Student should listen to one full respiratory cycle (inspiration and expiration) and compare bilaterally.

Note – student must listen to a full inspiration and expiration in all locations and compare bilaterally or all 5 points will be lost

Bronchial – heard over trachea and larynx, high pitched, loud amplitude, I<E,

**Note – bronchial sounds are not heard on posterior exam (0.5)*

Bronchovesicular – heard over major bronchi, moderate pitch, moderate amplitude, I=E (0.5)

Vesicular – heard over peripheral lung fields, low pitch, soft amplitude, I>E (0.5)

Comments _____

CV and Peripheral Vascular System (15)

Palpate: **Carotid artery (0.5)** (with patient sitting palpate each carotid artery separately, should be symmetric bilaterally)

Auscultate: **Carotid artery (0.5)** (with patient sitting auscultate for bruits, listen in 3 places with patient's breath held, no bruits should be present)

**Note – At this point in the exam have the patient lie in a supine position*

Inspect: **Precordium (1 point)** (note any pulsations, heaves or lifts)

Describe: Correctly where the **5 precordial points** are located:

Aortic – 2nd right ICS along the sternal border (0.25)

Pulmonic – 2nd left ICS along sternal border (0.25)

Erb's Point – 3rd left ICS along sternal border (0.25)

Tricuspid – 4th left ICS along sternal border (0.25)

Mitral – 5th ICS, left midclavicular line (0.25)

Palpate: **Precordium (1.0)** (note any thrills; student should know that a thrill is a palpable vibration that signifies turbulent blood flow and may accompany a loud murmur),

Palpate and auscultate: **Apical impulse (0.5)** (normally located at 5th ICS left MCL); student should know when to check an **apical pulse (0.5)** and that an apical pulse should be counted for 1 full minute; student should check an apical pulse on their validation partner

Describe: **Where normal heart sounds are heard best**

S1 – best heard over apex (or mitral area) (0.25)

S2 – best heard over base (or aortic area) (0.25)

Auscultate: **(5 points)** (1) With patient supine, auscultate all **5 precordial points (Aortic, Pulmonic, Erb's point, Tricuspid, Mitral)** utilizing **bell** and **diaphragm** of stethoscope correctly noting **S1, S2** and any **extra heart sounds** (2) Have patient turn to left and listen with bell of stethoscope over mitral (apex) area for any extra heart sounds (S3, S4 will be heard best here)

Note: Student must auscultate all 5 precordial points correctly in order to receive 5 points

Palpate: **Extremities** (Skin temperature (0.25), color (0.25), moisture (0.25), texture (0.25), any lesions (0.25), skin turgor (0.25)), **nails** (capillary refill < 2 seconds (0.25), nail profile sign 160 degrees (0.25)), **peripheral pulses** (assess and compare bilaterally, compare the force on a 4 point scale with 0 being absent and, 1+ weak, diminished, 2+ normal, 3+ full, increased 4+ bounding):

Radial – describe/compare (0.25)

Femoral – can say that you will defer at this time, but describe location of pulse and inguinal lymph nodes (0.25)

Popliteal – describe/compare (0.25)

Posterior tibialis – describe/compare (0.25)

Dorsalis pedis – describe/compare (0.25)

Palpate: For presence of **peripheral edema** in lower extremities (0.5)

Perform: test for **Homan's sign** (flex the patient's knee and sharply dorsiflex foot toward the tibia, normally this does not cause pain; positive Homan's sign may be an indicator of deep vein thrombosis) (0.5)

Comments (CV and Peripheral vascular) _____

Abdomen (10)

Inspect: **Skin characteristics (1 point)** (color, scars, nevi, rashes, striae, lesions, masses, dilated veins), **contour (1 point)** (flat, scaphoid/sunken, rounded, protuberant), **symmetry (1 point)** (should be symmetric bilaterally, note any visible mass or bulging), **Identify 4 (1 point) and 9 quadrants (0.5)**

Auscultate: **bowel sounds (2 points)** (listen in all 4 quadrants, normal sounds range from 5-30 times per minute, listen for 5 minutes in each quadrant before determining absent bowel sounds), **describe possible sounds (1 point)** (normoactive, hypoactive, hyperactive, borborygmus), **bruits (0.5)** (Iliac, renal, aortic w/bell)

Percuss: **(1 point)** All quadrants, describe **percussion tones** (dull over liver if enlarged, tympanic throughout abdomen)

Palpate: **(1 point) Light palpation** (begin in RLQ, depress about 1cm, cover all 4 quadrants, note any tenderness, masses, muscle rigidity, guarding)

Comments _____

Musculoskeletal System (8)

Inspect and palpate joints: note color, any swelling or deformity of joints

Perform: complete ROM and muscle strength testing

**Note – perform muscle strength testing of upper extremities, hands, lower extremities, feet,*

**Note - shoulder and cervical spine were tested with CN XI*

**Note - must use correct terminology when describing ROM*

Grade muscle strength on **0-5 scale**

0 – Zero, no visible muscle contraction

1 – Trace, muscle contraction detectable, but no movement of the joint

2 – Poor, Complete ROM with the joint supported; cannot perform ROM against gravity

3 – Fair, Complete ROM against gravity

4 – Good, Complete ROM against gravity and moderate resistance

5 – Normal, Complete ROM against gravity and full resistance

**Note – can begin with lower extremities while patient is still supine and then have patient sit up for remainder of MSK exam*

Note – For each joint listed below, **0.5 points each for ROM of joint and muscle strength testing/**0.5 points** for inspection and palpation of joint. Full ROM of joint must be performed in order to receive 0.5 points*

Hips: (1 point) flexion (with knee straight and flexed), extension, abduction, adduction, internal rotation (with knee bent), external rotation (with knee bent)

Ankle: (1 point) plantar flexion, dorsiflexion, inversion, eversion

Toes: (1 point) flexion, extension

Wrist and hand: (1 point) flexion, extension, abduction (spread fingers apart), tight fist

Elbow: (1 point) flexion, extension, pronation, supination

Shoulder: (1 point) forward flexion, hyperextension, internal rotation, external rotation, abduction, adduction, circumduction

Neck: (1 point) flexion, extension, rotation, lateral bending

**Note – have patient stand to test ROM of spine*

Spine: (1 point) flexion, extension, hyperextension, rotation to right, rotation to left, right lateral bending, left lateral bending

Comments _____

Neurological (6)

**Note – begin with patient sitting*

Perform DTR's - (biceps, triceps, brachioradialis, patellar, Achilles), grade on a 4+ scale
Must perform one upper extremity and one lower extremity DTR (2 points/1 point for each)

Cerebellar Function/Coordination/Skilled Movements – rapid alternating movements (0.5)
(touch thumb to each finger quickly and then reverse; finger to nose, turning of hands back and forth on thigh); **heel to shin (0.5)**

Sensory – pain and light touch (0.5) (ability to perceive sharp object and light touch with cotton ball), **stereognosis (0.5)** (ability to recognize a familiar object in hand with eyes closed), **vibration sensation (0.5)** (tuning fork on upper and lower distal joints)

**Note – have patient stand*

Balance/Gait - observe **gait (0.25)** (should be smooth, and effortless), **tandem walking (0.25)** (heel to toe), **Romberg test (0.5)** (feet together, arms at sides, close eyes, and hold for 20 seconds), **shallow knee bend (0.5)**

Comments _____

Physical Assessment General Evaluation (3)

Completes exam: In systematic fashion within 40 minutes (1 point)

Describes: Expected normal and possible abnormal findings (1 point)

Technique: Utilizes correct technique (1 point)

Comments _____

Student Name: _____

Total Possible Score: 100

Total Score Earned: _____

Faculty Signature: _____