

#32 – HEAD TO TOE ASSESSMENT

(TEST)

I acknowledge I have physically practiced and successfully learned the following skill(s):

Student: _____ Date: _____

Time Limit: 30 Minutes		P2	P3	TEST	Points/ Comments
1.	Verified the health care provider's orders.				*
2.	Gathered the necessary equipment and supplies.				1
3.	Performed hand hygiene.				*
4.	Introduced self to the patient and family.				*
5.	Provided for the patient's privacy.				*
6.	Identified the patient using two identifiers.				*
7.	General Inspection				
a.	Performed an initial focused inspection. Assessed patient's mobility, gait, posture, build, and any deformities.				2
a.	Assessed skin color, facial expression, alertness, eye contact.				2
b.	Assessed Mental Status (alert and oriented to Person, Place, Time, Event)				*
b.	Assessed for speech, hearing, or vision concerns				3
c.	Assessed hygiene and grooming habits				1
d.	Assessed nutritional status				1
e.	Took the patient's vital signs.				*
f.	Skin assessed as moved through each area				*
8.	Pain Assessment (skill #22)				
a.	Asked patient if he/she had any pain/discomfort. Told patient to let them know if they experienced any pain or discomfort during the exam.				*
a.	Examined site of the patient's pain or discomfort when possible. Inspected the area for discoloration, swelling, or drainage. Palpated the area for any temperature change, altered sensation, pain, or areas that trigger pain. Observed the range of motion (ROM) of any involved joints. Used percussion and auscultation when necessary to identify abnormalities.				2
b.	Used the PQRSTU mnemonic to assess patient's pain. Had patient rate pain using a pain scale				*
c.	Assessed patient's response to previous pharmacological interventions. Determined if there were any side effects.				1
9.	Head and Face				
a.	Inspected and palpated the scalp and hair.				1

	b. Palpated the temporomandibular joints.				1
	c. Palpated the facial bones and frontal and maxillary sinuses.				2
	• Tested cranial nerve VII. <i>Ask them to squeeze eyes shut tight, raise eyebrows, smile, and puff out cheeks</i> (CNVII – facial – taste in front 2/3 of tongue and facial expression)				2
	d. Tested cranial nerve V. <i>Ask pt to open jaw and clench teeth as you palpate the masseter muscle.</i> (CN V – trigeminal – muscles for chewing)				2
10.	EYES.				1
	a. Inspected eyelids, eyelashes, eyebrows, sclerae, and conjunctiva				
	b. Assess visual fields (CN II – optic nerve) <i>(Use a snellen eye chart for visual acuity or assess peripheral vision from behind patient)</i>				2
	c. Test pupillary response to light (with lights dimmed) and accommodation -PERRLA				*
	d. Test extraocular eye movements -H movement with penlight (CN III – oculomotor – pupil constriction and EOM) (CN IV- trochlear- EOM) (CN VI – abducens – abducts the eyes with accommodation) <i>Hint: “3, 4 & 6 make your eyes do tricks”</i>				3
11.	EARS				1
	a. Inspected the external auditory canals and palpated auricles				
	b. Evaluated hearing (<i>Whisper test</i>) CN VIII – vestibulocochlear/auditory- hearing and balance				2
12.	NOSE				1
	a. Inspected the nasal mucosa, septum, and turbinates. Checked for nostril patency				
	b. Tested sense of smell. (<i>hold alcohol swab under patients nose</i>) CN I – Olfactory- smell				2
13.	MOUTH & PHARYNX				
	a. Inspected the lips, buccal mucosa, teeth, gums, and tongue.				1
	b. Had the patient say "Ah". (CN IX – glossopharyngeal –swallowing)				2
	c. Have pt. stick out tongue straight and then move from side to side (CN XII – hypoglossal)				2
	d. Checked the gag reflex. (CN X – vagus)				2
14.	Neck				
	a. Inspected the neck structures				1
	b. Tested neck range of motion.				1
	c. Checked shrug against resistance. Test strength of head and neck and shoulder shrug with resistance (CN XI – spinal accessory nerve)				2
	d. Palpated carotid arteries- Only one side at a time				*
	e. Palpated regional lymph nodes and trachea.				2

	f. Auscultated carotid arteries with bell of stethoscope for bruits				1
15.	Upper Extremities				
	a. Inspect and palpate shoulders, arms, and hands for hair distribution and muscle tone, skin and nail characteristics, temperature, edema				1
	b. Assess strength of grip and against resistance				2
	c. Checked joint ranges of motion. wrists (rotation), elbows (flexion/extension), shoulders (circumflexion)				3
	d. Assessed Radial and Brachial pulses				*
	e. Assess capillary refill of one finger on each hand by blanching and releasing				*
16.	Back & SPINE				
	a. Inspected the back. Ask patient to bend over as though touching their toes, but only as far as is comfortable: Palpate spinal processes and place hands on scapulae and hips				2
17.	Chest & Lungs				
	a. Inspect Skin and Observe for respiratory excursion.				2
	b. Inspect respiratory effort/depth, rhythm, and any pulsations. Noted respiratory characteristics.				2
	c. Palpated the chest wall.				1
	d. Checked thoracic expansion.				1
	e. Auscultated breath sounds: (Minimum of 6 spots Anterior & 6 spots Posterior)				*
18.	Heart				
	a. Palpated the precordium; located the point of maximal impulse.				2
	b. Auscultated for heart sounds				*
	1. Aortic valve (2 nd ICS right sternal border)				
	2. Pulmonic valve (2 nd ICS left sternal border)				
	3. ERBS point (3 rd ICS left sternal border)				
	4. Tricuspid valve (4 th ICS left sternal border), and				
	5. Mitral valve (5 th ICS left midclavicular line)				
19.	Abdomen				
	a. Asked patient when was their last bowel movement and any problems with the stool				*
	b. Inspected abdominal skin and contour				1
	c. Auscultated all quadrants for bowel sounds (RLQ, RUQ, LUQ, LLQ)				*
	d. Auscultated for bruits in aortic artery.				1
	e. Percussed all quadrants for tone				1
	f. Lightly palpated all 4 quadrants 2 cm depth				1
	g. Deeply palpated all 4 quadrants 4 cm depth				1
	h. Assessed femoral pulses and inguinal lymph nodes.				2
	i. Assessed Urinary function				*

20. Lower Extremities				
a. Inspected and palpated hips, thighs, calves and feet for hair distribution and muscle tone, skin and nail characteristics, temperature, edema				1
b. Assessed capillary refill of one toe on each foot by blanching and releasing				*
c. Palpate femoral, popliteal, posterior tibialis and dorsalis pedis pulses				*
d. Assess range of motion – hips (abduction/adduction/flexion and extension), knees (flexion and extension) ankles (circumduction), and feet (plantar flexion and dorsiflexion)				4
e. Assess strength of thighs, lower legs, and feet against resistance				2
21. Health Promotion Questions				
Men: monthly self-chest and self-testicular exams, annual prostate exam after 40, colonoscopy after 50 (every 10 years)				*
Women: monthly self-breast exam, annual gynecologic exam, menses assessment, annual mammogram after 40, colonoscopy after 50 (every 10 years)				
22. Helped the patient into a comfortable position, and placed toiletries and personal items within reach.				1
23. Placed the call light within easy reach, and made sure the patient knew how to use it to summon assistance.				*
24. Raised the appropriate number of side rails and lowered the bed to the lowest position. Bed wheels locked				*
25. Disposed of used supplies and equipment. Left the patient's room tidy.				1
26. Removed and disposed of gloves. Performed hand hygiene.				*
27. Documented and reported the patient's response and expected or unexpected outcomes.				*

S = Satisfactory **U** = Unsatisfactory **NP** = Not Performed *****=Must Perform to Pass

TOTAL POINTS _____ / **79**

% _____

PASS _____

FAIL _____

Instructor: _____ Date: ____ / ____ / _____

By signing below I acknowledge that I witnessed the skill performed and the student successfully passed the skill.

Practice 1: Evaluator: _____ Signature: _____

Practice 2: Evaluator: _____ Signature: _____

FINAL Student Evaluator: _____ Signature: _____