SUL ROSS STATE UNIVERSITY

DEPARTMENT OF NURSING
NUR 3540
Comprehensive Patient Assessment in Rural/Border Communities
Fall Junior Year

SEMESTER HOURS: Four (4) Credit Hours
CLINICAL HOURS: 2 Credit Hours
DIDACTIC HOURS: 2 Clock Hours/Week
CLINICAL HOURS: 8 Clock Hours/Week
TOTAL CONTACT HOURS: 160 Clock Hours

PREREQUISITES: Successful Completion of Summer Semester Courses

FACULTY INFORMATION:

Name: Ms. Rebecca Lewis Co-Instructor: Ms. Yolanda Juardo
Contact Information: university email
Office Hours: TBD
Hours available via e-mail:
Hours available on campus:
Hours available via phone office/home/cell:
Phone number(s): updated information to follow
University e-mail: rebecca.lewis@sulross.edu

COURSE DESCRIPTION:

This course addresses techniques and application of bio-psycho-socio-behavioral and cultural principles of assessment applicable across the life span for individuals with health-care needs in rural/border communities. This educational process links previous basic knowledge and experience with concepts, skills to utilize diagnostic tools and equipment, therapeutic communication skills, body-systems assessment, screenings, diagnostic data, pathophysiologic knowledge, and standardized data scales to obtain a comprehensive patient assessment. Assessment techniques will be applied in all areas of nursing including obstetrics, pediatrics, geriatrics, medical-surgical patients, mental health, and acute care. Classroom, laboratory, and on-line experiences will be utilized throughout the semester.

STUDENT LEARNING OUTCOMES:

At the end of this course, the student will be able to:

MEMBER OF THE PROFESSION

1. Function within the legal scope of practice for comprehensive patient assessment as designated within state and national guidelines.

2. Incorporate current evidence-based practice principles, data from refereed journals, and information from nursing disciplines throughout the database and process of assessment.

PROVIDER OF PATIENT-CENTERED CARE

3. Develop and implement a comprehensive database for health assessment and adaptation for varied patient populations, including change in age, gender, culture, and ethnicity.
4. Demonstrate physical examination techniques, including observation, auscultation, palpation, and percussion for each body system during a head-to-toe assessment.
5. Use effective interview techniques, communication skills, and appropriate terminology when conducting a health history, compiling a heritage history, and performing a physical examination.
6. Modify the assessment approach for health variables such as growth and development, reproduction, nutritional status, patient safety, health promotion, antecedents/risk factors, diagnostic data, and disease prevention principles during the assessment process.
7. Demonstrate appropriate selection and utilization of assessment tools for each body system.

PATIENT SAFETY ADVOCATE

8. Follow safety principles and infection control when obtaining physical data from patients of all ages.
9. Maintain patient privacy and anonymity throughout the assessment process and recording.
10. Assess learning styles and barriers for learning in age groups and other variables to facilitate appropriate strategies for teaching health promotion, illness prevention, and risk-factor modification within a rural, border environment.

MEMBER OF THE HEALTH CARE TEAM

11. Utilize appropriate terminology and recording principles when documenting and sharing assessment data with health-team members.
12. Communicate with all members of the health-care team to obtain timely and accurate patient data.

MARKETABLE SKILLS FOR THE DEPARTMENT OF NURSING

The following marketable skills and dissemination plan has been submitted to the Texas Higher Education Board after approval from the Assistant Vice President for Institutional Effectiveness at Sul Ross State University:

Students will:

1. develop inquiry skills to evaluate situations (Sense of Inquiry);
2. develop communication skills to evaluate situations (Communication Skills);
3. develop research skills to promote their lifelong learning (Continuous Lifelong Learning); and
4. comport themselves verbally and visually in a professional manner (Professionalism).

Plan for Dissemination:

Students learn the marketable skills by first being exposed to them in all course syllabi. Each of the marketable skills is closely observed and evaluated by clinical faculty and preceptors as students' progress through the educational program. Students hone their research and communication skills through assignments and activities in multiple classes.

REQUIRED TEXTS:

1. Jarvis, C. (2020). *Physical Examination & Health Assessment* (8th ed.). St. Louis, MO: Saunders-Elsevier.
2. Jarvis, C. (2020). *Physical Examination & Health Assessment Student Laboratory Manual* (8th ed.). St. Louis, MO: Saunders-Elsevier.
3. Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic & laboratory test reference* (14th ed.). St. Louis, MO: Elsevier.
4. Pearson. (2019*). Nursing: A concept-based approach to learning, Volume 1, 2, & 3 (*3rd ed.). New York, NY: Pearson.
5. Halter, M. J. (2018). *Varcarolis' foundations of psychiatric mental health nursing. A clinical approach* (8th ed.). St. Louis, MO: Saunders-Elsevier.
6. Touhy, T. A., & Jett, K. F. (2020). Ebersole & Hess: Toward healthy aging: Human needs and nursing response (10th ed. Rev.). St. Louis, MO: Elsevier.
7. Winters, C. A. & Lee, H. J. Eds. (2018*). Rural Nursing: Concepts, Theory, and Practice* (5th ed.). New York, NY: Springer.

Recommended Textbooks:

ATI Drug Handbook may be referenced.

RECOMMENDED REFERENCES:
Articles, Web Resources, and References are listed in specific modules included in this course schedule. Additional resources which will enhance the learning process for students include material from Med-Com, which provides a review of physiologic activity and assessment hints and guidelines for patient assessment, and ATI resources.

COURSE LEARNING ACTIVITIES, ASSIGNMENTS, GRADING, AND EXPECTATIONS:

LEARNING ACTIVITIES:

Students will participate in all learning activities which are designed to meet course objectives. Classroom activities will provide the foundation for subsequent learning experiences, which will occur in the skills laboratory, simulation laboratory, and an introduction to patient assessment in selected clinical agencies. Basic assessment skills will be initiated in the skills lab with time for

practice and guidance from faculty members. The most significant learning experience will occur in the simulation lab where students will practice communication and assessment techniques with high-fidelity mannikins. Faculty guidance will be provided for students to establish assessment skills, followed by opportunities to practice techniques and to demonstrate selected assessment principles during laboratory experience. Scheduled clinical experiences will provide each student with beginning experience to assess patients. Each learning opportunity will be evaluated to assist students to establish mastery of comprehensive patient assessment.

Students are expected to participate in all course activities. As assessment knowledge and assessment skills are being developed, students will be expected to take leading roles in simulation scenarios and debriefing opportunities. Student dialogue is expected to reflect knowledge of assigned resources directed toward critical thinking and clinical reasoning.

ASSIGNMENTS:

Students are expected to complete and submit assignments as specified in the course outline. Many opportunities will be planned and implemented to assist students to understand the rationale for and to demonstrate knowledge and skill of their ability to complete a comprehensive assessment. Assessment data provide the foundation for planning, implementing, and evaluation of appropriate nursing actions consistent with the role of the professional nurse. In addition to demonstrating the ability to obtain pertinent data for each body system, students will be expected to alter tools and techniques needed to obtain accurate data from all age groups and genders. Incorporation of appropriate terms and descriptions for documentation will be exercised throughout the course.

ASSESSMENT OF STUDENT LEARNING:

Evaluation of student performance is based on evidence related to course-objective achievement. Students are graded on their attendance and participation in class discussion, accurate utilization of assessment tools, patient communication, assessment techniques, documentation, clinical performance, completion of across-the-life-span body system competencies, reflection of a sincere, caring demeanor, and evidence of assignment completion. Criteria for each course activity and assignment, including grading rubrics, are included in the syllabus. Following is a summary of measures to be graded and the percentage allotted for grade achievement:

Summary of Measures for Evaluation:

Course Requirements	Percentage
1. Class Discussion	10%
2. Skills Lab Activities	20%
3. Examinations	20%
4. Completion of Body System Competencies (All Ages)	10%
5. Simulation Lab Activities	20%
6. Clinical Experiences	20%
Total	*100%*

Calculation of Final Grade:

The final grade is derived as a summary of the points delineated on specific rubrics for assignments and participation. The final letter grade will follow the program grading scale:

Grading Scale
A = 90-100
B = 80-89
C = 75-79
D = 69-74
F = 69 OR BELOW

POLICIES FOR EXAMS AND ASSIGNMENTS

All policies listed in the *Nursing Student Handbook* will apply to this course. It is anticipated that all assignments and examinations will be completed as scheduled. If scheduling conflicts and/or personal or family emergencies arise, students must contact the faculty of record by phone as soon as possible. If students have spoken with the faculty of record and an agreement is reached in advance, late make-up exams and make-up assignments can be arranged without a grading penalty.

COURSE EXPECTATIONS:

Orientation to Course:

Orientation to all course learning activities will be discussed on the first day. Learning activities to be held in the skills and simulation labs will also require clarification to student expectation and requirements.

Faculty and Student Picture and Biography:

The faculty of record, additional faculty members, and assistants assigned to the course will submit a picture and summary of educational and professional experiences that prepared them to teach in this course. Since some on-line activities may be included in the educational process, pictures and biographies will be posted online.

STUDENT/FACULTY EXPECTATIONS IN THE TEACHING/LEARNING PROCESS:

Learning is a shared endeavor based upon respectful and collaborative relationships between students and faculty. The learning activities designed for this course were developed based upon the following:

1. As adult learners we are partners in learning.
2. Faculty members serve as a mentor, resource, guide, or coach and professional peer.
3. Our work and life experiences differ and serve to enrich our individual and mutual learning.
4. Each member of the class is committed to preparing for and successfully completing class learning activities.
5. Each member of the class will organize time, learning goals, work schedules, and family arrangements to fully participate in the course and assignment activities.
6. Each member of the class is able to use computer technology and access resources via the Internet and other mobile technologies as needed for this and other courses.

COMMUNICATIONS:

- **Announcements** – Check announcements each time you log onto the course.
- **Course email** – Check course email frequently for communications and make sure that your email address is current. Faculty will respond to inquiries and comments within 24 hours Monday-Friday.
- **Use of technology**: If you have any technical questions, problems, or concerns with Blackboard, do not spend more than 15 minutes on any technical problems. Seek help immediately. Contact 24-7 Help Desk at: 1-888-837-2882 and/or techassist@sulross.edu.
- **Responses to emails and course postings**: Please respond to faculty requests and/or communications within 24 hours. Use course or Sul Ross email and, if not available, mobile phone or texting between the hours of 9 AM and 6PM if possible. Messages received on the weekends or holidays will be answered by the next working day.
- **Assignments:** Assignments will be reviewed and returned with feedback/grade within 7 days of submission.

- **Writing and use of APA**: All written assignments and bulletin board postings will be submitted using the American Psychological Association (APA) Guidelines, as indicated by faculty. http://owl.english.purdue.edu/owl/resource/560/01

ATTENDANCE AND PARTICIPATION:

- Your attendance is expected at every class meeting, both face-to-face and online.
- Readings and learning activities relevant to the weekly topic are identified in the course schedule and modules.
- Scholarly and knowledgeable participation requires that you read your assigned readings prior to joining the class discussions.
- An online course requires participation in all areas for accurate evaluation of performance, including responding to faculty requests or communications.
- If you have an emergency and cannot attend a class meeting or complete an assignment by the due date, you must contact your faculty by phone, email, or text as soon as possible and make arrangements to make up the assignments.
- Blackboard course platforms have a tracking feature. This feature quantifies how often and when students are active in the course and also provides information if the student has accessed different pages of the course. The Blackboard tracking function may be utilized to verify student online participation.

RULES OF NETIQUETTE:

The term "netiquette" refers to written and unwritten rules regarding appropriate communication on the Internet. It primarily applies to your interactions on the course Discussion Board, assignments both individual and group, and e-mail communications.

1. Help create a community of scholars by encouraging a cooperative win-win attitude in which all members of the class are willing to work together, each contributing in their own way.
2. Be courteous and respectful to students and faculty in the course.
    a. There is a difference between making a statement that is a critical appraisal of an idea and criticizing someone for their point of view.
    b. Be careful with the tone of what you are communicating, i. e., sarcasm and subtle humor; one person's joke may be another person's insult.
    c. Do not use all caps in the message box (it is considered shouting).
    d. Do not use language that is inappropriate for a classroom setting or prejudicial in regard to gender, race or ethnicity.
3. Be helpful and be sure to do your part in an online class or in group work so that assignments can be completed.
4. Common courtesy and good manners, along with proper use of grammar, sentence structure, and correct spelling, are essential when taking an online class.
    a. Use a meaningful title in the Subject line. For e-mail, include course number.
    b. Use the person's name you are writing to as a greeting in the first line of the message – this helps ensure you are writing to the intended person (group).
    c. Close the posting by writing your full name at the end of the message.
5. Discussion Boards are public, and the University archives all materials. Do not post anything too personal as all students in the class and your instructor will see what you write.

a. Keep the messages you post to the Discussion Board relevant to the course and assignment, and provide a rationale including references as appropriate to support your point-of-view.
b. Avoid duplication. Read the previous discussions before you comment or ask a question as the information may have already been covered.
c. When posting a response, make sure you identify the post to which you are responding.
d. If the topic you plan to address is covered in an existing thread, do not start a new thread.
e. When responding to a specific comment, quote only the relevant part of the comment and stay focused on the assignment.
f. Try not to lurk, meaning you are just reading and not participating.

6. Quality of online communications/postings is important.
    a. It is not acceptable to present work or ideas of others as your own. Use APA format when you quote directly from a source—use quotation marks and provide the original author's name, year, and page or location in the body of the narrative; when you paraphrase a source—using your own words to explain your understanding of another's ideas or work—provide author and year in the body of the narrative. At the end of the posting provide the complete reference using APA format.
    b. If the posting is going to be long, use paragraphs.
    c. Do not overuse acronyms like you use in text messaging. Some of the participants may not be familiar with acronyms.
    d. Just as you would proofread a formal paper, before posting:
        i. Read what you have written for content;
        ii. Rethink what you have written for tone;
        iii. Reread what you have written for organization and coherence; and
        iv. Revise what you have written for grammar, punctuation and mechanics.
        v. Once you submit your work, discussion, or e-mail, you cannot change what you have written.
7. Don't send large files, since someone may have a relatively slow internet connection.
8. Be sure to check for viruses when sending files.
9. Be patient if you do not get an immediate response to your postings as others may be on a different schedule. If it is urgent, you can contact other students or faculty by e-mail, phone, or text.

MANDATORY UNIVERSITY STATEMENTS:

ADA Statement

SRSU Disability Services. Sul Ross State University (SRSU) is committed to equal access in compliance with Americans with Disabilities Act of 1973. It is SRSU policy to provide reasonable accommodations to students with documented disabilities. It is the student's responsibility to initiate a request each semester for each class. Alpine Students seeking accessibility/accommodations services must contact Rebecca Greathouse Wren, LPC-S, SRSU's Accessibility Services Coordinator at 432-837-8203 (please leave a message and we'll get back to you as soon as we can during working hours), or email rebecca.wren@sulross.edu. Our office is located on the first floor of Ferguson Hall (Suite 112), and our mailing address is P.O. Box C122, SUI Ross State University, Alpine. Texas, 79832.

Library Information

The Bryan Wildenthal Memorial Library in Alpine offers FREE resources and services to the entire SRSU community. Access and borrow books, articles, and more by visiting the library's website, library.sulross.edu. Off-campus access requires logging in with your LobolD and password. Librarians are a tremendous resource for your coursework and can be reached in person, by email (srsulibrary@sulross.edu), or phone (432-837-8123).

SRSU Distance Education Statement

Students enrolled in distance education courses have equal access to the university's academic support services, such as library resources, online databases, and instructional technology support. For more information about accessing these resources, visit the SRSU website. Students should correspond using Sul Ross email accounts and submit online assignments through Blackboard, which requires secure login. Students enrolled in distance education courses at Sul Ross are expected to adhere to all policies pertaining to academic honesty and appropriate student conduct, as described in the student handbook. Students in web-based courses must maintain appropriate equipment and software, according to the needs and requirements of the course, as outlined on the SRSU website. Directions for filing a student complaint are located in the student handbook.

Academic Integrity

Students in this class are expected to demonstrate scholarly behavior and academic honesty in the use of intellectual property. A scholar is expected to be punctual, prepared, and focused; meaningful and pertinent participation is appreciated. Examples of academic dishonesty include but are not limited to: Turning in work as original that was used in whole or part for another course and/or professor; turning in another person's work as one's own; copying from professional works or internet sites without citation; collaborating on a course assignment, examination, or quiz when collaboration is forbidden. Academic Dishonesty includes:

1. Copying from another student's test paper, laboratory report, other report, or computer files, data listings, and/or programs, or allowing another student to copy from same.
2. Using, during a test, materials not authorized by the person giving the test.
3. Collaborating, without authorization, with another person during an examination or in preparing academic work.
4. Knowingly, and without authorization, using, buying, selling, stealing, transporting, soliciting, copying, or possessing, in whole or in part, the contents of a non-administered test.
5. Substituting for another student; permitting any other person, or otherwise assisting any other person to substitute for oneself or for another student in the taking of an examination or test or the preparation of academic work to be submitted for academic credit.
6. Bribing another person to obtain a non-administered test or information about a non-administered test.
7. Purchasing or otherwise acquiring and submitting as one's own work any research paper or other writing assignment prepared by an individual or firm. This section does not apply to the typing of a rough and/or final version of an assignment by a professional typist.
8. "Plagiarism" means the appropriation and the unacknowledged incorporation of another's work or idea in one's own written work offered for credit.
9. "Collusion" means the unauthorized collaboration with another person in preparing written work offered for credit.
10. "Abuse of resource materials" means the mutilation, destruction, concealment, theft or alteration of materials provided to assist students in the mastery of course materials.
11. "Academic work" means the preparation of an essay, dissertation, thesis, report, problem, assignment, or other project that the student submits as a course requirement or for a grade.

All academic dishonesty cases may be first considered and reviewed by the faculty member. If the faculty member believes that an academic penalty is necessary, he/she may assign a penalty, but must notify the student of his/her right to appeal to the Department Chair, the Associate Provost/Dean, and eventually to the Provost and Vice President for Academic Affairs before imposition of the penalty. At each step in the process, the student shall be entitled to written noticeof the offense and/or the administrative decision, an opportunity to respond, and an impartial disposition as to the merits of his/her case.

In the case of flagrant or repeated violations, the Vice President for Academic Affairs may refer thematter to the Dean of Students for further disciplinary action. No disciplinary action shall become effective against the student until the student has received procedural due process except as provided under Interim Disciplinary Action.

Classroom Climate of Respect
Importantly, this class will foster free expression, critical investigation, and the open discussion of ideas. This means that all of us must help create and sustain an atmosphere of tolerance, civility, and respect for the viewpoints of others. Similarly, we must all learn how to probe, oppose and disagree without resorting to tactics of intimidation, harassment, or personal attack. No one is entitled to harass, belittle, or discriminate against another on the basis of race, religion, ethnicity, age, gender, national origin, or sexual preference. Still we will not be silenced by the difficulty of fruitfully discussing politically sensitive issues.

Diversity Statement
I aim to create a learning environment for my students that supports a diversity of thoughts, perspectives and experiences, and honors your identities (including race, gender, class, sexuality, religion, ability, socioeconomic class, age, nationality, etc.). I also understand that the crisis of COVID, economic disparity, and health concerns, or even unexpected life events could impact the conditions necessary for you to succeed. My commitment is to be there for you and help you meet the learning objectives of this course. I do this to demonstrate my commitment to you and to the mission of Sul Ross State University to create an inclusive environment and care for the whole student as part of the Sul Ross Familia. If you feel like your performance in the class is being impacted by your experiences outside of class, please don't hesitate to come and talk with me. I want to be a resource for you.

GENERAL CAMPUS REGULATIONS AND CONDUCT:

All students are expected to conduct themselves in a manner consistent with the University's functions as an educational institution. It is also expected that all students who enroll at Sul Ross State University agree to assume the responsibilities of citizenship in the university community. Association in such a university community is purely voluntary, and any student may resign from it at any time when he/she considers the obligation of membership disproportionate to the benefits. All students are subject to University authority, and those students whose conduct is not within the policies of the University rules and regulations are subject to dismissal. Students are responsible for abiding by all published University rules and regulations. Failure to read publications will not excuse the student from the requirements and regulations described therein. The SRSU Student Handbook and other official University publications outline specific regulations and requirements.

GUIDELINES FOR DATA BASE DEVELOPMENT

Data Base Date _____

Patient Identification

Psuedonym_____ Age _____ Race _____ Sex _____
Birthdate _____

Chief Complaint

Patient Profile

Birth Place

Present Residence

Occupation

Marital Status

Religion

Armed Services Dates _____ Discharge _____

Locations_____

Home Situations

Family

Family Relations

Income

Amount

Sources

Functional ability

Housing

Type

Number of Occupants

Transportation

Availability of Family or Neighbors

Hobbies or Special Interests

Average Day
Average Weekend

Habits (Alcohol, Tobacco, Drugs)

Sleep Pattern

Activity Limitations

Prosthesis

Eye

Ear

Extremities

Dentures

Diet

	Beverages	Meat, Fish, Eggs	Fruit & Veg.	Milk & Cheese	Bread, Cereal
Breakfast					
Lunch					
Dinner					
Snacks					

Diet

Salt Use

Other Diet Information

Ability to Communicate and Understand

Behavior during Assessment

Comments

History of Present Illness

(Provide a Narrative Statement Regarding the Patient's Rendition of the Present Illness)

(Circle positive responses and comment appropriately. Underline negative responses and leave unaltered if information not available.)

Past Medical History

1. Pediatric and adult illnesses: mumps, measles, chickenpox, rheumatic fever, arthritis, rheumatism, chorea, scarlet, fever, pneumonia, tuberculosis, diabetes mellitus, heart disease, renal disease, hypertension, jaundice.
2. Immunizations
3. Hospitalizations
4. Trauma
5. Transfusions
6. Allergies
7. Medications (prescribed)

   Time and/or day medication taken

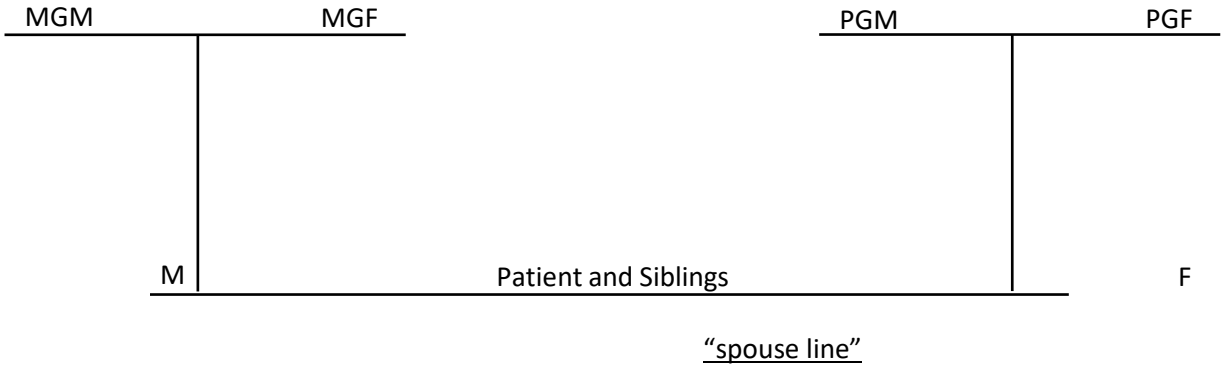
   How does the medication make you feel?

8. Medications (unprescribed) and why taken
9. Habits

Family History

Diabetes mellitus, tuberculosis, cancer, stroke, hypertension, renal disease, deafness, gout/arthritis, anemia, heart disease, syphilis, allergies, hemophilia, mental or emotional disturbance, endocrine disorders, migraine headaches, epilepsy, other.

Diagram family pedigree. (Place siblings in order of birth from left to right, use a "/" to indicate an individual is deceased, draw a line from the patient to the "spouse line," and indicate the spouse and any children on the "spouse line.")



Systems Review

1. General: weakness, fatigue, change in weight _____, appetite, sleeping habits, chills, fever, night sweats

2. Integument: color changes, pruritis, nevus, infections, tumor (benign/malignant), dermatosis, hair changes, nail changes

3. Hematopoietic: anemia, abnormal bleeding, adenopathy, excessive bruising, polycythemia

4. Central Nervous System: headache, syncope, seizures, vertigo, amaurosis, diplopia, paralysis/paresis, muscle weakness, tremor, ataxia, dysesthesia, disturbance of smell, disturbance of taste, difficulty of speech, difficulty in swallowing, loss of memory or intellect

5. Eyes: vision, glasses/contact lens, date of last eye exam _____, scotomata, pain excessive tearing color blind

6. Ears: tinnitus, deafness, other

7. Nose, Throat and Sinuses: epistaxis, discharge, hoarseness, thryo-megaly, sore throats

8. Dentition: caries, pyorrhea, dentures

9. Breasts: masses, discharge, pain

10. Respiratory: cough (productive/nonproductive), change in cough, amount and characteristic sputum, duration of sputum production_____, tobacco usage _____ years_____pkg. per day_____, wheezing, hemoptysis, recurrent respiratory tract infections, positive tuberculin test

11. Cardiovascular: chest pain, typical angina pectoris, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, peripheral edema, murmur, palpitation, varicosities, thrombophlebitis, claudication, Raynaud's phenomenon, syncope, near syncope

12. Gastrointestinal: nausea, vomiting, diarrhea, constipation, melena, hematemesis, rectal bleeding, change in bowel habits, hemorrhoids, dysphagia, food intolerances, excessive gas or indigestion, abdominal pain, jaundice, use of antacids, use of laxatives

13. Urinary tract: dysuria, hematuria, frequency, polyuria, urgency, hesitancy, incontinence, renal calculi, nocturia, urinary tract infection (recurrent), proteinuria, renal trauma, glomerulonephritis, nephrosis

14. Genito-Reproductive System:
    Male: penile discharge, lesion, history of veneral disease, serology, testicular pain, testicular mass, infertility, impotence, libido

    Female:
        Gynecologic history:
            Age of menarche _____
            Last Menstrual Cycle_____
            Regularity of Menses _____
            Amount of Flow during Menses _____
            Intermenstrual bleeding, postcoital bleeding, leukorrhea, pruritus, history of venereal disease, serology, uterine fibromyomas, libido
            Last Pap smear_____Results
            _____
            Age of Menopause_____Post-Menopausal Bleeding
            _____

        Obstetric History:
            Pregnancies_____
            Abortions_____
            Full-term Deliveries _____
            Living Children _____
            Complications of Pregnancies, Infertility

Methods of Contraception

Past

Present

15. Musculoskeletal:
    a. Joints: pain, edema, heat, rubor, stiffness, deformity, gout

    b. Muscles: myalgias

16. Endocrine: goiter, heat intolerance, cold intolerance, change in voice, polydipsia, polyphagia, glycosuria, excessive sweating, flushed face, recent weight loss, anxious, secondary sex characteristics

17. Psychiatric: hyperventilation, nervousness, depression, nightmares, memory loss

18. Additional historical data

Physical Examination

Vital Signs:

Pulse_____reg/irreg. Respiration_____ Temp. _____ oral/rectal

Blood Pressure—supine R. Arm _____ L. Arm _____

Leg _____

Sitting_____Arm _____

Standing_____Arm_____

Weight_____ Scales Used_____ Height _____

General

Integument: turgor, texture, pigmentation, cyanosis, telangiectasia, petechiae, purpura, ecchymosis, infection, lesions, hair, nails, mucous membranes

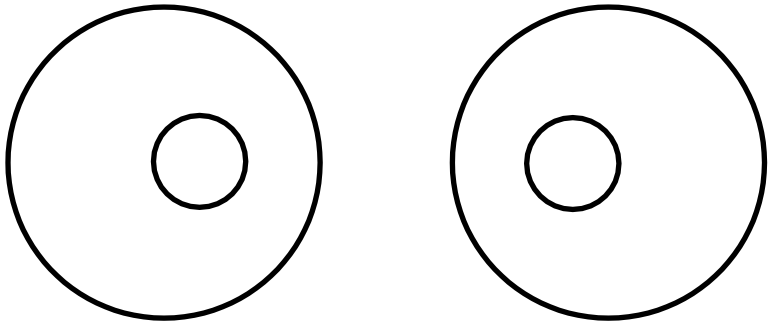
Lymph Nodes: cervical, post-auricular, supra-clavicular, axillary, ulnar, inguinal

Skull: trauma, bruits, other

Eyes: lacrimal glands, cornea, lids, sclerae, conjunctivae, exophthalmos, lid lag

Fundi: discs, arteries, veins, hemorrhages, exudates, micro aneurysms

Grade _____



Ears: tophi, tympanic membranes, external canal, hearing, air conduction_____, bone conduction_____, lateralization _____

Mouth, Nose and Throat: dentition, gingiva, tongue, tonsils, pharynx, nasal mucosa, nasal septum, sinuses

Neck: mobility, scars, masses, thyroid, salivary glands, tracheal shift, bruits

Breasts: masses, discharge, nipples, asymmetry, gynecomastia

Chest:

Respiratory Rate_____/min Amplitude: Shallow
Deep
Normal

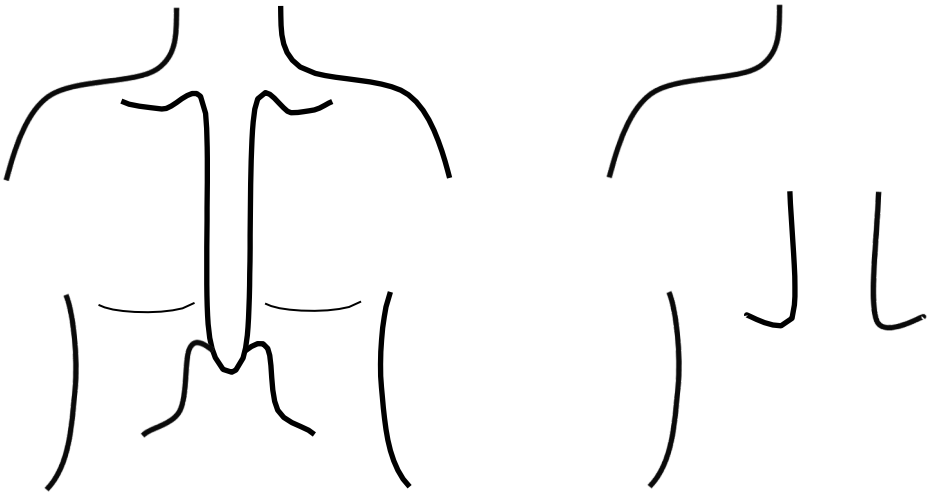
Respiratory Rhythm: Regular
Irregular
Periodical
Inspiration/Expiration Ratio

Chest Wall: Deformities
Motion
Lateral Motion: good, fair, absent
Use of Accessory muscles: yes, no

Auscultation: Rales, wheezes, rhonchi
Breath Sounds: increased, decreased, normal

Other:

(Diagram location of abnormal breath sounds, transmitted voice, or abnormal percussion.)



Cardiovascular System:
External Jugular veins are distended to_____cm. above the angle of Louis at_____degrees of truncal elevation from supine.
PM is in the_____ICS at the
_____,

S_1

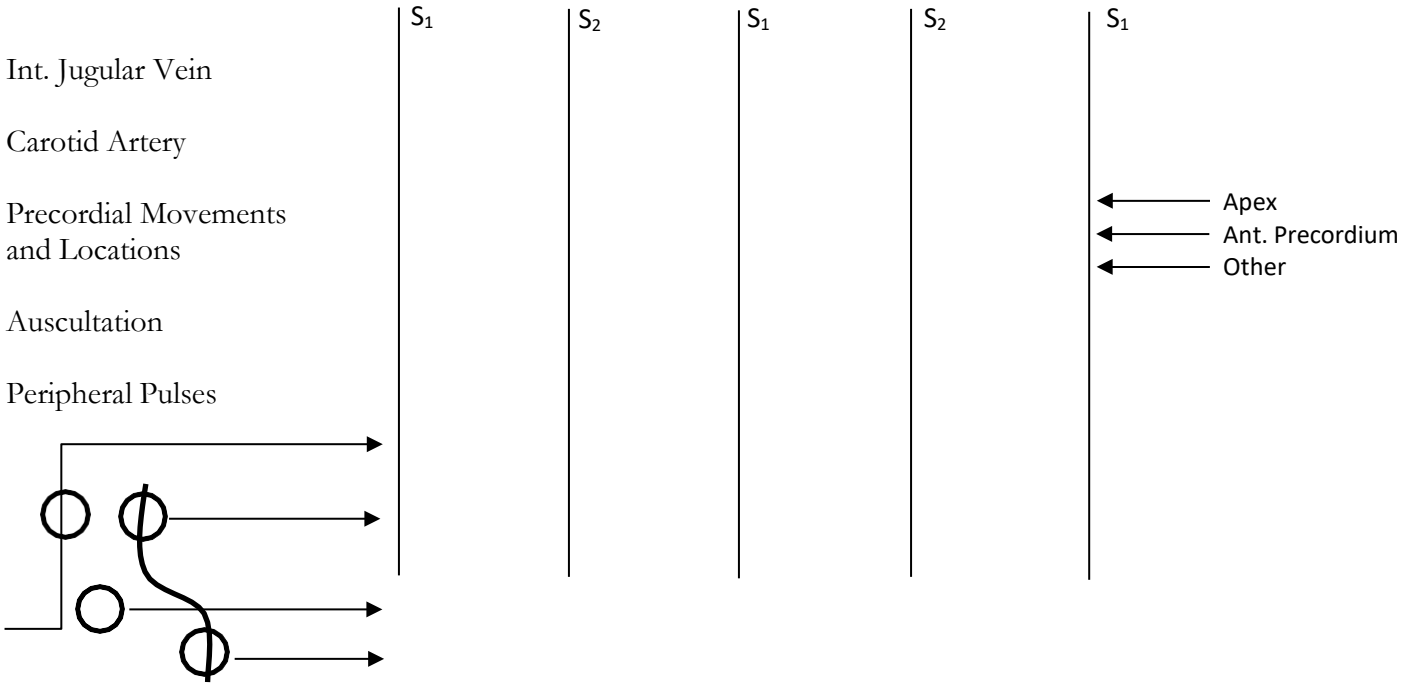
S_2

Gallops

Systolic Murmur

Diastolic Murmur

Other



Ceratoid	Brachial	Radial	Aorta	Femoral	Popliteal	dp	pt

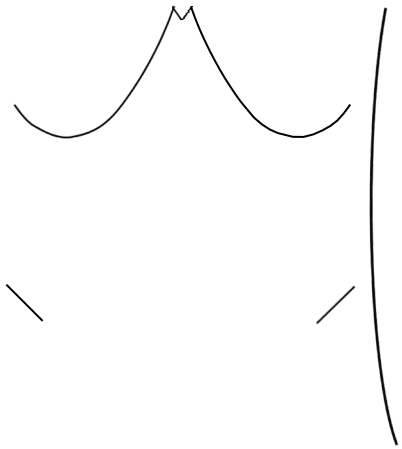
0 – Absent 1 /- Thready 2 /- Decreased 3 /- Normal 4 /- Hyperactive

Extremities: edema, cyanosis, stasis, ulceration, hair distribution, clubbing

Abdomen: obesity, contour, scars, tenderness, CVA tenderness, masses, rebound, rigidity, fluid wave, shifting dullness, frank ascites, bruits, hernia, venous collaterals

Bowel Sounds: normal, absent, hyperactive, hypoactive, obstructive
Organomegaly: liver, spleen, kidneys, bladder, gall bladder
Liver Size_____cm (total dullness)
Liver Tenderness: absent, increased
Liver Edge: smooth, irregular, nodular

(Diagram any finding as needed to help in explanation.)



Male:
Genitalia: penis, scrotum, testes, epididymis, masses, other
Rectal: perineum, hemorrhoids, sphincter tone, prostate, bleeding, masses
Stool_____

Female:
External Genitalia: labia, clitoris, introitus, urethra, perineum, other

Internal Genitalia: vagina, cervix, adnexa, cul-de-sac, discharge

Pap smear: done, omitted

Rectal: hemorrhoids, sphincter tone, bleeding, masses
Stool _____

Joints: deformity, rubor, calor, tenderness, edema
Range of Motion: fingers, wrists, elbow, shoulder, hips, knees, ankles
Spine: deformity (kyphosis, lordosis, scoliosis), thoracic, excursion
Neurological:
Cerebral Function: alert wakefulness, lethargic, obtunded, stuporous, semi-comatose, comatose

Mental Status:

Cranial Nerves:

I. (List test materials)

II. Discs, papilledema, venous pulses, optic atrophy, visual fields, visual acuity

III, IV, VI. Ptosis, palpebral fissure

Pupils: R_____mm L_____mm Shape _____
Reaction to light: R _____ L _____
Consensual Reaction: R to L _ L to R _____
Reaction to Near Vision R_____ L _____

Extraocular Movements: full, abnormal, dolls-eyes, cold calorics, gaze preference, nystagmus, optico-kinetic nystagmus

V. Sensory: 1st Division 2nd Division 3rd Division

R Corneal L Corneal

Motor: masseters, pterygoids, temporalis

VII. Intact, RL central, RL Peripheral

VIII. Sternocleidomastoids, trapezii

IX. Tongue in midline, deviation to R-L, atrophy, fasciculations

Gait and Station:

Walking: normal, abnormal, heel walking, toe walking, tandem walking

Truncal Ataxia

Romberg: present, absent, R-L

Involuntary Movements

Cerebellum: rapid alternating movements, finger-nose, finger-finger, heel-shin, past-pointing, rebound, posturing

Sensory: pain, temperature, light-touch, joint-position, vibratory, two-point discrimination, stereognosis

Associative functions: speech, writing, reading, apraxia, agnosia, other

Motor: tone, mass, fasciculations, tremor

_____ and_____hemiplegia

Reflexes

0 – Absent with Facilitation tr-trace 1/- Decreased 2/- Normal 3/- Hyperactive
4/- Sustained Clonus

	Bi	Tri	F	K	A	Plantar	Abdomen		Snout	Grasp	Jaw	Suck
R												
L												

Laboratory Data

Hematology:

CBC Differential

RBC Morphology Platelet Estimation

Chemistry:

Na - mEq/liter BUN

K - Creatinie

CO2 Uric Acid
Cl Cholesterol

Blood Sugar mg/100cc.
Albumin Level

Urinalysis:

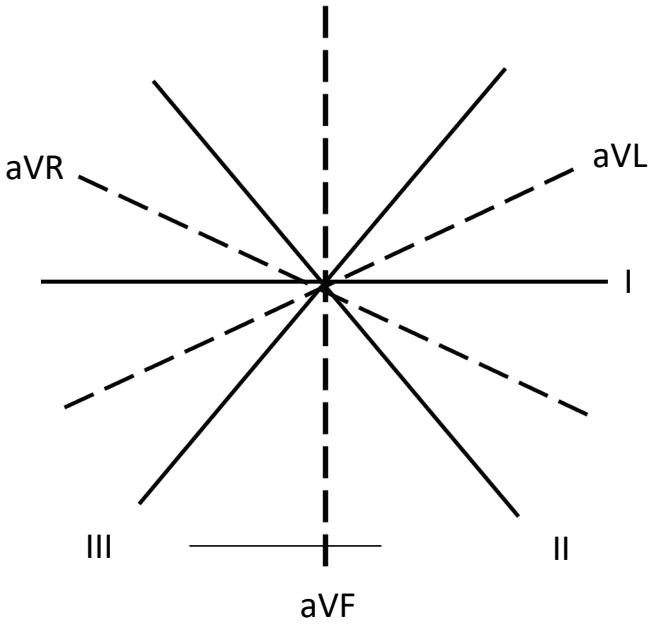
Protein Other

Sugar

Blood

Bacteria

Chest X-Ray (Diagram if appropriate): routine, protable, A-P



Electrocardiogram:

Rate

Rhythm

P-R_____QRS_____QT

Interpretation

RUBRIC FOR DEVELOPMENT OF POPULATION BASED DATA BASE

STUDENT NAME_____ DATE _____

	Exceptional (4)	Good (3)	Average (2)	Needs Development (1)

CONTENT TO BE DEVELOPED

1. Clearly identifies the selected patient population
2. Demographic Data targeted to patient population
3. Patient Profile/Relationship of Family Members
4. Family History/Pedigree
5. Resources & Support
6. Social History
7. Sexual/Obstetrical History
8. History of Present Illness
9. Individual's Reason for Seeking Assistance: Chief Complaint
10. Expectation of Treatment
12. Past Medical History
13. Past Surgical History
14. Summary of Diet
15. Review of Systems
16. Functional Ability
17. Physical Assessment
18. Grid for Pertinent Diagnostic Data
19. Summary of Findings
20. Common Nursing Diagnosis for Patient Population

SAMPLE OF PHYSICAL ASSESSMENT OF BODY SYSTEMS

Students will be required to complete competencies for each body system during the course. Two body systems, Pulmonary and Neurological Competencies, are included to provide samples of the student learning expectations.

Physical Assessment of Body Systems

Competency: GASTROINTESTINAL SYSTEM

Name:_____Date: _____

Method of Evaluation

DI = Discussion / Interview	**QI = Quality Improvement Monitors**
PO = Performance Observation	**RD = Return Demonstration**
PR = Presentations	**SS = Simulation Scenarios**

Level	Competency Statement: The licensed nurse will demonstrate competence in performing a physical assessment.	Method of Evaluation	Date/ Initials
	MEMBER OF PROFESSION		
	Follows and documents all standards of care (HIPAA, privacy, handwashing, & introducing self).		
	Interacts with patient in a calm, direct manner to obtain cooperation and enhance understanding during the physical examination.		
	Mentors less-experienced colleagues in performing a physical assessment of the gastrointestinal system.		
	Promotes Evidence Based Practice as personal philosophy.		
	PROVIDER OF PATIENT-CENTERED CARE		
	Key Terms Gastrointestinal Cirrhosis Cholecystitis Distention Hernias Jaundice Pancreatitis Paralytic ileus Peristalsis Peritonitis Polyps Striae Bruits Liver span Organomagaly		
	Procedure Steps		
	Gathers equipment necessary to perform a physical assessment: such as stethoscope, pen light, alcohol pads, pen and paper, measuring tape.		
	Performs a general visual assessment.		
	Inspection, auscultation, palpation, percussion, patient interview. Palpates unaffected side first.		

	Conducts examination in a quiet, well-lit room maintaining patient's privacy.		
	While examining each region, considers the underlying anatomic structures, their function, and possible abnormalities.		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	General Appearance The general survey is an overall impression of the patient/client, any past medical conditions /treatments, surgeries of the gastrointestinal system, or any current signs or symptoms /chief complaints. Make note of any guarding or splinting. Note any excess or deficiency in weight, type of diet (obtain a 24-hour food recall). Inquire about routine bowel elimination patterns, characteristics of stool, or any recent changes.		
	Assesses status of oral cavity and daily oral hygiene practice, notes any stomatitis, dentition, erosive areas on enamel, dental caries, lesions or ulcers.		
	Verifies that patient has an empty bladder for comfort throughout the assessment.		
	Assists patient to a supine position.		
	Identifies the 4 quadrants of the abdomen.		
	Identifies 2 organs located in each quadrant.		
	Assesses bowel sounds in each quadrant, starting with the right lower quadrant.		
	Examines the abdomen in the correct order: Inspection, auscultation, light palpation, and percussion:		
	a. Inspects the abdomen for color, distention, symmetry, bulges, visible pulsations, contour, venous patterns, scars. discolorations, silver striae or stretch marks, rashes, lesions, and presence of tubes, drains or incisions. b. Inspects for hernias which may manifest as protrusion of the umbilicus. c. Inspects the umbilicus for contour, location, and any signs of inflammation or herniation. d. Observes the contour of the abdomen: is it flat, rounded, protuberant, or scaphoid? Do the flanks bulge or are there any local bulges. Surveys the inguinal & femoral areas. e. Observes for pulsations visible in the epigastrium. f. Auscultates bowel sounds in each quadrant (5 minutes is adequate time before charting absence of bowel sounds). Notes frequency and character of bowel sounds, (normal, hypoactive and hyperactive).		

	Auscultates for bruits, uses the stethoscope bell to listen for abdominal and renal bruits. Reports immediately to physician if bruit is detected. g. Lightly palpates the abdomen for tenderness and distention. Light palpation is done with one hand only, palpating for masses, organs, and distention. Makes note of masses by location, shape, consistency and size. h. Percusses each quadrant assessing areas of dullness and tympani. i. Examines areas of dullness very carefully that might indicate an underlying mass or enlarged organ. j. Percusses liver span, percussing upward from the right iliac crest mid-clavicular line until tympani is no longer heard, marks this area, now percusses from the right clavicle downward till resonance changes to dullness and marks this change and measure from both markings. k. Rebound tenderness is performed to determine whether pressure or release affects the pain. l. Palpates the abdomen for tenderness and distension. m. Discusses a process for pain assessment with incorporation of other findings related to the abdominal findings. n. Deep palpation could be used to delineate abdominal masses. Correlates palpable findings with percussion notes. Assesses for abdominal pain and tenderness. Asks the patient to cough to determine if coughing will help determine the location of the pain. o. Discusses issues related to tenderness of a non-palpable liver. p. Assesses for a positive splenic percussion sign. q. Assesses for kidney tenderness. r. Discusses the relationship of shifting dullness, borders of tympany and a fluid wave shift.		
	Prioritizes interventions based upon physical assessment findings.		
	Uses the nursing plan of care to individualize and evaluate care.		
	Documents all findings per institution policy.		
	PATIENT SAFETY ADVOCATE		
	Identifies patient by 2 identifiers (patient name, birthday and/or medical record number).		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		

	MEMBER OF THE HEALTHCARE TEAM		
	Differentiates normal vs. abnormal findings for each body system and reports to RN/MD as appropriate.		
	Mentors less-experienced colleagues in performing a physical assessment.		
	Documents assessment findings accurately and promptly.		
	GERIATRIC CONSIDERATIONS		
	Keeps instructions simple and direct, allowing time for patient to process information and ask questions.		
	Demonstrates knowledge that atrophy of the gastrointestinal mucosa occurs with a reduction in the number of stomach and intestinal glands, resulting in alterations in secretion, motility, and absorption.		
	Demonstrates knowledge that changes in elastic tissue & colonic pressures may result in diverticulosis leading to diverticulitis.		
	Demonstrates knowledge that changes in pancreas result in increased half-life of lipid-soluble drugs as well as hyperglycemia.		
	Demonstrates knowledge that changes in hormones can lead to thyroid problems, increase secretion of ADH and atrial natriuretic hormone causing alter fluid balance, and increase levels of norepinephrine.		
	Demonstrates knowledge that aging may blunt the manifestations of acute abdominal disease, pain may be less severe, little or no fever.		
	Demonstrates knowledge that signs of peritoneal inflammation i.e. muscular guarding and rebound tenderness may be diminished or absent.		
	Demonstrates knowledge that alteration in bowel elimination is common.		
	Demonstrates knowledge that adipose tends to accumulate in the lower abdomen and near the hips, along with weakened abdominal muscles projects a potbelly appearance.		
	PEDIATRIC CONSIDERATIONS		
	Patient – nursing interaction is based on child's age, growth and development, and intellectual understanding.		
	Is honest. Informs patient what they're about to do based on the child's age, growth and development, and intellectual understanding. Provides some play time or show and tell for cooporation with the child when needed.		
	Keeps instructions simple and direct and uses appropriate words based on child's age, growth and development, and intellectual understanding.		

	Newborn:		
	Inspects for hernia especially umbilical hernia		
	Inspects umbilical cord for 3 vessels		
	Checks patency of rectum (depends on institution)		
	Infant:		
	Inspects umbilicus (umbilical hernias are common)		
	Inspects for large peristaltic waves movements		
	Toddler & Preschooler:		
	Inspects abdomen		
	Inspects umbilicus (belly button)		
	Auscultates bowel sounds (any bruits)		
	Inspects anus		

For any area not further emphasized for the pediatric patient, follow guidelines for general assessment of the gastrointestinal system.

Recommendation: Pass_____ Needs more practice_____
Student Signature:_____Date:_____
Evaluator's Signature: _____Date:_____
Remarks: _____

References:

Perry, A. G., Potter, P. A., & Ostendorf, W. R. (2020). *Nursing interventions and clinical skills* (7th ed.). St. Louis, MO: Elsevier.

Lewis S. L., Bucher, L., Heitkemper, M. M., Harding, M. M., Kwong, J., & Roberts, D. (2017). *Medical-surgical nursing assessment and management of clinical problems* (10th ed.). St. Louis, MO: Elsevier.

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Physical Assessment of Body Systems

Competency: PULMONARY SYSTEM

Name:_____Date _____

Method of Evaluation

DI = Discussion / Interview **PO = Performance Observation**	**QI = Quality Improvement Monitors** **RD = Return Demonstration** **SS = Simulation Scenarios**

Level	Competency Statement: The licensed nurse will demonstrate competence in performing a physical assessment of the pulmonary system	Method of Evaluation	Date/ Initials
	MEMBER OF PROFESSION		
	Follows and documents all standards of care (HIPPA, privacy, handwashing, & introducing self).		
	Interacts with patient in a calm, direct manner to obtain cooperation and enhance understanding during the physical examination.		
	Promotes Evidence Based Practice as personal philosophy.		
	PROVIDER OF CARE		
	Key Terms Pulmonary System Auscultation Percussion Palpation Atelectasis Bronchoscopy Cyanosis Diaphragmatic breathing Dyspnea Hematemesis Hemoptysis Hemothorax Hypoxia Orthopnea Pneumothorax Wheezing Rales Rhonchi Rales Infiltrates Percussion Pack-year Bronchophony Clubbing		
	Procedure Steps		
	Gathers equipment necessary to perform a physical assessment: such as stethoscope, pen light, alcohol pads, pen, paper, and tape measurement.		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	Performs a general visual assessment.		
	Conducts examination in a quiet, well-lit room while maintaining patient's privacy.		
	Assessment techniques: Inspection, palpation, auscultation, percussion, patient interview. <u>Inspection</u>: Assesses the patient's breathing for depth of chest, rhythm, rate, symmetry, effort of breathing, shape of		

	fingernails, shape of the chest, chest movement symmetry of respirations and position of the trachea. Observes the color, amount, consistency and odor of any sputum. Student may choose to perform inspection, auscultation, palpation, and percussion on the anterior chest before assessing the posterior chest. Assesses history of tobacco use, including type of tobacco, duration and amount. *Pack- years* = number of years smoking x packs per day. Notes the age started, efforts to stop smoking, and length of time since stopped smoking. Purposeful observation for abnormal retraction of the interspaces. While examining each region, considers the underlying anatomic structures, their function, and possible abnormalities.		
	Palpation: focuses on areas of tenderness & abnormalities, tests for respiratory expansion, feels for tactile fremitus. Palpates and compares symmetrical areas of the lungs.		
	Auscultates all lung fields for quality of breath sounds and presence of adventitious sounds. Begins at the upper posterior lung and works downward, then begins again at the upper anterior lung field and works downward. Auscultates throughout inspiration and expiration for adventitious sounds. Technique should be bilateral for comparison. Recognizes: Crackles, Rhonchi, Stridor, and Wheezes. a. 3 lobes on right b. 2 lobes on left c. Anterior and Posterior lung fields d. Apex Auscultation should never be done over clothing; the diaphragm/bell of the stethoscope should be placed on the patient's skin.		
	Assesses vocal resonance using Bronchophony, Whispered sounds, pectoriloquy, or Egophony. An increase in the clarity of sound so the words may be recognized distinctly is called bronchophony or, when very clear, pectoriloquy. Egophony is the nasal quality of spoken voice sounds heard over consolidated lung or lung compressed by fluid. Whispered sounds ("one, two, one, two") are heard in the normal chest only over the distribution of the trachea and major bronchi. Intensification of whispered sounds, whispered pectoriloquy, may be recognized over pulmonary infiltrations too small to change the percussion note or breath sounds.		

	Percussion over a solid organ, such as the liver, produces a *dull,* low-amplitude, short-duration note without resonance. Percussion over a structure containing air within a tissue, such as the lung, produces a *resonant,* higher-amplitude, lower-pitched note. Percussion over a hollow air-containing structure, such as the stomach, produces a *tympanic*, high-pitched, hollow-quality note. Percussion over a large muscle mass, such as the thigh, produces a *flat*, high-pitched note. Percussion: Uses proper technique to percuss patterned areas and describes flatness, dullness, resonance, hyper-resonance, and tympany.		
	Describes the normal lung sounds and expected locations of: Bronchovesicular sounds, Vesicular sounds, and Bronchial sounds. Description should relate to duration of sounds on inspiration and expiration, intensity of expiratory sound, pitch of expiratory sound, and location where normally heard. Utilizes appropriate terms and locations on the chest including: fremitus, supraclavicular, infraclavicular, interscapular, infra-scapular and bases of the lungs.		
	Prioritizes interventions based upon physical assessment findings and patient condition.		
	Documents all findings per institution policy.		
	Uses the nursing plan of care to individualize and evaluate care.		
	Positions the patient for evaluation of the anterior and posterior chest.		
	PATIENT SAFETY ADVOCATE		
	Identifies patient by 2 identifiers (patient name, birthday and/or medical record number).		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	MEMBER OF THE HEALTHCARE TEAM		
	Differentiates normal vs. abnormal findings for each body system and reports to RN/MD as appropriate.		
	Mentors less-experienced colleagues in performing a physical assessment.		
	Documents assessment findings accurately and promptly.		
	GERIATRIC CONSIDERATIONS		
	Keeps instructions simple and direct, allowing time for patient to process information and ask questions.		
	The older adult has decreased elasticity of lung tissue resulting in decrease vital capacity and oxygen diffusion. There are decreases in forced vital capacity & expiratory flow rate.		

	Begins the auscultation for an older adult at the base of the lung fields and works upward, first posterior then anterior lung fields.		
	The AP diameter (anterio-posterior) may be increased causing a barrel-chest appearance		
	A degeneration of bronchial epithelium & mucous glands increase risk of infection.		
	Skeletal changes contribute to decrease in vital capacity.		
	PEDIATRIC CONSIDERATIONS		
	Patient – nursing interaction is based on child's age, growth and development, and intellectual understanding.		
	Is honest. Informs patient what they're about to do based on the child's age, growth and development, and intellectual understanding. Provides some play time or show and tell for the child's cooperation when needed.		
	Keeps instructions simple and direct and uses appropriate words based on child's age, growth and development, and intellectual understanding.		
	Newborns:		
	Respiratory rate : 30 to 60 breaths per a minute (when quite)		
	Breathing done by diaphragm & nose breathers		
	Infant:		
	When auscultating; tracheal breath sounds are transmitted to the chest		
	Assesses for s/s of respiratory distress (use of accessory muscles, head bobbing, nasal flaring, stridor, etc.)		
	Toddler & Pre-schooler:		
	Inspects shape of the chest		
	Assesses respiratory rate		
	Palpates for tactile fremitus		
	Auscultates when the child is not aware of this part of the examination		

For any area not further emphasized for the pediatric patient, follow guidelines for general assessment of the pulmonary system.

Recommendation: Pass_____ Needs more practice_____

Student Signature:_____Date:_____

Evaluator's Signature: _____Date:_____

Remarks: _____

_____

References:

Lewis S. L., Bucher, L., Heitkemper, M. M., Harding, M. M., Kwong, J., & Roberts, D. (2017). *Medical-surgical nursing assessment and management of clinical problems* (10th ed.). St. Louis, MO: Elsevier.

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Physical Assessment of Body Systems

Competency: GENITOURINARY SYSTEM

Name: _____

Method of Evaluation

DI = Discussion / Interview	**QI = Quality Improvement**
PO = Performance Observation	**Monitors**
	RD = Return Demonstration
PR = Presentations	**SS = Simulation Scenarios**

Level RN	Competency Statement: The licensed nurse will demonstrate competence in performing a physical assessment.	Method of Evaluation	Date/ Initials
	MEMBER OF PROFESSION		
	Follows and documents all standards of care (HIPAA, privacy, handwashing, and introducing self)		
	Interacts with patient in a calm, direct manner to obtain cooperation and enhance understanding during the physical examination.		
	Promotes Evidence Based Practice as personal philosophy.		
	PROVIDER OF PATIENT-CENTERED CARE		
	Procedure Steps		
	Gathers equipment necessary to perform a physical assessment: such as a stethoscope, pen light, etc.		
	Performs focused assessment		
	Conducts examination in a quiet, well-lit room while maintaining patient's privacy.		
	While examining each region, considers the underlying anatomic structures, their function, and possible abnormalities.		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	Genitourinary System		
	Assesses urine elimination pattern and characteristics of urine:		
	a. Color and consistency, hematuria		
	b. Presence of dysuria, polyuria or oliguria		
	Measures Intake and Output (I/O).		
	Prioritizes interventions based upon physical-assessment findings.		
	Uses the nursing plan of care to individualize and evaluate care.		
	Documents all findings per institution policy.		
	PATIENT SAFETY ADVOCATE		
	Identifies patient by 2 identifiers (patient name, birthday and/or medical record number).		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	MEMBER OF THE HEALTHCARE TEAM		
	Differentiates normal vs. abnormal findings for each body system and reports to RN/MD as appropriate.		

	Mentors less-experienced colleagues in performing a physical assessment.		
	Documents assessment findings accurately and promptly.		
	GERIATRIC CONSIDERATIONS		
	Keeps instructions simple and direct, allowing time for patient to process information and ask questions.		
	Understands that decrease in numbers of glomeruli and thickening of the basement membrane in Bowman's capsule result in reduced renal function.		
	Understands that renal blood flow is decreased and vascular changes may contribute to reduced glomerular filtration rate.		
	Understands that, in men, prostatic atrophy or prostatic hypertrophy develops. The penis decreases in size and the testicles hang lower in the scrotum.		
	Understands that, in women, postmenopausal women have a reduction in estrogen, which is associated with increase in osteoporosis. The labia and clitoris reduce in size and the vaginal mucosa becomes thin and dry. The pubic hair decreases and becomes gray.		
	FYI: Sexuality and prevention of STDs		
	PEDIATRIC CONSIDERATIONS		
	Patient – nursing interaction is based on child's age, growth and development and intellectual understanding.		
	Is honest. Informs patient what they are about to do based on the child's age, growth and development, and intellectual understanding. Provides some play time or show and tell for the child's cooperation when needed.		
	Keeps instructions simple and direct and uses appropriate words based on child's age, growth and development, and intellectual understanding.		
	Newborn:		
	Male: inspects for external urethral meatus, descending of the testicles		
	Female: inspects labia major (should cover labia minor), possible vaginal discharge, inspects for external urethral meatus		
	Infant:		
	Inspects external genitalia		
	Assesses for diaper rash		
	Observes for urethral meatus		
	Male: Foreskin does not fully retract until 1 year of age or older. Inspects scrotum and trans illuminating for any mass, palpating testes.		
	Female: vaginal discharge		
	Toddler and Preschooler:		
	Male:		
	Inspects penis. By age 4 foreskin should be about 80% retractable.		
	Inspects urethral meatus		
	Inspects scrotum		
	Female:		
	Inspects vaginal area (rash or discharge present)		

	FYI: sexual abuse: S&S: difficulty walking, vaginal or anal infections, genital irritation or swelling, torn or stained underclothes, vaginal or anal bleeding, and/or bruising. MOST HAVE NO PHYSICAL FINDINGS.		
	School Age and Adolescence:		
	Secondary Sexual Characteristics Development		
	Males: pubic hair development, increase muscle mass, facial hair growth, increase sweat gland production, and growth spurts		
	Testicular development: assessing for and instructing on self-examination in regards to testicular cancer		
	Females: pubic hair development, increase sweat glad production, and growth spurts		
	Breast development and education on self-examination for breast cancer		
	Menstruation starts, patient education on perineal care and treatment for symptoms that occur during the cycle		
	Pap Smears		
	FYI address STDs and birth control issues		

For any area not further emphasized for the pediatric patient, follow guidelines for general assessment of the genitourinary system.

Recommendation: Pass_____ Needs more practice_____
Student Signature: _____
Evaluator's Signature: _____
Remarks:_____
_____

Date: _____

References:

Lewis S. L., Bucher, L., Heitkemper, M. M., Harding, M. M., Kwong, J., & Roberts, D. (2017). *Medical-surgical nursing assessment and management of clinical problems* (10th ed.). St. Louis, MO: Elsevier.

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Physical Assessment of Body Systems

Competency: NEUROLOGICAL SYSTEM

Name:_____ **Date** _____

Method of Evaluation

DI = Discussion / Interview **PO = Performance Observation** **PR = Presentations**	**QI = Quality Improvement Monitors** **RD = Return Demonstration** **SS = Simulation Scenarios**

Level RN	Competency Statement: The licensed nurse will demonstrate competence in performing a neurological physical assessment.	Method of Evaluation	Date/ Initials
	MEMBER OF PROFESSION		
	Follows and documents all standards of care (HIPAA, privacy, handwashing and introducing self)		
	Interacts with patient in a calm, direct manner to obtain cooperation and enhance understanding during the physical examination.		
	Promotes Evidence Based Practice as personal philosophy.		
	PROVIDER OF PATIENT-CENTERED CARE		
	Key terms Neurologic System Stereognosis Conductive hearing loss Strabismus Tactile Proprioceptive Romberg test Pronator drift Snellen chart Babinski Glasgow coma scale Cranial nerves know name, function, and testing technique Deep tendon reflexes, normal abnormal and grading		
	Procedure Steps		
	Gathers equipment necessary to perform a physical assessment: such as stethoscope, pen light, etc.		
	Performs focused assessment.		
	Conducts examination in a quiet, well-lit room while maintaining patient's privacy.		
	While examining each region, considers the underlying anatomic structures, their function, and possible abnormalities.		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	General Appearance The general survey is an overall impression of the patient/client, noting mental status, affect, speech, signs of distress, posture gait, grooming, dress (appropriate for season), hygiene, any past medical conditions and/or treatments/surgeries of the neurologic system, or any current signs or symptoms/chief complaints		

	Neurological System		
	Determines level of consciousness (LOC) by observing response to person, place and time. (Symmetry of function and findings on both sides of the body are important to note).		
	a. Best verbal response (oriented to person, place and time)		
	b. Best motor response (strength of each extremity)		
	GLASGOW COMA SCALE – TOTAL SCORE WILL BE FROM 3 – 15		
	Eyes Open: Spontaneously = 4		
	To verbal Command = 3		
	To pain = 2		
	No response = 1		
	Best Motor Response: Obeys Verbal Command = 6		
	Painful Stimulus/ localizes = 5		
	Painful Stimulus/ flexion withdrawal = 4		
	Painful Stimulus/ flexion – abnormal = 3		
	Painful Stimulus/ Decorticate rigidity = 2		
	Painful Stimulus/ Decerebrate rigidity = 1		
	Best Verbal Response:		
	Oriented & converses = 5		
	Disoriented & converses = 4		
	Inappropriate words = 3		
	Incomprehensible sounds = 2		
	No response = 1		
	LANGUAGE SKILLS		
	Ability to talk		
	Fluency of speech		
	Word-finding difficulty		
	Spontaneous speech		
	Follows commands		
	MEMORY		
	Short-term memory		
	Long-term memory		
	CRANIAL NERVE FUNCTION		
	CN I (Olfactory) Smell (test with alcohol pad, coffee etc.)		
	CN II (Optic) Visual acuity (read newsprint)		
	CN III (Oculomotor)		
	Consensual light response		
	Elevation of the eyelids		
	Eye movement medially		
	Nystagmus		

	Light reflex		
	Constricts Pupils		
	Pupil size		
	Pupil shape		
	Pupil equality		
	Moves eye right, up, down, and left		
	CN IV (Trochlear)		
	Gaze		
	Superior oblique eye muscle		
	Moves eye right, up, down, and left		
	CN V (Trigeminal)		
	Sensory nerve to skin of face – lightly touch cornea with wisp of cotton; assess corneal reflex		
	Measure sensation of light pain and touch across skin of face.		
	CN VI (Abducens)		
	Controls lateral rectus muscle of the eye		
	Moves eyes laterally		
	Motor nerve to muscles of jaw – palpate temple as client clenches teeth		
	CN VII (facial)		
	Sweet and salty tastes on front of tongue		
	Smile		
	Frown		
	Puff out cheeks		
	Symmetrical movements		
	CN VIII (auditory)		
	Assess ability to hear spoken word		
	CN IX (Glossopharyngeal)		
	Sour or sweet taste on back of tongue		
	Gag reflex		
	CN X (Vagus)		
	Sensation of pharynx: Ask client to say "ah". Observe movement of palate and pharynx		
	Movement of vocal cords: Assess speech for hoarseness		
	CN XI (hypoglossal)		
	Position of tongue: ask client to sitck out tongue to midline and move it side to side		
	CN III, IV, VI in concert to evaluate:		
	Unconscious patient:		
	Oculocephalic response (Doll's Eyes Maneuver)		
	a. Intact (eyes move opposite direction of head movement)		
	b. Abnormal (eyes move same direction as head movement or remain midline)		
	Oculovestibular response (ice water calories)		
	a. Normal response (eyes move in direction of ice water)		
	b. Abnormal (any other response indicates brain-stem injury)		
	MOTOR STATUS		

	Muscle Strength: hand grip, squeeze fingers		
	Muscle Tone strength against resistance		
	Deep Tendon Reflex		
	Babinski's reflex		
	Coordination of movement		
	Abnormal posturing		
	Drift Test		
	SENSORY		
	Superficial sensation: sharp and dull		
	Spatial / perceptual		
	Neurovascular assessment – "Ps" **Pulselessness** **Pallor** **Paresthesia** **Paralysis** **Pain** **Pressure (compartment syndrome)** **Polikilothermia (cool extremities)**		
	Prioritizes interventions based upon physical assessment findings.		
	Uses the nursing plan of care to individualize and evaluate care.		
	Documents all findings per institution policy.		
	PATIENT SAFETY ADVOCATE		
	Identifies patient by 2 identifiers (patient name, birthday and/or medical record number).		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	MEMBER OF THE HEALTHCARE TEAM		
	Differentiates normal vs. abnormal findings for each body system and reports to RN/MD as appropriate.		
	Mentors less-experienced colleagues in performing a physical assessment.		
	Documents assessment findings accurately and promptly.		
	GERIATRIC CONSIDERATIONS		
	Keeps instructions simple and direct, allowing time for patient to process information and ask questions.		
	Understands that changes in brain function may affect memory, intelligence, and skills like language or attention span.		
	Understands that brain weight is reduced due to atrophy.		
	Understands that there is decrease blood flow to the brain. Vascular changes such as atherosclerosis may result in multiple infarctions or transient ischemic attacks.		
	Understands that reflexes are reduced and the gag reflex may be absent (increasing risk for aspiration).		
	Understands significance of decreased tolerance to temperature extremes.		
	Understands that pupillary response to light may be altered (slowed) in the elderly patient. (Decreased visual acuity. Decreased taste and smell).		
	Observes dulled sensation of pain or pressure.		

	Observes decreased motor strength and/or slower, more deliberate gait.		
	PEDIATRIC CONSIDERATIONS		
	Patient – nursing interaction is based on child's age, growth and development, and intellectual understanding.		
	Is honest. Informs patient what they are about to do based on child's age, growth and development, and intellectual understanding. Provides some play time or show and tell for the child's cooperation when needed.		
	Keeps instructions simple and direct and use appropriate words based on child's age, growth and development, and intellectual understanding.		
	Newborn:		
	Inspects: posture, symmetry of extremities, spontaneous movements, facial expressions and symmetry, eye movement and symmetry.		
	Assesses Rooting reflex		
	Assesses Plantar and palmar reflex		
	Assesses Moro reflex		
	Assesses Babinski reflex		
	Infant:		
	By 4 months, when infant supine and is pulled into a sitting position, there should be no head lagging. (developmental milestone)		
	By 8 months, infant should sit without support. (developmental milestone)		
	Coordination of hands begins by 5 months especially when reaching and grasping objects (developmental milestone).		
	At 7 months, can transfer objects from hand to hand. (developmental milestone)		
	At 8 to 9 months, infant should be using pincer grasp to pick up small objects. (developmental milestone)		
	Toddler and Preschooler:		
	Assesses development of speech, reading ability, ability to manipulate small objects, throw a ball, and understand simple directions (best indicators of normal developing neurological system).		

For any area not further emphasized for the pediatric patient, follow guidelines for general assessment of the neurological system.

Recommendation: Pass_____ Needs more practice_____
Employee Signature: _____
Evaluator's Signature: _____
Remarks: _____

_____

Date: _____

References:

Lewis S. L., Bucher, L., Heitkemper, M. M., Harding, M. M., Kwong, J., & Roberts, D. (2017). *Medical-surgical nursing assessment and management of clinical problems* (10th ed.). St. Louis, MO: Elsevier.

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Physical Assessment of Body Systems

Competency: CARDIOVASCULAR SYSTEM

Name: _____

Method of Evaluation

DI = Discussion / Interview	**QI = Quality Improvement Monitors**
PD = Performance Observation	**RD = Return Demonstration**
PT = Post Tests	**SS = Simulation Scenarios**
PR = Presentations	**WA = Written Assessment**

Level RN	Competency Statement: The licensed nurse will demonstrate competence in performing a physical assessment.	Method of Eval.	Date/ Initials
	MEMBER OF PROFESSION Follows and documents all standards of care (HIPAA, privacy, hand washing, introducing self, & identifying patient.		
	Interacts with patient in a calm, direct manner to obtain cooperation and enhance understanding during the physical examination.		
	Promotes Evidence Based Practice as personal philosophy.		
	PROVIDER OF PATIENT-CENTERED CARE		
	Key Terms Cardiovascular System Aneurysm Apical Pulse Bruit Capillary Refill Dysrythmia Edema Murmurs Cyanosis PMI Thrill NSR Pulmonic Mitral JVD ECG Aortic		
	PROCEDURE STEPS – Head to Toe Assessment		
	Gathers equipment necessary to perform a physical assessment: Stethoscope, pen light, alcohol pads, pen and paper, measuring tape		
	Conducts examination in a quiet, well-lit room while maintaining patient's privacy.		
	While examining each region, considers the underlying anatomic structures, their function, and possible abnormalities.		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	General Appearance A general survey of the patient is the overall impression of the patient, noting mental status, orientation, affect, speech, signs of distress, anxiety or pain, vital signs, ht/wt, posture gait, grooming, dress (appropriate for season) hygiene.		

	Cardiovascular System		
	Assures proper blood pressure cuff size for patient and arm placement, preferably utilizing a manual cuff.		
	Obtains baseline blood pressure in both arms while patient is lying down or sitting; follows with blood pressure in both arms while standing unless contraindicated. Notes any readings that would indicate orthostatic hypotension (increased heart rate 15-20 beats above resting, systolic drop up to 15mm Hg., diastolic drop of 5-10 mm Hg.)		
	Obtains baseline heart rate rhythm and quality (bounding, normal, diminished)		
	Inspects internal jugular veins for distention with the patient at a 45 degree angle.		
	Auscultates each valve site for heart rate and rhythm and normal or abnormal heart sounds; i.e. S1, S2, S3, S4, murmurs, pericardial rub.		
	a. Aortic Valve area (located in the 2nd intercostal space on the right side of the sternum).		
	b. Pulmonic Valve area (located in the 2nd intercostal space on the left side of the sternum).		
	c. Tricuspid Valve area (located in the 5th intercostal space on the left side of the sternum).		
	d. Mitral Valve area (located at the 5th intercostal space, at or just medial to the midclavicular line). Identify the point of maximal impulse (PMI) of this Apical beat.		
	Assesses for edema and capillary refill in upper and lower extremities		
	Assesses peripheral pulses for rhythm, amplitude and bilateral equality.		
	a. Radial		
	b. Femoral		
	c. Posterior tibial		
	d. Dorsalis pedis		
	Auscultates each valve site for heart rate and rhythm and normal or abnormal heart sounds; i.e. S1, S2, S3, S4, murmurs, pericardial rub. a. Aortic Valve area (located in the 2nd intercostals space on the right side of the sternum) b. Pulmonic Valve area (located in the 2nd intercostals space on the left side of the sternum). c. Tricuspid Valve area (located in the 5th intercostals space on the left side of the sternum). d. Mitral Valve area (located at the 5th intercostals space on the left side of the sternum).		
	Differentiates normal vs. abnormal findings for each indicator and reports to MD as appropriate.		
	Prioritizes interventions based upon physical assessment findings.		
	Uses the nursing plan of care to individualize and evaluate care.		
	Documents all finding per institution policy.		

	PATIENT SAFETY ADVOCATE		
	Identifies patient by 2 identifiers (patient name, birthday and /or medical record number).		
	Adequately explains procedures to patient as examination progresses in order to avoid alarming patient and to encourage cooperation.		
	Assures patient safety when utilizing equipment and changing patient position.		
	MEMBER OF THE HEALTHCARE TEAM		
	Follows and documents all standards of care		
	Interacts with patient in a calm, direct manner to obtain cooperation and enhance understanding during the physical examination.		
	Documents assessment findings accurately and promptly.		
	Prioritizes interventions based upon physical assessment findings.		
	Mentors less-experienced colleagues in performing a physical assessment.		
	GERIATRIC CONSIDERATIONS		
	Keeps instructions simple and direct, allowing time for patient to process information and ask questions.		
	Understands that skin is frequently 'thinner' and more subject to injury. Bedrest places the elderly at greater risk for tissue breakdown due to impaired circulation.		
	Understands that changes in cardiovascular assessment findings are more common. Blood pressure may be higher and an irregular heartbeat occurs more often in the elderly patient.		
	Understands that systolic blood pressure raises with age where as diastolic pressure levels off around the age of 60, leading to isolated systolic hypertension.		
	Understands that noncompliance of the peripheral arteries may result in hypertension with a widened pulse pressure.		
	Understands that a loss in elasticity of the aorta may result in aortic dilation. The valves may degenerate and cause regurgitation or the valves may become sclerotic and cause stenosis.		
	Understands that degeneration or calcification to the conduction system may cause heart block or arrhythmias.		
	Understands that coronary atherosclerosis may produce angina, myocardial infarction, or nonspecific symptoms such as confusion or tiredness.		
	PEDIATRIC CONSIDERATIONS		
	Patient-nursing interaction is based on the child's age, growth and development, and intellectual understanding. Uses appropriate words based on age and interaction with the child. Understands that utilizing dolls or animals to demonstrate the procedure may be beneficial. This can be consistent with some play time or show and tell for cooperation with the child.		

	Newborn: Follows the Apgar Scale process after birth according to hospital protocol.		
	Point of Maximum Impulse is usually at xiphoid region.		
	Heart rate: 120 to 160 beats per minute.		
	Peripheral Pulses are usually assessed at brachial & femoral pulse sites.		
	Murmur may be noted, usually associated with closure of the patent ductus arteriosus.		
	Infants:		
	Continues to assess for cyanosis and/or retractions with breathing.		
	Assesses for CHF (persistent tachycardia, tachypnea, & enlarged liver, feeding problems, fatigue with exertion, diaphoresis)		
	Auscultates S3 & S4 which are common, and assess for murmurs.		
	Toddler & Preschooler:		
	Inspects the precordium.		
	Palpates for lifts, heaves, or thrills.		
	Auscultates for murmurs or abnormal sounds		
	Observes for color changes that may occur during activity.		
	Palpates peripheral pulses (comparing both radial & femoral pulses at the same time).		

For any area not further emphasized for the pediatric patient, follow guidelines for general assessment of the cardiovascular system.

Recommendation: Pass_____ Needs more practice_____
Employee Signature: _____
Evaluator's Signature: _____
Remarks:

Date:_____

References:

Lewis S. L., Bucher, L., Heitkemper, M. M., Harding, M. M., Kwong, J., & Roberts, D. (2017). *Medical-surgical nursing assessment and management of clinical problems* (10th ed.). St. Louis, MO: Elsevier.

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COURSE CONTENT LINKAGE WITH STATE AND NATIONAL GUIDELINES

The Table below demonstrates which elements of TBON DECs and AACN Essentials are addressed in relation to course objectives.

Objectives	TBON DECs	AACN Essentials
1. Function within the legal scope of practice for comprehensive patient assessment as designated within state and national guidelines.	I-A, C, 5a & b. III-A & B	II
2. Incorporate current evidence-based practice principles, data from refereed journals and information from nursing disciplines throughout the data base and process of assessment.	I-A; II-B; III A & B	III
3. Develop and implement a comprehensive database for health assessment with adaptation for varied patient populations including change in age, gender, culture, and ethnicity.	I-A 1, 2, 3, 4 a, b, c; II-B 1, 2, 3, 4, 5, 6, 7, 8, 9; III B-1	VI, IX
4. Demonstrate physical examination techniques including observation, auscultation, palpation, and percussion for each body system during a head-to-toe assessment.	II-B & C; III-B 1	IX
5. Utilize effective interview techniques, communication skills, and appropriate terminology when conducting a health history, compiling a heritage history, and performing a physical examination.	II-B 4, 5; II-C 4, 5; II-F 2, 3.	VII
6. Modify the assessment approach for health variables such as growth and development, reproduction, nutritional status, patient-safety principles, health promotion, antecedents/risk factors, diagnostic data, and disease-prevention activities during the assessment process.	II-G 1, 2, 3; III-A 1, 2, 3, 4, 5, 6; III-B 1, 5	V; VI; VII; IX
7. Demonstrate appropriate selection and utilization of assessment tools for each body system.	II-B; IV-F 1, 2	VI, VII, IX
8. Follow safety principles and infection control when obtaining physical data from patients of all ages.	II-D; III-A	II
9. Maintain patient privacy and anonymity throughout the assessment process and recording.	II-E 11	III; VIII
10. Assess learning styles and barriers for learning in all age groups and other variables to facilitate appropriate strategies to teach health promotion, illness prevention, and risk-factor modification within a rural, border environment.	I-B,4b; II-B; III-A & B	VIII
11. Utilize appropriate terminology and recording principles when documenting and sharing assessment data with health-team members.	II-C	VI
12. Communicate with all members of the health-care team to obtain timely and accurate patient assessment data.	IV-A, B, C, D	VI