NORTHERN ARIZONA UNIVERSITY
Department of Nursing

NUR 307
Nursing Assessment
RN - BSN Students only

2 Credits

Faculty
Angela Golden, RN, MS, FNP-C

Fall, 2001
Course Overview
Course Number: NUR 307 (2 credits)/4 clock hours

Course Title: Nursing Assessment
             RN - BSN students Statewide

Delivery Modality: Weekend seminar
Self guided instruction
E-mail contact with instructor

Time/Location: Weekend Seminar Friday, September 7 5 – 9pm, Saturday September 8, 2001 - 8am – 4pm (Nursing building NAU Flagstaff campus)
Self-guided instruction

Faculty: Angela Golden, RN, MS, FNP-C
         Room 218
         Phone: 928/286-2571 (home)
         Cell: 928/380-3790
         Email: akgrn@aol.com

Catalog Description: The purpose of the course is to provide the nursing student with beginning cognitive and psychomotor skills in the area of problem oriented recording, history taking, and physical examinations.

Course Objectives: By the end of this course, the student will:

Competency
1. Apply the nursing process in performing health assessments with individuals across the life span.
2. Integrate teaching regarding health promotion into the complete health assessment.

Critical Thinking
3. Evaluate the bio-psycho-social, developmental, cultural and spiritual dimensions of the individual as a basis for nursing diagnoses.

Caring
4. Use caring interactions in the physical assessment process.

Culture
5. Recognize the bio-psycho-social, developmental, cultural and spiritual dimensions of the individual using a variety of assessment tools appropriate for age and setting.

Communication
7. Communicate findings to the individual and other appropriate referral sources.

Health
8. Differentiate normal vs. abnormal findings and develop nursing diagnoses and outcome criteria.

9. Recognize the importance of environmental factors and constraints in the assessment of health.

8. Identify the role of the professional nurse in performing health assessments.

9. Demonstrate professional behavior in performing health assessments.

Teaching Strategies:
Weekend seminar followed by independent, self-directed study using required book and video, written history and physical exam focus papers, quizzes, and email contact with instructor.

Textbook:
**Required:**

**Video:**
Expert Nurse Video Series - Performing Head-to-Toe Assessment. The video can be obtained from Springhouse by going to the web site [www.springnet.com](http://www.springnet.com) or calling 1-800-666-5597. The ISBN number is 1-58255-086-7.

**Recommended:**

Evaluation:
Examinations
Quizzes 5 @ 20 pts. each 100

Documentation
3 Focus Assessments@ 25 pts. each 75
Final assessment practical 50
Final Assessment paper 100
Total Points 325

Scale: A - 292-352
B - 260-291
C - 227-259
F - 226 points and below

General Information about course.
You may have heard that this is a self-paced course. While it is true that the course is self-guided instruction, it is only self-paced in the sense that you may go as fast as you wish, but you cannot go beyond a scheduled due date for a specific assignment without losing points for lateness. In other words, it is possible to go as fast as you want, but it is not acceptable for you to go so slow that your assignments are submitted to the instructor after scheduled deadlines for that assignment. It is also not acceptable for you to turn in all of the required papers in one batch at the end of the semester. Students are expected to proceed through the course as they would in the same way they would in a course offered in any other delivery modality. The course is designed to go over a 16 week semester.

In order to do this health assessment class, you will need to have a preceptor in your community who will watch as you perform the assessment techniques for each system. This preceptor must be a nurse practitioner, physician’s assistant or physician and you will be responsible for setting up times to meet with this professional to practice your skills. It is your responsibility to find this preceptor and notify your instructor (the assigned NAU faculty member) of the name and contact information of the preceptor. In addition, you will need to have 3 separate “patients” with whom you will be doing your history and physical exam focus papers. One of the patients can be a family member, the other two patients can include acquaintances, or patients you are dealing with in your work situations. You may do the papers on pediatric or geriatric patients but one of the papers must be a well-adult. **You will not be performing breast, gynecological or genitourinary exams on any of the patients.**

The final paper and assessment will be a complete history and physical on one patient. This may be one of the patients you have already done a previous focused history and assessment on. The physical needs to be done with your preceptor observing and completing the check off list that will be supplied by the instructor. The final paper will include a complete history and the write-up of your physical assessment, including a nursing assessment and plan.

The quizzes will be distributed to each student at the beginning of the semester. You will need to complete those by the due dates as listed in this syllabus. The quiz answers will then be e-mailed to the Instructor. The packet will be made available at the weekend seminar.

---

**History and Physical Focus Papers**

Students will be responsible for submitting 3 focused nursing assessments (history and physical exams) based on the assessment skills learned on the video and chapters read in the textbook. These papers will be e-mailed to the Instructor via email listed on the first page. Please look at the paper requirements included at the end of the syllabus. Everything that is required for the paper is included in the paper format at the end of the syllabus. You will need to pick a new individual for each assessment. One of the “patients” may be a family member. Choose an acquaintance or patient for the other two papers. One of the papers must be a well-adult. You may also do a pediatric or geriatric patient but this is not required.
The nursing assessments must include:

1) History
2) Physical
3) Summary of Findings
4) Plan for Intervention

Each nursing assessment is worth 25 points. Paper must be typed and can be no longer than 3 pages. When you are finished, submit the paper via email to your instructor. The final is worth 100 points and will be longer than 3 pages.

Grading criteria for Focused Assessment Papers

I. History          8 points
   1. Complete all components of the health history
   2. Demonstrates use of symptom descriptors as appropriate

II. Physical Examination Documentation     8 points
    1. Documents significant positive and negative findings
    2. Uses correct terminology
    3. Documents using an organized format

III. Summary of Data                3 points
    1. Demonstrates ability to summarize pertinent findings from
       the history and physical examination in a summary paragraph

IV. Develop Plan for Interventions       6 points
    1. Based on summary and appropriate for nursing role

No matter how healthy your patient may be, there are always health promotion/illness prevention nursing interventions you can provide. Additionally, there are interventions included in the recommended Health Assessment textbooks if needed.

Using “normal” and “abnormal” or “good” or “bad” in not acceptable. Utilize the terminology as you see in your textbook. DESCRIBE what you see, hear, touch, smell.

PAPER REQUIREMENTS- SEE DOCUMENTATION at the end of SYLLABUS

Paper #1 - Skin, hair, nails, neck, regional lymphatics, HEENT Due no later than Oct 15th
Paper #2 - Lungs, Thorax, Heart, peripheral vascular system Due no later than Nov 5th
Paper #3 - Lungs, Heart, peripheral vascular, Abdomen, Mental Status, Neuro, M-S Due no later than Dec 7th
Final assessment due no later than December 14th, 2001
### Course Policies and Additional Requirements

Please read these carefully so that you are aware of the requirements of the course:
The following expectations are required of every student enrolled in the RN-BSN section of Nursing 307:

1. Papers must be typed and then e-mailed to the instructor. Late papers will have 10% of the grade subtracted for each day late.
2. A weekly e-mail to the instructor is required. This is to ensure that the student is moving through the course without problems.
3. The student will need to set up a preceptor in the community to demonstrate the newly learned skills. This preceptor must be a Nurse Practitioner or, Physician’s Assistant or, Physician. The preceptors contact information must be to the instructor by September 15, 2001.
4. For the final physical exam the student will be performing a head-to-toe physical exam with your preceptor and submitting a complete history and physical write-up of the interview and exam.
NAU’s Safe Working and Learning Environment Policy seeks to prohibit discrimination and promote the safety of all individuals with the university. The goal of this policy is to prevent the occurrence of discrimination on the basis of sex, race, color, age, national origin, religion, sexual orientation, disability, or veteran status and to prevent sexual harassment, sexual assault, or retaliation by anyone at this university.

You may obtain a copy of this policy from the college dean’s office. If you have concerns about this policy, it is important that you contact the departmental chair, dean’s office, the Office of Student Life (523-5181), the academic ombudsperson (523-9368), or NAU’s Office of Affirmative Action (523-3312).

Students with Disabilities

If you have a learning and/or physical disability, you are encouraged to make arrangements for class assignments/exams so your academic performance will not suffer because of the disability or handicap. If you have questions about special provisions for students with disabilities, contact the Counseling and Testing Center (523-2261).

It is your responsibility to register with the Counseling and Testing Center. Application for services should be made at least eight weeks before the start of the semester.

If the Counseling and Testing Center verifies your eligibility for special services, you should consult with your instructor during the first week in the semester so appropriate arrangements can be made. Concerns related to noncompliance with appropriate provisions should be directed to the Disability Support Services coordinator in the Counseling and Testing Center.

Institutional Review Board

Any study involving observation of or interaction with human subjects that originates at NAU—including a course project, report, or research paper—must be reviewed and approved by the Institutional Review Board (IRB) for the protection of human subjects in research and research-related activities.

The IRB meets once each month. Proposals must be submitted for review at least fifteen working days before the monthly meeting. You should consult with your course instructor early in the course to ascertain if your project needs to be reviewed by the IRB and/or to secure information or appropriate forms and procedures for the IRB review. Your instructor and department chair or college dean must sign the application for approval by the IRB. The IRB categorizes projects into three levels depending on the nature of the project: exempt from further review, expedited review, or full board review. If the IRB certifies that a project is exempt from further review, you need not resubmit the project for continuing IRB review as long as there are no modifications in the exempted procedures.
A copy of the *IRB Policy and Procedures Manual* is available in each department’s administrative office and each college dean’s office. If you have questions, contact Carey Conover, Office of Grant and Contract Services, at 523-4889.

**Academic Integrity**

The university takes an extremely serious view of violations of academic integrity. As members of the academic community, NAU’s administration, faculty, staff, and students are dedicated to promoting an atmosphere of honesty and are committed to maintaining the academic integrity essential to the educational process. Inherent in this commitment is the belief that academic dishonesty in all forms violates the basic principles of integrity and impedes learning.

It is the responsibility of individual faculty members to identify instances of academic dishonesty and recommend penalties to the department chair or college dean in keeping with the severity of the violation. Penalties may range from verbal chastisement to a failing grade in the course. The complete policy on academic integrity is in Appendix F of NAU’s *Student Handbook*.

**Approved 4/96**
HOLISTIC ASSESSMENT

Learning Objectives:
1. Recognize the need for a health assessment.
2. Identify factors which place an individual at risk for the development of health problems.
3. Acknowledge the value of cultural, spiritual and developmental aspects of the client.
4. Describe information in conducting a life style assessment.
5. Increase the psycho-physiologic aspect of the mind-body connection.
6. Identify major components of a comprehensive health history.
7. Identify sources of information.
8. Identify instruments used in the assessment of health.
9. Conduct a systematic and accurate health history using appropriate format and recording techniques.
10. Learn basic terms commonly used in the health history.
11. Differentiate acceptable from unacceptable vocabulary for use in documenting health assessment findings.
12. Discuss different methods of recording assessments.
13. Construct a family tree history.
14. Describe the application of the nursing process to the health assessment of an individual.

Learning Content:
A. Introduction to course
   1. Expectations for faculty and students
   2. Review of syllabus
      a. Goals and limitations
      b. Weekly process
      c. Assignments
B. Life Style Assessment
C. Body - Mind Connection
D. Tools for assessment
   1. Instruments
      a. Frequent tools
         1. Thermometer
         2. Stethoscope
         3. Sphygmomanometer
         4. Oto-ophthalmoscope
         5. Tuning fork and hammer
         6. Other
      b. Selection, care & maintenance
   2. Ordered process
      a. Nursing process
      b. Health Assessment
         1. Aspects of person
            a. Bio-psycho-social
            b. Developmental
            c. Cultural
            d. Spiritual
2. Head to toe
   a. History
   b. Examination

3. Documentation
   a. Findings
   b. Vocabulary

4. Safety
   a. Hand washing
   b. Client limitations

3. Assessment techniques
   a. Inspection
   b. Palpation
   c. Percussion
   d. Auscultation
   e. Sequencing

E. Types of examinations
   1. Screening
   2. Branch
   3. Complete

F. Screening examination
   1. Purpose
   2. Setting
   3. Consent

Learning Content: History - Taking
A. Health history
   1. Overview of health history
      a. Importance
   2. Components of health history
      a. Biographical data
      b. Chief concern
         1. Well client
         2. Ill client
      c. Present health status or Present Illness
      d. Past history
      e. Family history
      f. Review of symptoms
      g. Additional historical information, lifestyle
   3. Recording health history
   4. Analyzing health history
      a. Assets/risks
      b. Specific assessment areas
         1. Biological
            a. Genetic
            b. Familial
c. Physiological state

2. Psycho/social
   a. Cultural
   b. Environmental
   c. Economic
   d. Spiritual
   e. Psychological state
   f. Support systems

**General Assessment and Assessment of Integumentary System**

**Learning Objectives:**
1. Discuss knowledge and skills needed to attain an adequate general assessment.
2. Identify signs of distress in the general assessment that might influence the process of the physical assessment.
3. Recognize conditions and locations of common skin lesions.
4. Compare normal and abnormal findings in inspection of the nails and hair.
5. Identify normal hair and skin and characteristics based on age, sex and ethnic background.
6. Perform and record the appraisal of the skin, hair and nails using appropriate terminology.

**Learning Content:**

A. General Assessment
   1. General assessment inspection
      a. Observational areas
         1. State of health according to appearance
         2. Signs of distress
         3. Height, weight, age, sex according to appearance
         4. Body type, statue, symmetry, habitus
         5. Body posture, movement, gait
         6. Odors
         7. Speech and mental status
         8. Pain
      b. Recording the general survey
   2. Height and weight
   3. Vital signs

B. Assessment of the skin
   1. Review of system
      a. Inspection
      b. Palpation
      c. Abnormal Changes
         Description
         1. Location
         2. Color
         3. Size
         4. Number
         5. Distribution
         6. Configuration
HEENT/Neck

Learning Objectives:
1. List factors included during the review of systems for the EENT.
2. Identify the anatomical structures relevant to inspection.
3. Demonstrate techniques used to assess the ear, nose and throat, differentiating between normal and abnormal variations.
4. Incorporate components of the neurological examination in the ENT assessment.
5. Record an ENT Exam using correct terminology.
6. List factors included during the review of systems for vision and eye assessment.
7. Describe methods for testing distant and near visual acuity.
8. Administer a standard visual acuity test using either an alphabet or an E chart and record the test findings.
9. List and locate the anatomical structure of the external and internal eye that are assessed by inspection.
10. Perform an examination of the external and internal structures of the eye differentiating between normal and abnormal variations.
11. Record an assessment of the eye using correct order and terminology.

Learning Content:
A. Purpose
B. Assessment of E.E.N.T.
   1. Review of Systems
   2. Physical Examination of the ear
      a. External ear
         1. Inspection
         2. Palpation
      b. Internal ear
         1. Inspection
         2. Other techniques
         3. Hearing function (neuro)
   3. Assessment of vision
      a. Anatomy and physiology of vision
b. Testing visual activity
   1. near vision
   2. distance vision
4. Assessment of eye movement (Neuro)
   a. Muscles and cranial nerves
   b. Cardinal positions of gaze
   c. Corneal light reflex
   d. Cover-uncover test
   e. Selected abnormalities
5. Examination of the eye
   a. Structures assessed
   b. Assessment procedures
   c. Clinical observations
      1. variations of normal
      2. abnormal
6. Assessment of the nose and sinuses
   a. Anatomical structure
   b. Palpation of the sinuses
   c. Selected abnormalities of the nose and sinuses
7. Assessment of the mouth and pharynx
   a. Inspection of the external and internal oral structures
   b. Inspection of the structures of the pharynx
   c. Palpation of oral structures
   d. Evaluation of cranial nerve functions (Neuro)
   e. Selected abnormalities of the mouth and pharynx

Lymphatic and Breast Assessment

Learning Objectives:
1. Identify historical data and review of systems questions pertinent to assessment of lymphatic system and breasts.
2. Anatomically locate the lymph nodes of the head, neck, extremities and breasts.
3. Demonstrate the correct technique for palpating lymph nodes.
4. Describe the clinical significance of findings such as enlargement, tenderness, non-mobility when assessing lymph nodes.
5. Demonstrate and document a lymphatic assessment using correct form and terminology.
6. Identify the normal anatomical features of the breast, and describe the lymphatic drainage of the breast.
7. Demonstrate the correct procedure for inspection and palpation of the thyroid.
8. Describe normal and abnormal findings upon assessment and record appropriately.
(Remember no breast exam are to be done on patients for this class even with your preceptor)

Learning Content:
A. Purpose
B. Assessment
   1. Review of systems
2. Assessment of the Endocrine System  
a. Thyroid assessment  
b. Other  
3. Assessment of the Lymphatic system  
a. Anatomical location  
b. Palpation  
c. Descriptive findings  
d. Historical data  
4. Assessment of the Breast  
a. Breast anatomy  
   1. Tissue types and divisions  
   2. Lymphatic drainage  
b. Breast exam (NOT to be done – this is for information only)  
   1. Setting  
   2. Positioning  
   3. Inspection  
   4. Palpation  
   5. Recording  

Assessment of the Lungs and Thorax  

Learning Objectives:  
1. Identify pertinent historical data and review of systems questions related to assessment of the lungs and thorax.  
2. Identify and locate the anatomical contents of the thorax.  
3. Identify the anatomical landmarks and reference lines of the anterior, posterior, and lateral thoracic cage commonly used during assessment.  
4. Locate, using correct terminology, the thoracic components of the respiratory system: Trachea, mainstem bronchi and lobes of each lung.  
5. Identify normal findings during percussion of the thorax in terms of sounds produced as they relate to underlying structures.  
6. Demonstrate the method for determining the level of the diaphragm by percussion.  
7. Name and describe the different normal breath sounds and locations for each.  
8. Define each of the abnormal breath sounds in terms of origin, cause, sound produced and clinical significance.  
9. Compare and contrast normal respiratory and thoracic findings with findings of common pathologic states.  
10. Perform and record assessment of the lungs and thorax with supervision.  

Learning Content:  
A. Purpose  
B. Review of systems  
   1. General  
   2. Specific  
C. Thoracic anatomy  
   1. Structural landmark  
   2. Imaginary lines
3. Underlying organs

D. Assessment techniques
1. Inspection
   a. General
   b. Chest configuration
2. Palpation
   a. Technique
   b. Findings
3. Percussion
   1. Techniques
   2. Findings
4. Auscultation
   a. Technique
   b. Normal sounds
   c. Abnormal sounds

E. Developmental Differences

Cardiac Assessment

Learning Objectives:
1. Identify historical data and review of systems questions pertinent to the assessment of these systems.
2. Identify the common normal and abnormal findings of a cardiac exam during inspection, palpation and auscultation.
3. Identify common normal and abnormal findings of a peripheral vascular exam during inspection, palpation and auscultation.
4. Compare the cardiac cycle to auscultatory findings.
5. Perform and document an exam of the cardio-vascular and peripheral vascular systems, using correct sequence and terminology, and demonstrating appropriate use of landmarks.

Learning Content:
A. Purpose
B. Assessment
   1. Historical data (ROS)
   2. Anatomical landmarks
   3. Events of the cardiac cycle
   4. Assessment techniques
      a. Inspection
         Apical impulse
         Retractions
         Heaves
      b. Palpations
         Apical impulse
         Apex area
         Left sternal border
c. Percussion
d. Auscultation
   1. Heart sounds
      Normal
      Abnormal
   2. Method (areas) old system
      Mitral
      Aortic
      Pulmonic
      Erbs
      Tricuspid

5. Assessment of neck vessels
   a. Inspection
      Jugular venous pulsation
   b. Palpation
      Carotid pulse
   c. Auscultation
      Carotid bifurcation
      Recording findings

Abdomen and Gastrointestinal System

Learning Objectives:
1. Identify historical data and review of systems questions pertinent to assessment of the abdomen.
2. Identify landmarks and describe underlying structures of the abdomen.
3. Demonstrate and record an abdominal exam, using correct technique, sequence and terminology.
4. Discuss normal versus abnormal findings of an abdominal exam as they relate to normal variants versus pathology.
5. Describe different techniques for assessing nutritional status.
6. Demonstrate techniques for the assessment of abdominal pain, and clinical implications of findings.

Learning Content:
A. Purpose
B. Assessment of the GI system
   1. Nutritional Assessment
      a. Review of systems
      b. Physical findings
      c. Analysis
   2. Assessment of the abdomen
      a. Review of systems
      b. Techniques of anatomical mapping of the abdomen
         1. Four quadrants
         2. Nine area
      c. Assessment procedures
         1. Positioning the client
2. Sequence of techniques
   d. Inspection of the abdomen
      1. General
      2. Contour and symmetry
      3. Pulses and waves
   e. Auscultation of the abdomen
      1. Technique
      2. Normal bowel sounds
      3. Abnormal bowel sounds
      4. Other sounds
   f. Percussion
      1. Technique
      2. Normal findings
      3. Abnormal findings
   g. Palpation
      1. Technique
      2. Information gathered
      3. Normal findings

Genital/Urinary System

Learning Objectives:
1. Identify historical data and review of systems questions pertinent to assessments of the GU/GI systems.
2. Discuss normal physiologic changes related to the development of reproductive organs and secondary characteristics.
3. Recognize normal and abnormal findings, and relate abnormal findings to common GU/GI pathology.
4. Define terminology and identify anatomical landmarks used in assessment and documentation of the GU/GI systems.
5. Describe specific tests used routinely to assess genitalia.

(NO genital/urinary system exam will be done on a patient even with your preceptor)

Learning Content:
A. Assessment of the male genital-urinary system (NO exam – this is information only)
   1. Review of systems
   2. General inspection
      a. Skin
      b. Hair distribution
      c. Inguinal area
   3. Inspection of the penis
      a. Lesions
      b. Lesions
      c. Urethral discharge
      d. Malposition of urethral meatus
      e. Phimosis and paraphimosis
   4. Inspection of the scrotum
      a. General appearance
b. Size, shape and symmetry
c. Lesions
d. Edema
5. Palpation of the scrotum
   a. Testes
   b. Common scrotal abnormalities
6. Overview of other areas in comprehensive assessment
7. Male testicular self exam
B. Assessment of the female genitalia (NO exam this is for information only)
   1. Historical data
      a. Review of system
      b. Menstrual history
      c. Obstetrical history
   2. Anatomical consideration
      a. External genitalia
      b. Internal genitalia
      c. Developmental factors
         1. Age related changes
         2. Changes during pregnancy
   3. Preparation for the examination
   4. Components of the screening examination
   5. Inspection of the external genitalia
      a. Observations included
      b. Normal versus abnormal findings
         1. Development of secondary sex characteristics
   6. Inspection of the vagina and cervix
      a. Observations included
      b. Normal versus abnormal findings
         1. Mucous membrane
         2. Cervix
      c. Laboratory procedures
         1. Papanicolaou
         2. Gonorrheal culture
         3. Vaginal infections
   7. Palpation

**Neurological Assessment**

**Learning Objectives:**
1. Identify historical data and review of systems questions pertinent to assessment of mental status and neurologic systems.
2. List the components of a neuro assessment and mental status exam.
3. Recognize normal, normal variants and abnormal findings.
4. Name the cranial nerves by number and function.
5. Demonstrate a method for assessing the function of each of the cranial nerves.
7. Describe and demonstrate procedures for assessing proprioceptor and cerebellar function.
8. Demonstrate the procedures used in testing sensory function of peripheral nerves.
9. Describe normal and abnormal findings in assessment of sensory testing of peripheral nerves.
10. Describe and demonstrate techniques used to assess the superficial reflexes.
11. Describe and demonstrate the method for eliciting deep tendon reflexes.
12. Perform and document the findings of a complete neurologic and mental status assessment.

Learning Content:
A. Purpose
B. Assessment
  1. Review of systems
     a. Purpose
     b. Assessment
  2. Mental status examination
  3. Cranial nerve function assessment
     a. Testing procedures
     b. Normal findings
  4. Proprioception & Cerebellar function assessment
     a. Posture, balance and coordination
     b. Muscle movement and control
     c. Gait
     d. Rapid alternating movements
  5. Motor function
  6. Sensory function assessment
     a. Testing procedures
        1. Light Touch
        2. Point localization
        3. Pain sensation
        4. Temperature
        5. Vibration
        6. Tactile discrimination
        7. Extinction
        8. Kinesthetic sensation
        9. Graph esthesia
     b. Normal finding
  7. Reflexes
     a. Deep tendon reflexes
        1. Testing procedures
        2. Normal responses
     b. Superficial reflexes
        1. Testing procedures
        2. Normal findings

Musculoskeletal System

Learning Objectives:
1. Identify the components of the musculoskeletal system examination.
2. Identify common normal and abnormal findings in the musculoskeletal assessment.
3. Demonstrate a musculoskeletal examination.
4. Accurately record a musculoskeletal assessment using correct terminology.

Learning Content:
A. Purpose
   1. Structural assessment
   2. Functional assessment
B. Assessment
   1. Historical data
   2. Physical examination
      a. Inspection
         1. Symmetry
            a. Swelling
            b. Deformity
            c. Redness
            d. Measurement
         2. Range of motion
            a. Movement
            b. Tenderness
            c. Temperature
            d. Crepitation
            e. Strength
            f. Adjacent tissue
      b. Palpation
   3. Special Assessment Techniques
      a. Hands
      b. Spine
      c. Knee
      d. Ankles

Specialty Areas of Physical Assessment

Learning Objectives:
1. Identify developmental and physiologic differences in special population groups across the lifespan.
2. Using assessment findings, identify risk factors related to these specialty groups.
3. Adapt adult exam format and techniques for use with special populations.
4. Recognize normal and abnormal data for the specialty assessments.
5. Demonstrate assessment techniques specific to unique populations.
6. Formulate nursing diagnoses based on specialty area assessments.
7. Demonstrate understanding and use of pediatric growth.
8. Describe purpose and basic administration of the DDST exam.
10. Identify biological, psychological, sociological and cultural factors that contribute to human development, and influence data gathering.

Integration of History and Physical Exam
Learning Objectives:
1. List equipment and supplies generally needed for a complete physical examination.
2. Prepare individual for a complete physical examination.
3. Outline and perform procedures of a complete physical exam.
4. Record concise findings from a complete physical examination.
5. Use guidelines to adapt examination techniques that accommodate individual client needs.
6. Integrate teaching and health promotion into the performance of the P.E.
7. Demonstrate basic safety and competency in the use of physical assessment instruments.
8. Use an approach that respects the dignity, uniqueness and value of the individual.
9. Use the decision-making process to facilitate decision making.

Learning Content:
A. Prepare for exam
   1. Equipment and supplies
   2. Preparing the individual
B. Performing the exam
   1. Smooth sequence
   2. Correct techniques
   3. Respect for the dignity and comfort of the individual
C. Integrating teaching and health exam
D. Recording the physical exam
   1. Balance between conciseness and comprehensiveness
   2. Accuracy
E. The Decision Making Process
   1. Gathering information
   2. Making decisions based on theory
   3. Using a classification system based on theory
   4. Decision making and the nursing process
      a. Assessment
      b. Nursing diagnoses
      c. Planning and clinical management
      d. Intervention
      e. Evaluation

Paper #1 Skin, Hair, Nails, HEENT, Neck, Regional Lymphatics, Due: No later than October 15th, 2001
Vital signs:
S: Subjective
   Allergies (medication and environmental)
   Current medications
   Immunizations
   Past medical history (chronic disease, surgeries, hospitalizations)
   Family History
   Personal Habits: Smoking, drugs, ETOH, exercise, nutrition
   specific habits related to Paper focus areas

Skin, Hair, Nails
Previous hx of skin disease, family hx of skin disease
Change in pigmentation
Change in mole (size and color)
Excessive dryness or moisture
Pruitis, bruising
Rash or lesion
Hair loss
Change in nails
Environmental or occupational exposures

Head and Neck
Headache, head injury
dizziness
Neck pain
limited neck ROM
lumps or swelling
Hx of head or neck surgery

Eyes
Vision difficulty (decreased acuity, blurring, blind spots)
Pain
Strabismus, diplopia
eye redness or swelling, watering or discharge
Past hx of ocular problems
Glaucoma
use of glasses or contact lenses/ last eye exam

Ears
Earaches, ear infections, ear discharge
hearing loss / environmental noise
Tinnitus , Vertigo

Nose
Nasal discharge, frequent colds, sinus pain
Nose trauma, epistaxis
allergies
altered smell

Mouth, throat
oral sores or lesions, sore throat
bleeding gums, toothache, hoarseness, dysphagia, altered taste
smoking, alcohol consumption
dental care

Self care behaviors (Skin, hair, nails, HEENT, neck)

O: Objective
SKIN
Color, temperature, moisture, texture, edema, turgor, hygiene,
Describe a lesion: name the type then: size, color, elevation, pattern or shape, location, distribution, exudate
HAIR
Color, texture, Distribution, lesions (scalp and extremities)

NAILS
Shape and contour, consistency, color (Fingernails and toenails)

HEAD
Skull shape, size
TMJ
Face- expression, symmetry

EYES
Visual acuity
Visual fields
EOMs
  Corneal Light Reflex
  Cover Test
  6 cardinal positions
External
  Eyebrows, eyelids, eyelashes, conjunctivae, sclera
Anterior
  PERRLA
Funduscopic
  Red Reflex

EARS
External
  Size, shape, skin condition, tenderness
External canal
Otoscopic exam
  Tympanic membrane
Hearing acuity
  Voice or whisper test
Tuning fork
  Weber, Rinne

NOSE, MOUTH, THROAT
External nose symmetry, patency
Nasal cavity - turbinates
Palpate sinuses
Mouth - lips, teeth, gums
Tongue
Buccal mucosa, palate, uvula,
Throat

NECK
Symmetry (head position)
ROM
Lymph glands
Trachea
Thyroid
A: Summary Paragraph - be sure to include significant family history or chronic issues, any positive findings in the exam

P: Nursing Interventions or Plan- There are always health promotion, preventive issues to discuss with your patient

Paper #2- Lungs, Thorax, Heart and Peripheral Vascular System Due no later than November 5th, 2001

Vital signs

S: Subjective
  Allergies (medication and environmental)
  Current medications
  Immunizations
  Past medical history (chronic disease, surgeries, hospitalizations)
  Family History
  Personal Habits: Smoking, drugs, ETOH, exercise, nutrition
  specific habits related to Paper focus areas

Lungs, Thorax
  Cough, SOB, Chest Pain while breathing
  Hx of respiratory disease/ Hx of respiratory infections
  Cigarette Smoking
  Environmental exposure
  Self-care behaviors

Heart, Peripheral Vascular system
  Chest pain, dyspnea, orthopnea, cough, fatigue
  cyanosis or pallor
  edema, nocturia
  Past cardiac hx, Family cardiac hx
  Cardiac risk factors
  leg pain or cramps
  skin changes on arms or legs
  any swelling in the legs

O: Objective
  Thoracic cage
    shape and configuration
    position in breathing
    Skin color and condition
    Symmetric chest expansion
    Tactile fremitus
    Percussion of lung fields
      Diaphragmatic excursion
    Auscultation
      Breath sounds
    Neck vessels
Describe and palpate carotid, describe jugular venous wave

Precordium
- Inspection and Palpation of apical impulse (thrill or heave?)
- Auscultate
  - Identify anatomic areas, note rate and rhythm of heartbeat, identify S1 and S2
  - Listen for murmurs or extra sounds in systole and diastole
  - Use diaphragm and bell
  - Listen at apex in left lateral position
  - Listen at base with person sitting

Extremities
- Inspect arms and legs for color, size and lesions (cardiac related)
- Palpate radial, brachial, femoral, popliteal, posterior tibial, dorsalis pedis
- Palpate temperature of feet and legs, capillary refill

A: Summary paragraph

P: Nursing Intervention or plan

Paper #3 Due no later than December 7th, 2001

Abdomen, Mental Status, Neurological System, Musculo-Skeletal system

Vital signs

S: Subjective
- Allergies (medication and environmental)
- Current medications
- Immunizations
- Past medical history (chronic disease, surgeries, hospitalizations)
- Family History
- Personal Habits: Smoking, drugs, ETOH, exercise, nutrition
  - specific habits related to Paper focus areas

Abdomen
- Change in appetite
- dysphagia, food intolerance
- Abdominal Pain, N and V, Bowel habits
- past Abdominal History
- Personal habits
- Nutritional habits

Neuro and Mental Status
- Headaches, head injury, dizziness/vertigo
- Seizures, tremors, weakness, Incoordination,
- Numbness or tingling
- difficulty swallowing, difficulty speaking
- Past history
Environmental / occupational hazards

Musculoskeletal

Hx of injury, fractures, strains, sprains
Family History
Osteoporosis risk factors
exercise patterns

O:
Abdomen
Inspect contour, symmetry, umbilicus, skin, pulsation or movement
Auscultate bowel sounds, aorta
Percuss general tympany, liver span,
Palpation - light, deep - liver, kidneys

Neuro
LOC, Mini- Mental status
Cranial nerves
Gait and balance - Romberg, Rapid alternating movements
Motor system
Upper and lower extremities - general strength and tone
Sensory function - 2 places on upper and lower extremities
Superficial pain, light touch, vibration
Stereognosis, graphesthesia, two-point discrimination
Reflexes
DTRs: biceps, triceps, patellar, Achilles
Superficial: plantar

Musculoskeletal
Upper/ lower extremity equal mass
Upper / lower extremity ROM
Spine - ROM

A: Summary paragraph

P: Nursing plan or intervention

The final history, exam and paper are all three of the above on a single patient, then written up and submitted no later than December 14th, 2001.