ANGELO STATE UNIVERSITY

Generic Bachelor of Science in Nursing

NUR 3304

Health Assessment

Fall 2018

Melissa McDowell, EdD, MSN, RN, CCRN
Brenda Sanchez, MSN, RN

ANGEOLO STATEUNIVERSITY

Department of Nursing
ANGELO STATE UNIVERSITY
College of Health and Human Services
Department of Nursing

COURSE NUMBER
NUR 3304

COURSE TITLE
Health Assessment

CREDITS
Three Semester Hours (3-0-0)
Lecture course housed in BlackBoard; utilizes the Sherpath fully integrated digital educational platform with adaptive algorithms, integrating lessons, adaptive quizzing, and simulation to produce a blended/flipped classroom.

PREREQUISITES
All prerequisites will be completed before application into the Nursing program. Prerequisite into this course is acceptance into the Angelo State University Nursing Program.

PRE-REQUISITE SKILLS
Accessing internet web sites, use of ASU Library resources, and proficiency with Microsoft Word and/or PowerPoint are an expectation of the Generic BSN program. Computer requirements are further delineated in the Department of Nursing Undergraduate Student Handbook. Tutorials for ASU Library and for Blackboard are available through RamPort. The ASU Nursing Program Undergraduate Student Handbook should be reviewed before taking this course (http://www.angelo.edu/dept/nursing/handbook/index.html).

COURSE DELIVERY
This course is face-to-face course delivery. Class meets on Tuesdays from 1:30pm-4:20pm in Archer College of Health and Human Services– HHS 106. This class has a blackboard component where course information is accessed: http://blackboard.angelo.edu. The Sherpath program utilized in this course is accessible in http://evolve.elsevier.com where each student has access.

BROWSER COMPATIBILITY CHECK
It is the student’s responsibility to ensure that the browser used to access course material on his/her computer is compatible with ASU’s Blackboard Learning System. The faculty reserves the right to deny additional access to course assignments lost due to compatibility issues. Students are responsible for reviewing the guidelines posted in this course regarding accessing Blackboard assignments. Problems in this area need to be discussed with faculty at the time of occurrence, either via a phone call (preferred) during posted acceptable hours for calling, or via email notification during times outside those posted for calls.

Be sure to perform a browser test. Select the “Technology Support” tab from the Blackboard homepage (http://www.blackboard.angelo.edu). Then select “Test your Browser” option located under the Browser Test header.

Please see computer requirements for BSN classes at this link:
FACULTY NAME
Melissa McDowell, EdD, MSN, RN, CCRN
Office: Archer College of Health and Human Services 318 J
Phone: 325-942-2224
Fax: 325-942-2236
melissa.mcdowell@angelo.edu

OFFICE HOURS
Monday 1200-1700
*Alternate times available by appointment
Virtual Office via appointment

Brenda Sanchez, MSN, RN
Office: Archer College of Health and Human Services 318U
Phone: 325-942-2224
Fax 325-942-2236
bmedrano@angelo.edu

OFFICE HOURS
Tuesday 1030-1330
Thursday 1130-1330
*Alternate times available by appointment

COURSE DESCRIPTION
Students learn to (a) perform thorough and accurate interviews, take histories, and perform physical assessments of culturally diverse individuals with health problems, (b) identify and apply pathophysiologic principles across the lifespan, (c) relate findings to prevention and early detection of disease, and (d) document and communicate findings effectively and accurately.

BSN PROGRAM OUTCOMES
Upon completion of the program of study for the Generic BSN, the graduate will be prepared to:
1. Integrate nursing and related theories into the planning and/or delivery of safe nursing care.
2. Engage leadership concepts, skills and decision-making in the planning and/or implementation of patient safety and quality improvement initiatives.
3. Identify and appraise best research evidence to improve and promote quality patient outcomes.
4. Utilize technology to access information, evaluate patient data, and/or document care.
5. Participate in political/legislative processes to influence healthcare policy.
6. Engage in effective collaboration and communication within interdisciplinary teams.
7. Design and/or implement health promotion & disease prevention strategies for culturally competent care.
8. Demonstrate standards of professional, ethical, and legal conduct.
9. Practice and/or coordinate, at the level of the baccalaureate prepared nurse, to plan and/or implement patient centered...
<table>
<thead>
<tr>
<th>Student Learning Outcomes</th>
<th>Assignment(s) or activity(ies) validating outcome achievement:</th>
<th>Mapping to BSN Program Outcomes</th>
<th>Mapping to BSN Essentials</th>
<th>Mapping to QSEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>By completing all course requirements, students will be able to:</td>
<td>Health History Assignment Lecture, Sherpath lessons Weekly peer check-offs Adaptive Quizzing/Weekly quizzes Exams Assessment Videos Class participation – discussion and activities, skills practice, in class assignments and case studies EHR assignments ATI Health Assessment Module</td>
<td>1, 3, 4</td>
<td>VI, VII, IX</td>
<td>PCC TC EBP S I</td>
</tr>
<tr>
<td>1. Employ professional communication and interviewing strategies to obtain an accurate health history.</td>
<td>Lecture, Sherpath lessons Weekly Peer Check Offs Adaptive Quizzing/Weekly quizzes Exams Assessment Videos Class participation – discussion and power points, skills practice, group activities, and case studies Skills practice Comprehensive Physical Assessment Sherpath Simulation ATI</td>
<td>4</td>
<td>IX</td>
<td>PCC TC S EBP S I</td>
</tr>
<tr>
<td>2. Perform holistic psychosocial and physical assessments of individuals in a simulated setting using knowledge &amp; skills from humanities, nursing, biological, &amp; behavioral sciences.</td>
<td>Health History Assignment Lecture, Sherpath Lessons Weekly Check Offs Adaptive Quizzes/Weekly quizzes Exams Class participation- discussion and power points, skills practice, group activities, and case studies Skills Practice Simulations</td>
<td>1, 4</td>
<td>I, VII, IX</td>
<td>PCC TC EBP QI S I</td>
</tr>
<tr>
<td>3. Examine risk factors, preventive health practices, protective mechanisms, and traditional and complementary health practices that influence the health of individuals and their families across the lifespan.</td>
<td>Lecture, Sherpath lessons Adaptive Quizzing/Weekly quizzes Exams Class participation – discussion and power points, skills practice, group activities, and case studies Skills practice EHR documentation</td>
<td>3, 4</td>
<td>IX</td>
<td>PCC TC EBP QI S I</td>
</tr>
<tr>
<td>4. Relate normal and abnormal assessment findings to underlying physiologic, pathophysiologic processes, medical diagnoses, and therapeutic interventions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Examine risk reduction, and disease prevention for individuals based on standards of care, health promotion models, and behavioral and developmental theories.

<table>
<thead>
<tr>
<th>ATI Simulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture, Sherpath Lessons, Adaptive Quizzing, Weekly quizzes</td>
</tr>
<tr>
<td>Exams</td>
</tr>
<tr>
<td>Class participation – discussion and skills practice, group activities, and case studies</td>
</tr>
<tr>
<td>Skills practice</td>
</tr>
<tr>
<td>Simulations</td>
</tr>
<tr>
<td>1, 4</td>
</tr>
<tr>
<td>VI, VII, IX</td>
</tr>
<tr>
<td>PCC TC EBP QI S I</td>
</tr>
</tbody>
</table>

**QSEN Competencies:** Patient-Centered Care (PCC), Teamwork and Collaboration (TC), Evidence-based Practice (EBP), Quality Improvement (QI), Safety (S), Informatics (I)

**REQUIRED TEXTS AND MATERIALS**

EHR Tutor Academic Electronic Health Records System


OR Ebook


**Cost saving bundles:**

- **ISBN: 9780323574419** Includes Sherpath, Jarvis Ebook, and Jarvis Pocket Companion

- OR

- **ISBN: 9780323574426** (adds Jarvis print textbook to the aforementioned package)

**OTHER REQUIRED MATERIALS**

- Computer with MAC or Windows Operating System
- High Speed Internet Access
- Refer to Angelo State University’s Distance Education website for further technology requirements: [http://www.angelo.edu/distance_education/](http://www.angelo.edu/distance_education/)

Bring a laptop or wifi access device to class each week to access Sherpath course content on Evolve. Since laptops tablets, and/or ipads are not required of students in the nursing program, please notify instructor if assistance is needed for access to a device during class.

5
TOPIC OUTLINE
See course calendar in Blackboard and Evolve for specific module dates, objectives, lessons, activities, and assignments.

Module 1: Interviewing and Cultural Considerations
Module 2: Patient History Taking
Module 3: Lymphatic System
Module 4: Examination Techniques and Equipment
Module 5: Vital Signs and Pain
Module 6: Growth and Measurement
Module 7: Nutrition
Module 8: Mental Status
Module 9: Skin, Hair, and Nails
Module 10: Head and Neck; Eyes, Ears, Nose, and Throat (EENT)
Module 11: Chest and Lungs
Module 12: The Heart
Module 13: Peripheral Vascular System
Module 14: Abdomen
Module 15: Musculoskeletal System
Module 16: Neurologic System
Module 17: Head to Toe Examination
Module 18: Breasts and Axillae
Module 19: Female Genitalia
Module 20: Male Genitalia and Prostate

GRADING SYSTEM
Course grades will be dependent upon completing course requirements and meeting the student learning outcomes.

The following grading scale is in use for this course:

- A = 90.00-100 points
- B = 80.00-89.99 points
- C = 70.00-79.99 points
- D = 60.00-69.99 points
- F = 0-59.99 points  (Grades are not rounded up)

EVALUATION AND GRADES
Graded assignments, activities, and percent of the overall course grade:

<table>
<thead>
<tr>
<th>Assessment Activity</th>
<th>Grade%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>30%</td>
</tr>
<tr>
<td>Weekly Quizzes</td>
<td>10%</td>
</tr>
<tr>
<td>Weekly Course Participation</td>
<td>10%</td>
</tr>
<tr>
<td>Health History Assignment</td>
<td>10%</td>
</tr>
<tr>
<td>Comprehensive Physical Assessment and Documentation</td>
<td>40%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>
TEACHING STRATEGIES
- Class Lecture and Discussion
- Simulation and Demonstration
- Videos
- Assigned Readings/Lessons
- Weekly assigned quizzes
- Adaptive quizzing
- Exams
- Weekly Peer Check-offs
- Handouts and Presentations
- Pair & Group Activities
- Class Activities and Interactions
- Internet Resources
- Case Studies
- ATI Tutorial
- EHR Tutor Electronic Health Record assignments

Students are expected to be “active learners.” It is a basic assumption of the instructor that students will be involved (beyond the materials and lectures presented in the course) discovering, processing, and applying the course information using peer-review journal articles, researching additional information and examples on the Internet, and discussing course material and clinical experiences with their peers.

ASSIGNMENT/ACTIVITY DESCRIPTIONS

Exams
4 exams over the course of the semester will evaluate student’s knowledge, comprehension, application, and analysis of course content and objectives. 50 multiple choice questions will be given over 75 minutes each test. The exams will be pencil and paper and scored using a scantron form. Scantron forms will be provided. Students must bring a pencil to each exam. All exams will be given in a proctored environment. The first 3 exams are scheduled during lecture days and will be given at the beginning of class. Lecture and routine class activities will immediately follow. The 4th exam will be scheduled during the designated date and time for the final exam. Failure to complete any exam will result in a zero on the exam. Failure to complete the 4th and final exam will result in course failure. Please see the course calendar for the specific assigned test days.

Exam reviews will be provided for exams. Exam reviews will be held within one week after the respective exam has been completed by all students. The time, duration, place, and day of each review will be determined by the course instructor. During exam reviews, all students must leave all personal belongings at the door. Students will be required to sign-in at the door of the exam review. The student will be allowed to review every question, option, and correct answer on the respective exam. Exam reviews are meant to provide students the opportunity to review exam content only and are not to offer time to debate correct answers. There will be faculty present to answer questions during the exam review. Once a student has completed an exam review, no request to review that same exam will be granted for the course of the semester.

Adaptive Quizzing
Elsevier Adaptive Quizzing (EAQ) is a mobile, optimized formative assessment tool within Sherpath that provides personalized questions to help students succeed in the course and study more effectively for high-stakes exams. Students will be assigned an EAQ during the week prior to class day. Credit for completion of
the adaptive quizzing assignment for the week will be incorporated as a portion of the course participation grade. Failure to complete the adaptive quizzing assignment for the week will result in a 50 point deduction from the participation grade.

**Weekly in class quizzes**

Non-adaptive weekly quizzes will be given at the end of lecture each day to evaluate students’ knowledge of assigned weekly reading and lessons. Quizzes will be given online at the beginning of class, consisting of 10-20 questions from the corresponding weekly Sherpath lessons and reading.

**Course Participation**

Course participation consists of student’s active participation in this course. Students will be assigned a weekly grade for course participation per the Course Participation Rubric. Course participation consists of discussion, class activities, presentations, and/or demonstrations in class along with completing weekly assignments, documentation, and active skills practice.

**Sherpath Weekly Lessons**

Lessons deliver course content as engaging, didactic experience with multimedia, confidence indicators, adaptive remediation, mini assessments, and a summary assessment to gauge understanding of the material

**EHR Tutor**

EHR Tutor online electronic charting tool will be used in this course by students to practice electronic documentation of history and physical assessment data. EHR tutor provides students a realistic charting experience with standard charting of history and physical data.

**ATI**

The ATI Physical Assessment Adult Tutorial Module provides the student comprehensive information about physical assessment for the adult patient. This tutorial and corresponding pre and post-tests are to be completed according to the course calendar. The Post-test grade logged in ATI will count as that week’s quiz grade. Students are encouraged to utilize the ATI Health Assessment Videos in the module throughout the semester.

**Health History Assignment**

Students will demonstrate knowledge of interviewing skills, the components of a health history, recording the history data, and assigning three nursing diagnoses. A complete health history will be completed and submitted mid-semester according to the attached grading rubric and course schedule. Students will submit a detailed subjective health history on a volunteering adult over age 50 on the provided form. Students are not to provide any identifying data on the patient – only the demographics requested in the grading rubric. The health history assignment is totally SUBJECTIVE - interviewing and questioning the patient. Students are encouraged to practice the physical assessment but will not be required to document or submit. Use Chapter 4 of the course text “The Complete Health History” as a guide to complete the assignment along with the subjective interview portion of each chapter as needed to elaborate on noted problems.
Comprehensive Physical Assessment:
Students will demonstrate skills of inspection, percussion, palpation, and auscultation; demonstrate correct use of instruments; use appropriate medical terminology; choreograph the complete examination in a systematic manner; describe the findings of the examination; demonstrate appropriate infection control and safety measures, and demonstrate proper documentation of the normal physical exam. At the end of the semester, students will conduct the complete physical assessment for faculty review during a timed 30 minute period on a fellow classmate volunteer according to the Physical Assessment Grading Rubric. The grading rubric may be used as a reference during the assessment; although, points will be deducted for reference to the rubric. Students are responsible for self-study and seeking additional guidance or assistance as needed in preparing for the comprehensive physical exam. Chapter course videos, ATI Health Assessment Videos, and Clinical Skills Health Assessment videos are available for review/practice and the Jarvis Head to Toe Examination of the Adult Guide are suggested resources for practice along with course textbook. It is highly suggested students utilize Nursing Lab facilities for practice and self-study throughout the semester. A minimum grade of 70 on this assignment is required to pass the course. Failure to complete during the time allotted will result in loss of points for the remaining time.

GENERAL POLICIES RELATED TO THIS COURSE
All students are required to follow the policies and procedures presented in the following documents:
- Angelo State University Student Handbook located on the ASU website: http://www.angelo.edu/student-handbook/
- ASU Nursing Program Undergraduate Student Handbook, located on the Nursing website http://www.angelo.edu/dept/nursing/handbook/index.html

IMPORTANT UNIVERSITY DATES
August 27th First Day of Class
September 3rd Labor Day Holiday
September 5th Withdraw period begins for 1st 8 week classes
October 15th Finals Week
December 15th December Commencement

STUDENT RESPONSIBILITY & ATTENDANCE
Class attendance/participation is required for successful and satisfactory completion of all course objectives. Failure to attend will result in a class participation grade of zero for the missed day and a zero on any other quizzes or exams missed. If a situation arises that prevents a student from attending, he or she should notify the course instructor at the earliest time possible.

According to the undergraduate handbook, a week’s worth of cumulative absences in any one course will result in faculty evaluation of the student’s ability to meet course objectives and may result in failure of the course. Three tardies (over 5 minutes late for lecture, campus laboratory, or clinical) will equal 1 hour of absence. Failure to meet these requirements hinders the student’s ability to complete the course. Attendance will be recorded each class day.
COMMUNICATION
Faculty will respond to email and/or telephone messages within 24 hours during working hours Monday through Friday. Weekend messages may not be returned until Monday.

**Written communication via Blackboard:** It is an expectation of this class that you use formal writing skills giving appropriate credit to the source for your ideas. Follow APA (2010) 6th edition (2nd Printing or higher only) guidelines for referencing.

**Written communication via email:** All private communication will be done exclusively through your ASUemail address. Check frequently for announcements and policy changes.

**Virtual communication:** Office hours and/or advising may be done with the assistance of the telephone, Skype, Join.me, Google Hangouts, etc.

Use Good "Netiquette":
- Check the discussion frequently and respond appropriately and on subject.
- Focus on one subject per message and use pertinent subject titles.
- Capitalize words only to highlight a point or for titles. Otherwise, capitalizing is generally viewed as SHOUTING!
- Be professional and careful with your online interaction. Proper address for faculty is by formal title such as Dr. or Ms./Mr. Jones unless invited by faculty to use a less formal approach.
- Cite all quotes, references, and sources.
- When posting a long message, it is generally considered courteous to warn readers at the beginning of the message that it is a lengthy post.
- It is extremely rude to forward someone else’s messages without their permission.
- It is fine to use humor, but use it carefully. The absence of face-to-face cues can cause humor to be misinterpreted as criticism or flaming (angry, antagonistic criticism). Feel free to use emoticons such as J or :) to let others know you are being humorous.

(The "netiquette" guidelines were adapted from Arlene H. Rinald's article, The Net User Guidelines and Netiquette, Florida Atlantic University, 1994, available from Netcom.)

ASSIGNMENT SUBMISSION
In this course, the Health History Assignment is to be submitted through the assignments link in the Blackboard course site for grading. All other class assignments are to be submitted in class or are housed and automatically recorded in Sherpath when completed (lessons, adaptive quizzing). Issues with technology use arise from time to time. If a technology issue does occur regarding an assignment submission, email course instructor with attached copy of submission to verify timely assignment completion. Once the problem is resolved, submit assignment through the appropriate link. This process will document the problem and establish a timeline. Keep a backup of all work.

LATE WORK OR MISSED ASSIGNMENTS POLICY
Due dates and times for assignments are posted. Failure to submit an assignment by the deadline will result in a fifteen point deduction per day past the posted deadline. If revisions to the late assignment are deemed necessary, a new submission deadline will be assigned and an automatic 15 point deduction will be taken (i.e. all revised assignments will start at an 85% as the maximum grade). Failure to submit the revised assignment by the deadline will result in a zero. Further revisions are at the discretion of the instructor. If a situation arises, such as a mandatory university sponsored event, that mandates a student to miss class, students should contact course faculty for arrangements.
ACADEMIC INTEGRITY
Academic honesty is expected on all work. Students are expected to maintain complete honesty and integrity in their educational experiences. Any student found guilty of any form of dishonesty in academic work is subject of disciplinary action and possible expulsion from ASU. All codes and policies are set forth in the University Student Handbook of Angelo State University http://www.angelo.edu/student-handbook/ as well as the Department of Nursing Undergraduate Student Handbook http://www.angelo.edu/dept/nursing/handbook/index.html.

PLAGIARISM
Plagiarism at ASU is a serious topic. The Angelo State University’s Honor Code gives specific details on plagiarism and what it encompasses. Plagiarism is the action or practice of taking someone else's work, idea, etc., and passing it off as one’s own. Plagiarism is literary theft.

In your discussions and/or your papers, it is unacceptable to copy word for word without quotation marks and the source of the quotation. Use the APA Style Manual of the American Psychological Association as a guide for all writing assignments. Quotes should be used sparingly. It is expected that you will summarize or paraphrase ideas giving appropriate credit to the source both in the body of your paper and the reference list. Papers are subject to be evaluated for originality via Bb Safe Assignment or Turnitin. Resources to help you understand this policy better are available at the ASU Writing Center http://www.angelo.edu/dept/writing_center/academic_honesty.php.

PERSONS WITH DISABILITIES AND SPECIAL ACCOMMODATIONS REQUEST
“Angelo State University is committed to the principle that no qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of the university, or be subjected to discrimination by the university, as provided by the Americans with Disabilities Act of 1990 (ADA), the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), and subsequent legislation.”
Students with disabilities must contact the Student Life and Student Services Office to request any necessary academic accommodations. This student request should be made early in the semester to allow time for appropriate arrangements. The request must be repeated every semester accommodations are needed. For more information on DISABILITY ACCOMMODATIONS, contact the Student Life Office at 942-2191 or student.life@angelo.edu.
Students with a disability who request reasonable accommodations must meet with the Student Life Program Director within the first week of classes. Reasonable accommodations will be provided as authorized by the Office of Student Life as long as course requirements are not compromised. Faculty will provide no accommodations without authorization from the offices of Student Life. Students are responsible for obtaining appropriate documentation, such as from a health care provider to support the need for the accommodation. It is the student’s responsibility to be a self-advocate when requesting accommodations. A request must be submitted every semester accommodations are needed.

INCOMPLETE GRADE POLICY (OP 10.11 Grading Procedures)
It is policy that incomplete grades be reserved for student illness or personal misfortune. Please contact faculty if you have serious illness or a personal misfortune that would keep you from completing course work. Documentation may be required.

STUDENT ABSENCE FOR OBSERVANCE OF RELIGIOUS HOLY DAYS
“A student who intends to observe a religious holy day should make that intention known in writing to the instructor prior to the absence.” Please see ASU Operating Policy 10.19.
COPYRIGHT POLICY
Students officially enrolled in this course should make only one printed copy of the given articles and/or chapters. You are expressly prohibited from distributing or reproducing any portion of course readings in printed or electronic form without written permission from the copyright holders or publishers.

SYLLABUS CHANGES
The faculty member reserves the option to make changes as necessary to this syllabus and the course content. If changes become necessary during this course, the faculty will notify students of such changes by email, course announcements and/or via a discussion board announcement. It is the student’s responsibility to look for course communications about the course on a daily basis.

WEBLINKS:
Board of Nursing for the State of Texas http://www.bne.state.tx.us/
BSN Student Resources http://www.angelo.edu/dept/nursing/student_resources/

COURSE EVALUATION
Students are provided the opportunity, and are strongly encouraged to participate in a course evaluation at the end of the semester. Areas on the IDEA evaluation may include:
1. Gaining a basic understanding of the subject (e.g., factual knowledge, methods, principles, generalizations, theories)
2. Developing knowledge and understanding of diverse perspectives, global awareness, or other cultures
3. Learning to apply course material (to improve thinking, problem solving, and decisions)
4. Developing specific skills, competencies, and points of view needed by professionals in the field most closely related to this course
5. Acquiring skills in working with others as a member of a team
6. Developing creative capacities (inventing; designing; writing; performing in art, music, drama, etc.)
7. Gaining a broader understanding and appreciation of intellectual/cultural activity (music, science, literature, etc.)
8. Developing skill in expressing oneself orally or in writing
9. Learning how to find, evaluate, and use resources to explore a topic in depth
10. Developing ethical reasoning and/or ethical decision making
11. Learning to analyze and critically evaluate ideas, arguments, and points of view
12. Learning to apply knowledge and skills to benefit others or serve the public good
13. Learning appropriate methods for collecting, analyzing, and interpreting numerical information

RUBRICS FOR ASSIGNMENTS
NUR 3304 Weekly Course Participation
Grading Rubric

<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Points Earned Comments</th>
<th>Points Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Discussion/Activities/Presentations/Demonstrations</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Actively participates in discussion, activities,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>demonstrations, presentations; asks questions, offers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ideas to the group, is attentive, radiates positive energy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not actively participate in discussion, activities,</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>demonstrations, and presentations; does not ask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>questions, and/or offer ideas to the group; inattentive;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disruptive; radiates negative energy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Assignments/Documentation/Skills</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Actively participates in and completes weekly assignments/documentation (including electronic documentation, simulation, lessons, adaptive quizzing, peer check-offs), and skills practice; stays engaged, works cohesively with others, and radiates positive energy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not actively participate in and complete weekly</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>assignments/documentation (including electronic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>documentation, simulation, lessons, adaptive quizzing,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>peer check-offs), and skills practice; does not stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>engaged, and/or work cohesively with others; disruptive;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>radiates negative energy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL POINTS EARNED/POINTS POSSIBLE

FINAL GRADE

__/ 2

_____ %
# NUR 3304 Health History Assignment
## Grading Rubric

**Student Name________________________________________ Date________________________**

<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Points Earned</th>
<th>Points Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Biographic Data - (ONLY Age, Gender, Marital Status, Occupation, Race/Ethnic Origin)</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>II. Source and Reliability</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>III. Reason for Seeking Care</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>IV. Present Health or History of Present Illness – (Healthy or use PQRSTU or OLDCARTS for complaint)</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>V. Past Health (Medications – list medication, strength, dose form, route, time, reason, date/time last taken)</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>VI. Family History (18)/Genogram (5)</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>VII. Review of Systems – address ALL direct questions and record presence or absence of (denies) all symptoms listed. Must elaborate PQRSTU or OLDCARTS on positive findings</td>
<td></td>
<td>37</td>
</tr>
<tr>
<td>VIII. Functional Assessment</td>
<td></td>
<td>77</td>
</tr>
<tr>
<td>IX. Nursing Diagnoses - 3 - include related to, as evidenced by for each diagnosis</td>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

**Total Points Earned/Total Points Possible**

193

**Final Grade**

___

*Note: Points will be deducted for blanks and unaddressed questions.*

**References**


<table>
<thead>
<tr>
<th>NUR 3304 Physical Assessment</th>
<th>Comprehensive Physical Assessment Grading Rubric</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td>Introduce self</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Explain procedure</td>
<td>2 1 0</td>
</tr>
<tr>
<td>WHIPPS-wash hands, identify patient x 2 (ask pt to state name, DOB, match armband to chart) provide privacy and safety</td>
<td>2 1 0</td>
</tr>
<tr>
<td><strong>GENERAL SURVEY</strong></td>
<td></td>
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<tr>
<td>Appears stated age</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Orientation: oriented x 4 to person, place, time, situation</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Memory: short (current president, last meal) and long term (past president, or state where born)</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Skin color: appropriate for race/ethnicity, warm, dry</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Nutritional status: wt appears normal for ht/body build (no obesity, cachexia)</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Posture and position: relaxed, erect, resting on bed/chair</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Obvious physical deformity: no obvious deformities</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Mobility/Activity: gait smooth balanced, no assistive devices, no involuntary movements; no limits to activity, no assistance needed</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Facial expression: appropriate to behavior</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Mood &amp; affect: appropriate for situation</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Speech: clear and appropriate for native language</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Hearing: hears spoken word</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Personal hygiene: clean, groomed appropriately for situation</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Level of consciousness: GCS score 15 (eyes open spontaneously, motor response intact (patient</td>
<td>2 1 0</td>
</tr>
<tr>
<td><strong>MEASUREMENT and VITAL SIGNS</strong></td>
<td></td>
</tr>
<tr>
<td>Height, Weight, BMI – normal for gender</td>
<td>2 1 0</td>
</tr>
<tr>
<td>I &amp; O (1 - fluid intake, IV; O- urine, vomitus, drains, tubes) equal/appropriate for patient’s condition; meal intake-%; last BM – COCA, normal for patient, no</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Vital signs – within normal limits for the patient (temperature, pulse, respirations, BP, oxygen saturation)</td>
<td>2 1 0</td>
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<tr>
<td>Pain: assess 0-10 pain scale</td>
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<tr>
<td><strong>SKIN – state all to be assessed with each body system</strong></td>
<td>2 1 0</td>
</tr>
<tr>
<td>Inspect and palpate skin: color normal for race with no color changes noted, warm and dry, normal nevi/birthmarks (ABCDE), skin integrity intact (no edema, bruising, lesions, skin breakdown) non-tender</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Teach SSE (instruct patient to perform monthly)</td>
<td>2 1 0</td>
</tr>
<tr>
<td><strong>HEAD AND FACE</strong></td>
<td></td>
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<tr>
<td>Inspect and palpate skull: normocephalic, symmetric –no lesions, lumps, scaling, parasites or tenderness</td>
<td>2 1 0</td>
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<tr>
<td>Inspect hair: clean, normal texture and color, no flakes, parasites</td>
<td>2 1 0</td>
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<tr>
<td>Inspect face: symmetric, no involuntary movements</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Palpate temporal arteries: no tenderness, abnormal pulsation</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Palpate and frontal and maxillary sinus: no tenderness</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Palpate TMJ: non-tender, ROM full with no pain or crepitation</td>
<td>2 1 0</td>
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<tr>
<td>Palpate lymph nodes: Preauricular, Postauricular, Occipital, Tonsillar, Submandibular, Submental Anterior Cervical, Posterior Cervical, Supraclavicular, Infraclavicular – no lymphadenopathy or tenderness</td>
<td>2 1 0</td>
</tr>
<tr>
<td><strong>EARS</strong></td>
<td></td>
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<tr>
<td>Inspect size and shape: symmetrical bilaterally no swelling or thickening, no skin breakdown if on O2; canals clear</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Palpate pinnae and tragus - no masses and tenderness</td>
<td>2 1 0</td>
</tr>
<tr>
<td>Otoscopic exam: external canal clear, TM pearly gray, flat, intact, landmarks intact, cone of light toward nasal side (pinna up, back, insert 1cm)</td>
<td>2 1 0</td>
</tr>
</tbody>
</table>
| EYES | Inspect and palpate skin and external structures: symmetrical, no ptosis, lid lag, discharge or  
|      | crust | 2 1 0 |
|      | Inspects internal eye: conjunctiva clear, sclera white, no lesions or redness; **PERRLA 3-5mm**,  
|      | dilate with far vision, constrict with near vision; corneal light reflex symmetric | 2 1 0 |
|      | Inspect with ophthalmoscope –red reflex present (examiners R eye to patient R eye, L eye to L  
|      | eye) | 2 1 0 |
| NOSE | Inspect and palpate nose: symmetric, no deformities or tenderness to palpation. Nares patent.  
|      | Mucosa pink and moist with no lesions; no septal deviation or perforation | 2 1 0 |
| MOUTH & THROAT | Inspect lips, oral cavity: lips pink and soft, tongue, mucosa and gingivae, posterior pharynx  
|      | pink and moist with no lesions, exudate, or bleeding; tonsils grade 2; teeth in good repair | 2 1 0 |
| NECK | Inspect: head position straight midline erect, symmetrical, trachea midline; No JVD | 2 1 0 |
|      | Palpate carotid artery pulsation one side at a time: 2+, equal | 2 1 0 |
|      | Auscultate carotid arteries: no bruits (hold breath on exhalation) then auscultate bronchial breath  
|      | sounds over sternal notch/trachea – high pitch sounds | 2 1 0 |
|      | Test ROM – full, no pain or crepitus (flexion, extension, hyperextension, lateral flexion,  
|      | rotation) | 2 1 0 |
|      | Inspect and palpate thyroid gland: no thyromegaly, nodules, tenderness (from behind while patient  
|      | swallows) | 2 1 0 |
| POSTERIOR CHEST/BACK | Inspect: no bony deformity; AP<transverse diameter; respirations even and non-labored; no  
|      | skin breakdown | 2 1 0 |
|      | Palpate: no chest wall or spinoius process tenderness; no CVA tenderness (12th rib): symmetrical | 2 1 0 |
|      | Percuss intercostal spaces: resonance (side to side) | 2 1 0 |
|      | State the normal breath sounds and note where they should be heard:  
|      | Bronchovesicular sounds (moderate pitch) between scapula nearest spine; Vesicular sounds  
|      | (low pitch) in peripheral lung fields | 2 1 0 |
|      | Auscultate lung fields from C7 to T10 supra, infra, and subscapularly side to side and then  
|      | laterally from axilla to 8th rib – note sounds as clear bilaterally with full movement of air in all  
|      | lobes and no adventitious sounds (crackles, wheezes, rhonchi) | 2 1 0 |
| ANTERIOR CHEST | Inspect: no bony deformity; respirations regular, even and non-labored  
|      | no cough, no sputum | 2 1 0 |
|      | Palpate chest wall: no tenderness, lumps, masses, symmetrical chest expansion | 2 1 0 |
|      | Assess turgor under clavicle: elastic or returns promptly | 2 1 0 |
|      | Percuss intercostal spaces: resonance (side to side) | 2 1 0 |
|      | State the normal breath sounds and note where they should be heard:  
|      | Bronchovesicular sounds (moderate pitch) sternal borders  
|      | Vesicular sounds (low pitch) over most of anterior lung fields  
|      | Auscultate lung fields from supraclavicular areas to 6th ribs MCL bilaterally side to side – note  
|      | sounds as clear bilaterally with full movement of air in all lobes, no adventitious sounds (crackles,  
|      | wheezes or rhonchi) | 2 1 0 |
| BREASTS | Inspect: breast tissue (patient sitting): symmetrical, no redness, edema, dimpling, focal vascular  
|      | pattern; symmetrical movement | 2 1 0 |
|      | Inspect nipples: symmetrical, protruding: no scaling, crusting, fissures, ulcerations. | 2 1 0 |
Palpate (while patient supine -include tail of spence); firm and uniform, no masses, tenderness; no discharge or bleeding from nipples (while patient supine).

Palpate axillary lymph nodes: no lymphadenopathy

Teach SBE (instruct patient to perform monthly)

**HEART**

Inspect precordium: no heaves or lifts; note apical impulse (4th-5th intercostal MCL)

Palpate precordium for apical impulse: present, short, gentle tap - no thrills noted (4th-5th MCL (1cmX2cm)

Auscultate: normal S1, S2; repeat with bell for murmurs (Z pattern)

Aortic -2nd ICS, right sternal border
Pulmonic - 2nd ICS, left sternal border
Erbs Point -3rd ICS, left sternal border
Tricuspid - 4th ICS, left sternal border
Mitral- 5th ICS, left midclavicular line (apex)

Auscultate apical pulse: RRR (full minute)

**ABDOMEN**

Inspect: flat, symmetric, smooth with no abnormal pulsations, bulging, scars

Auscultate vascular sounds: no bruits (aorta, renal arteries, iliac arteries, femoral arteries with bell)

Auscultate bowel sounds: normoactive high pitch (begin in RLQ)

Percuss in all 4 quadrants: tympany over stomach, lower quadrants; dullness over enlarged liver, spleen, bladder

Palpate light (1cm) and deep (5-8cm): soft, no guarding, rigidity, rebound tenderness, organomegaly, masses

Palpate for liver and spleen: non-palpable (right costal margin) and spleen (left costal margin) non-palpable

**GENITOURINARY**

Inspect penis, scrotum (male) external genitalia vestibule (female) - normal color, no skin breakdown, lesions, abnormal bleeding or discharge; palpate male testis - oval, rubbery, smooth, freely moveable, no nodules; spermatic cord smooth, non-tender; sacrum/coccyx - no skin breakdown; rectum intact with no fissures, hemorrhoids, bleeding, or discharge

Palpate femoral/inguinal area: no hernias; no lymphadenopathy or tenderness; femoral pulses: 2+

Teach STE: instruct male patient to perform monthly in shower

**MUSCULOSKELETAL/VASCULAR/LYMPHATICS**

Upper Extremities: assess bilaterally and symmetrically

Inspect and palpates: symmetrical, no swelling, atrophy, temperature or color change or tenderness

Assess radial and brachial pulses: 2+

Inspect nails: smooth and reg, pink firm beds160, uniform thickness, no discolorations

Palpate capillary refill: 1-2 seconds

Assess ROM fingers: full, no pain or crepitus (flexion, extension, hyperextension, abduction, adduction, thumb opposition)

Assess hand grips = 5/5 strength

Assess ROM wrists: full, no pain, crepitus (flexion, extension, hyperextension, ulnar deviation, radial deviation, rotation)

Assess ROM elbow: full, no pain, crepitus (flexion, extension, hyperextension

Assess strength of biceps, triceps: 5/5 strength (flex/extend elbow against resistance)

Assess ROM shoulder: full, no pain or crepitus (flexion, extension, hyperextension, internal rotation, external rotation, abduction, adduction, circumduction)
Assess strength of shoulder girdle: 5/5 strength bilaterally (abduct/adduct straight arm against resistance)  

**Lower Extremities: assess bilaterally and symmetrically**

- Inspect and palpate: symmetrical in size, no edema, atrophy, temperature or color change or tenderness, no varicosities, no soft heels  
- Assess popliteal, dorsalis pedis and posterior tibial pulses: 2+  
- Inspect nails: pink beds, no thickening, discolorations  
- Assess capillary refill in toes: 1-2 sec  
- Assess ROM toes: full, no pain or crepitus (flexion, extension, hyperextension, abduction, adduction)  
- Assess ROM ankles: full, no pain or crepitus (dorsiflexion, plantar flexion, inversion, eversion, rotation)  
- Assess strength at ankle joint: 5/5 strength (dorsiflexion/plantar flex against resistance)  
- Assess ROM knees: full, no pain or crepitus (flexion, extension, hyperextension)  
- Assess strength at kne joint: 5/5 strength (flex/extend against resistance_)  
- Assess ROM hip: full, no pain or crepitus (flexion, extension, hyperextension, circumduction, abduction, adduction, internal rotation, external rotation)  
- Assess strength at hip joint: 5/5 strength (abduct/adduct against resistance, straight leg raises)

**SPINE**

- Inspect and palpate: spinous processes, shoulders, scapulae, iliac crests, and gluteal folds symmetrical; no tenderness or deformity, no kyphosis, scoliosis, or lordosis  
- Assess ROM of the spine: full, no pain or crepitus (flexion toe touch, extension, hyperextension, lateral flexion, and rotation)  

**NEUROLOGICAL (GCS, pupils, strength, facial symmetry, communication previously assessed)**

**CRANIAL NERVES**

- CN 1 Olfactory (S) Smell - intact  
- CN 2 Optic: Visual acuity 20/20 bilaterally by Snellen chart (just state this) ; near vision intact (have patient read something near), visual fields full (perform confrontation test)  
- CN 3 Oculomotor CN 4 Trochlear CN 6 Abducens: EOM (perform 6 cardinal fields of gaze) intact  
- CN 5 Trigeminal: muscles of mastication intact (palpate over the temporal and masseter muscle as patient clenches teeth, try to open jaw; sensation of face intact (sharp, dull forehead, cheek chin)  
- CN 7 Facial: symmetrical facial muscle movement intact (smile, frown, close eyes tightly lift eyebrows, show teeth, puff cheeks; labial speech intact (states BMW); taste intact (tastes sweet, salty, sour, bitter); saliva and tear secretion intact  
- CN 8 Acoustic: hearing intact (whispered words heard bilaterally)  
- CN 9 Glossopharyngeal CN 10 Vagus: uvula and soft palate rise symmetrically (when patients state "aahh") gag reflex intact  
- CN 11 Spinal Accessory: intact (shrug shoulders against resistance, rotate head against resistance)  
- CN 12 Hypoglossal: tongue protrudes midline, no tremor; lingual speech intact (state light, tight, dynamite)  

ASSESS BALANCE (Cerebellar function):
### Assess Gait and Tandem Gait
- Smooth, coordinated, steady: 2
- Walk on tiptoes then on heels: 2
- Romberg Test: 2
- Hop in place on one foot then the other: 2
- Shallow knee bend: 2

### ASSESS SENSORY SYSTEM:
- Superficial pain, light touch to face, upper, and lower extremities: 2
- Stereognosis: 2
- Graphesthesia: 2

### ASSESS COORDINATION:
- Rapid alternating movements: 2
- Finger to finger test (patient to tester): 2
- Finger to nose test: 2
- Heel to shin test: 2
- Assess Deep Tendon Reflexes (DTR) with reflex hammer:
  - Brachioradialis: 2+ (elbow flexion & hand pronation): 2
  - Biceps: 2+ (flexion at the elbow): 2
  - Triceps: 2+ (extension of the elbow): 2
  - Patellar: 2+ (extension at knee): 2
  - Achilles: 2+ (plantar flexion of the foot): 2
- Plantar: 2+ (toe flexion) Note extension + Babinski and abnormal in adults, normal in infants: 2

### CLOSURE
- Thank patient: 2

### Proceeds in Systemic, Professional Manner, Appropriate Terminology, Stating Normal and Abnormal Findings as Noted, and Appropriate Teaching
- Yes: 10
- No: 0

### Submitted Complete/Proper Documentation on Jarvis 7th Ed. Complete Physical Exam Form
- 24

### Key:
- 0 – did not complete or completed unsatisfactorily
- 1 – partially completed
- 2 – completed satisfactorily

Shaded areas - Bedside Assessment

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess gait and tandem gait – smooth, coordinated, steady</td>
<td>2</td>
</tr>
<tr>
<td>Walk on tiptoes then on heels</td>
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</tr>
<tr>
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<td>ASSESS SENSORY SYSTEM:</td>
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<td>Heel to shin test</td>
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<tr>
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<td>CLOSURE</td>
<td></td>
</tr>
<tr>
<td>Thank patient</td>
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</tr>
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</table>

**SUBTOTAL /266**

**SUBTOTAL /24**

**TOTAL /290 = GRADE**

**Key:**
- 0 – did not complete or completed unsatisfactorily
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**Shaded areas - Bedside Assessment**
End of syllabus