*FALL 2015*

*Nursing 3320*

*Holistic Health Assessment*

*Course Guide*

*(Supplement to Syllabus: Classroom & Lab Assignments)*

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**Course Objectives for Nursing 3320**

1. Utilize basic principles, techniques and evidence-based tools for physical assessment.

2. Recognize and document variations from normal assessment findings to selected pathophysiological processes.

3. Integrate social, psychological, cultural, spiritual and genetic factors into assessment across the lifespan.

4. Perform a holistic health assessment, including a detailed health history, comprehensive physical assessment, as well as nutritional, physical, psychosocial, cultural and spiritual dimensions.

5. Interpret and analyze normal and abnormal assessment findings for individuals across the lifespan.

6. Analyze subjective and objective data to formulate nursing diagnoses.

7. Use effective communication techniques to perform a holistic health assessment on individuals across the lifespan.

8. Recognize safety concerns and utilize evidence-based knowledge in their practice.

**Course Objectives and Associated Clinical Application**

1. Utilize basic principles, techniques and evidence-based tools for physical assessment.

A. Demonstrate skills of inspection, percussion, palpation, and auscultation.

B. Demonstrate correct use of instrumentation for physical examination and patient

positioning.

2. Recognize and document variations from normal assessment findings to selected

pathophysiological processes.

3. Integrate social, psychological, cultural, spiritual and genetic factors into assessment across the

lifespan.

A. Exhibit behaviors that are culturally sensitive in patient-nurse interactions.

4. Perform a holistic health assessment, including a detailed health history, comprehensive

physical assessment, as well as nutritional, physical, psychosocial, cultural and spiritual

dimensions.

A. Choreograph the physical examination in a systematic manner including integration of

regional assessments throughout the examination (such as musculoskeletal).

B. Coordinate procedures to limit position changes for examiner and patient.

C. Recognize and maintain the privacy and dignity of the patient.

D. Adequately explain what is being done during an examination.

E. Demonstrate confidence, empathy, and a gentle manner.

F. Acknowledge and apologize for any discomfort caused, PRN.

G. Provide for privacy and warmth at all times.

H. Summarize findings for the patient and thank them for their time.

5. Interpret and analyze normal and abnormal assessment findings for individuals across the

lifespan.

6. Analyze subjective and objective data to formulate nursing diagnoses.

7. Use effective communication techniques to perform a holistic health assessment on individuals

across the lifespan.

A. Use appropriate terminology and correct pronunciation of medical terminology with

clinical instructor and patient.

B. Describe accurately the physical findings including normal and abnormal findings.

C. Demonstrate professional demeanor in facial expressions and comments.

8. Recognize safety concerns and utilize evidence-based knowledge in their practice.

A. Demonstrate appropriate infection control procedures.

B. Wash hands, use hand hygiene and/or don gloves appropriately.

**CLASS PARTICIPATION**

As mentioned in the Syllabus, students are expected to attend class and actively participate. In-Class Quizzes and Classroom Activities will be given or assigned PERIODICALLY during the semester except on days where there is an Exam or OSCE. If a student misses class, whether for an excused or unexcused absence, ANY class quiz or activity for that day **may NOT be made up**, and the grade is recorded as zero (0). If a student arrives late to class or after the quiz or activity has started, no extra time will be allowed; the student may take the quiz or complete the activity until time is called. Lippincott PrepU quizzes are assigned to be completed outside of regular class. **Note**: The lowest of the combined quiz activities grades, (including in-class quizzes, activities and PrepU Quizzes) will be dropped.

The Participation Grade consists of the activities listed below (total 6%). The components of the Participation Grade include:

1. Three to Four In-Class Quizzes or Class Activities

2. Thirteen required; three optional Prep U Online Quizzes.

The In-Class Activities will consist of both Closed-Book Quizzes and Class Activities that count as a Quiz. The closed-book Quizzes will be taken from the Weber and Kelley Assessment text, class discussion, and any handouts, and are scored out of a possible 100 points (10 questions each). The IF-AT (Immediate Feedback-Assessment Testing) Scratch-off Test Sheets may be used. For quizzes given in that format, students will receive full credit for answering correctly on the first attempt and will receive partial credit for answering correctly on subsequent attempts. Students whose Test Sheets appear to have multiple answers scratched off will have those counted as incorrect answers.

The information beginning on p. 7 details the guidelines for the Lippincott Prep U Quizzes.

Student Instructions for IF-AT Quiz Testing

You may have some anxiety about this type testing, so you take a Practice Exam to give you an idea of how the IF-AT testing system works (Immediate Feedback Assessment Technique).

1. **USE** the top edge of the question sheet (or any straight edge) to insure that you are *scratching on the correct line* of the IF-AT form.

2. Carefully **READ** each question and all options **slowly and accurately**.

3. **SCRATCH** carefully so as not to tear the answer form.

4. **REMEMBER** the Star for the correct answer can appear anywhere within the box, so be sure to scratch the entire box.

5. **CHOOSE** the correct answer on the first attempt, and receive full credit. If your first response is **incorrect**, you can earn partial credit points, **RE-READ** the question and remaining responses and “IF-AT first you don’t succeed, try, try again.” You will learn to become more careful, accurate readers, to think before responding, and to persist in seeking a correct answer.

6. **USE** any of the following “tools” to scratch off. Popular tools include: a penny, a toothpick, a popsicle stick, the edge of a plastic student I.D. card, or the top of a Bic-type pen.

7. **SCORE** your Quiz. Neatly write the value of your answers on the line to the right of each item. Keep a running total of points earned. Your Instructor will quickly check for accuracy.

The Table below indicates the score received and partial credit for subsequent attempts.

|  |  |
| --- | --- |
| **CORRECT ANSWER** | |
| Attempt | Points |
| 1st | 10 |
| 2nd | 5 |
| 3rd | 2 |
| 4th | 0 |

IF-AT IMMEDIATE FEEDBACK ASSESSMENT TECHNIQUE

SAMPLE TEST CARD

Name\_\_\_\_\_Jane Doe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test # \_\_\_Practice Quiz\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subject\_\_\_\_\_\_N3320 Assessment\_\_\_\_\_\_\_\_\_\_\_\_ Total\_\_\_\_\_\_72\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCRATCH OFF COVERING TO EXPOSE ANSWER**

The blue shaded area represents incorrect attempts. The \* indicates a correct attempt.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Q # | A | B | C | D | (Item) Score | (Running Total) Score |
| 1. | \* |  |  |  | 10 | 10 |
| 2. |  | \* |  |  | 5 | 15 |
| 3. |  |  | \* |  | 10 | 25 |
| 4. |  |  |  | \* | 10 | 35 |
| 5. |  | \* |  |  | 2 | 37 |
| 6. | \* |  |  |  | 10 | 47 |
| 7. |  |  |  | \* | 10 | 57 |
| 8. |  |  | \* |  | 5 | 62 |
| 9. | \* |  |  |  | 0 | 62 |
| 10. |  | \* |  |  | 10 | 72 |

**Prep U Quiz Assignments**

**Lab Overview:**

Prep U is an adaptive quizzing system, similar to that of NCLEX. With adaptive quizzing, your ability level is determined and continuously updated by your response to questions based on the difficulty level. As you answer a question, you achieve a “mastery level” on topics you have taken quizzes in. A Mastery Level is a measure of the average difficulty level of the questions you answer correctly. As you answer more difficult questions correctly, you are given even more challenging questions on future quizzes. If these questions are answered correctly, you then move up a Mastery Level. Adaptive quizzes motivate and help you master the content you need to learn. Your performance is compared with that of thousands of students using PrepU across the country. Educators conducting research have seen results indicating PrepU helps students prepare and succeed with NCLEX.

Once you have registered for Lippincott’s “The Point” and completed enrollment using the course code provided you, you will see your electronic books, PrepU, Skills Mastery and critical thinking activities, and other resources. You will be assigned specific quizzes and due dates (See Weekly course schedule).These will be completed outside of class. These quizzes are to benefit you in mastering content, being prepared for class and unit exams. The grade is based on completion, not a specific grade.

**Instructions**: Go to the CoursePoint and locate assignments due per the schedule. Your assignment is to take the quizzes as many times as is necessary to achieve **MASTERY LEVEL 3**. You can select the number of questions to take per quiz; the recommended number is 20. **Thirteen Required Quizzes**: Ch. 9 Pain; Ch. 13 Nutrition; Ch. 14 Skin; Ch. 15 Head & Neck; Ch. 16 Eyes; Ch. 17 Ears; Ch. 18 Nose, Mouth & Throat; Ch. 19 Thorax & Lungs; Ch. 21 Heart and Neck Vessels; Ch. 22 Peripheral Vascular System; Ch. 23 Abdomen; Ch. 24 Musculoskeletal; and Ch. 25 Neurologic system. There are **3 optional quizzes** that will not count for a grade, but will help you with content not covered in class: Ch. 20 Breast and Lymphatics; Ch. 26 Male, and Ch. 27 Female.

**NOTE**: In order to achieve Mastery Level 3 (which indicates BASIC content), you would typically need to answer 40-50 questions. Per the publisher’s guidelines, IT IS HIGHLY RECOMMENDED that you read first, which allows you to achieve the mastery level with fewer numbers of questions. When students attempt to take the quizzes without reading, it may take 100-200 questions to achieve the mastery level of 3.

**VERY IMPORTANT**: Questions on Assessment unit exams, will be written at a much higher mastery level, closer to 7-8. It is recommended that you continue to practice taking quizzes to achieve a higher mastery level, in order to be successful on exams. Mastery level 3 indicates you have read and are prepared for class discussions.

**Simulation Experiences**

Simulation includes all the activities you practice in lab. Simulation allows you to safely practice assessment skills in a practice environment.

You will work with a lab partner each week to learn interview and physical exam skills. On occasions, scenarios will be incorporated to allow you to apply what you have learned. You will be given a patient history and chief complaint, and will practice collection of subjective and objective data, in order to formulate a plan of care.

Simulation also includes OSCEs, (objective structured clinical examinations), where you take the weekly body system assessments, and incorporate them into a logical head to toe exam. OSCE 1 is performed on a patient actor (Standardized patient); OSCE 2 is performed on a student lab partner. The final simulation includes interactive “high fidelity manikins” (with breath sounds, heart sounds, bowel sounds, pulses, and verbal responses) whose condition can change based upon your actions.

At times your simulation involves working as a group to provide care for the patient. You may be assigned to act as the nurse, family member, observer, and recorder of data. You are expected to demonstrate professional behaviors at all times and, when manikins are used, to treat manikins with the same care and respect as live human patients. If instructors and/or simulation facilitators observe students involved in unprofessional behaviors, those actions will be addressed, and performance improvement plans implemented.

BE AWARE: Observational cameras and audiovisual equipment are situated throughout the rooms in the Smart Hospital, so you may be observed at any time.

**RULES FOR ASSESSMENT SMART LAB AND SMART HOSPITAL**

1. Limit the number of materials/backpacks, etc. that you bring as there is limited space. Consult with your instructors regarding supplies you will need to complete the activity.

2. Bring what you need to complete the simulation. Bring a pencil, paper, and textbook/lab book.

3. Students **MUST** come wearing UTA approved Scrubs including UTA ID and approved footwear for lab/clinical and adhering to guidelines for dress code.

4. **Do not bring ink pens – only pencils, to protect the manikins from permanent damage**.

5. You should always treat the patients/manikins as if they were real patients in the hospital. Treat them with respect, provide for privacy. Consider safety issues, such as side rails. Act as if you are in a hospital setting – avoid excessively loud talking as you would consider the needs of your patients. Demonstrate professional demeanor and respect.

6. Always return the patients/manikins to the way they were when you arrived. Side rails up, manikins covered up, etc.

7. Failure to demonstrate professional behaviors during lab, simulation or with manikins at the Smart Hospital will constitute grounds for a Performance Improvement Plan.

8. Food is not permitted in the Smart Lab or Smart Hospital. Drinks may be allowed provided they are in a closed container.

**OPTIONAL LAB PRACTICE**

There MAY BE additional opportunities to practice lab skills throughout the semester. Pay attention to dress code, supplies, and treatment of manikins.

1. You MAY be asked to register for attendance at practice sessions. All dress code policies listed below must be adhered to. There will be a sign-in form to document your attendance at practice.

2. If unsupervised practice sessions are scheduled, those are limited to noninvasive skills, such as BP and physical exams.

3. Students should bring supplies necessary for the skill, including stethoscope, alcohol, patient gown, penlight, reflex hammer, or BP cuff, and any Skills checklists.

**ESSENTIAL SKILLS EXPERIENCE**

Each UTACON clinical course has a designated set of essential nursing skills. An essential nursing skill is one that is “required” for each student to have instruction on AND either laboratory or clinical experience performing. Experience is defined as “hands on” performance of a skill in a laboratory setting using standardized patients, manikins, human patient simulators, task trainers, and computer

simulation modules or in a clinical setting involving actual patients or communities. **(See Syllabus for complete details).**

Many of the skills for Health Assessment will be practiced in the weekly labs; some may be achieved after completion of the OSCEs; and some after all end of course work is completed. (See details below for a list of skills for this course and how each is addressed). These skills must ALL be completed **in order to obtain a passing grade for the clinical component of this course.** At the end of the course, faculty will document your completion of these essential (passport) skills on your Final Clinical Evaluation Form. It is your responsibility to assure that skills are completed.

**Nursing 3320 – Holistic Health Assessment Skills and How they will be Addressed**

\*Some revisions could be made regarding how skills are addressed.\*

| **Skill** | **How Addressed** |
| --- | --- |
| Heart rate, apical pulse and rhythm | Practice in lab |
| Respiratory rhythm | Practice in lab |
| Temperature | Practice in lab |
| Blood pressure, manual or automated | BP competency assessment |
| Pulses, rate and quality | Lab practice, OSCE 1, OSCE 2 |
| Auscultation of heart sounds | Lab practice, OSCE 1, OSCE 2 |
| Auscultation of lung sounds | Lab practice, OSCE 1, OSCE 2 |
| Pain assessment | AP Note on Pain, Symptom Analysis #1 |
| Physical assessment, head to toe | OSCE 1 & 2 |
| Level of Consciousness | OSCE 1 & 2 and SLUMS Mental Status Assessment |
| Mental Status Exam | SLUMS Mental Status Assessment performed on lab partner or another person |
| Obtain a patient health history r/t chief complaint | Symptom Analysis #2, performed on clinical patient in Foundations  Health History Write-up on Lab Partner |
| Interpret & analyze normal & abnormal assessment findings | Symptom Analysis #2, performed on clinical patient in Foundations  Focused Assessment activities |
| Handwashing/cleansing | Weekly lab practice  OSCE 1 & OSCE 2 |
| Documentation | Weekly lab write-ups & AP Notes (written or submitted electronically)  OSCE Documentation |
| Therapeutic communication techniques– patients | Weekly lab write-up (subjective interview); “Interview evaluation” in lab  Simulation activities  Lab Teaching Assignment |

**LAB OVERVIEW**

**Weekly Lab Practice:** The purpose of the Holistic Health Assessment lab time is for you to learn and practice the skills and techniques involved in performing an assessment. This includes collecting subjective data and performing physical exams to obtain objective data. On the first clinical lab day, you will select a partner to work with throughout the semester. Each week you are expected to come to lab familiar with the content and prepared to participate actively and use your time efficiently. Therefore, if you complete an assignment early you are expected to practice skills taught in lab from the previous sessions or work on other assignments. **Students are not to leave until dismissed by the**

**Clinical Lab Instructor. Refer to the Syllabus and to the UTACON Undergraduate Student Handbook-2015-2016 for specific information on dress code and clinical lab expectations regarding participation and preparation.**

Attendance in all labs is **REQUIRED, including the Simulation Labs. NOTE:** See Syllabus for absence & tardiness policies, instructor notification, Performance Improvement Plans, and Lab make-up. Students are responsible to assure that missed lab hours are made up.

**Lab Supplies:** Please refer to the Weekly Student Lab Activities found in Blackboard under each week’s Resources for instructions on necessary supplies for each week’s lab. These include: 1) A stethoscope (must have diaphragm and bell OR be “tunable” for detecting high-pitched and low-pitched sounds; 2) Items from your Clinical Nurse Kit which includes the Patient Gown, BP Cuff, Penlight, and Reflex Hammer. There are also shared items such as alcohol wipes and the tape measure that are needed for weekly Assessment Lab. Please bring these required items to lab as directed. **NOTE**: Bringing necessary supplies to EACH AND EVERY LAB is an EXPECTATION. Failure to do so will result in written Performance Improvement Plans and documentation on Clinical Evaluations.

**Interview and Exam**: Clinical Lab Instructors will demonstrate the interview and physical exam, including best correct terminology for documentation. On select days during the semester, students will demonstrate the lab skills as part of their teaching assignment. You will then interview your lab partner to obtain a health history (**subjective data**) and perform the physical examination (**objective data**), and document the findings. The subjective health history questions are located in the Weber and Kelley Student Laboratory Manual. Each week you will perform a focused or limited exam. You are preparing to take these individual body system exams and coordinate them into a focused head-to-toe exam, and demonstrate clinical proficiency during the two Objective Structured Clinical Examinations (OSCEs). You will also learn the importance of providing privacy and draping patients to keep them covered during an exam. **All health history information and physical assessment findings are private and confidential, and are NOT to be released or discussed with others.**

**Lab Documentation (6% of total grade)**. Lab Write-Ups and AP Notes (Assessment—Nursing Diagnosis and Plan) are assigned to assist in developing proficiency in documentation of assessment findings. Instructors will give feedback to guide the student to improve and excel in documentation, and to be successful in documenting OSCE findings. See specific Rubrics below. Some Lab Write-ups may be completed via paper/pencil in the Student Laboratory Manual.

**NOTE:**  **For the first week only**, instructors may return the written Health History assignment, and ask students to re-submit for completion or correction, with such assignments to be resubmitted within one week. If resubmitted on time, full credit will be received. If not resubmitted **correctly** **and completely**, no credit will be given. **From that point forward**, Lab Write-ups are graded per the specific Rubric, and according to the schedule below.

**Documentation of Subjective and Objective Information (Lab write-ups)**

A complete write-up of an interview and examination includes documentation of the history (subjective data) and the exam (objective data). Beginning **Week 2**, students work with the Lab Partner and will use the Student Laboratory Manual to take notes in Write-up Section. The information is used to document on the template provided. Beginning **Week 3**, Subjective and Objective Write-ups will be submitted via Blackboard. Refer to Weber and Kelley for examples of documentation.

**A/P Notes:**

You will also have opportunities to begin the development of the patient plan of care. The Assessment (Nursing Diagnosis) is a statement of the patient’s problem. The Plan consists of basic nursing interventions. Together you will write Assessment/Plan (A/P) Notes to learn the skills of formulating nursing diagnoses and the plan of care.

AP Notes will be written using case scenarios about patients exhibiting abnormal assessment findings. You will be given instructions on how to write a Nursing Diagnosis and how to use your Care Plans book to select nursing interventions, specific to assessment. The A/P Notes will be submitted at the end of each lab in hard copy, and returned to you for instructor feedback. The clinical scenarios used for writing the A/P Notes are based on the Top 10 DRGs (diagnoses, reasons for admission) in the Dallas-Fort Worth Metroplex. These are completion grades, but MUST BE SUBMITTED in order to meet course objectives and pass the course.

**Refer to the Syllabus under Academic Integrity**, with language addressing OSCE performance, and in any documentation. Please consult your Assessment Lab Instructor for assistance with ANY documentation questions. If uncertain about assessment findings, students should seek assistance or clarification from Instructors prior to documentation. Reporting or documentation of assessments not performed or haphazard documentation of findings when uncertain about accuracy, is considered academic dishonesty, and students will be disciplined in accordance with University regulations and procedures.

As you progress through the semester, you will become more proficient in learning how to document accurately and thoroughly. **Refrain from using words such as “normal” or “good”.** Occasionally textbooks use these words, but look for more descriptive terms. Rarely the word “normal” can be used if comparing to something (i.e., normal for height and genetic heritage). Refer to your textbook and any samples provided. **Important Note:** If you use 5 or more words directly from the textbook or other source to document findings, please cite the source and page number. (See APA Information on page 14 of this Guide).

**NOTE**: *All lab assignments and write-ups are due per the course schedule unless the student makes alternative arrangements with the clinical instructor PRIOR to the assignment due date. Assignments that are late will be assessed a -10 point penalty (or 10%) per day for up to three days. After the end of the third day, the clinical instructor will not accept the assignment. The instructor will grade the*

*assignment as a zero.* **If assignments are repeatedly late or not turned in, Faculty will implement a Performance Improvement Plan. (See Syllabus).**

Write-ups will be completed and submitted per the schedule listed below: (10 write-ups due, each worth 0.6) for a total of 6% of total grade.

|  |  |  |  |
| --- | --- | --- | --- |
| **Topic** | **Tuesday Lab**  **Due Dates** | **Wednesday Lab**  **Due Dates** | **Thursday Lab**  **Due Dates** |
| Ch. 2 (Health History) | Tuesday, 9/8/15 at the START OF LAB | Wednesday, 9/9/15 at the START OF LAB | Thursday, 9/10/15 at the START OF LAB |
| Ch. 6 & 8 (Mental Status; General Status & Vital Signs) | Tuesday, 9/8/15 at the END OF LAB | Wednesday, 9/9/15 at the END OF LAB | Thursday, 9/10/15 at the END OF LAB |
| Ch. 14 & 24 (Skin, Hair & Nails & Musculoskeletal) | Tuesday, 9/15/15 by 2359 in Blackboard | Wednesday, 9/16/15 by 2359 in Blackboard | Thursday, 9/17/15 by 2359 in Blackboard |
| Ch. 19 (Thorax & Lungs) | Tuesday, 9/29/15 by 2359 in Blackboard | Wednesday, 9/30/15 by 2359 in Blackboard | Thursday, 10/1/15 by 2359 in Blackboard |
| Ch. 21 & 22 (Heart & Neck Vessels; Peripheral Vascular) | Tuesday, 10/6/15 by 2359 in Blackboard | Wednesday, 10/7/15 by 2359 in Blackboard | Thursday, 10/8/15 by 2359 in Blackboard |
| Ch. 23 (Abdomen) | Tuesday, 10/13/15 by 2359 in Blackboard | Wednesday, 10/14/15 by 2359 in Blackboard | Thursday, 10/15/15 by 2359 in Blackboard |
| Ch. 25 (Neurologic System) | Tuesday, 11/3/15 by 2359 in Blackboard | Wednesday 11/4/15 by 2359 in Blackboard | Thursday 11/5/15 by 2359 in Blackboard |

**Performance Objectives**

* Develop skill at documenting findings from the history and physical exam.
* Recognize normal and abnormal conditions involving each body system.
* Use correct terminology to document normal and abnormal findings.
* When pertinent, practice performing additional symptom analyses (history of preset health concern).

**Instructions**

1. Interview your partner each week and perform subjective and objective assessments.

2. Complete all sections, unless otherwise told to leave blank, or document “not performed”.

3. Practice using correct terminology to document your findings.

4. Reference your sources when citing documentation terms using APA format.

5. Complete the AP Note portion on a case scenario provided by your Lab Instructor.

**Rubric for Documentation of Lab Write-ups:**

These assignments are graded per the Rubrics listed below. (10 regional write-ups at 0.6% each, **total six (6%).** The rubric will vary slightly for some week’s assignments, as noted below.

**Rubric Week 1 Assignment – Ch. 2 Health History. (See above for due dates).**

|  |  |  |
| --- | --- | --- |
| **Assignment** | **Correct** | **Incorrect** |
| Documentation of Ch. 2 Complete Health History | 1. All areas addressed, leaving no blanks.  2. Assignment completed in paper/pencil in Workbook.  100% | 1. Areas left blank.  2. Assignment not completed.  0 |

**Rubric Weeks 2-Week 10 Lab Write-ups. (See above for due dates).** For these assignments, you will use your Weber and Kelley Student Lab Manual to take notes on the findings form your Lab Partner. You will then type the information on the assignment templates, for each chapter. **Week 2 (Chs. 6 & 8) will be submitted in hard copy.** Beginning with **Week 3,** assignments are to be submitted in Blackboard. See above regarding penalties for late submissions.

|  |  |  |  |
| --- | --- | --- | --- |
| **Lab Write-up Assignment** | **Lab Write-up On Partner** | | |
| Ch. 6 Assessing Mental Status and Substance Abuse  Ch. 8 Assessing General Status and Vital Signs  Ch. 14 Skin, Hair & Nails  Ch. 24 Musculoskeletal  Ch. 19 Thorax and Lungs  Ch. 21 Heart and Neck Vessels  Ch. 22 Peripheral Vascular System  Ch. 23 Abdomen  Ch. 25 Neurologic | **Subjective**: For this section, EACH element must be addressed. If a question is asked about multiple conditions or areas, you MUST address each element. DO NOT LEAVE ANY AREAS BLANK.  **50 points for SUBJECTIVE** | | |
| **1.** All questions addressed and ALL elements addressed | **50 points** | |
| **2.** 1 question left blank **AND/OR**  Failure to address each element in 1 question | **25 points** | |
| **3.** More than 1 question left blank **AND/OR**  Failure to address each element in 2 or more questions | **0 points** | |
| **Objective:** The purpose of this assignment is to assist you to document using correct medical terminology. You are not penalized for documentation that needs improvement for accuracy or clarity. HOWEVER the expectation is that you take instructor feedback for improvement. See #3 below. When uncertain about findings, clarify with instructor. **50 points for OBJECTIVE** | | |
| **1**. In areas where documenting a choice by placing an “X” in all areas that apply | | |
| All items addressed | | **50 points** |
| 1 item left blank (not addressed) | | **25 points** |
| 2 or more items left blank (not addressed) | | **0 points** |
| **2.** In areas where asked to describe assessment findings: | | |
| All items addressed with descriptive terms | | **50 points** |
| 1 item left blank | | **25 points** |
| 2 or more items left blank | | **0 points** |
| **3.** If instructor makes recommendations for improvements and students fail to make corrections on future assignments, at instructor’s discretion: | | **Deduction of up to 10 points per assignment** |
| **A/P Note (Abnormal) on Case Scenarios** | | | | |
| Using Case Scenario Provided:  1. Introductory statement of patient initials, age, gender, occupation/student, reason for seeking care.  2. Assessment (2 or 3-part Nursing Diagnosis correctly written). You must use ONLY the specific nursing diagnoses as provided by your Lab Instructor.  3. Plan: Include 2 interventions specific to assessment, written in your own words, providing a rationale from the Care Plans book or your textbook. The interventions must include a specific time frame.  Credit – MUST BE COMPLETED TO PASS THE COURSE. | | | | |

**APA FORMAT**

APA Format (American Psychological Association) is the format used by the UTA College of Nursing and Health Innovation to direct the format for papers and written assignments, including grammar, punctuation, and citation of references. The paperback book APA: The Easy Way! A Quick and Simplified Guide to the APA Writing Style (2nd ed.), (Houghton & Houghton, 2009) is used by the College of Nursing and Health Innovation as a resource.

Some assignments in this course may require you to include a UTA College of Nursing and Health Innovation Title Page (which may vary from that provided in the APA, the Easy Way book, see **Example of this on Blackboard**). Other assignments will require you to cite your source, primarily your textbook, and any other resources used. Please use this handy reference book and samples that may be posted on Blackboard, to assure you are using correct APA Format. For this semester, faculty will not deduct specific points for APA accuracy, but will deduct points for failure to include a Title Page or Reference Page when required per the Rubric.

For documentation on Weekly Lab Write-ups, if five or more words in sequence are taken directly from a source (such as your Weber and Kelley textbook) you should reference the source with the author’s name, date of publication and page number (i.e. Weber and Kelley, 2041, p. 85). When a reference page is used, for the Weber and Kelley book, there is no need to include the page number on the reference page.

**LAB ASSIGNMENTS**

**Lab assignments** **(13% of total grade)** will be given as part of the lab experience and to help meet essential skills, described on subsequent pages. **With the exception of the Self-Genogram and Teaching Assignment, ALL LAB ASSIGNMENTS will be typed and submitted via Blackboard.** The Lab Assignments are listed below:

Lab Assignments:

1. Genomics

A. Self-genogram (0.5%)

B. Genetics Assignment (0.5%)

2. Symptom Analysis #1 (1%)

3. Symptom Analysis #2 (5%)

4. Lab Teaching Assignment (2%)

5. Cultural Assignments:

A. Self-Assessment (FICA) (1%)

B. Cultural Assessment of Partner (1%)

6. 20 BP Assignment (2%)

See Assignment guidelines and rubrics detailed on subsequent pages, as well as due dates.

***NOTE****: All lab assignments and write-ups are due per the course schedule unless the student makes alternative arrangements with the clinical instructor PRIOR to the assignment due date. Assignments that are late will be assessed a -10 point penalty (or 10%) per day for up to three days. After the end of the third day, the clinical instructor will not accept the assignment. The instructor will grade the assignment as a zero.*

**If assignments are repeatedly late or not turned in, faculty will implement a Performance Improvement Plan. (See Syllabus).**

**Assignments for Credit to meet Essential Skills**

**Some assignments are completed for credit only, to meet the essential skills of the Passport. This includes the** SLUMS Mental Status Assessment**,** Interview Evaluation, AND Two Focused Assessments, as well as the Assessment/Plan (AP Notes) for each body system, as listed above in Documentation. These assignments MUST BE COMPLETED in order to pass the course.

**Genomics Assignments**

**There are 2 genomics assignments. This includes a Genogram that you will complete on your family and a Genetics Assignment regarding a specific genetic disorder. See details below.**

**Self Genogram Assignment**

**Lab Overview: Self Genogram**

During Week 1, you will learn about conducting a health history. As a way to look at health risks in your own family, please look at p 23 of the Weber and Kelley text, and read about how to draw a genogram. A genogram is a graphic family tree that uses symbols to depict the gender, relationship, and age of immediate blood relatives in at least 3 generations, (self/siblings plus 2 previous generations including parents and grandparents). Drawing a genogram helps to organize and illustrate the client’s family history. As you will see on the next page, a standard format is used, with standard symbols to represent genders, deaths, and adoptions. Straight vertical and horizontal lines are used to show relationships.

You will create a genogram for your family. **This is due AT THE BEGINNING OF LAB, in hard copy, turned in to your Lab Instructor Week 2 (Tuesday, Wednesday or Thursday, September 8th, 9th or 10th).**

**Instructions:**

**1.** Ask about the **age and health** or the **age and cause of death** of genetic (blood) relatives. Include maternal and paternal grandparents, aunts and uncles on both sides, parents, siblings, and the client’s children. This degree of thoroughness usually identifies those diseases that may skip a

generation, such as autosomal recessive disorders. Include the client’s spouse but indicate that there is

no genetic link. Identifying the spouse’s health problems could explain disorders in the client’s children not indicated in the client’s family history.

2. Place yourself at the first level and include either a square (for male) or circle (for female). For the client, note that this is designated by a square within a square for males and a circle within a circle for females.

3. You and your siblings are at the first level; then go back 2 generations to parents, aunts and uncles, and then to grandparents.

4. Identify all relatives, living or dead, by age, and provide a brief list of diseases or conditions. If the relative has no problems, the letters “A/W” (alive and well) should be placed next to the age. If relatives are deceased, list the age at death and cause of death.

5. If you have info about most of your family or one side of the family, but lack info on one or more individuals or one side of the family, go ahead and complete, but state specifically that information is not available so it is clear the info was not omitted. **NOTE**: If you have no information about your family (adoption, no contact, etc.) please discuss with your lab instructor. The idea is to obtain this information so you may be able to complete the assignment on an adoptive family or another person for credit).

6. **Be sure to do a legend/key for the genogram to explain your symbols**. PLEASE REFER TO Weber and Kelley P. 23 FOR APPROVED SYMBOLS WHICH MAY BE USED. PLEASE USE ONLY THESE SYMBOLS.

This assignment is scored as **Complete/Not Complete and is worth 0.5%** of your Lab Assignments grade.

**Performance Objective:**

* Apply knowledge of the health history of obtain family medical information.
* Prepare a 3-generation genogram using correct symbols, and include a key for symbols.

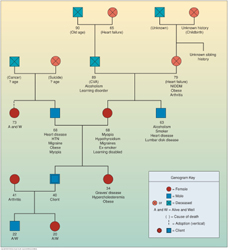
**Rubric for Self-Genogram**

|  |  |  |
| --- | --- | --- |
| **Tasks** | **Correct** | **Incorrect** |
| Three-generation genogram | Self/sibling plus 2 previous generations | Incomplete |
| Inclusion of health information | Health information for individuals to include, as  applicable:  1. Congenital disorders  2. Chronic diseases  3. Reason for death  4. Alive/Well on **all** individuals without health problems  **If information not available on some individuals, must state that specifically.** | Individuals with NO health information listed. |
| Symbols | Correct symbols used per Weber and Kelley text including the correct symbol for the Client. | Incorrect symbols used; not from Weber and Kelley |
| Key/Legend | Included | Not included |
|  | 100 | 0 |

A Genogram example from the Weber and Kelley text is provided below. You may choose to complete this in a typed format or hand-drawn. Please use this example and the Weber and Kelley text for a guide, but follow the above rubric. Your genogram need not be elaborate, or taken from any sort of genogram software.

**Genogram Example FOUND ON WEBER AND KELLEY TEXT, p. 23**

**See textbook for a clear picture – use this as your guide.**



**Genetics Assignment**

There will be electronically prepared posters describing specific genetic medical disorders. The poster will give background information about the disorder, and the elements that would be included in an assessment. You will be assigned an activity to review the posters and post a discussion. See assignment below. **Due in Blackboard at 2359 Sunday for all groups, November 29th at 2359. (Worth 0.5% of total 13% Lab assignments).**

Several students have chosen to participate in an Honors Project for this course involving genetics. Each Honors student will prepare an electronic poster describing a genetic disorder which may or may not have been covered in class. You will learn a little more from these posters about the background, risk factors, screening and findings that may be seen on assessment.

**Your instructions for this assignment:**

1. Go to Blackboard, Lab, Genetics Posters. There are several posters or links to a poster regarding genetic disorders. The poster will give background information about the disorder, and the elements that would be included in an assessment.

2**.** Your assignment is to view **two (2) of the posters**. You will then access the Genetics Discussion Board and choose the 2 posters you wish to comment on. For each poster, please answer the following questions:

A. For each poster – give 2 statements:

1. What did you learn from the poster.

2. What did you LIKE about poster.

B. ANYTHING OTHER THAN POSITIVE COMMENTS will result in your discussion

post being removed and you will receive a “0” for this assignment.

Example: Genetics Poster #1: I learned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from this poster. I LIKED \_\_\_\_\_\_\_ about this poster.

Separate Posting: Genetics Poster #2: I learned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from this poster. I LIKED \_\_\_\_\_\_\_\_ about this poster.

**Genetics Assignment**

|  |  |  |  |
| --- | --- | --- | --- |
| Tasks | Acceptable | Partial Credit | Unacceptable |
| Discussion Posts  POSITIVE COMMENTS ONLY | Poster 1: Post stating:  A. What you liked  B. What you learned  (50 points)  Poster 2: Post stating  A. What you liked  B. What you learned  (50 points)  POSITIVE COMMENTS ONLY | Only 1 post initiated with both comments  (50 points)  Only 1 post and 1 comment (25 points) | Did not initiate any discussion postings  (0 points) |

**SLUMS (Mental Status) Examination**

**Instructions: PLEASE PRINT OUT THE FORM found in Week 2 Assignments.** The St. Louis University Mental Status (SLUMS) Examination is a quick measure of cognitive function to screen for Dementia/Alzheimer’s Disease. A score between 27-30 for clients with a high school education and a score of 20-30 for clients with less than a high school education is considered normal. Follow instructions to administer the examination, then score based on the instructions on the form. Include the clock drawing on the form. This assignment is due in hard copy to your Lab Instructor at the **BEGINNING OF LAB** Week 3 (Tuesday, 9/15; Wednesday 9/16 or Thursday 9/17).

**Evaluation of Interview Skills**

**INSTRUCTIONS**: This form is located in Week 2 Assignments. Please print the form. For each general category (Communication Process, Asking Questions, avoiding traps) please mark a “check mark” in the appropriate category to describe how well your partner completed the Health History Interview and asked you the interview questions. **Due AT THE BEGINNING OF LAB in hard copy Week 4 (September 22, 23, or 24).**

Please rate your Interviewer on a scale of 1-4. GIVE comments on a least 2 areas

|  | 1  Needs More Practice | 2  Satisfactory  (Keep Working) | 3  Good  (You’ve got it!) | 4  Excellent  (WOW!) | Comments |
| --- | --- | --- | --- | --- | --- |
| Communication Process (Internal Factors)   * Showed respect * Demonstrates empathy * Good Listener   External Factors   * Ensured Privacy * Avoided Interruptions * Made the physical environment comfortable * Dress (Professional) |  |  |  |  |  |
| Asking Questions   * Asked Open-ended questions when appropriate * Used Closed-ended questions when appropriate * Used appropriate responses to assist narrative (Evaluate as a whole on 1-4 scale; add comments as may be helpful).   + Facilitation   + Silence   + Reflection   + Empathy   + Clarification   + Confrontation   + Interpretation   + Explanation   + Summary |  |  |  |  |  |
| * Avoided the 10 traps of interviewing   + False Reassurance   + Unwanted Advice   + Authority   + Avoidance   + Distancing   + Jargon   + Leading Questions   + Talking too much   + Interrupting   + Why questions |  |  |  |  |  |
| Appropriately used:   * Eye contact * Touch * Posture * Facial expression * Nonverbal skills * Tone of voice |  |  |  |  |  |
| Closed the Interview   * Summarized findings * Allowed time for additional questions |  |  |  |  |  |
| Professionalism:   * Remained in character * Interview completed in a timely manner * Explained unfamiliar terms |  |  |  |  |  |

**Name of Client (Person being interviewed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Interviewer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**N3320 Holistic Health Assessment Procedure for Measuring MANUAL Blood Pressure   
Supplement to Procedure found in Weber and Kelley (W&K) (Reviewed 8-16-15)**

* Measure the blood pressure cuff. The **width** of the rubber bladder should equal 40% of the circumference of the person’s arm. The **length** of the bladder should equal 80% of this circumference. (See W&K, Chapter 8, pp. 139). \*See BP Competency as part of OSCE 1.
* The person may be sitting or lying, with the bare arm supported at heart level. If using a mercury manometer place so it is vertical and at your eye level). When sitting, the patient’s feet should be flat on the floor because BP has a false high measurement when legs are crossed versus uncrossed.
* Palpate the brachial artery, which is located just above the antecubital fossa, medial to the biceps tendon. With the cuff deflated, center it about 2.5 cm (1 inch) above the brachial artery and wrap it evenly. Position the sphygmomanometer at eye level no more than three feet away. Close the valve on the pressure bulb clockwise until it is tight but easily releasable with one hand.
* Palpate the brachial or radial pulse with the fingertips of one hand while inflating the cuff rapidly; note the point at which you no longer feel the pulse, and continue to inflate 20 to 30 mm Hg above this point. This will avoid missing an **auscultatory gap**, which is a period when Korotkoff’s sounds disappear during auscultation (See Table 8-1, p. 128). Slowly release the valve to deflate the cuff and **note the point at which the pulse reappears**; **this is the palpated systolic pressure**. Immediately deflate the cuff completely.
* Wait for 15-30 seconds before re-inflating so that the blood trapped in the veins can dissipate. Place the stethoscope over the site of the brachial artery, making a light but airtight seal. The diaphragm endpiece is usually adequate, but the bell is designed to pick up low-pitched sounds such as the sounds of a blood pressure reading, so the bell may also be used.
* Rapidly inflate the cuff to the maximal inflation level you determined (palpated systolic pulse) **then inflate 20-30 mm Hg above that level**. Then deflate the cuff slowly and evenly, about 2 mm Hg per heartbeat. Note the point on the sphygmomanometer when the first Korotkoff sound is heard; this is the systolic pressure. Continue to deflate the cuff slowly and note the point where sounds disappear. The last audible sound (marking the disappearance of sounds) is the diastolic pressure. The fifth Korotkoff sound is now used to define diastolic pressure in all age groups.
* Deflate the cuff completely and remove it from the patient’s arm. **Record the measurement IN EVEN NUMBERS.**

**Orthostatic or Postural Vital Signs**

* If the client takes antihypertensive medications or has a history of fainting or dizziness, assess for possible orthostatic hypotension.
* Measure BP and pulse with the client in a standing or sitting position AFTER measuring the blood pressure with the client in a supine position.
* A drop of LESS than 20 mm Hg from recorded sitting position is normal.
* **Abnormal Findings:** A drop of 20 mmHg or more from the recorded sitting blood pressure may indicate orthostatic hypotension Pulse will increase to accommodate the drop in BP. Orthostatic hypotension may be related to a decreased baroreceptor sensitivity, fluid volume deficits (e.g. dehydration), or certain medications (i.e. diuretics, anti-hypertensives). Symptoms of orthostatic hypotension include dizziness, lightheadedness, and falling. Further evaluation and referral to the client’s primary care provider are necessary.

**Nursing 3320 Holistic Health Assessment**

**OSCE 1**

**Grade Sheet – Detailed Instructions for BP Evaluation**

**Fall 2015**

Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty completing Competency Evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OSCE I BP Form subject to revision by Lead Teacher & Instructors prior to OSCE

\*Denotes items that are considered critical elements and must be met to successfully meet competency requirements.

|  |  |  |  |
| --- | --- | --- | --- |
| **Skill** | **Grade** | **Comments** | |
| **Blood Pressure:**  \*Hand Hygiene  \*Identifies patient  \*Explains procedure  \*Correctly uses stethoscope/equipment  \*Correctly sizes BP cuff and places in correct location  The width of the rubber bladder should equal 40% of the circumference of the person’s arm. The length of the bladder should equal 80% of the circumference of the arm.  Correctly palpates systolic blood pressure and reports within 12 bpm (point at which pulse reappears).  \*Performs procedure correctly and identifies BP +/- 4 systolic and +/- 4 diastolic |  | BP Setting | Student Reading |
| **PASS/FAIL** | \_\_\_\_\_\_\_ |  |  |

**FOCUSED ASSESSMENT ACTIVITIES**

**Lab Overview: Focused (or Problem-Oriented) Assessment**

Nurses perform a variety of assessments in the clinical setting. It is essential that nurses distinguish between situations requiring a complete assessment from a focused or problem-centered assessment. According to Weber and Kelley, p. 5, a focused or problem-centered assessment is performed when a comprehensive database exists for a client who comes to the health care agency with a specific health concern.

There are **2** Focused Assessment Assignments. Each will include a case scenario with clinical information provided. Your assignment is to identify additional subjective health history data to obtain, and which physical exam skills need to be performed to accurately assess the patient related to their presenting problem, and your rationale. **These Focused Assessments are activities which you will work on during lab and submit at the end of lab**. See the Rubric below. Focused Assessment #1 is due in Lab **Week 7 (October 13/14/15).** Focused Assessment #2 is due in lab **Week 12 (November 17/18/19).**

**Performance Objective:**

* Given a case scenario, describe the necessary elements to perform a focused assessment
* List additional history questions (subjective data) to ask the client based on the scenario given
* Identify the specific physical assessment techniques (objective data) necessary to be performed.

**Instructions:**

1. Review the Case Scenario.

2. Write out additional history questions you would like to have the patient answer.

3. Write out all assessments to be performed pertinent to the condition listed in the scenario.

NOTE: In a hospital setting, during a shift assessment, nurses should routinely perform certain assessments, regardless of the presenting symptom (heart and lung sounds, etc.). List these assessments if they relate specifically to the presenting symptom, but ADDITIONALLY, list the specific focused elements related to the symptom.

**This assignment is required to meet your Essential Skills and is for credit as completed during Lab. The Rubric below is a guide to help you complete the assignment.**

|  |  |  |
| --- | --- | --- |
| **Tasks** | **Target** | **Unacceptable** |
| Subjective Data included | Included 3-4 questions to expand on symptom | Less than 3 questions included |
| Objective Data included | Identified at least 3 of the elements listed on Instructor Key | Significant information missing. |
| Rationale | State rationale for inclusion of subjective/objective data. | Not complete or missing. |

**Symptom Analysis (COLDSPA)**

**Lab Overview: Symptom Analysis (COLDSPA)**

One of your first assignments in lab is to complete a Symptom Analysis on a problem assigned to you by your Lab Instructor. Refer to p. 20 in Weber and Kelley, (Box 2-4) and the example below.

Performing a symptom analysis or expanding on the “History of Present Health Concern” takes into account several aspects of the health problem and asks questions whose answers can provide a detailed description of the concern.

First encourage the client to explain the health problem or symptom in as much detail as possible by focusing on the onset, progression, and duration of the problem; signs and symptoms and related problems; and what the client perceives as causing the problem. Also ask about what makes the problem better, worse, what treatments have been tried and what effect the problem has had on daily life or lifestyle. Also include questions to ask what expectations are held regarding recovery and the client’s ability to provide self-care.

Because there are many characteristics to be explored for each symptom, a memory tool or mnemonic “COLDSPA” can help with remembering to include all essential elements. The client’s answers to the questions provide the nurse with a great deal of information about the client’s problem.

COLDSPA can be used for pain AS WELL AS other symptoms.

**Example using COLDSPA for a symptom of back pain:**

|  |  |  |  |
| --- | --- | --- | --- |
| **C** | Character | Describe the sign or symptom (feeling, appearance, sound, smell, or taste, if applicable). **Example**: **“What does the pain feel like?”** | |
| **O** | Onset | When did it begin? **Example: “When did this pain start?”** | |
| **L** | Location | Where is the pain? Does it radiate? Does it occur anywhere else? **Example: “Where does it hurt the most? Does it radiate or go to any other part of your body?”** | |
| **D** | Duration | How long does it last? Does it recur? **Example: How long does the pain last? Does it come and go or is it constant?”** | |
| **S** | Severity | How bad is it? How much does it bother you?  **Example: “How intense is the pain? Rate it on a scale of 0-10.”**: | |
| **P** | Pattern | What makes it better or worse? **Example: “What makes your back pain worse or better? Are there any treatments you have tried that relive the pain?”** | |
| **A** | [2 parts here]  Associated Factors  How it affects the client. | 2 parts here:  Associated Factors question - What other symptoms occur with it? What do you think caused it to start? **Example: Do you have any other problems that seem related to your back pain?** | How does it affect you? **Example: How does this pain affect your life and daily activities?”** |

**Example using COLDSPA for a symptom of insomnia (inability to sleep)**

|  |  |  |  |
| --- | --- | --- | --- |
| **C** | Character | Describe the sign or symptom (feeling, appearance, sound, smell, or taste, if applicable). **Example: “Describe the nature of your inability to sleep? [To expand on this, you could ask whether they have difficulty getting to sleep, or staying asleep, or waking frequently.]** | |
| **O** | Onset | When did it begin? **Example: When did you first start having problems with sleeping?”** | |
| **L** | Location | NOT APPLICABLE FOR THIS SYMPTOM. | |
| **D** | Duration | How long does it last? Does it recur? **Example: “How long have you been having a problem with sleeping?”** | |
| **S** | Severity | How bad is it? How much does it bother you?  **Example: “How bad is your problem with not sleeping?” or “How much does your sleeping problem bother you?”** | |
| **P** | Pattern | What makes it better or worse? **Example: “Does anything make your sleep problem better or worse?” “Have you tried any treatments or medications to help your sleep problem?”** | |
| **A** | [2 parts here]  Associated Factors  How it affects the client. | 2 parts here:  Associated Factors question - What other symptoms occur with it? What do you think caused it to start? **Example: Besides difficulty sleeping, are there other symptoms such as headaches, or dizziness? What do you think caused this?”** | How does it affect you? **Example: “How does the insomnia affect your life?”** |

**Performance Objective:**

* Collect and analyze data regarding a symptom to obtain a history of present illness (symptom analysis) using the COLDSPA mnemonic.
* For the “A” element, include 2 questions to address BOTH Associated Factors AND how the problem affects the client.

There are 2 Symptom Analysis Assignments. Symptom Analysis #1 is a hypothetical assignment, completed on your Assessment Lab Partner. (See Rubric below).

**Instructions for Symptom Analysis #1**

There will be **two** Symptom Analysis assignments. For Symptom Analysis #1, you will be assigned a problem (example “Shoulder Pain”) and your partner will hypothetically “have the symptom.” You will ask questions to perform a symptom analysis. See the text for example questions for your symptom. Write out your questions and their answers. Your partner will make up hypothetical answers to go with the symptom. **SYMPTOM ANALYSIS #1 IS GRADED ACCORDING TO THE RUBRIC BELOW (Worth 1% out of a total 13% Lab Assignments).** Symptom Analysis #1 is **due in Blackboard** **Week 4 at 2359 (September 25/26/27). Part of this assignment is following directions according to the Rubric.**

The COLDSPA mnemonic is often used to analyze the symptom of “pain”, however it can be used for any symptom, including shortness of breath, weakness, nausea, vomiting, etc. Some elements may not be pertinent – ask your Lab Instructor about this. See the following example below.

**Rubric for Symptom Analysis #1 (Total 1%).**

**NOTE**: If this paper is not typed, it will not be graded and 10 points will be deducted. If the paper is re-submitted within 24 hours of notification, the assignment will be graded starting at 90%.

|  |  |  |
| --- | --- | --- |
| **Tasks** | **Correct** | **Not Correct** |
| Symptom Analysis  Detailed Questions and Answers  100 points total | **1**. Sufficient questions for each element of the mnemonic, as needed to give sufficient detail to analyze the symptom (COLDSPA) see below.  **C**: CHARACTER: Include 1 question and 1 answer **(5 points each, 10 total.**  **O**: ONSET: Include 1 question and 1 answer **(5 points each 10 points total).**  **L**: LOCATION: Include 1 question and 1 answer EACH about location and whether the symptom radiates **(2 points each, 8 points total).** If does not apply, state that specifically.  **D**: DURATION: Include at least 1 question and 1 answer EACH to address how long the symptom lasts and whether it recurs **(4 points each, 16 points total).**  **S**: Must include at least 1 question and 1 answer **4 points each, 8 points total**  **P**: Must include at least 1 question and 1 answer EACH about what makes better/worse and about treatments tried, **5 points each, 20 total.**  **A**: Must ask 1 question and 1 answer EACH about other symptoms AND about how the symptom affects you **5 points each, 20 total.** | 1. Incomplete information. Not asking sufficient questions to adequately analyze the symptom.  Answers not included (0) points.  2. Questions and answers written in the third person or summarizing what the person said (0) points.  3. Not using quotation marks for EACH question and EACH answer (0) points.  **4. VERY IMPORTANT: If you ask an incorrect question, you will RECEIVE NO CREDIT for either the question or the answer. (Example: Asking a question about “C”—character in the “A” Associated factors section. You would not be able to get the correct answer).** |
|  | **2.** The questions and answers MUST BE WRITTEN in the first person, a conversation, NOT A SUMMARY OF THEIR INFORMATION **4 points total.** |  |
|  | 3. QUOTATIONS must be used for each question and each answer. **4 points total** |  |

|  |
| --- |
| **Exercise Gear**  **ALL STUDENTS WILL BE WEARING PATIENT GOWNS WHEN BEING ASSESSED DURING THE PHYSICAL EXAM. Students should wear exercise gear underneath the patient gown, which includes shorts or loose-fitting sweat pants that can easily be rolled up to thigh level. Undershirts are optional for males. For females, sports bras, loose-fitting regular bras or tank top are suggested underneath the gown.**  During the assessment, the goal is to easily access the area being examined for the week/body system. For instance during the week of skin, hair and nails, the top of legs/thighs MUST be easily accessed to examine skin. For the week of Peripheral Vascular, the same is true to assess peripheral pulses. For abdomen, students must access the abdomen.  See specific guidelines in each week for proper draping and maintaining privacy of the patient being examined. |

**OSCE 1 Overview**

What will you do?

**Lab Overview (OSCE 1): (Pass/Fail – MUST SCORE 70% TO PASS)**

OSCE 1 consists of competency in performing manual blood pressure AND performing physical examination skills learned in the Assessment lab, on a standardized patient. (In the event of student illness, or inability to complete the OSCE on the scheduled day, on a standardized patient, the student will work with the Lead Teacher and Clinical Lab Instructor to make alternate arrangements to complete the OSCE. Students will be expected to perform the examinations, verbalize normal/abnormal findings and document the findings of the exam. OSCE 1 serves as an indicator of how the student has integrated knowledge and skills at mid-term, and shows the student’s preparation to perform assessments in the clinical setting.

**The Blood Pressure Competency must be successfully PASSED prior to the student being able to participate in OSCE 1** (Exceptions must be approved by the Lead Teacher and/or Clinical Lab Instructor). Taking a manual blood pressure is an essential skill which is demonstrated and then practiced in the clinical setting. **Failure to successfully complete the Blood Pressure Competency prior to mid-term will result in the student demonstrating failing clinical performance at mid-term. This will result in clinical and subsequent course failure, OR the student may withdraw before the drop date to avoid a course failure.**

OSCEs will be timed. The Clinical Lab Instructor will use the detailed Rubric to assign points corresponding to required actions. Certain elements of the OSCE exam, including patient safety, or correct procedure, may be weighted more heavily than others. Failure to include or successfully perform these items will result in failure of the OSCE.

**Equipment**: Each student is responsible for knowing how to operate his/her equipment in the lab and for check-off/OSCEs.

Students will document the findings of their OSCE in Blackboard, and submit to the Clinical Lab Instructor, for feedback.

Students must perform OSCE 1 with a minimum score of **70%**, prior to mid-term to be successful in meeting course requirements at mid-term, and to progress to the 2nd half of the semester. **OSCE 1 (mid-term OSCE) serves as an indicator of how the student has integrated knowledge and skills at mid-term, shows the student is prepared to perform assessments in the clinical setting in the clinical course, and** **indicates areas for improvement to focus on for the 2nd half of the semester.**

Students who score greater than 70% but less than 90% should work with their Clinical Lab Instructor to plan activities to improve proficiency to be successful on OSCE 2. Students who score less than 70% on OSCE 1 MUST meet with the Clinical Instructor and/or the Lead Teacher to plan remediation activities. A Performance Improvement Plan will be implemented detailing the actions required to prepare the student for the second attempt at the OSCE. A second attempt to perform OSCE 1 (mid-term OSCE) with a score of 70% or greater will be scheduled prior to the drop date.

**Failure to successfully complete OSCE 1 with a score of at least 70% on two attempts, will result**

**in the student failing clinically, and failure of the course. A failing grade will be recorded, or the**

**student may withdraw from the course prior to the drop date, to avoid a course failure.**

OSCE 1 is scheduled for **October 20/21/22.** You will schedule a time to perform the OSCE.

**SEE DETAILED RUBRIC POSTED IN BLACKBOARD PRIOR TO THE OSCE.**

**Performance Objectives:**

* Apply the knowledge and skills learned to perform a patient assessment, including general survey, skin, lungs, heart and peripheral vascular system, musculoskeletal system, and abdomen.
* Perform the assessment including safety elements (patient identification, hand hygiene, explanation of procedures, provision of privacy and confidentiality), and professional performance).
* Document your physical assessment findings using correct terminology.

**OSCE 1 (Mid-Term OSCE) Instructions:**

1. OSCE 1 consists of the following elements:

A. Blood Pressure (performed prior to the day of the OSCE)

B. General status/general survey

C. Assessment of skin.

D. Assessment of the lungs and respiratory system

E. Assessment of cardiovascular and peripheral vascular system

F. Assessment of the Musculoskeletal system

G. Assessment of the Abdomen

H. Elements of patient safety, environment and equipment including as detailed above.

1) Patient Identification

2) Hand hygiene

3) Explanation of procedures to patient

4) Recognition of ordered elements present (correct IV fluid infusing; oxygen

cannula in place, etc. (The detailed OSCE Rubric will be posted on Blackboard

prior to the OSCE for your review).

I. Overall Professional Performance

2. Students will demonstrate correct technique for taking a manual blood pressure, using the technique taught in class. This portion of the OSCE will be done prior to the actual day of the OSCE.

**The Blood Pressure Competency must be successfully** **PASSED** **prior to the student being able to participate in the OSCE. (Exceptions must be approved by the Lead Teacher and/or Clinical Lab Instructor).** The Blood Pressure competency consists of assessment procedures and patient safety aspects. Certain of the elements are designated as “Critical Elements”. The student must successfully complete ALL Critical Elements to pass the Blood Pressure Competency. Students who are unsuccessful on the first attempt will be provided remediation and a second attempt. **Failure to successfully complete the Blood Pressure Competency prior to mid-term will result in the student demonstrating failing clinical performance at mid-term, resulting in clinical and subsequent course failure, OR the student can withdraw before the drop date to avoid a course failure.**

3. OSCE 1 is scored out of 100 points. A detailed rubric will be provided for students in Blackboard.

4. Performance of the OSCE 1 skills are based on safety and assessment techniques. Points are awarded for correct performance and deducted for incorrect performance. Certain elements, including patient safety, may be weighted more heavily than others. Failure to include or successfully perform these items will result in failure of the OSCE. (See detailed Rubric provided on Blackboard).

5. Students will verbalize assessment findings during the OSCE.

6. The OSCE 1 **WILL be timed** (Time limit will be announced prior to OSCE)

7. **Students MUST REFRAIN from discussing any aspect of the OSCE experience with others, including details of the OSCE scenarios and faculty grading. Further, students working with standardized patients during OSCEs MUST keep patient information confidential and private, and must not share information with others.**

8. The student may use a blank OSCE form (which may be limited to major headings of

exam procedures) during the exam, but may only view it a limited number of times (**TO BE DETERMINED PRIOR TO THE OSCE**) so the student does not rely too heavily on the written instructions. Students **may** be allowed to view the OSCE form prior to completing the OSCE, however points may be deducted for procedures performed after viewing the form.

9. Students will complete the OSCE on the day of their lab (October 20/21/22). Documentation of assessment findings are due in **Blackboard at 2359 on the same day of the OSCE.**

**NOTE:** OSCEs are often evaluated by the Assessment Lab Faculty the student is assigned to, HOWEVER circumstances may dictate that students are evaluated by a different Lab Instructor.

**Symptom Analysis #2 and Assessment**

**Instructions for Symptom Analysis #2 and Assessment**

\*\*These Guidelines are subject to revision.\*\*

Now that you have completed a hypothetical symptom analysis on your lab partner, you will apply the knowledge to an actual patient in the clinical setting. The **second** symptom analysis must be completed on an **actual patient** experiencing an actual symptom, in your Foundations clinical experience this semester.

**NOTE:**

1. If you are not enrolled in Clinical Nursing Foundations, check with the Lead Teacher for assistance).
2. If your clinical site is an extended care facility, check with your Assessment instructor about how to select a patient and modify the symptom analysis form for data that might be difficult for you to find. Under lab or diagnostic findings, if none are available to you, in order to receive credit for this section, you MUST describe tests that might have been performed in an acute care setting. See instructor for clarification.

Choose one of your patients that you care for, and perform a symptom analysis on one of their major symptoms. Be familiar with the types of questions to ask for each symptom. Use the COLDSPA to guide your questions. **You will write out the questions you asked your client, and their answers and use quotation marks, to show this was a conversation, not a summary of responses.**

As part of your essential skills, you are learning to interpret and analyze abnormal data. For this symptom analysis, you will include, in addition to the Symptom Analysis questions, a summary including:

1. Demographic data: Patient’s age and Date of Birth, Gender, Ethnicity and Past Medical History
2. Symptom being analyzed must be cleared stated (typically should be different from the medical diagnosis).
3. The client’s medical diagnosis
4. Pertinent lab work or diagnostic tests

HINT: Please check carefully. In many cases, such as when a patient goes to surgery, you would expect some lab work, an x-ray, etc. Please be careful before you report “none found”.

If your patient does not have information available in the chart, they are probably not a good choice for this assignment.

1. Assessment findings (includes basic assessment, plus expanded assessment on area involved in symptom).
2. Your analysis of the symptom and patient’s condition in 3 or more sentences.

**Examples of Lab and Diagnostic Data**: These are examples only. You may find others.

| Symptom | Lab or Diagnostic Tests |
| --- | --- |
| Pain | What type pain?  If fracture—look for x-ray or CT  If tumor—look for CT, ultrasound, MRI  If sickle-cell anemia—CBC with cell morphology (sickle-cell)  If surgical: what surgical procedure – then look for appropriate  tests, i.e. hysterectomy, splenectomy, appendectomy,  look for CT scans, sonograms |
| Nausea/vomiting | Medical diagnosis will help, i.e.:  Pancreatitis (pancreatic enzymes such as lipase, amylase)  Upper abdominal pain or jaundice (pancreatic or liver enzymes or Upper GI series)  Chemotherapy (CT or diagnostic test for tumor)  Cholecystitis (CT, ultrasound)  GERD (EGD)  Pregnancy test if female of child-bearing age  Obstruction (CT scan) |
| Dyspnea | Diagnosis helps – suspected pneumonia, COPD, CHF, bronchitis, asthma, etc.  Chest x-ray, CT scan, EKG and 12-lead EKG, ABGs, exercise treadmill test, Echocardiogram, pulmonary function testing, BNP. |
| Fatigue | Look at Diagnosis – CHF, musculoskeletal disorder, obesity, anemia, hypothyroidism, diabetes.  CBC – H&H, sleep studies, blood glucose, thyroid function tests, |
| Weakness | Musculoskeletal issues – x-rays; anemia-CBC, related to chemotherapy—CT scans, MRI, ultrasound, EKG; if consider stroke—CT or MRI, blood chemistries, thyroid hormones, CK enzymes, electromyography (EMG), |
| Numbness/tingling | Based on the etiology, diagnosis. (Stroke, Guillain-Barre, Multiple sclerosis). MRIs, CT scans. |

The Symptom Analysis #2 and Assessment **MUST BE COMPLETED** in order to meet criteria for one of your “Essential Skills”. See the Rubric below for complete grading guidelines. **(Worth 5% of total 13% of Lab Assignments).** Symptom Analysis #2 and Assessment is due in Blackboard at 2359 Week 14 (December 4/5/6).

Symptom Analysis #2 is a synthesis assignment meaning it incorporates elements of all major concepts from Holistic Health Assessment (health history, physical exam, and interpretation and analysis of normal and abnormal findings). **This assignment must be passed with a score of 70% or greater to be successful in the course.** **If a student scores less than 70%, he/she should work with his clinical instructor to discuss corrections or additional work needed to successfully complete this assignment with a 70% or greater. The maximum score a student may make on the second attempt is 70%. If the student does not score 70% or greater on the second submission, that constitutes failure of the course.**

**Performance Objective:**

* Collect and analyze data regarding a symptom to obtain a history of present illness (symptom analysis) using the PQRSTU mnemonic.
* Include **at least one question** that addresses EITHER the **Setting** of the Symptom OR **Associated Factors** (See information on Symptom Analysis #1).
* Analyze clinical assessment and diagnostic findings.
* Provide an APA approved Title Page and Reference page.

Use the following format and rubric to guide your work for Symptom Analysis #2. **Symptom Analysis #2 is worth 5% of the total 13%** Lab Assignments. This Assignment will be submitted (uploaded) to Blackboard. You will be given instructions on how to accomplish this.

**NOTE**: If this assignment is not typed and in the table format shown below, it will not be graded and 10 points will be deducted. If the paper is re-submitted within 24 hours of notification, the paper will be graded starting at 90%. Assignments not resubmitted within the 24 hours will be assessed a -10 point penalty (or 10%) per day for up to two late days. After that, the clinical instructor will not accept the assignment. The instructor will grade the assignment as a zero.

**Instructions:**

1. Locate the Assignment and Template in Week 14 Assignments. Print this form and take with you to Clinical to use to gather information. When finished, compile the information, type and submit when due.

2. You MUST include a UTA approved cover page (See sample in Blackboard) and you must usethe table format below, included as the 2nd page. (-5 points for failure to include cover page).

3. Use correct grammar and spelling. (1-5 points deducted for poor spelling/grammar).

A. 1-2 errors: 1 point deduction

B. 3-4 errors: 3 point deduction

C. Greater than 4 errors: 5 point deduction.

4. Attach a Reference page. This should be titled “References”, double spaced, following APA format. (-3 points for failure to include Reference page).

These points are deducted from the 100 points detailed below.

**[Include UTA Approved Title Page Here prior to the first page of the**

**Assignment Template]**

| **Instructions and rubric** | **Patient information** |
| --- | --- |
| **General Patient Information (10 pt. total)** |  |
| **Symptom**  **(NOT THE MEDICAL**  **DIAGNOSIS) (1 pt.)**  NOTE: List and address only ONE  symptom – be specific (Ex. pain in  the right knee). |  |
| **Demographics (1 pt. each, 2 total)**  Patient Age  Date of Birth |  |
| **Medical Diagnosis:**  **(1 pt.)** |  |
| **Past Medical History (1 pt. each—4**  **Total)**  Serious or Chronic Illness  Past Surgeries  Allergies  Smoking and Alcohol Use |  |
| **Patient Gender and Ethnicity (1 pt.**  **each—2 Total)**  Gender  Ethnicity |  |
| **History of Present Illness (COLDSPA): (18 points total)**  Sufficient questions for each element of the mnemonic, as needed to give sufficient detail to analyze the symptom (see below) | **MUST WRITE OUT QUESTIONS AND ANSWERS. Write Q&A in first person using quotation marks.** |
| **Formatting**  **Use of First Person and Quotation Marks** | For each section below, **NO credit** given for questions and answers written in the third person or summarizing what the person said.  Failure to use quotation marks in any section (COLDSPA element) will result in deduction of **half of the points for that section**. |
| **C**  At least 1 question and 1 answer (**1 pt. for each Q & each A—2 pts. Total**) |  |
| **O**  At least **1** question and **1** answer (**1** pt. for each Q & each A—**2 pts. Total**) |  |
| **L**  At least **2 questions and 2 answers**. Include both location and radiation, if appropriate. If not applicable, state NA (i.e. dyspnea). (**1/2 pt**. for each Q & each A—**2 pts. Total**) |  |
| **D**  Two questions & 2 answers (duration and recurrence) **(1/2 pt**. for each Q & each A—**2 pts. Total)** |  |
| **S**  At least 1 question and 1 answer.  (**1 pt. for** each Q and each A – 2 **pts. Total)** |  |
| **P**  At least 2 questions and 2 answers (address what makes the symptom better/worse AND treatments tried)  **(1 pts. for each Q & each A**—**4 pts Total**) |  |
| **A**  At least 2 questions and 2 answers (address associated factors AND how the symptom affects the client/patient) **1 points each, 4 total.** |  |
| **Laboratory/Diagnostic Data** |  |
| **Pertinent Laboratory or Diagnostic Data: (1 point each, 5 pts. total)**  **(See examples in the Instructions for this assignment. This must relate to the SYMPTOM). If there is no lab or diagnostic data, this is NOT a good patient to choose for this assignment.**  A. Name of lab or diagnostic test  B. Briefly describe the test and  purpose  C. Normal ranges or findings  D. Your results  E.What lab or diagnostic tests, if any, were NOT present, that you would like to have had (If none, indicate that).  **(Note: Normal ranges or findings of diagnostic tests. If a numeric value, include the normal parameters. If other diagnostic tests, i.e. CT scan, ultrasound, the normal finding would be that no disease/tumor, etc. was found.)** |  |
| **Assessment Findings:**  **(Not from the History & Physical, but YOUR findings from your assessment) (55 Total)** | Points will be awarded on the basis of completeness of pertinent information for your patient. Follow the format—do not insert different assessment forms or formats in order to receive credit. Use correct medical terminology. **Note**: Please include findings in the SPECIFIC area where listed on the general headings below. Any deviation from this could result in loss of points. |
| **1. Vital Signs**: (**1 point each**, **5**  **points total**)  Temperature (route, finding)  Blood pressure  Pulse  Respirations/O2 sat if available  Pain rating  **(5 items)** |  |
| **2. Height, Weight and BMI**:  (**3 items, 1 pt. each**, **3 points total**) |  |
| **3. Mental Status:** (**1 point each**, **5 points total**)  Level of Consciousness  Orientation  Behavior/affect  Recent/remote memory  Speech clear  **(5 items)** |  |
| **4. General Survey**: **(1 point each, 4**  **points total)**  Appears stated age/or not  Distress present/not present  Physical development/body build  Posture/gait  **(4 items)** |  |
| **5. Skin, hair & nails:** **(10 points**  **total)**  Skin:  General skin coloration AND  presence/absence of color  variations cyanosis, pallor,  erythema or jaundice) **(2)**  Temperature Upper/Lower **(2)**  Skin Breakdown/Incisions/  Wounds/Dressings/lesions  (present/not present & describe)(**3**)  **(**Must address all that apply to your patient or state not present).  Hair: Describe appearance **(1)**  Nails: Capillary refill Upper/  Lower **(2)**  **(5 items)** |  |
| **6. HEENT:** (**1 point each, 4 points**  **total)**  Facial features symmetric  Able to see nurse  Able to hear and respond  Able to breathe/patent air flow  **(4 items)** |  |
| **7. Lungs/Respiratory:** (**5 points**  **total)**  Breath sounds (location,  finding) **(2)**  Quality and effort of breathing **(1)**  Accessory muscles/position used for  breathing **(1)**  Address if Oxygen used/device  chest tubes /None used **(1)**  (**4 items**) |  |
| **8. Heart & Vascular:** **(1 point each,**  **7 points total)**  Heart sounds actually heard  (S1, S2) **(1)**  Presence/absence of extra  sounds or murmurs **(1)**  Heart rhythm **(1)**  Radial pulses **(1)**  Dorsalis pedis/posterior tibial  Pulses **(1)**  Presence/absence of edema **(1)**  Appearance of skin on legs/feet  (lesions, ulcers, abnormal  coloration **(1)**  **7 items** |  |
| **9.** **Abdomen:**  **(4 points total**)  Bowel sounds (location, finding) (1)  Palpation (report finding or  state not performed) (1)    Appearance of skin: coloration,  striae, scars, distention, vascularity  or state none (2)  **3 items** |  |
| **10.** **Musculoskeletal**: (**6 points total**)  Range of motion upper/lower **(2)**  Muscle strength upper/lower **(2)**  Gait/ambulatory/bedrest **(1)**  Assistive devices/none **(1)**  **4 items** |  |
| **11. Neurological: 2 points**  [Most areas addressed under  mental status or HEENT.  NO NEED to routinely assess  cranial nerves, reflexes or  sensory function unless  specifically indicated. If no  other findings to document,  state “ALL NEUROLOGIC  ASSESSMENT  DOCUMENTED  ELSEWHERE”.  **(Items per individual patient need.)** |  |
| **Analysis (8 pts. Total)**  Your analysis of the Symptom and Patient’s Condition. How do you put it together? Does it make sense? |  |
| 1. How do(es) the assessment data fit with the lab/diagnostic findings. (For example, in your opinion, does the patient’s pain rating seem to correlate with the nature of the fracture as shown in the x-ray?) (**1 pt.)** |  |
| 2. Would you have expected the assessment findings to be the same as what they were, or to be different? Explain this. **(1 pt.)** |  |
| 3. In a paragraph of at least 3 sentences, describe the pathophysiology involved in your patient’s MEDICAL diagnosis and give a reference (**textbook, CDC website, REPUTABLE source**. (Source, year, & page #. **LIST here AND on reference page**). (**3 pts.)** |  |
| 4. Write at least a 3-4 sentence summary of your analysis of these findings. Must be substantive with details. (**3 pts**.) |  |
| **Nursing Diagnosis and Interventions ( 4 pt. total)** |  |
| Nursing Diagnosis (Actual dx. with 3 parts or Risk dx. with 2 parts) (**2 points**)  **The Nursing Diagnosis should address the SYMPTOM or the RISK.** |  |
| Two (2) Nursing Interventions that are SPECIFIC to your nursing diagnosis.  (1 pt. each—**2 total**) |  |

**Student Teaching of Lab Skills**

**Lab Overview: Student Teaching of Lab Skills**

During lab on **EITHER** the week of Neuro (Week 10) or Eyes/Ears (Week 11), each student will teach a specific skill(s) and/or **one or more** of the Cranial Nerves to the other students in the lab group. The skill(s) will be assigned 1-2 weeks prior to this lab. The student is to be familiar with how to perform the skill, and will **DEMONSTRATE on his/her partner, i.e. performing the rapid alternating movements test, Snellen chart, etc.**

**Demonstrate means to perform/show/act out ANY skill assigned or ANY cranial nerve. It is not sufficient to simply explain verbally.** It is not necessary to do research outside of the textbook, but the student is expected to be able to demonstrate the skill.

Some form of **handout is required for your instructor and a copy for each student in your lab group**, but can be simple. Be creative in your presentation and handout, but especially avoid simple copy from the text. Try to devise creative strategies to assist memory of the skill. This will be completed in lab either **Week 10 (November 3/4/5) OR Week 11 (November 10/11/12)** as assigned by your Instructor. The handouts are due hard copy to your Instructor at the time teaching is performed.

**Performance Objective:**

* Demonstrate knowledge of assessment techniques for the neurologic**/sensory** system.
* Use effective teaching strategies, including a simple handout.
* Refine oral communication skills.

**Instructions:**

**1.** Use your textbook or other resources to prepare. **NOTE: You must list/cite your source**

**for information AND any graphics/pictures on the handout. Include source (book,**

**website, etc.) and year.** If using Weber and Kelley, include page numbers.

2. Practice the skill(s) you will teach to your lab group and provide accurate information. Use

effective teaching strategies. **You must DEMONSTRATE/SHOW/ACT OUT your**

**teaching of how to perform the skill AND/OR CRANIAL NERVES**. It is not sufficient to

simply explain verbally. Information MUST be accurate and detailed.

3. Prepare a simple handout for each member of the lab and your Lab Instructor. **DO NOT**

**COPY WORD FOR WORD FROM WEBER AND KELLEY**. Use your own words or

summary for techniques/findings. Use creativity to maximize the number of points received

and to enhance learning.

4. Include references for your handout, either on the handout itself or on a separate page.

5. Student MUST be prepared to FULLY demonstrate on the date assigned, and handout

complete, when called upon.

6. Practice speaking clearly, with audible voice volume, and using correct words and medical

terminology.

**This assignment is scored per the Rubric below (worth 2%). Teaching Lab Skills**

|  |  |  |  |
| --- | --- | --- | --- |
| Task | Correct | Partial Credit | Incorrect |
| Teaching performed on assigned date/time  40 points | Demonstrates ALL assigned skills/cranial nerves/tests assigned during lab on assigned date; correct techniques DEMONSTRATED. (This means shows & presents to lab group how to assess assigned skill and/or cranial nerve.  **(40 POINTS)** | Student not prepared on assigned date/time, but presents at a later date/time, at Instructor’s discretion.  **(30 POINTS)**  Student fails to DEMONSTRATE one or more assigned skills or cranial nerves. Note: simply verbalizing or describing the technique is NOT sufficient)  **(20 points)** | Teaching not presented.  **(0 points)** |
| Information Detailed and Accurate  40 points | **ACCURATE information**. Info must be accurate AND thorough/detailed. Must NOT contradict Weber and Kelley.  **(40 points)** | Most information accurate. 1-2 errors **(30 points)**  Major errors (3-5 inaccurate teaching points **(20 points)** | Greater than 5 inaccurate teaching points.  **(0 points)** |
| Handout Provided  10 points | 1. Name on handout **(1 pt.)**  2. Excellent Personal creativity **(5 points)**  3. Reference for content AND graphics (include source & year) **(4 points)**  **(10 points)** | 1. NA  2. Some creativity, such as helpful hints to help remember how to perform, other creative strategies. **(0-4 points).**  3. No partial credit. | 1. Handout not provided  2. See middle column.  3. No references  **(0 points)** |
| Communication  10 points | Student speaks clearly, with sufficient voice volume to be heard and understood, correct word usage, grasp of medical terminology.  **(10 points)** | Some difficulty with speaking clearly or sufficient volume. Using incorrect words; unfamiliar with medical terms.  **(5-8 points)** | Student does not present orally.  **(0 points)** |

**OSCE 2 Instructions**

**Lab Overview (OSCE 2): (Pass/Fail)**

**OSCE 2** consists of performing physical examination skills learned in the Assessment lab, on a student partner. The student will be expected to perform the examination technique, verbalize normal or abnormal findings, and document the findings of the exam. These skills include many elements of a hospital shift assessment, but will typically be performed on your lab partner. You will again include certain critical safety elements of patient identification, hand hygiene, explanation of procedures, and patient privacy and confidentiality, as well as the actual assessment. OSCE 2 is designed to validate that each student is able to perform a shift assessment in a timely manner, prior to the completion of the course.

OSCEs will be timed. The Clinical Lab Instructor will use the detailed Rubric to assign points corresponding to required actions. Certain elements of the OSCE exam, including patient safety, or correct procedure, may be weighted more heavily than others. Failure to include or successfully perform these items will result in failure of the OSCE.

**Equipment**: Each student is responsible for knowing how to operate his/her equipment in the lab and for check offs/OSCEs.

Students will document the findings of their OSCE in Blackboard, and submit to the Lab Clinical Instructor for feedback.

Students must perform the OSCE within the time limit with a **minimum score of 90%** to demonstrate successful achievement of learning objectives, and pass the course. OSCEs are scored on the student’s ability to perform assessment techniques in an organized manner. A detailed Rubric will be provided. **The student will have 2 attempts to successfully pass OSCE 2.** Students who score less than 90% on the first attempt MUST meet with the Lead Teacher and/or Clinical Lab Instructor to plan remediation activities to help the student improve clinical skills, and to assist with successful performance on the second attempt. (This may include additional practice or written assignments). The second attempt will be observed by two faculty members. The second attempt MAY be videotaped.

Should the student be unsuccessful after 2 attempts to perform the OSCE with a minimum score of 90%, **the student will fail the OSCE. This results in a clinical/lab failure and subsequent course failure. The OSCE 2 is entered in the Gradebook as a Pass/Fail.**

OSCE 2 is scheduled for **November 24th and 25th. NOTE: This is Thanksgiving week. Thursday labs must coordinate a time on either Tuesday or Wednesday to complete.** You will schedule a time to perform the OSCE with your lab partner and instructor.

**SEE DETAILED RUBRIC POSTED IN BLACKBOARD PRIOR TO THE OSCE.**

**Performance Objectives:**

* Apply the knowledge and skills learned to perform a patient assessment, including pain assessment, assessment of head, neck, neurologic system, lungs, heart and peripheral vascular system, abdomen, and musculoskeletal system.
* Perform the assessment including safety elements (patient identification, hand hygiene, explanation of procedures, provision of privacy and confidentiality), and professional performance).
* Document your physical assessment findings using correct terminology.

**Instructions:**

1. OSCE 2 is scored out of 100 points, and must be passed with a score of at least 90%.

2. OSCE 2 consists of the following elements:

A. Introduction and Critical Safety Elements

1) Patient Identification

2) Hand hygiene

3) Explanation of procedures to patient

B. Pain Assessment

C. Head and Neck/Neuro

D. Assessment of the Lungs

E. Assessment of the Heart and Peripheral vascular system

F. Assessment of the Abdomen

G. Assessment of Skin.

H. Assessment of the Musculoskeletal/Neuro

I. Overall Professional Performance

H. Elements of patient safety, environment and equipment including as detailed above.

3. To prepare for OSCE 2, you should have practiced the OSCE assessment at least 3 times prior to the OSCE.

4. Performance of the OSCE 2 skills are based on safety and assessment techniques. **Points are awarded for correct performance and deducted for incorrect performance. Certain elements, including patient safety, may be weighted more heavily than others. Failure to include or successfully perform these items will result in failure of OSCE 2.**

5. Student will verbalize assessment findings.

6. The OSCE 2 **WILL be timed** (Time limit will be announced prior to OSCE).

7. A detailed rubric will be provided (See Blackboard). The student may use a blank OSCE form (which may be limited to major headings of exam procedures) during the exam, but may only view it a limited number of times (**TO BE DETERMINED PRIOR TO THE OSCE**) so the student does not rely too heavily on the written instructions. Students **may** be allowed to view the OSCE form prior to completing the OSCE, however points may be deducted for procedures performed after viewing the form.

8. **Students must perform the OSCE within the time limit with a minimum score of 90% to demonstrate successful achievement of learning objectives, and pass the course, as stated above.**

9. **Students are NOT to discuss any aspect of the OSCE experience with others, including details of the OSCE scenarios and faculty grading. Further, students MUST maintain all health information and exam findings confidential and private, and must not share information with others.**

10. The student will have 2 attempts to successfully pass OSCE 2. The second attempt will be observed by two faculty members. The second attempt MAY be videotaped. **Should the student be unsuccessful on OSCE 2 second attempt, then the student will fail the OSCE** because of inability to meet course outcomes. **This results in a clinical/lab failure and subsequent course failure.**

11. Students will document their assessment findings **in Blackboard** **due at 2359 November 29th (due to the Thanksgiving holiday).**

**NOTE:** OSCEs are often evaluated by the Assessment Lab Faculty the student is assigned to, HOWEVER circumstances may dictate that students are evaluated by a different Lab Instructor.

**20 BP Assignment (Manual BP)**

**Lab Overview: Blood Pressures and Vital Signs** Blood pressure and vital signs are some of the most important skills you will perform for patients. It is important to master the techniques early. See the procedure below for measuring **manua**l blood pressure, which combines information from the Weber and Kelley text, plus other sources to clarify the techniques.

You will first perform a blood pressure competency (See this Assignment and form). Once you have demonstrated competency, you will work to complete this assignment to develop proficiency in performing vital signs, and in particular, **MANUAL** blood pressures. As discussed in class, many facilities are moving towards all electronic blood pressure equipment, which may or may not always be the best choice, given a patient with an irregular heart rhythm or certain other health conditions.

It is essential that you maintain the skill of manual blood pressure. As you have read, blood pressure and vital signs vary with age and gender. Note the measurements that you obtain in individuals across the lifespan and analyze your findings.

See **Procedure for Measuring Manual Blood Pressure** (Reviewed 8-16-15) in an earlier section of this Course Guide.

**Performance Objective:**

* Demonstrate correct technique to measure the blood pressure, pulse and respirations of selected individuals across the lifespan.
* Recognize normal and abnormal vital signs.
* Analyze the findings from your sample of 20 individuals and answer the questions from this activity, including those individuals with hypertension, and taking medication.

**Instructions**

**VERY IMPORTANT:** There are 2 parts to this Assignment. The first is the actual performance of obtaining manual blood pressure on the individual. The second is the Analysis of your findings. See

details below. This entire assignment must be Typed in order to be graded. If not typed, it will be returned to you. (See rubric).

**PART I**

1. Measure and record the manual blood pressure, pulse and respirations on **20 individuals**. (You will not be performing temperature as part of this assignment). List the client initials and gender of each individual, and indicate whether or not they take blood pressure medication. You may complete vital signs on classmates in lab. **You are on the honor system about completing this assignment.** The remainder of blood pressures can be performed on patients in the hospital, family or friends.

2. In order to count an individual as part of the **20**, you must have all vital signs and information.

3. List the client initials, BP, pulse, and respirations under the appropriate age in the table that follows. A. Note if the blood pressure constitutes pre-hypertension by \*

B. Note if the blood pressure constitutes hypertension by \*\*

*C.* ***BP must be recorded in EVEN NUMBERS ONLY***

**PART II**

1. Compute the mean (average) systolic blood pressure, diastolic blood pressure, pulse, and respirations for each of the 3 groups.

2. Type your responses to the following questions.

A. What pattern of variation in blood pressure and pulse occurs with age, based on

your measurements? Describe the trend that you noted.

B. In which age group did you experience the greatest difficulty in obtaining an

accurate blood pressure? What factors contributed to this?

C. Do any of the blood pressure values you obtained denote pre-hypertension or

hypertension?

D. In a brief paragraph, discuss the importance of obtaining absolutely accurate vital sign measurements?

**NOTE**: You may obtain blood pressures during lab on classmates and instructors, as well as patients in the hospital clinical setting. **Students MUST NOT take blood pressures/vital signs in a community setting, where you are UNSUPERVISED (i.e. church, setting up a booth at a grocery store, or other setting)**. Students must not look for opportunities in the community, unless directly supervised by a nurse or instructor, in a setting with referral guidelines in place for patients with abnormal findings. You MUST have a specified number of individuals in each group, but a **TOTAL of 20 Blood Pressures**

**This Assignment is due in Blackboard at 2359 Week 12 (November 20/21/22). (See rubric below and is worth 2% of the total lab grade of 13%).**

20 MANUAL Blood Pressures & Vital Signs Assignment

PART I of II (Must add up to 20)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinical Instructor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*See Note below

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Age: 18-30 years (Pt. Initial) | Gender | B/P  EVEN #s | P | Respirations | Taking BP Medication? |
| **Must have at least 8 in this group** | Must have at least 8 in this group | Must have at least 8 in this group | Must have at least 8 in this group | Must have at least 8 in this group | Must have at least 8 in this group |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| 5. |  |  |  |  |  |
| 6. |  |  |  |  |  |
| 7. |  |  |  |  |  |
| 8. |  |  |  |  |  |
| **Means** |  |  |  |  |  |
| Age: 31-60 years (Pt. Initial) | Gender | B/P  EVEN #s | P | Respirations | Taking BP Medication? |
| **Must have at least 8 in this group** | Must have at least 8 in this group | Must have at least 8 in this group | Must have at least 8 in this group | Must have at least 8 in this group | Must have at least 8 in this group |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| 5. |  |  |  |  |  |
| 6. |  |  |  |  |  |
| 7. |  |  |  |  |  |
| 8. |  |  |  |  |  |
| **Means** |  |  |  |  |  |
| Age Over 60  (Pt. Initial) | Gender | B/P  EVEN #s | P | Respirations | Taking BP Medication? |
| **Must have at least 4 in this group** | Must have at least 4 in this group | Must have at least 4 in this group | Must have at least 4 in this group | Must have at least 4 in this group | Must have at least 4 in this group |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| **Means** |  |  |  |  |  |

|  |
| --- |
| **PART II OF II – Analysis of Information** |
| 1. Compute the mean (average) systolic blood pressure, diastolic blood pressure, pulse, and respirations for each of the 3 groups. Either list here or along with the data in Part I. **(6 points)** |
| 2. What pattern of variation in blood pressure and pulse occurs with age, based on your measurements? Describe the trend that you noted. Must include substantive information, at least 3 sentences. **(3 points)** |
| 3. Do any of the blood pressure values you obtained denote hypertension? PLACE AN ASTERISK (\*) BESIDE THOSE BP THAT ARE CONSIDERED PRE-HYPERTENSIVE. PLACE TWO ASTERISKS (\*\*) BESIDE THOSE BP THAT ARE CONSIDERED HYPERTENSIVE. **(2 points)** |
| 4. In which age group did you experience the greatest difficulty in obtaining an accurate blood pressure? What factors contributed to this? Must give substantive information. **(3 points)** |
| 5. In a brief paragraph, discuss the importance of obtaining absolutely accurate vital sign measurements? **(20 points – must contain at least 50 words and cite one reference (textbook or scholarly website).** |

**Rubric for Manual BP Assignment**

**This assignment is worth 2% (out of a total 13% Lab Assignments).**

**THIS ASSIGNMENT MUST BE TYPED. IF NOT TYPED, IT WILL NOT BE ACCEPTED & WILL BE RETURNED TO YOU AND 10 POINTS DEDUCTED. If RESUBMITTED within 24 hours of notification, the assignment will be graded starting at 90%.** Assignments not resubmitted within the 24 hours will be assessed a -10 point penalty (or 10%) per day for up to two late days. After that, the clinical instructor will not accept the assignment and record a grade of 0.

|  |  |  |  |
| --- | --- | --- | --- |
| **Tasks** | **Correct** | **Partial Credit** | **Incorrect** |
| **Info obtained for 20 individuals.**  **60 points** | **1. BP, VS and medication information completed on 20 individuals.**  **2 points for each individual. Must have all elements to receive credit. (40 points)**  **2. BP recorded in even numbers (20 points)** | **1. Complete info for 15-19 individuals**  **(30-38 points—2 points each)**  **2. If 1 BP recorded in odd numbers, (15 points awarded)** | **1. Less than 15 individuals (0 points)**  **2. 2 or more BP recorded in odd numbers (-20 points)** |
| **Information for individuals in all age groups.**  **6 points** | **1. Correct number of individuals required for each group.**  **(6 points).** | **1. One group with less than required # of individuals.**  **(3 points).** | **2 groups with less than 5 individuals**  **(0 points).** |
| **Computations of means of vital signs.**  **6 points** | **Information complete**  **(2 pts. ea)**  **(Total 6 pts.)** | **NA** | **Information not complete.**  **(0 points).** |
| **Analysis of information**  **28 points** | **1. Q#2 re: Analysis of variations (3 points)**  **2. Q#3 ID of patients with hypertension or pre-hypertension (2 points)**  **3. Q#4 difficulties encountered (3 points)**  **4. Q#5 Discussion paragraph (20 points) Include: discussion and reference.** | **NA** |  |

**Culture Assignments**

**Cultural and Spiritual Self-Assessment (FICA)**

**Overview: Cultural and Spiritual Self-Assessment (Note 2 parts to this Assignment Cultural Assessment AND Spiritual Assessment)** The first step to developing cultural competency is to understand your own heritage on the basis of cultural values, beliefs, attitudes, and practices relevant to health and illness. In order to provide optimal care for others, nurses must first develop self-awareness of these concepts. You will complete the Personal Cultural History questionnaire thoughtfully and reflect upon understanding the perspectives of others **(worth 1% of the grade).**

The comprehensive discussion on Cultural Competence will be scheduled for Week 15, however there will be a brief podcast prior to the due date for this assignment, focusing on understanding your own cultural beliefs, in order to allow you to **complete the assignment Week 8**.

**Learning Objectives:**

* As the first step to cultural competency, explore beliefs and attitudes of your own culture.
* Describe factors or people that have influenced your cultural beliefs and interactions with people of other cultures.
* Describe the role religion and/or spirituality plays in your life.

**Instructions:**

Please see the Rubric that follows below. You should answer the 5 Cultural Assessment questions and 4 FICA Questions below. **Please prepare this in a typed paper, noting the format requirements as detailed in the Rubric.** This assignment is **due IN BLACKBOARD at 2359 (October 23/24/25).**

**Cultural Assessment**

“In order to provide optimal care for others, one must first understand oneself.” Answer this Personal Cultural History questionnaire thoughtfully prior to class.

1. **Describe the earliest memory you have of an experience with a person (people) of a cultural or ethnic group different from your own.**
2. **Who or what has had the most influence in the formation of your attitudes and opinions about people of different cultural groups? In what way?**
3. **What influences in your experiences have led to the development of positive and negative feelings about your own cultural heritage and background?**
4. **What changes, if any, would you like to make to your own attitudes or experiences in relation to people of other ethnic or cultural groups?**
5. **Describe an experience in your life when you feel you were discriminated against for any reason, not necessarily because of your culture.**

**Spiritual Assessment**

In order to effectively assess the spiritual needs of others, one must be comfortable with one’s own spiritual beliefs. You will complete the **Spiritual Assessment Tool (FICA)** to articulate your beliefs and reflect upon assessing the spiritual needs of others.

An acronym can be used to remember what to ask in a spiritual history:

**F**: Faith or belief

**I**: Importance and influence

**C:** Community

**A:** Address

Complete this **Spiritual Assessment Tool (FICA)** prior to class. Answer the questions thoroughly. We will build upon this in lab. In order to effectively assess the spiritual needs of others, one must be comfortable with one’s own spiritual beliefs.

**F:** What is your **faith** or belief? Do you consider yourself spiritual or religious? What things do you believe in that give meaning to your life?

**I:** Is it **important** in your life? What influence does it have on how you take care of yourself? How have your beliefs influenced your behavior during illness? What role do your beliefs play in regaining health?

**C:** Are you part of a spiritual religious **community**? Is this of support to you and how? Is there a person or group of people you really love or who are really important to you?

**A:** How would you like your healthcare provider to **address** these issues in your healthcare?

**Rubric for Culture and Spiritual Self-Assessment**

Use this rubric to guide your work. (Score out of 100 points) **1% of total 13% Lab Assignment**

**THIS ASSIGNMENT MUST BE TYPED. IF NOT TYPED, IT WILL NOT BE ACCEPTED & WILL BE RETURNED TO YOU AND 10 POINTS DEDUCTED. If RESUBMITTED within 24 hours of notification, the assignment will be graded starting at 90%.** Assignments not resubmitted within the 24 hours will be assessed a -10 point penalty (or 10%) per day for up to two late days. After that, the clinical instructor will not accept the assignment and record a grade of 0.

|  |  |  |  |
| --- | --- | --- | --- |
| **Tasks** | **Target (Max points)** | **Acceptable/Partial Credit** | **Unacceptable** |
| **Format and Grammar**  (max 10 points) | 1. Student’s name on each page. (1 point)  2. Faculty’s name on each page. (1 point)  3. Paper typed (2)  4. APA Title page included (2)  5. Correct spelling and grammar (4 points). | #1-4 NA  5. 1-2 errors (2 points) | Student or Faculty Name not on paper  (0 points)  3. Paper handwritten (0 points).  4. Cover page not provided (0 points)  5. Multiple errors (0 points) |
| **Culture Questions #1-5**  (max 50 points) | Questions are answered substantively **AND** (at least 3 sentences each).  (10 points awarded each question) | 1. Questions are answered with 2 sentences (8 points awarded each)  2. Questions answered with 1 sentence (3 points awarded each) | Questions left blank.  (10 points deducted per question). |
| **FICA Questions (4 questions)**  (max 40 points) | Questions are answered substantively **AND** (at least 3 sentences).  (10 points awarded each) | 1. Questions are answered with 2 sentences (8 points awarded each)  2. Questions answered with 1 sentence (3 points awarded each). | Questions left blank.  (10 points deducted per question) |

**Cultural Assessment of Client (Subjective and Objective)**

**Assessment of Culture:** According to Weber and Kelley (2014), the main purposes of assessing culture in a health care setting are to:

1. Learn about the client’s beliefs and usual behaviors associated with health and illness, including beliefs about disease causes, caregiving, expected treatments (both Western medicine and folk practices), daily hygiene, food preferences and rituals, and religious beliefs relative to health care.

2. To compare and contrast the client’s beliefs and practices to standard Western health care.

3. To compare the client’s beliefs and practices with those of other persons from a similar cultural background (to avoid stereotyping); and

4. To assess the client’s health relative to diseases prevalent in the specific cultural group.

Cultural assessment can mean adding various elements of cultural assessment to the overall health assessment. Elements that may be addressed include value orientation, beliefs about human nature, beliefs about relationship with nature, beliefs about the purpose of life, beliefs about health, illness, and healing, beliefs about what causes disease, beliefs about health, and beliefs about who serves in the role of healer or what practices bring about healing.

There will be a brief assessment of culture that will be completed during the final lab during Week 15. (Template to be provided). This will be completed in hard copy and turned in at the end of lab. See additional details in Blackboard.

**Learning Objectives:**

* Explain how culture plays a role to affect health status
* Discuss the role of cultural competence of the caregiver in nursing assessment;
* Describe the parts of a cultural assessment;
* Complete a cultural assessment interview on a person in your lab group.

**Instructions:**

Work with your partner during lab OR you may choose to interview another peer in lab who is of a different cultural background than you. The assignment is to complete these the Cultural Assessment in lab **December 8/9/10**. **This assignment is worth 1% of total 13% Lab Assignment grade.**

References

Houghton, P.M. & Houghton, T.J. (2009). *APA: The easy way! A quick and simplified guide*

*to the APA writing style* (2nd ed.). Flint, MI: Baker College.

Kleinman, A. (1980). *Patients and healers in the context of culture*. Thesis. Berkeley, CA:

University of California Press.

Weber, J.R. and Kelley, J.H. (2014), Health Assessment in Nursing, 5th edition, Wolters Kluwer

Health, Lippincott, Williams and Wilkins, Philadelphia.

Wilson, S. & Giddens, J. (2009). *Health assessment for nursing practice* (4th ed.). St. Louis,

MO: Elsevier.

**Make-Up Lab Sheet**

**If you should miss a lab, take this paper to your lab instructor ASAP.**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessment lab instructor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your lab must be made up by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Make-up forms must be in to your Lab Instructor by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was missed in the lab:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. You are required to complete any e-learning material, and/or lab workbook assignments, view DVDs, etc., as directed by the Assessment Lab Instructor, that relate to what you missed in class.
2. You are required to complete all of the workbook pages corresponding to your missed work and fill them out correctly as part of your make-up time. Your lab instructor/GTA will check them and sign them off as completed and correct. The workbook pages should be attached to this form, which you will then return to your clinical instructor.
3. The lab instructor/GTA will check your technique on whatever assessments were necessary for the lab.
4. You are required to copy this paper and take it with you when you make up your lab. You are also responsible for returning this sheet to your lab instructor.
5. If there are no workbook pages, you may be required to write a paper on the topic provided by your lab instructor, with instructions provided at that time. This will be due within one week of the absence.
6. In some instances you may be asked to attend OSCE practice to make up all or part of missed lab time.

Date student made up the lab: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Performance evaluation by Instructor and/or GTA:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor or GTA Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date this sheet returned to Lab Instructor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_