

**UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
GRADUATE SCHOOL OF NURSING**

COURSE OUTLINE

Course Title: Advanced Health Assessment Postmasters ANP Students

Course Number: GSN 0631

Credits: 4 semester hours (over two semesters)
(90 hours of Clinical the Second Semester)

Prerequisites: None

Placement: First Year/ Fall/Spring/ Semesters

Course Director: Christine Engstrom MS, CS, CRNP, AOCN

Faculty: Diane Seibert, MS, WHCNP, ANP
Will also include the names of lecturing faculty in the course once they are confirmed.

COURSE DESCRIPTION

This course has been developed for students who have a clinical nurse specialist background and who are functioning in an advanced practice role. The elements of basic history taking and physical examination techniques are reviewed, and the advanced skills such as examination of male and female genitalia, fundoscopic examination of the eye, basic radiography, EKG interpretation, laboratory evaluations and other skills needed to function effectively as an Adult Nurse practitioner are addressed. Performance skills as well as ability to document clinical findings are evaluated in both a monitored laboratory setting the first semester followed by 90 hours of clinical time the second semester.

Advanced Health Assessment is a foundational course offered to post masters adult nurse practitioner students during their first year of study. Lectures will be held every other week for two hours the first semester. On the alternating week participating VA sites will be responsible for delivering a one-hour lecture on a pre-assigned "special topics" list throughout the first semester. This will afford specialist at the various sites to share their expertise with the other participating sites.

There will be a two-hour clinical lab held every other week in conjunction with the lecture where techniques discussed in class will be demonstrated by the lead preceptor and students will practice these techniques on one another using a case study approach. Variations commonly seen in the geriatric populations will be highlighted as appropriate, as will cultural and racial assessment variations. The case will be presented to the lead preceptor and the students' ability to demonstrate they have mastered the clinical skills discussed in class that week will be evaluated by the lead preceptor. The laboratory

sessions will be used to assist students in perfecting their clinical assessment skills as well as developing their abilities to communicate patient findings in both written and verbal formats.

Students will be required to successfully perform (passing grade of 80%) a videotaped history and physical examination before they progress to the clinical setting.

The knowledge gained in the laboratory session will be augmented in the second semester with ninety hours of clinical practice. During this portion of the course students will interview, examine, and organize an assessment of patients in the outpatient setting. A verbal report will be given to the faculty preceptor followed by written documentation of clinical findings. All students are to successfully complete a male genital examination, a complete examination of a female patient including pelvic and breast examination, observe a fundoscopic examination on a dilated eye, and perform a comprehensive history and physical examination by the end of the clinical rotation. There will also be self-paced seminars on EKG interpretation, Basic Radiology interpretation and evaluation of laboratory studies, including a bright field lab experience that need to be completed during the second semester. All of the pre-identified clinical objectives for this course need to be successfully completed before the students can progress to the next course in the program.

Health maintenance and disease prevention is considered foundational topics throughout the curriculum. The Putting Prevention into Practice (PPIP) is addressed, as appropriate to the topics under discussion.

The course challenges the student's critical thinking and problem solving abilities as they apply to the outpatient setting. The purpose of the course is to refresh the postmasters' adult nurse practitioner student in health assessment skills and develop their advanced health assessment skills so they will be prepared to succeed in the clinical setting.

RATIONALE

Comprehensive assessment requires a synthesis of the components of advanced health assessment skills. The synthesis of this information leads to a statement of the wellness/illness status of the individual. Adult nurse practitioners need to know how to assess changes in the health status of patients and respond to these changes as they affect the over all well being of the patient over the life span.

COURSE OBJECTIVES

At the conclusion of this course the student will be able to:

1. Assess the health status of patients:
 - A. Demonstrate skillful interviewing with patients. Obtain appropriate age-related comprehensive data from patients, families, team members, records, and other sources necessary for a complete database.
 - B. Perform an age-appropriate comprehensive physical examination of clients.
 - C. Record a complete history and physical examination using the problem-oriented medical record system formats.
 - D. Report verbally and in writing accurate, concise, organized, and pertinent information about patient evaluations.

GSN Terminal Objective 1. a, b, c and 5. a, b, c, and d

2. Analyze health assessment data to determine or monitor health status over time.

GSN Terminal Objective 5. a, b, c, and d

3. Differentiate between the components of a complete health history and an episodic history of present illness.

GSN Terminal Objective 1. c

4. Demonstrate appropriate use of the techniques of inspection, palpation, percussion, and auscultation throughout the physical exam.

GSN Terminal Objective 5. a and d

5. Differentiate normal from abnormal findings in the adult age group and multi- cultures.

GSN Terminal Objective 5. a and d

6. Utilize appropriate equipment accurately and efficiently in performing physical assessment including demonstration of proper techniques in doing a GYN examination, Male genitalia examination, and breast examination

GSN Terminal Objective 5. a and d

7. Incorporate disease detection/prevention into patient assessment

GSN Terminal Objective 5. a, b, c, and d

8. Interpret epidemiological data as relevant to clinical practice.

GSN Terminal Objective 5. a and b

9. Analyze and interpret patterns of growth, developmental stages, and behavior as they apply to primary care practice.

GSN Terminal Objective 5. a and b

10. Analyze the interaction of the individual, the illness, and family dynamics as they affect health status.

GSN Terminal Objective 5. a ,b, c, and d

TEACHING METHODS

Lecture

Readings

Video tapes (*Jarvis*)

CD ROM (Heart Sounds, Breath Sounds)

Demonstration of physical exam techniques (Lab)

Student demonstration of techniques (Lab)

Case presentations/critical-thinking exercises/problem solving

Student video-taped physical examination

EVALUATION METHODS

1. Attendance to all lectures and laboratory sessions with evidence of preparation through high quality participation.
2. Students will preview *Jarvis* video tapes of physical examinations and read all assignments prior to class and come to the lab prepared to demonstrate exam of system under discussion.

3. Student must give satisfactory demonstration in assessment lab prior to clinical experience.
4. Using guidelines outlined by the faculty, case presentations will be given by students in the lab setting in order to assist with refining and demonstrating their communication abilities.
5. Students will be responsible for on-going write-ups of physical exam findings using the SOAP format. Every time new physical examination content is introduced in class, a complete write-up of that system is due to the lead preceptor by the following lab for their review and comments.
6. Students will take two examinations that will test didactic material presented in the lectures.
7. Each student will video tape a complete physical exam using a standardized patient at his or her site. Students will evaluate their performance with their lead preceptors using a criterion-referenced evaluation checklist for both the health history and the physical examination.
8. A written journal will be maintained during the 90-hour clinical experience. The student is to bring the journal to clinic each week and it should include the following:
 - a. Critical Elements for complete PE form
 - b. Students objectives for that specific day in clinic
 - c. Clinical Log Summary (see attached copy)
 - d. Student Skills Check of List
 - e. Preceptor comments from observations of clinical experience, this can be written at the bottom of the Clinical Log Summary sheet at the end of each clinical day, should include constructive feedback to students that they can work on at next clinical experience.

Three notes using the SOAP format will be graded when the student is in the clinical setting (1 comprehensive, 2 episodic).

EVALUATION & GRADING:

1. Didactic:

I. Exams (2) 20%each	Total:	40%
II. Laboratory write-ups (5% each) (1comprehensive/2 episodic)	Total:	15%

2. Clinical:

I. Comprehensive write-up (1)*	Total: 10%
II. Episodic notes (2) @ 5% *	Total: 10%
III. <i>Clinical Log</i>	Total: 10%
IV. <i>Clinical Quiz</i>	Total: 5%
V. <i>Video taped physical exam (1)</i>	Total: 10%
	<u>Total: 100%</u>

You may choose to take a Pass/Fail on the 1 comprehensive and the episodic notes. This process will be explained in the class.

Textbooks:

Required:

Jarvis, Carolyn. Physical Examination and Health Assessment, Third Ed., Philadelphia: W.B. Saunders, Company 2000.

Jarvis Videotaped Assessment Series

The following Fitzgerald Taped Series:

Laboratory Interpretation

Basic ECG Interpretation

Advanced ECG Interpretation

Basic Radiographic Interpretation

Recommended:

Report of U.S. Preventive Services Task Force. Clinician's Handbook of Preventive Services: Put Prevention into Practice, Second Ed., U.S. Government Printing Office, 1998.

DeGowin/DeGowin. Bedside Diagnostic Exam, MacMillian, Co.

Davis. How to Quickly & Accurately Master ECG. (2nd ed.). Lippincott Raven.

Goldstein, B & Goldstein, A. Practical Dermatology (2nd ed.) Mosby 1997

McRae, R. Clinical Orthopaedic Examination (4th ed.) Churchill Livingstone 1997.

SPRING 2002

CLINICAL INFORMATION SHEET

Welcome to your FIRST clinical nursing course in the VA/DoD Post-Masters ANP Certificate program at the Uniformed Services University of the Health Sciences (USUHS). Your clinical rotation will not start until the spring of 2002. However the faculty has prepared this fact sheet to clarify details related to the clinical requirements for this course.

Equipment:

You will need a stethoscope with a reversible bell and diaphragm. If you will be purchasing a new one at this time, be sure and check to see that the ear pieces are **comfortable** for your individual ear shape. Prices range from approximately \$30.00 to as much as \$150.00 for a good quality model. Tuning fork, reflex hammer, and ophthalmoscopes/otoscope are also required. If your preceptor has this equipment available, and with their permission, you may use the equipment at the site.

Uniform:

Students should wear a white lab coat unless otherwise advised by their preceptor.

Name Tags:

When the student is seeing patients in the student role they should wear a name tag with the following information displayed.

Jane Doe, RN(include appropriate graduate credential)
USUHS
Post-Masters ANP Certificate program

Professional Liability Insurance:

Students can purchase their own liability insurance, if so desired. Clinical placements are permitted only within a VA health care facility and therefore, additional liability insurance may not be necessary. Please discuss with your VA site coordinator.

Library:

A library is available at each VA site.

Computers:

Each student will need access to a computer. Students should learn how to use the Internet, electronic databases and other computerized technology.

Risks Inherent in Clinical Practice:

Please refer to VA materials about the risks inherent in nursing practice. All students should be immunized against Hepatitis B. Universal precautions should be reviewed.

CLINICAL JOURNAL

Directions: This journal, brought to each clinical visit, should consist of a 3 - ring binder/folder and contain the following documents:

Log Evaluation Checklist:

1. Lead preceptor will give student written feedback using this form at each time the log is reviewed
2. One (1) SOAP or clinical note should be reviewed for every block of time the student spends in the clinical setting. The log evaluation checklist can be utilized to give the student written feedback and a letter grade should be assigned each week.

Clinical Log Includes:

1. Critical elements for complete History and PE
2. Student objectives for that clinical day
3. Clinical Log Summary:
This form is to be distributed to the student to copy, as many as needed, for the clinical journal. The log consists of a brief clinical summary of the patient problem, demographics, diagnosis, and plan for each clinical encounter throughout the semester. It is to be used by the student to track his/her progress and by the preceptor to determine that each student is getting the number and variety of patients to meet course objectives.
4. Skills Checklist
5. Preceptors evaluation and student self evaluation of their clinical experience, reactions, and/or concerns

The log should be neat and easy to read.

Lead preceptors should review the log weekly

COURSE REQUIREMENTS
Spring 2002

The students' clinical experience commences the week of January 14th 2002. Students must have successfully completed the Fall semester with a B (80%) average or better in this course to progress. Students are required to rotate through the G/U clinic to get experience doing digital rectal examinations, the GYN clinic, to get experience performing a complete GYN examination including the breast examination, and the eye clinic to get experience performing funduscopic examinations on dilated pupils. The rest of the clinical experiences can be negotiated between the student and the lead preceptor.

Other clinics that might afford good assessment experiences include Dermatology, Physical therapy, Ear, Nose, and Throat, Cardiology, Neurology, Respiratory Therapy to mention a few. Students are required to record the patients they see on the clinical log form and to write an episodic SOAP on all patients they see. The lead preceptor should review these notes during the clinical experience and give constructive comments made to assist the student in improving their documentation skills. Students can select 3 notes for grading, one comprehensive and 2 episodic.

In addition to the clinical experience students will be required to complete 4 self paced assessment tapes on Laboratory, Basic and Advanced ECG, and Radiology assessment. There will also be a bright field lab experience coordinated by the lead preceptor and the laboratory personnel at the VA site that students must attend. There will be clinical quiz on this information worth 5% of the total grade.

Maintaining communication with the lead preceptor will be of the utmost importance. In addition, students should discuss their role and expectations with their lead preceptor. If a student is experiencing any difficulty in meeting his/her clinical goals, please advise the clinical preceptor and the faculty coordinator/mentor as soon as possible.

If a student must miss clinical due to illness or emergency, each clinical hour missed must be made up over the course of the semester. **Please notify faculty and preceptors if absences are necessary.**

SOAP NOTE GRADING CRITERIA

Worth 5% points

2% points if completely correct:

Complete **SUBJECTIVE** note to include: Chief Complaint, History of Present illness, Any significant concurrent illnesses, **Significant** PMH, FH, SH, **all medications and allergies**

2% points if completely correct

Complete and organized **OBJECTIVE** data relevant to the CC, and HPI

.5% points if completely correct

ASSESSMENT including any relevant differential diagnosis that might apply

.5% points if completely correct

PLAN to include diagnostic testing, treatments and or medications (including dosage, route, duration, and refills), problem oriented teaching, and health promotion.

INSTRUCTIONS FOR PHYSICAL EXAMINATION VIDEO TAPE

1. The lead preceptor will obtain camera equipment from the medical media department (use a 60-minute videotape) and reserve an examination room (approximately 1 hour per student) complete with all the appropriate equipment to perform a complete history and physical examination.
2. The lead preceptor will be identifying a standardized patient who the student will be examining for this assignment. All students will use the same patient with the same exact PMH and PE.
3. It is the students' responsibility to make certain that the camera can record what you are doing. Make certain that the patient is visible in the areas to be examined; we cannot grade what we cannot see.
3. You have 45 minutes to complete this assignment. The camera is to run for 45 minutes and then be turned off. If you do not finish, you will be graded on what you did in that time and no more. The camera is not to be stopped or started during the exam time.
4. During the examination explain what you want the patient to do. Protect modesty. Patients will need to strip down (i.e. take off bra) but will not need to remove underpants or shorts.
5. You will do a complete examination with the exception of external genitalia, pelvic and rectal exam.
6. Completed videotape is to be evaluated together by the lead preceptor and the student using the following grading criteria: critical elements for a history, critical elements for a PE and the patient check off list. The graded videotape should be sent to Chris Engstrom at the USUHS no later than January 22th 2002. There will be 5% points deducted for each day the tape is late.

(See Grading Criteria for Video Tape)

**EVALUATION OF VIDEOTAPED PHYSICAL EXAMINATION
FOR 10% OF COURSE GRADE**

1. Each area on the designated physical evaluation form is worth **1 point** if performed. If all areas are performed and done correctly a total score of 100% is obtained.
2. Each critical element forgotten is **0 points**.
3. Each technique not performed correctly is **0.5 point** subtracted from your grade
4. A maximum of **5 points** will be given for overall presentation and organization.

The video tape is to be evaluated by:

- a. the student as a self assessment
- b. the standardized patient will evaluate the session, immediately post exam
- c. USUHS faculty
- d. Lead preceptor

REVIEW OF SYSTEMS QUESTIONS

GENERAL SURVEY

ADL, weight change, fatigue, fever/chills, night sweats, frequent infections, exercise tolerance, emotional state & current stressors, developmental problems (children/adolescents)

SKIN

Changes: (pigmentation, texture, moisture, and discoloration)
(rash, pruritis, pain, poor wound healing, unusual hair, scars, odor, growth, nail changes) sun exposure hx & use of sunscreens

HAIR

Change in: (amount—patchy or generalized loss, texture, character, use of dyes)

SCALP

Itching, infestations, rash, lumps, irregularities

HEAD

Headaches, sinus pain or tenderness, dizziness or vertigo or dysequilibrium

EYES

Vision change, inflammation, discharge, photophobia, eye pain, need for glasses or contact lenses.

Last: eye exam, glaucoma evaluation if 40 or over

EAR

Hearing change (decreased acuity, tinnitus), earache, obstruction, discharge

NOSE

Epistaxis, discharge, sinus pain, obstruction, postnasal drip, problems with smell, polyps, allergies

MOUTH and THROAT

Teeth: (pain, loose, denture problems)

Last dental exam

Gums: (bleeding, painful, non-healing ulcers)

Oral cavity: (lesions, painful tongue, change in taste, halitosis, h/o oral cancer)

Throat: (soreness, difficulty swallowing, and hoarseness)

Smoking history in pack/year

NECK

Stiffness, pain, swollen glands, limited motion, goiter, mass

BREAST

Lump, pain, nipple discharge (galactorrhea), skin changes (orange peel appearance, dimpling, retraction, nipple change), Size change, F/H of breast cancer in first degree female relative

Breast self-exam frequency?

Last mammogram; results—baseline age 35-40, Q2yrs after 40, then yearly after 50

RESPIRATORY

Hx respiratory problems, pain, shortness of breath, cough, wheeze, sputum, hemoptysis, hoarseness, paroxysmal nocturnal dyspnea, Hx smoking (pack/year), Hx recurrent respiratory Infections, Allergies, pleuritic pain

Last CXR; results—why done?

Last TB test; results—high risk?

CARDIOVASCULAR

Chest pain, palpitations, dyspnea, orthopnea, edema, murmurs, HTN, intermittent claudication, varicose veins, circulatory problems in hands &/or feet

Last EKG; results—baseline men age 40, women age 50; or strong family history

GASTROINTESTINAL

Dysphagia, odynophagia, hematemesis, melena, hematochezia, flatus, eructation, heartburn, abdominal pain, nausea, vomiting, diarrhea, constipation, jaundice, hemorrhoids, antacid use

Stools: Change in frequency, character, appearance (diameter), incontinence

Stool guaiac cards: results

Family history of colon cancer

Screening tests: flexible proctosigmoidoscopy or Colonoscopy—date/results/? f/u ordered

GENITOURINARY

Dysuria, urgency, frequency, hematuria, proteinuria, hesitancy, straining, oliguria, nocturia, incontinence, Hx of stone, sexual function, # sexual partners, contraception type & needs, Hx STD's

Last U/A; abnormalities

Special tests done on urinary tract—why?

MALE

Date last prostate exam; result

Last PSA; result

FEMALE

LMP, Age menarche, menstrual cycle: (interval, regularity, volume) PMS, Dysmenorrhea, amenorrhea, GYN surgery, age of menopause, post menopausal bleeding/spotting,

Menopausal Sx's: (hot flashes, vaginal dryness, mood swings)

Last Pap; date/results--?h/o abnormalities

HEMATOLOGICAL

Bleeding or bruising tendency, anemia. Hx blood disorder
CBC; date/results--? why done

LYMPHATIC

Enlarged or tender lymph nodes
HIV test; date & why done

MUSCULOSKELETAL

Joint pain, stiffness, swelling, inflammation, deformity, bone disease, fractures, weakness
(pattern: proximal vs. distal), muscle tenderness, history of back pain, radiculopathy, sciatica,
gait change, dislocations, exercise program, occupational environment

NEUROLOGICAL

Numbness, tingling, or other sensory changes, weakness, seizures, memory loss, dizziness or
vertigo or dysequilibrium, tremors/shakes, syncope, headache, LOC, disorientation

PSYCHIATRIC

Present mental status: depression, anxiety, irritability, insomnia (primary vs. secondary sleep
disorder), hallucinations, delusions, mood swings, suicidal ideation/attempts, homicidal ideation,
phobia's

Psychiatric History: Family history of psychiatric problems, psychotherapy, psychiatric
medications

ENDOCRINE

Goiter, tremor, polyphagia, polyuria, polydipsia, growth changes, heat/cold intolerance, sweats,
hormone therapy, hirsutism