Component II: Clinical Practice
Module A: Assessment
Topic 1: Examination

I. **Statement of Purpose**
To provide an overview of clinical ambulatory care practice and associated responsibilities for the Registered Nurse

II. **Terminology**
1. Acuity
2. Acute
3. Chronic
4. Cognitive
5. Crisis
6. Neglect
7. non-acute
8. orientation
9. Urgent

III. **Performance Standards**
1. Discuss the importance of pathophysiology and its impacts on patient outcomes
2. Identify the basic stages of growth and development in the Illness/Wellness continuum
3. Demonstrates a systematic and comprehensive patient assessment
4. Simulate the process of obtaining a patient's history and physical information
5. Formulate a nursing diagnosis

IV. **References**
1. American Heart Association, Advanced Life Support
http://www.heart.org/HEARTORG/CPRAndECC/HealthcareTraining/AdvancedCardiovascularLifeSupportACLS/Advanced-Cardiovascular-Life-Support-ACLS_UCM_001280_SubHomePage.jsp

2. Hurston PhD., Heidi, January, 2004, Growth and Development across the Lifespan – A Health Promotion Focus, Clinical Psychologist, Stanford University Medical Center, University of California at San Francisco, San Francisco, CA.

Content Outline Theory Objectives	
Objective 1 **Discuss the importance of pathophysiology and its impacts on patient outcomes** A. Assessment 1. Disease Process/Pathophysiology a. Patient assessment occurs through the use of critical thinking. 1) Includes disease specific knowledge which guides the nurses to determine the level of acuity and level of required intervention 2) Requirements include review of information from the patient, family members, care providers and clinical findings (e.g. lab and radiology results). 3) Interpret, analyze and evaluate the patient's condition based on the examination and interview. It is key to avoid judgments or conflicts associated with personal beliefs, life-style, religious beliefs or cultural understanding. 4) Perform a systematic review of cognitive, interpersonal and psychomotor skills also guide the care provider to an accurate and rapid focused assessment of the patient.	See Nursing Care of Infants and Children, Whaley & Wong's 5th edition 2010, Mosby. See Growth and Development across the Lifespan – A Health Promotion Focus by Heidi Hartston, PhD, Clinical Psychologist, Stanford University Medical Center: Assistant Clinical Professor, University of California at San Francisco, San Francisco, CA text- Jan-2010
Objective 2 **Identify the basic stages of growth and development in the Illness/Wellness continuum** A. Stages of growth and development across the lifespan 1. Is development continuous or discontinuous? 2. Some theorists believe that development is a smooth, continuous process. Individuals gradually add more of the same types of skills. 3. Other theorists think that development takes place in discontinuous stages. 4. Types of Psychosocial Development in infancy and early childhood a. Eric Erikson 1) One of the best known theories of personality in psychology. Erikson believed that personality develops in stages across the life span and was influenced by social experiences.	See Weber & Kelley, 2012; Health Assessment in Nursing.

1) Examples of Erikson's stages of development: Psychosocial Stages • Trust vs. Mistrust • Autonomy vs. Shame and Doubt • Initiative vs. Guilt • Inferiority vs. Industry • Identify vs. Role Confusion • Intimacy vs. Isolation • Generatively vs. Stagnation • Ego identity vs. Despair	Classroom discussions to list symptoms that could identify changes in patient acuity.
b. Sigmund Freud – One of the most influential and controversial figures in psychology; his views of childhood, personality, memory, sexuality and therapy have had a lasting impact on our culture. 1)The Conscious and Unconscious Mind • Freudian slip is a verbal or memory mistake that is believed to be linked to the unconscious mind. For example: calling his or her spouse by an ex's name, saying the wrong word. 2)The Id, Ego and Superego • Id - is the only component of personality that is present from birth • Super Ego – moral component of the psyche ◊ Doing what is morally right vs. a correct action ◊ For Example: ◊ Ego – is the component of personality that is responsible for dealing with reality ◊ "White Lies"	See American Heart Association, Advanced Life Support See Assessment for a crisis intervention – a triage assessment model by Rick Myer. July 2010
c. Jean Piaget – According to Piaget, intelligence enables individuals to make adaptations to the environment that increase the probability of survival, and through their behavior individuals establish and maintain equilibrium with the environment.	Classroom discussion to identify life threatening clinical conditions and vs. potential patient issues that could advance into more acute events.
○ Growth and Development is influenced by: 1) Early and Middle Childhood 2) Adolescence 3) Young, Middle and Late Adulthood 4) Geriatrics	**<u>Sample Teaching Activities</u>** Small group break out

5) Bereavement **Objective 3** **Demonstrates a systematic and comprehensive patient assessment** A, Head to Toe Assessment 1. Performing a rapid assessment a. The ability to perform adequate patient assessment during triage allows the nurse to perform a systematic and comprehensive approach that is critical in providing safe and effective patient care. 1) A, B, C, D, E provides an initial assessment a) Airway b) Breathing c) Circulation d) Disability e) Exposure 2) For example: if A, B, C and D are present, the higher brain functions have not yet been affected. 3) Objective & Subjective Data a) Objective finding can be seen, touched, heard, tasted or smelled b) Subjective finding is the medical story and information provided by the patient or other verbal source c) O, P, Q, R, S, T is an easy mnemonic to obtain critical information in a systemic manner to obtain patient status and is reflective of objective medical finding. • O – Onset • P – Proactive and palliative • Q – Quality • R – Region and radiation • S – Severity • T – Timing 4) Secondary Assessment consists of a focused medical history using the SAMPLE mnemonic and a thorough physical examination. SAMPLE stands for: a) Signs and Symptoms b) Allergies c) Medications d) Past medical History e) Last meal f) Events leading to presentation	discussions Role playing / interview between patient/health care provider Practice samples of legal documentation in a clinic setting Return demonstration of limited focused assessment for various clinical complaints Practice scenarios for in taking financial information Word search games or Jeopardy game

2. Prioritizing patient care needs
    a. Immediate / Emergency Needs
        1) Airway – impairment due to:
            a) Foreign, edema
            b) Drug reaction or overdose
            c) Seizure- febrile or sepsis
            d) Trauma – head injury, internal blood loss
        2) Breathing –
            a) Rapid, uncontrolled, laboring
                - Exceeding 20 in adult patients respirations per minute
                - Changes in skin color
                    ◊ Diaphoretic, anxious & fearful
        3) Circulation – mental status changes
            a) Unresponsive
            b) Skin dry, hot
            c) Blood pressure below normal
            d) Pupils dilated
            e) Pulse irregular or thready/weak
3. Recognizing subtle changes through verbal and nonverbal cues
    a. Physical Evidence (Objective findings)
        1) Facial Cue Changes:
            a) Facial droop on one side
                - Inability to smile
                - Tongue deviates to one side
                - Drooling
                - Speech impairment
                - Orientation to time and place
        2) Limb Cue Changes:
            a) Gait change
                - Dragging a foot
                - Inability to lift a leg from a sitting position
                - Listing gait to one side
                - Hand grasps are not equal in strength
        3) Cognition
            a) Orientation to place and time
                - Inability to track conversation
                - Staring into space – distant gaze
                - Short term memory impaired
                - Repetition in conversation
                - Anxiety, emotional outburst
                - Fearful and paranoid

4) Personal and Physical Neglect:
   a) Daily hygiene
      - Clothes – general ill kept
      - Changes in weight
      - Withdrawn – lives alone
      - Danger to self

4. Triaging crisis situations
   a. Define Crisis –
      1) Perception of an event or situation
      2) Developmental or Situational in nature
      3) Exceeds the person's immediately available resources and coping mechanisms.
   b. Developmental Crisis
      1) Related to growth and stages of life
         a) Marriage, childbirth, illness, expected death, pregnant teen
      2) Evaluation of available resources
         a) Community
         b) Family support
         c) Religious and cultural sources
   c. Situational Crisis
      1) Unexpected event in a person's life
      2) Sudden in nature and not controlled by the patient. (e.g. floods, earthquakes, hurricanes and human caused disasters (acts of violence, loss of job)
      3) Determine acute vs. urgent
         a) Acute is life threatening – immediate
            - Example: unresponsive
         b) Emergent requires – immediate but not 911
            - Example: closed fractures
         c) Urgent – resolve within 4-6 hrs
            - Example: urinary tract infection
      4) Medical Emergency
         a) Utilize Emergency Response Guidelines
            - A,B,C
            - O,P,Q,R,S,T
            - Critical thinking and focused problem solving skills
   d. Levels of care
      1) Age
         a) Older and younger patients at highest risks
         b) Teens vulnerable to depression and suicide
            - Risky behaviors
               ◊ Drugs

◊ Alcohol
◊ Peer pressure
◊ Gender identity
◊ Emotional events
◊ Pregnancy
◊ Rape

Objective 5
Simulate the process of obtaining a patient's history and physical information

A. Using the following case studies differentiate what data is given and what data is needed for a complete health assessment on all the clients.

Objective 6
Formulate a nursing diagnosis

A. Using the following case studies determine what nursing diagnosis applies to each scenario after the assessment and data collection are complete.

1. Use the international accepted nursing diagnoses in www.**nanda**.org

    a. Describe a patient's actual or potential response to a health problem.
    b. Clinical interventions are within the guidelines of the nurse's license.
    c. A nurse identifies: Nursing problems

SAMPLE CASE STUDIES

Case Study-Adult Medicine

Maria, a 28-year-old female, presents to your office approximately 5 weeks pregnant. Her first language is Spanish and she speaks only broken English. Her cousin came with her to translate. This is her first pregnancy. She believes she is current on her shots but has no vaccine or previous health records. She is living with a cousin and has good extended family support, but limited financial support and no transportation or phone. She is excited about the pregnancy and the prospect of being a mother. She reports having a few sexual partners with intermittent use of protection. Maria did mention that her previous doctor had her watching her diet and trying not to eat a lot of sugar but she is unclear as to why.

Vital signs:

BP 124/82, Pulse 84, Resp Rate 12, Height 63", Weight 190 pounds

Blood sugar done in office was 174.

1) Identify primary health concerns for Maria.
   (Pregnancy; potential STDs; elevated blood sugar-potential diabetes…)

2) What tests do you anticipate being ordered?
   (HCG, fasting blood sugar, hemoglobin A1C, CBC, Chem panel, STD screening including HIV; varicella titer, rubella titer, Hep B antibodies)

3) Identify Maria's barriers to receiving medical care.
   (Health literacy challenges; language barrier; lack of transportation; limited income; limited communication means i.e.-no phone)

4) Identify teaching needs.
   (Pregnancy; expectations, s/s of concern-when to seek care/call office, visit intervals, need for prenatal vitamins, when to repeat blood work, weight gain expectations, medications to avoid, etc.; blood sugar management – possible meds, diet, checking blood sugars at home; safe sex practices)

5) Develop a teaching plan, including: consideration of learning barriers, time allotted for each teaching point, learning activities, and how to measure teaching success/retention.

Case Study – Staff Education Need

It has come to the attention of the office that there are inconsistencies in how blood pressures are being taken by all the medical staff. Cuff size, not taking BP on bare arm, using alternative extremity, and inability to perform proper orthostatic blood pressures are all items of concern.

You have 25 medical assistants to educate, from very new to 18 years in practice. Two of the medical assistants have already stated they are not concerned with changing anything as they feel what they are doing is working.

You have a 30-minute slot at the staff meeting later this week to perform this education.

1) How will you prepare for this? (Printed materials, supplies, etc.).
2) How will you manage the resistance?
3) How will you organize your teaching? (Time breakdown, learning station, lecture, demo, etc.)
4) How will you assess effectiveness of education?

Case Study – Adolescent Medicine

Sam is a healthy 16-year-old athlete. He is having increasing reactions to bee stings including significant site swelling, site itching, and facial swelling with his most recent bee sting. Sam is being referred to an Allergist for workup and possible allergy shots for bee sting allergy. At his visit today, the PCP just prescribed an EpiPen 2-Pack to carry at all times. You have been given the job of educating Sam and his father about the EpiPen. Sam and his father are in a hurry to get back to school for practice and seem pre-occupied.

1) What information does Sam need to hear before he leaves the office?(How to recognize signs and symptoms of anaphylaxis; when to use EpiPen; how to use EpiPen)
2) What teaching tools could be used?
3) How will you measure the success of your teaching?

Case Study- Pediatric Medicine

Scenario #1

Call received from mother of 3-year-old child, stating that she is being "so bad". When asked what behavior the child was showing, mother stated that she was having little urinary accidents in her panties for the last week and was got getting to the bathroom in time to void. Was also having night time accidents. Child had been completely trained (day and night) for over 6 months without accidents. Child was only having urinary accidents and no trouble with bowel movements, was also complaining of "tummy pain".

1) What additional questions would be appropriate to ask mother regarding her concern?
2) What would be your considerations for the differential diagnosis for this patient?
   Mother was encouraged to make appointment to rule out urinary tract infection as children in this age group have atypical presentation, often with urinary accidents and tummy pain. On evaluation, urinalysis showed 4+ glucose as well as bacteria. Blood glucose found child's blood sugar to be 389. Child was immediately admitted to the hospital with the diagnosis of Type I diabetes.
3) Upon learning that her child would be admitted to the hospital, what information about the need for hospitalization would be important for the mother to have?
4) What emotions might the mother be experiencing upon learning the diagnosis and what an appropriate strategy is for the ambulatory care nurse.
5) What information could be provided to mother regarding expected toddler behavior vs. illness symptoms?

Scenario #2

Call from mother who reports that 15-month-old child had been seen in Urgent Care three nights previously for "bad cough". Was told there were no abnormal findings on examination at that time and he had a viral illness. Mother calls because she thinks "cough is getting worse".

1) What assessment questions would be important to ask to determine if this child is currently in any respiratory distress? (length of illness, fever, description of cough, s/s of increased work of breathing, color, level of activity, counted respiratory rate while on phone with Advice Nurse)
2) What additional information would be important to know about the child's medical history? (any concurrent medical diagnoses, immunization status)
   Child is reported by mother to be having nasal flaring and substernal retractions. Mother was able to provide a counted respiratory rate of 60. Child had been having fever 103-

104 degrees for past 24 – 48 hrs. Poor feeding, only one wet diaper in last 24 hrs. Mother advised to take child to nearest Emergency Room. Child in ER had O2 saturation of 88%, respiratory rate of 64, mild dehydration, chest x-ray showing bilateral pneumonia. Started on nebulizer treatment, IV antibiotics and admitted for evaluation. Discharged home after 72 hours improved and stable.

3) What education to mother would have been important regarding follow-up for continued concerns after initial evaluation in Urgent Care? What parameters could be given to mother to evaluate worsening condition?