COURSE OUTLINE
Physical Assessment for the Practice of Nursing

Course Description
NR 104. Physical Assessment for the Practice of Nursing. 3 hours credit. Prerequisites: BI 240 or BI 226 and BI 227, BS 160, EG 101, MA 135 (or MA132, MA133, and MA134) or above, all with a C or better. Departmental acceptance to the nursing program. Corequisite: NR 105. This course will enable the nursing student to demonstrate competencies in assessment of the individual patient across the life span. The student will collect historical data and identify risk factors including genetic and environmental that affect the individual’s health. The student will use interviewing techniques to conduct, review, and document health history and physical assessments while incorporating culture, age, and gender considerations. The student will develop the knowledge, skills, and attitudes necessary to complete a thorough physical assessment. The student will embrace the American Nurses Association (ANA) Code of Ethics for Nursing with all class actions and interactions, demonstrating professional accountability and responsibility for behavior. Classroom: 32 hours Clinical: 45 hours

Required Materials
Butler Community College. Course manual-NR104. BCC

Online Resources/Software
Web-facilitated materials will be presented through the online course management system.

ExamSoft – Used for computerized testing through the ExamSoft company www.examsoft.com/butlernursing. Billing information will be sent via Pipeline email and payments will be completed online.

Supplies
A stethoscope, penlight, watch, and black pen are required for clinical in addition to the uniform described in the student handbook. http://www.butlercc.edu/nursing/h_intro.htm

* - For complete textbook information, refer to https://bookstore.butlercc.edu

Butler-assessed Outcomes
The intention is for the student to be able to:
1. Document a basic health history to identify current and potential health problems of patients across the life span.
2. Demonstrate a basic head-to-toe physical assessment of an adult patient based upon patient needs.
3. Demonstrate how to accurately assess and interpret vital signs for the adult patient.
4. Apply knowledge of developmental, gender, and cultural differences to health assessment.
5. Identify protective and predictive factors that influence the health of individuals.
6. Document focused physical assessments based on patient needs.

**Learning PACT Skills that will be developed and documented in this course**

Through involvement in this course, the student will develop ability in the following PACT skill area(s):

**Technology Skills**

Discipline-specific technology - Through observation and hands-on practice, the student will develop the selected nursing skill of physical assessment.

**Major Summative Assessment Task(s)**

These Butler-assessed Learning Outcome(s) and the Learning PACT skill(s) will be demonstrated by:

1. Performing and documenting a health history and head-to-toe physical assessment using the knowledge, skills, and attitudes of the professional nurse.

**Skills or Competencies**

Actions essential to achieve the course outcomes:

1. Document a basic health history to identify current and potential health problems of patients across the life span.
   A. Identify types of data that belong under each section of a health history.
   B. Explain the reasons why the nurse must document the health assessment in an accurate, concise, and legible manner, without bias or opinion.
   C. Prepare a three-generation genogram using standardized symbols and terminology.
   D. Identify environment, safety and health risks across the lifespan.
2. Demonstrate a basic head-to-toe physical assessment of an adult patient based upon patient needs.
   A. Use an organized approach in performing a physical examination.
   B. Display respect for the patient while performing assessment techniques.
   C. Describe the use of inspection, palpation, percussion, and auscultation in physical assessment.
   D. Identify the equipment used during a physical examination.
3. Demonstrate how to accurately assess and interpret vital signs for the adult patient.
   A. Demonstrate the correct techniques for the measurement of vital signs.
   B. Identify common errors associated with vital sign measurement.
   C. Describe physiologic factors that affect vital sign measurements.
4. Apply knowledge of developmental, gender, and cultural differences to health assessment.
   B. Describe ways to increase cultural sensitivity.
   C. Identify developmentally appropriate techniques used during physical assessment of the individual.
D. Describe the role of the family in health assessment.
5. Identify protective and predictive factors that influence the health of individuals.
   A. Identify recommended immunizations across the life span.
   B. Identify common problems and conditions across the life span.
   C. Describe normal anatomic and physiologic changes in older adults which may 
      impair ADLs.
   D. Interpret the results of a fall risk assessment tool.
6. Document focused physical assessments based on patient needs.
   A. Identify reasons why the nurse must document the health history and physical 
      assessment in an accurate, concise, and legible manner, without bias or opinion.
   B. Report normal and abnormal findings of a focused physical assessment.
   C. Document a focused physical assessment.

Learning Units

I. Foundation for health assessment
   A. Importance of health assessment
   B. Patient interview techniques for a health history
   C. Techniques and equipment for physical assessment
   D. General inspection and measurement of vital signs
   E. Ethnic, cultural, and spiritual considerations
   F. Pain assessment

II. Health assessment of the adult
    A. Skin, hair, and nails
    B. Head, eyes, ears, nose, and throat
    C. Lungs and respiratory system
    D. Heart and peripheral vascular system
    E. Abdomen and gastrointestinal system
    F. Musculoskeletal system
    G. Neurologic system
    H. Breasts and axillae
    I. Reproductive system and the perineum

III. Health assessment across the life span
    A. Developmental assessment throughout the life span
    B. Assessment of the infant, child, and adolescent
    C. Assessment of the pregnant patient
    D. Assessment of the older adult

IV. Application of health assessment
    A. Conducting a head-to-toe examination
    B. Documenting the comprehensive health assessment

Learning Activities
Learning activities will be assigned to assist the student to achieve the intended learning outcomes through textbook readings, case studies, online learning materials, and clinical/lab experiences.

**Grade Determination**
The student will be graded on learning activities and assessment tasks. Grade determinants may include the following: written assignments, quizzes, exams, class participation, and other methods of evaluation at the discretion of the instructor. The student must pass the lab component of this course in order to earn a passing grade. The student must also earn a 75% or higher on total exam only points (includes unit exams and comprehensive final) in order to pass the course. Once the student passes the clinical/lab component and earns a 75% or higher total exam only points, the points earned for all other course work will be added to determine the final course grade. The student must earn a letter grade of a C or higher (75%) to pass the course.