

WESTERN CONNECTICUT STATE UNIVERSITY
Department of Nursing

Course Number: NUR 575

Course Title: Advanced Health Assessment

Credits: 3 S.H. (2 hours lecture; 3 hours college laboratory)

Placement: Role Development

Pre-requisites: NUR 501, 504, 511; NUR 515

Basic physical assessment course within the past 5 years or successful performance on paper-and-pencil and practical examinations testing baseline assessment knowledge and skills prior to course enrollment.

Course Description:

Content and skills necessary to taking a comprehensive client history and performing a physical and psychological assessment of signs and symptoms, pathophysiologic changes, and psychosocial variations in adult clients.

Student Learning Outcomes:

1. Develop a comprehensive data base for the adult client, including complete functional assessment, health history, physical examination, and appropriate diagnostic testing.
2. Interpret basic laboratory tests and diagnostic data.
3. Perform a risk assessment of the client.
4. Relate assessment findings to underlying pathology or physiologic changes.
5. Establish a differential diagnosis based on the assessment data and problem list.
6. Develop an effective and appropriate plan of care for the client which takes into consideration life circumstances and cultural, ethic, and developmental variations.
7. Document findings based on current nursing practice standards.

8. Demonstrate competency and critical thinking and clinical decision making in conducting assessments in collaboration with the client to promote, maintain, and restore health.

9. Conducts a comprehensive health and physical assessment which incorporates knowledge about genetic, environmental, and genomic influences and risk factors.

Laboratory Objectives:

1. Elicit a comprehensive health history, including development, maturation, coping ability, activities of daily living, physiological function, and emotional and social well-being.

2. Perform a complete physical examination on adults.

3. Order and/or perform pertinent diagnostic tests.

4. Analyze the data collected to determine health status.

5. Formulate a problem list.

6. Develop a plan of care.

7. Record all pertinent data about the client derived from the history and physical examination, including identified problems.

Content Outline:

I. History

A. Focused history

B. Advanced history-taking skills including:

1. genetic and genomic focused health and physical assessment identifying environmental and lifestyle factors
2. minimum of three generational family history and informational genogram with standard pedigree nomenclature

II. The Complete Physical Examination / Advanced Assessment:

- A. Head, eyes, ears, nose, throat/neck
- B. Respiratory system
- C. Abdomen
- D. Cardiovascular system and EKG interpretation
- E. Dermatology – Skin, hair, and nails
- F. Genitourinary system
- G. Musculoskeletal system
- H. Neurological / Psychological system

III. Diagnostics

- A. Lab testing and interpretation
- B. Diagnostic testing
- C. Advanced diagnostics

Approved: Jan 2006 Graduate Council

Programs committee 2/20/13

Department of Nursing Feb 2013

AVP April 2013