MARYLAND BOARD OF NURSING
BOARD MEETING
OPEN AGENDA

DATE:	March 22, 2017
TIME:	9:00 A.M.
PLACE:	Maryland Board of Nursing 4140 Patterson Avenue Baltimore, Maryland

BUSINESS:

PLEASE NOTE: THE MEETING WILL BE IN OPEN SESSION FROM 9:00 A.M. UNTIL APPROXIMATELY 10:00 A.M. WITH EXECUTIVE (CLOSED) SESSION IMMEDIATELY FOLLOWING.

1. **Call to Order**

   Roll Call and Declaration of Quorum

2. **Consent Agenda**

   A. Approval of Nurse Practitioner Programs

      1. University of Akron, Akron, OH, Adult-Gerontological, Post Masters

      2. University of Iowa City, IA Family, Masters

      3. Wayne State University, Detroit, MI, Adult & Family Psychiatric Mental Health, Masters and Doctor of Nursing Practice

   B. Certified Nurse Aide Training Programs/Facilities

      1. Charlotte Hall Veteran's Home
         Greenbelt Career Academy
         Bello Machre – DDA Facility- CNA program only

      2. Request for Approval of CNA Training Program-Clinical Facility
         Hagerstown Community College-Western Maryland Hospital Center

   C. CNA Course Equivalency

Florida State University

D. Request for Approval of Nurse Refresher Program-Faculty

Hagerstown Community College-Susan K. Lyons, RN

E. CNA Advisory Committee – Long Term Care Nursing Assistant Designation (Carmello David)

3. **Discussion of Items Removed from Consent Agenda**

4. **Education** (Dr. Patricia Kennedy)

a. Wor-Wic Community College, Department of Nursing welcomed Kris Brown, BSN, RN as part-time clinical faculty

b. Wor-Wic Community College, Department of Nursing welcomed Jeannette Elliott, BSN, RN as part-time clinical faculty

c. Carroll Community College, Associate Degree Nursing Program granted NLN CNEA pre-accreditation status

5. **Practice**

None

6. **Licensure & Certification** (Cheyenne Redd)

Request to Approve Blended Format (online and face to face) Nurse Refresher Course-Montgomery College

7. **Advanced Practice**

None

8. **Administrative and Legislative (**Shirley Devaris)

a. Amended regulations for Nurse Licensure Compact - COMAR 10.27.22

… b. COMAR 10.27.07 - amendments for repeal of Insect Sting Program

c. HB 1632 - Public Health – Certificates of Birth – Birth Outside an Institution

d. Summary of Session Bills

9. <u>Other</u>

STATE OF MARYLAND

MARYLAND BOARD OF NURSING
4140 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215-2254

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1-888-202-9861 TOLL FREE

2A

MEMORANDUM

TO: Maryland Board of Nursing

RE: Approval of Nurse Practitioner Programs

DATE: February 22, 2017

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1. University of Akron, Akron, OH, Adult-Gerontological, Post Masters
2. University of Iowa, Iowa City, IA, Family, Masters
3. Wayne State University, Detroit, MI, Adult & Family Psychiatric Mental Health, Masters and Doctor of Nursing Practice

cc: File

M E M O R A N D U M

2B1

FROM: Jill Callan, BSN, RN
Nurse Program Consultant I
Maryland Board of Nursing
TO: The Board
DATE: March 22, 2017
IN RE: Request for Approval to Renew CNA Training Program

The following renewal application has been reviewed and has satisfied all COMAR 10.39.02 regulations for CNA Training Programs in the State of Maryland:

a. Bello Machre – DDA Facility

M E M O R A N D U M

2.B2

FROM: Jill Callan, BSN, RN
Nurse Program Consultant I
Maryland Board of Nursing
TO: The Board
DATE: March 22, 2017
IN RE: Request for Approval to Renew CNA-GNA Training Programs

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The following renewal applications have been reviewed and have satisfied all criteria as outlined in COMAR 10.39.02 for CNA/GNA Training Programs in the State of Maryland:

a. Charlotte Hall Veteran's Home

b. Greenbelt Career Academy

M E M O R A N D U M

2.B2

FROM: Cheyenne Redd, MSN, RN
Director of Licensure & Certification
Maryland Board of Nursing
TO: The Board
DATE: March 22, 2017
IN RE: Request for Approval of CNA Training Program-Clinical Facility

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The following clinical facility has been reviewed and have satisfied all requirements of COMAR 10.39.02 for CNA Training Programs-Clinical Facilities in the State of Maryland:

Hagerstown Community College is requesting the use of Western Maryland Hospital Center for the clinical portion of their CNA/GNA training program. Western Maryland Hospital Center is a skilled nursing home unit with sixty-three beds. This facility offers skilled nursing, inpatient dialysis, respiratory care, short term care and long term care.

Western Maryland Hospital Center employs Registered Nurses, Licensed Practical Nurses and Geriatric Nursing Assistants. This facility has fifty-six registered nurses and licensed practical nurses. This facility also has forty geriatric nursing assistants.

Hagerstown Community College will maintain the 1:8 instructor/student ratio for this clinical placement.

M E M O R A N D U M

2C

FROM: Cheyenne Redd, MSN, RN
Director of Licensure & Certification
Maryland Board of Nursing
TO: The Board
DATE: March 22, 2017
IN RE: Approval of Nursing Course Equivalent for CNA Training

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Florida State University is seeking approval of NUR 3056/L Foundations of Nursing Practice with Lab and NUR 3065/L Health Assessment, Wellness and Prevention across the Lifespan with Lab as course equivalents for CNA training. This portion of the Nursing Program meets the requirement that the Board has determined for a CNA Training Program. *See* Md. Health Occupations Code Ann. § 8-6A-05 and COMAR 10.39.02.05.07.

NUR 3056/L Foundations of Nursing Practice with Lab is a five credit course with a total of three credits of theory/didactic instruction, one credit of clinical instruction, and one credit of lab instruction. In the course, students will get an introduction to the foundations of professional nursing practice. The student will explore multidimensional aspects of clients/families and evidence based practice will be introduced.

NUR 3065/L Health Assessment, Wellness and Prevention across the Lifespan with Lab a four credit course with a total of three credits of theory/didactic instruction, zero credits of clinical instruction, and one credit of lab instruction. This course offers students an introduction to concepts and models of wellness and health promotion for clients. Formulation nursing diagnoses, understanding the role of a nurse and technical skills of performing an assessment are emphasized in this course.

NUR 3056 Foundations of Nursing Practice
Fall 2014

Instructor Contact Information

Name: Lauren Kendall DNP, RN

Address:
FSU College of Nursing
Room # 451 Duxbury Hall
Tallahassee, FL 32306-4310

Office Hours:
Monday 1100-1200

Email: lkendall@nursing.fsu.edu

Phone: office: 850-645-9929

Fax: 850-644-7660

Name: Lara Balbis MSN, ARNP

Address:
FSU College of Nursing
Room # 450 Duxbury Hall
Tallahassee, FL 32306-4310

Office Hours:
Thursday 1100-1200

Email: lbalbis@nursing.fsu.edu

Phone: cell: 561-315-9428

Fax: 850-644-7660

Credit Hours and Prerequisites

Credit Hours: 3 semester hours
Prerequisites: Admission to the Nursing Major
Co-Requisite: Semester I Nursing courses

Course Description

This course introduces the nursing student to the foundations of professional nursing practice, which include multidimensional aspects of clients/families, the relationship between quality of

care and client outcomes, patient safety, communication and use of evidence to support practice.

Course Objectives

Upon completion of this course the student will:

1. Use information technology to acquire knowledge and communicate effectively with faculty, peers, and others.
2. Explain multidimensional aspects of the individual/family to consider when planning nursing care.
3. Analyze situational variables that may impact methods of delivering safe and cost effective health care.
4. Explain the scientific evidence underlying the use of selected communication and psychomotor skills for safe, effective, and compassionate patient care within a culturally diverse population.
5. Value personal accountability and responsibility for individual judgments and actions.
6. Apply self-evaluation as a means to develop nursing knowledge base and skills.

Course Materials Required

Textbooks:

American Psychological Association, (2010) *Publication manual of the American Psychological Association*, (6th ed.). Washington, DC: Author.

Taylor, C., et al. (2011). *Fundamentals of nursing: The art and science of nursing care.* (7th ed.). Philadelphia: Lippincott Williams & Wilkins. ISBN: 978-0-7817-9383-4

or

Taylor, C., et al. (2011). *Fundamentals of nursing: The art and science of nursing care: Student set on thePoint.* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Taylor, C., et al. (2011). *Skill checklists for fundamentals of nursing: The art and science of nursing care.* (7th ed.). Philadelphia: Lippincott Williams & Wilkins. 978-0-7817-9385-8

or

Taylor, C., et al. (2011). *Skill checklists for fundamentals of nursing: The art and science of nursing care: Student set on thePoint.* (7th ed.). Philadelphia: Lippincott Williams & Wilkins. 978-0-7817-9385-8

Other Required Resources:

Taylor, C., et al. (2011). *Taylor's video guide to clinical nursing skills: Student set on enhanced DVD.* (2nd ed.). Philadelphia: Lippincott Williams & Wilkins. ISBN: 978-1-60831-145-3

or

Taylor, C., et al. (2011). *Taylor's video guide to clinical nursing skills: Student set on thePoint.* (2nd ed.). Philadelphia: Lippincott Williams & Wilkins.

Other required readings will be posted on the Blackboard Weekly Assignment sheets for each week.

Websites:

Taylor C., Lillis C., LeMone P., & Lynn P. *Lippincott Course Point Fundamentals of Nursing: The Art and Science of Nursing Care*, (7th) ISBN: 978-1-4698-7321-3

Lippincott's DocuCare LWW ISBN: 978-1-4511-7669-8

PrepU for Taylor's Fundamentals of Nursing, 7th Edition LWW ISBN: 978-1-4511-1845-2

Other Required Tools

Kaplan resources: Upon registering you will be enrolled in the Kaplan program and will receive Kaplan materials and have access to the secure Kaplan website for students. http://kaplanlwwtesting.kaplan.com/S_login.aspx

This course is Web- assisted course. Materials used for class can be found on the NUR 3056 course Blackboard website http://campus.fsu.edu

Grading Scale

A	93.0-100
A-	90.0-92.9
B+	86.0-89.9
B	83.0-85.9
B-	80.0-82.9
C	75.0-79.9
D	60.0-74.9
F	below 60.0

** Students will be required to earn a minimum 75.0 exam average in order to pass the course. There will be no rounding of points or extra credit.

Course Grade will be determined by:

Evaluation of the course is based on:

Assignment	Proportion of grade
Weekly PrepU Quizzes	10%
Class Participation	10%
Exam-1	25%

Exam-2	25%
Final Exam (Kaplan Standardized Exam)	30%

HIPAA Assignment S/U- Students are required to view the HIPAA materials on NUR3056 blackboard site and turn in the required documents as indicated on the course calendar

Tobacco Assignment- S/U- Students are required to view the tobacco education materials on NUR3056 blackboard site and turn in the required documents as indicated on the course calendar.

Kaplan Exam:

The final examination for the course is the Kaplan standardized examination. This exam will be administered on-line, at the FSU testing center. This is a challenging exam which will test the cumulative contend from the course. The exam is scored according to a 'raw score' that will be applied to a grading scale, which is posted below. The exam is a standardized examination with an established mastery score. The minimal mastery score will equilibrate to a grade of 75% for course grading purposes.

Raw Score	Assigned Grade (%)
75	100
74	100
73	99
72	98
71	97
70	96
69	95
68	94
67	93
66	92
65	91
64	90
63	89
62	88
61	87
60	86
59	85
58	84
57	83
56	82
55	81
54	80

53	79
52	78
51	77
50	76
49	75
48	74
47	73
46	72
45	71
44	70
43	69
42	68
41	67
40	66
39	65
38	64
37	63
36	62
35	61
34	60
33	59
32	58
31	57
30	56
29	55
28	54
27	53
26	52
25	51
24	50
23	49
22	48
21	47
20	46
19	45
18	44
17	43

Key

Benchmark Score

99th percentile
Kaplan Reported Mean
Failed to meet benchmark

Instructional Strategies

Lecture/discussion, demonstration, audio-visual material, individual practices, reading, Kaplan Assessment and Readiness exam.

Course Content

*****Students are held responsible for supplementary materials and text chapters referencing medical terminology and nursing documentation throughout the term.**

Unit	Chapters
I. Foundations of Nursing Practice (Unit I)	• Chapter 1: Introduction to Nursing • Chapter 2: Cultural Diversity • Chapter 3: Health and Illness • Chapter 4: Health of the Individual, Family, and Community • Chapter 5: Theory, Research, and Evidence-Based Practice • Chapter 6: Values, Ethics, and Advocacy • Chapter 7: Legal Implications of Nursing
II. Healthcare Delivery (Unit II) III. Asepsis	• Chapter 8: Healthcare Delivery Systems • Chapter 9: Continuity of Care • Chapter 10: Home Healthcare • Chapter 27: Asepsis and Infection Control
IV. Nursing Process (Unit III) V. Vital Signs	• Chapter 11: Blended Skills and Critical Thinking Throughout the Nursing Process • Chapter 12: Assessing • Chapter 13: Diagnosing • Chapter 14: Outcome Identification and Planning • Chapter 15: Implementing • Chapter 16: Evaluating • Chapter 17: Documenting, Reporting, Conferring, and Using Informatics • Chapter 24: Vital Signs
VI. Roles of the Nurse (Unit V) VII. Health Assessment	• Chapter 21: Communicator • Chapter 22: Teacher and Counselor • Chapter 23: Nurse Leader and Manager

		• Chapter 25: Health Assessment
VIII.	Promoting Health Across the Lifespan (Unit IV)	• Chapter 18: Developmental Concepts • Chapter 19: Conception Through Young Adult • Chapter 20: The Aging Adult
IX. X. XI.	Self-Concept Sexuality Hygiene	• Chapter 41: Self-Concept • Chapter 45: Sexuality • Chapter 31: Hygiene
XII.	Medications	• Chapter 29: Medications
XIII. XIV.	Stress and Adaptation Perioperative Nursing	• Chapter 42: Stress and Adaptation • Chapter 30: Perioperative Nursing
XV. XVI. XVII.	Skin Integrity Wound Care Complementary and Alternative Therapies	• Chapter 32: Skin Integrity and Wound Care • Chapter 28: Complementary and Alternative Therapies
VIII. XIX. XX. XXI.	Loss, Grief, and Dying Spirituality Rest and Sleep Comfort	• Chapter 43: Loss, Grief, and Dying • Chapter 46: Spirituality • Chapter 34: Rest and Sleep • Chapter 35: Comfort
XXII. XIII. XIV.	Sensory Stimulation Activity Safety	• Chapter 44: Sensory Functioning • Chapter 33: Activity • Chapter 26: Safety, Security, and Emergency Preparedness
XXV. XVI.	Nutrition Oxygenation	• Chapter 36: Nutrition • Chapter 39: Oxygenation
XVII.	Fluid, Electrolyte, and Acid–Base Balance	• Chapter 40: Fluid, Electrolyte, and Acid–Base Balance
VIII. XIX.	Urinary Elimination Bowel Elimination	• Chapter 37: Urinary Elimination • Chapter 38: Bowel Elimination

Course Requirements/Policies

Attendance and Absences: Students are expected to attend all scheduled university classes. The university reserves the right to deal at any time with individual cases of nonattendance.

Students who are late for class, or who miss class without instructor approval, will not be allowed to take the weekly quiz on the date missed.

With documentation, excused absences include documented illness, deaths in the immediate family and other documented crises, call to active military duty or jury duty, religious holy days, and official University activities. Accommodations for these excused absences will be made and will do so in a way that does not penalize students who have a valid excuse. Consideration will also be given to students whose dependent children experience serious illness.

Academic Honor Policy: The Florida State University Academic Honor Policy outlines the University's expectations for the integrity of students' academic work, the procedures for resolving alleged violations of those expectations, and the rights and responsibilities of students and faculty members throughout the process. Students are responsible for reading the Academic Honor Policy and for living up to their pledge to "…be honest and truthful and… [to] strive for personal and institutional integrity at Florida State University." (Florida State University Academic Honor Policy, found at http://dof.fsu.edu/honorpolicy.htm.)
Communication: Florida State University Bulletin states, "The official method of communication at Florida State University is your fsu.edu e-mail account. In order to stay informed and aware, you are required to set up and maintain your account and check it three times per week. If you choose to have your fsu.edu official account forwarded to another e-mail account, you are still held responsible for all information distributed by the University to your fsu.edu account". For more information (including how to set up an account) visit *www.its.fsu.edu*

Academic Penalties: In the FSU College of Nursing, students violating the Academic Honor Policy in any assignment, test, etc will receive a minimum penalty of a grade of zero (0) for the assignment in question, will be reported to the Dean and the University Judicial Officer, and may receive an "F" for the course at the option of the instructor.

Professional Critical Behavior Policy: The College of Nursing strictly adheres to the Florida State University Academic Honor Code as stated and as delineated in the FSU General Bulletin. In addition, the following apply in the College of Nursing: the CON Academic Honesty Policy, the CON Plagiarism Policy, the Substance Abuse Policy and the Professional Critical Behaviors Policy.
Since each nursing student represents the College of Nursing, the University and the nursing profession, the faculty believes the following are the behaviors deemed to be critical for all nursing students in each learning environment throughout the program of study:
1. Abide by the FSU Academic Honor Code and the Student Conduct Code, the College of Nursing Academic Honesty Policy, Plagiarism Policy, and Professional Critical Behaviors Policy.
2. Exhibit professional nursing behaviors including, but not limited to the following:

- Dress appropriately at all times when representing the College of Nursing such as adhering to the CON and Agency dress code for courses and clinical assignments.
- Communicate using appropriate language and terms and demonstrate respect for others including addressing them by proper name and title.
- Demonstrate ethical behavior including maintaining confidentiality.
- Resolve conflicts appropriately and follow appropriate lines of communication/chain of command.
- Deliver safe, effective nursing care including using appropriate judgment when making decisions; properly using and caring for equipment; and using correct techniques and cautions when delivering care,
- Adhere to the policies and protocols of the College of Nursing, affiliating agencies, the Florida Nurse Practice Act, and the legal mandates of society.

Note: An unsatisfactory in one or more of # 1 and # 2 will result in disciplinary action. This can include, but is not limited to failing the course regardless of grades in other course requirements; and/or expulsion from the nursing program.

Americans With Disabilities Act: Students with disabilities needing academic accommodation should: (1) register with and provide documentation to the Student Disability Resource Center; and (2) bring a letter to the instructor indicating the need for accommodation and what type. This should be done during the first week of class.
This syllabus and other class materials are available in alternative format upon request.
For more information about services available to FSU students with disabilities, contact the:
Student Disability Resource Center
874 Traditions Way
108 Student Services Building
Florida State University
Tallahassee, FL 32306-4167
(850) 644-9566 (voice) (850)
644-8504 (TDD)
sdrc@admin.fsu.edu
http://www.disabilitycenter.fsu.edu/

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Except for changes that substantially affect implementation of the evaluation (grading) statement, this syllabus is a guide for the course and is subject to change with advance notice. All changes will be done in writing and posted on the NUR 3056 Blackboard website.

Calendar NUR 3056/L Fall 2014

Monday	Thursday	PrepU Assignments & Additional Readings	Lab Activities
Aug 25 Orientation and review of syllabus Incivility	Aug 28 Chapter 1: Introduction to Nursing Chapter 2: Cultural Diversity Chapter 3: Health and Illness Chapter 4: Health of the Individual, Family, and Community	PrepU: Ch1-4	**NOTE:** Lab Prep Work must be done before you come to lab These prep instructions can be found on BB under Lab Prep weeks content will be included here **In Lab Activities:** Hand hygiene, Asepsis, Patient hygiene, Al care, Braden Scale, Patient Safety, Positioning, Body Mecha Bed making, Restraints, Ambulation, Crutches, TEDS, Patien Prevention (Morse Scale) **Taylor's Clinical Skills Videos: Modules** Required with Quiz submission: 3, 8 Recommended: 7, 10, 11, 13 Laboratory orientation, review of syllabus, laboratory entry HIPPA
Sept 1 **No Class-Labor Day**	Sept 4 Chapter 5: Theory, Research, and Evidence-Based Practice Chapter 6: Values, Ethics, and Advocacy Chapter 7: Legal Implications of Nursing	PrepU: Ch 5-7 HIPAA Pre and Post Test Due to your lab instructors	**In Lab Activities:** Sterile gloving, Trach Care & Suctioning, O Sterile wound care, Suture and Staple Removal **Taylor's Clinical Skills Videos: Modules** Required with Quiz submission: 9 Recommended: 16, 17, 19 **REVIEW 3 for Sterile gloving
Sept 8 Chapter 8: Healthcare Delivery Systems Chapter 9: Continuity of Care	Sept 11 Chapter 27: Asepsis and Infection	PrepU: 8-10, 27	**In Lab Activities:** Review CON Medication Administration Pc Procedures, Glucose Monitoring, Medication Errors Non-Parenteral Medications, SQ (Heparin, Insulin), IM Medication Orders, PO, Optic, Otic Medication administrati **Taylor's Clinical Skills Videos: Module** Required with Quiz submission: 5,6

Monday	Thursday	PrepU Assignments & Additional Readings	Lab Activities
Chapter 10: Home Healthcare			Recommended: 4
Sept 15 Chapter 11: Blended Skills and Critical Thinking Throughout the Nursing Process Chapter 12: Assessing Chapter 13: Diagnosing Chapter 14: Outcome Identification and Planning Chapter 15: Implementing Chapter 16: Evaluating	Sept 18 Chapter 17: Documenting, Reporting, Conferring, and Using Informatics Chapter 24: Vital Signs Chapter 25: Health Assessment	PrepU: Ch 11-16 Ch. 17, 24, 25	**In Lab Activities:** Phlebotomy, IV Primary, IV Secondary, Bl administration **Taylor's Clinical Skills Videos: Module** Required with quiz submission 18 Recommended: 11,19
Sept 22 Chapter 21: Communicator Chapter 22: Teacher and Counselor Chapter 23: Nurse Leader and Manager	Sept 25 Care Maps- Ms. Cutchens and Dr. Tucker	PrepU: Ch. 21-23	**In Lab Activities:** Catheterization, Intake and Output Measu Insertion (food and medication administration), Weights, Er Colostomy Care **Taylor's Clinical Skills Videos: Module** Required with Quiz submission 12, 14 Recommended: 15
Sept 29 **Exam I**	Oct 2 Chapter 18: Developmental Concepts	PrepU- Ch. 18-20	**In Lab Activities**: Final Skills Validations before Nursing hom begin

Monday	Thursday	PrepU Assignments & Additional Readings	Lab Activities
	Chapter 19: Conception Through Young Adult Chapter 20: The Aging Adult	Tobacco Pre/Post Test Due on Thursday 10/3	
Oct 6 Chapter 41: Self-Concept Chapter 45: Sexuality	Oct 9 Chapter 31: Hygiene	PrepU: 41, 45 Ch. 31	**Nursing Home Rotations Begin** **In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 27: Asepsis and Infection Control Practice and Learn: From Taylor's Interactive Nursing Skills: Removing Sterile Gloves **Skill Reinforcement** •Skill Checklists: SKILL 27-4: Putting on Sterile Gloves and Re Gloves •Skill Checklists: SKILL 29-7: Administering an Intramuscular •Skill Checklists: SKILL 29-8: Administering Medications by I Bolus or Push Through an Intravenous Infusion •Skill Checklists: SKILL 29-9: Administering a Piggyback Inter Intravenous Infusion of Medication **PrepU Fundamentals Cases/In Lab Activities** Fundamentals: Blood Glucose Testing: Kevin Gargan
Oct 13 Chapter 29: Medications	Oct 16 Chapter 42: Stress and Adaptation Ms. Bamber Lecturing Chapter 30: Perioperative Nursing	PrepU: Ch 29 Ch 42, 30	**In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 29: Medications Practice and Learn: From Taylor's Interactive Nursing Skills: a Subcutaneous Injection **Skill Reinforcement** • Skill Checklists: SKILL 27-4: Putting on Sterile Glo Removing Soiled Gloves • Skill Checklists: SKILL 29-7: Administering an Intra Injection • Skill Checklists: SKILL 29-8: Administering Medica Intravenous Bolus or Push Through an Intravenous Infusion • Skill Checklists: SKILL 29-9: Administering a Piggy Intermittent Intravenous Infusion of Medication

Monday	Thursday	PrepU Assignments & Additional Readings	Lab Activities
			PrepU Fundamentals Cases/In Lab Activities Fundamentals: Administering Oral Medications: Mildred Ca
Oct 20 Chapter 32: Skin Integrity and Wound Care	Oct 23 Chapter 28: Complementary and Alternative Therapies Ms. Bamber Lecturing	PrepU: Ch 32 Ch 28	**In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 31: Hygiene Practice and Learn: From Taylor's Interactive Nursing Skills: Care for the Dependent Patient **Skill Reinforcement** • Skill Checklists: SKILL 27-1: Performing Hand Hyg Soap and Water (Handwashing) • Skill Checklists: SKILL 32-1: Cleaning a Wound and Dry, Sterile Dressing **PrepU Fundamentals Cases/In Lab Activities** Fundamentals: Diabetes Mellitus, Type 2: Nicholas Soros
Oct 27 Chapter 43: Loss, Grief, and Dying Chapter 46: Spirituality	Oct 30 Chapter 34: Rest and Sleep Chapter 35: Comfort	PrepU: 43, 46 Ch. 34, 35	**In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 32: Skin Integrity and Wound Care Practice and Learn: From Taylor's Interactive Nursing Skills: Wound and Applying a Sterile Dressing **Skill Reinforcement** • Skill Checklists: SKILL 27-1: Performing Hand Hyg Soap and Water (Handwashing) • Skill Checklists: SKILL 32-1: Cleaning a Wound and Dry, Sterile Dressing **PrepU Fundamentals Cases/In Lab Activities** Fundamentals: Wound Care: Millie DeLong
Nov 3 Chapter 44: Sensory Functioning Chapter 33: Activity	Nov 6 Chapter 26: Safety, Security, and Emergency Preparedness	PrepU: 44, 33 Ch. 26	**In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 36: Nutrition Practice and Learn: From Taylor's Interactive Nursing Skills: Complications of Enteral Feeding **Skill Reinforcement**

Monday	Thursday	PrepU Assignments & Additional Readings	Lab Activities
			• Skill Checklists: SKILL 37-5: Catheterizing the Fem Bladder **PrepU Fundamentals Cases/In Lab Activities** Fundamentals: Inserting a Nasogastric Tube (NGT): Marjorie
Nov 10 Exam II Review	Nov 13 **Exam II**	** There is no Tuesday Lab group due to Veterans Day Observation	**In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 37: Urinary Elimination Practice and Learn: From Taylor's Interactive Nursing Skills: the Female **Skill Reinforcement** • Skill Checklists: SKILL 37-5: Catheterizing the Fem Bladder **PrepU Fundamentals Cases/In Lab Activities** Fundamentals: Catheterizing the Female Urinary
Nov 17 Chapter 36: Nutrition Chapter 39: Oxygenation	Nov 20 Chapter 37: Urinary Elimination Chapter 38: Bowel Elimination Ms. Bamber Lecturing	PrepU: 36, 39 PrepU: 37, 38	**In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 38: Bowel Elimination Practice and Learn: From Taylor's Interactive Nursing Skills: a Cleansing Enema **Skill Reinforcement** • Skill Checklists: SKILL 36-1: Inserting a Nasogastri • Skill Checklists: SKILL 36-2: Administering a Tube • Skill Checklists: SKILL 39-1: Using a Pulse Oximet • Skill Checklists: SKILL 39-2: Suctioning the Nasoph Oropharyngeal Airways • Skill Checklists: SKILL 39-3: Administering Oxyge Cannula • Skill Checklists: SKILL 39-4: Administering Oxyge • Skill Checklists: SKILL 39-5: Suctioning the Trache System • Skill Checklists: SKILL 39-6: Providing Tracheoston **PrepU Fundamentals Cases/In Lab Activities** Fundamentals: Changing and Emptying an Ostomy Applianc Franklin

Monday	Thursday	PrepU Assignments & Additional Readings	Lab Activities
Nov 24 Chapter 40: Fluid, Electrolyte, and Acid–Base Balance	Nov 27 No Class – Thanksgiving	PrepU: 40	**In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 39: Oxygenation Practice and Learn: From Taylor's Interactive Nursing Skills: Oxygen via Nasal Cannula **Skill Reinforcement** • Skill Checklists: SKILL 36-1: Inserting a Nasogastri • Skill Checklists: SKILL 36-2: Administering a Tube • Skill Checklists: SKILL 39-1: Using a Pulse Oximet • Skill Checklists: SKILL 39-2: Suctioning the Nasoph Oropharyngeal Airways • Skill Checklists: SKILL 39-3: Administering Oxyge Cannula • Skill Checklists: SKILL 39-4: Administering Oxyge • Skill Checklists: SKILL 39-5: Suctioning the Trache System • Skill Checklists: SKILL 39-6: Providing Tracheosto **PrepU Fundamentals Cases/In Lab Activities** Fundamentals: Administering Oxygen by Nasal Cannula: Ru
Dec 1 Exam Review	Dec 4 Exam Review		**In Lab Activities:** **Skill Mastery/Lab Prep** Chapter 40: Fluid, Electrolyte, and Acid-Base Balance Practice and Learn: From Taylor's Interactive Nursing Skills: Solution Tubing **Skill Reinforcement** • Skill Checklists: SKILL 40-1: Initiating a Peripheral Access IV Infusion • Skill Checklists: SKILL 40-2: Changing an IV Solut and Administration Set **PrepU Fundamentals Cases/In Lab Activities** Fundamentals: Initiating Peripheral Venous Access Infusion

Monday	Thursday	PrepU Assignments & Additional Readings	Lab Activities
Kaplan Final Exam: You will be assigned to a time slot			

***Students are held responsible for supplementary materials and text chapters referencing medical terminology and nursing documentation throughout the term.

Instructor Contact Information

Name: Theresa Winton, DNP, ARNP-C
FSU College of Nursing
Room # 435 Duxbury Hall
Tallahassee, Fl 32306-4310
Office Hours:
By appointment
Email: tbw09@fsu.edu
Phone: 850-567-2013 Cell --no texts/call after 9 pm

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Credit Hours: 2 semester hours (4 clock hours/week)
(Note: 1 clinical lab semester hour = 2 contact hours per week)
Prerequisites: Admission to the Nursing Major
Co-Requisite: Semester I Nursing courses

Class Meeting Days/Times-302/308

Section 1 Friday 8-12 Dr. Whyte
Section 2 Friday 8-12 Dr. Bamber
Section 3 Wednesday 8-12 Dr. Abbott
Section 4 Wednesday 8-12 Dr. Winton
Section 5 Tuesday 8-12 Dr. McLarty
Section 6 Tuesday 8-12 Dr. Park
Section 7 Wednesday 1-5 Dr. Winton
Section 8 Wednesday 1-5 Ms. Brewer

Please note: clinical days are from 6-10AM for those labs that are in the morning and 11-3 for those labs in the afternoon. Refer to Course Library for Clinical rotation dates.

Course Description

This course provides the application component of NUR3056. Under the guidance of lab instructors, the student is given opportunities to integrate theoretical knowledge from NUR3056 in practice sessions. Demonstration, low, medium, and high fidelity simulation scenarios, deliberate practice methods, debriefing, and reflective instructional approaches are used.

Course Objectives

Upon completion of this course the student will:

1. Use knowledge of situation appropriate communication techniques and technical resources to communicate effectively with faculty peers, and health care recipients. 2. Apply knowledge of multidimensional aspects of the individual/family when planning care.
3. Use knowledge of situational variables that may impact methods of delivering safe and cost effective health care.
4. Explain the scientific evidence underlying the use of selected communication and psychomotor skills for safe, effective, and compassionate patient care within a culturally diverse population.
5. Demonstrate personal accountability and responsibility for individual judgments and actions.
6. Use self-evaluation and reflection as means to develop a nursing knowledge base and skills.

7. Demonstrate the ability to perform selected communication and psychomotor skills in a safe competent manner.

Long Term Care Rotation Objectives

Upon completion of the Long Term Care Rotation the student will be able to:

1. Apply knowledge of theory for providing nursing care and support for clients and families in the contexts of physical, psychosocial and spiritual care. Physical care for clients in the long term care facility will include, but may not be limited to: (vital signs, bathing, feeding, toileting (taking the client to the toilet, applying and removing adult incontinent pads as needed, Foley care), dressing the client, making the client's bed, oral care, and transferring and ambulation.
2. Provide quality care by teaching and monitoring client's response.
3. Observe the level and quality of care delivered in relationship to cost.
4. Utilize effective and therapeutic communication techniques during interactions with clients, families, staff, and peers.
5. Differentiate the various roles of staff in each facility and how the roles affect the outcome of the patient's health.
6. Apply principles of time management and organization for the delivery of nursing care.
7. Apply knowledge of health assessment in the evaluation of the patient's safety, health, and environment.
8. Utilize self-evaluation as a means to build upon the student's knowledge base of nursing care and skills.

Course Materials Required

Textbooks:

American Psychological Association, (2010) *Publication manual of the American Psychological Association*, (6th ed.). Washington, DC: Author

Taylor, C., et al. (2015). *Fundamentals of nursing: The art and science of person-centered nursing care.* (8th ed.). Philadelphia: Lippincott Williams & Wilkins. ISBN: 978-1-4511-8561-4

OR

Taylor, C., et al. (2015). *Fundamentals of nursing: The art and science of person-centered nursing care: Student set on thePoint.* (8th ed.). Philadelphia: Lippincott Williams & Wilkins. ISBN: 978-1-4963-2418-4

AND

Taylor, C., et al. (2015). *Skill checklists for fundamentals of nursing: The art and science of person-centered nursing care.* (8th ed.). Philadelphia: Lippincott Williams & Wilkins. 978-1-4511-9366-4

Other Required Resources:

Taylor, C., et al. (2015). *Taylor's video guide to clinical nursing skills: Student set on thePoint.* (2nd ed.). Philadelphia: Lippincott Williams & Wilkins. ISBN: 978-1-496-31648-6

Lippincott DocuCare (2015) Philadelphia: Lippincott Williams & Wilkins **ISBN:** 978-1-4511-7669-8

Other required readings will be posted on the Blackboard Weekly Assignment sheets for each week.

Websites:

Taylor C., Lillis C., LeMone P., & Lynn P. *Lippincott Course Point + Fundamentals of Nursing: The Art and Science of Person-Centered Nursing Care*, (8th) ISBN: 978-1-4963-2418-4 https://lippincottdirect.lww.com/FloridaStateUniversityTallahassee-801d0000001Lz4wAAC.

Grading Scale

This course is graded using Satisfactory/Unsatisfactory measurement criteria. There are no numeric scores or letter grades other than S/U

Course Grade will be determined by:

Weekly Lab Prep Quizzes	S/U
Skills Assessment	S/U
Open Lab	S/U
Final Skills Validation	S/U
Long Term Care Rotation	S/U
(1) LTC Reflective Journals	S/U
SBAR	S/U

Satisfactory (S) in all S/U assignments are required to pass the course.

S/U – Satisfactory is defined as 100% weekly attendance, preparation and satisfactory achievement of weekly lab content evaluation, weekly assessments and final simulation. One week without satisfactory completion of lab preparation materials will result in discussion with lab faculty and establishment of learning contract. Second week without satisfactory completion results in final warning, third unsatisfactory in lab preparation

material results in dismissal from lab course. Skills validation will occur one time, unsuccessful completion of the validation will result in establishment of a remediation plan with assigned clinical faculty; this may include but is not limited to additional laboratory practice time, as well as simulations with assigned faculty member. Final simulation evaluation will allow 2 attempts, unsuccessful completion on the second attempt of the final simulation will result in unsuccessful completion of the course.

Preparation and Practice:
Each week the student can expect to spend a minimum of 4 hours in the skills lab. Students are expected to do the following:

- Come prepared for lab as outlined in weekly lab assignments that are to be completed BEFORE their lab experience each week.
- Wear proper attire (as outlined by CON protocols) in the lab at all times.

Students who miss a lab and have not contacted the instructor prior to the lab, will receive a grade of Unsatisfactory for that lab. Missed skills lab hours that have been **excused** must be made up within 1 week. The student is responsible for contacting their assigned faculty for rescheduling missed lab time.

Additional Practice Hours/Quizzes:
Prior to lab students will be required to view Taylor's videos (see course calendar) that are directly related to the skills being learned that week in lab. With the required videos there are associated quizzes. These quizzes MUST be completed with a score of 80% or above in order for the student to be able to enter the lab. **The quizzes are due no later than 8 pm the night before the student's regular lab time.** Along with the quizzes, students MUST attend 2 additional hours of open lab that will be assigned the week prior to lab. These extra hours of open lab is to ensure skills acquisition. During the extra open lab time, required skills/activities must be demonstrated and signed off by a faculty/TA in the lab (see Course Library for Checklists). Each required skill must only be checked off once during the 2 hours in lab. It is the student's responsibility to have the faculty/TA sign off on the activity/skill once the student has performed the skill. If the student has completed all the required skills/activities in their first hour of open lab they still must show up for the second hour of lab for a total of 2 hours a week. The student will turn in their completed checklist during lab the following week to their lab faculty. If the student has not completed the quizzes and all the open lab time and/or activities, the student will not be able to attend the regular lab time the next week. The student must inform their clinical faculty who will then communicate with the Simulation Coordinator for a scheduled make-up time. These missed skills lab hours must be made up within a week.

Description of Laboratory Activities:
During the semester there will be a clinical application exercise utilizing many of the skills for which the students will be evaluated. These clinical applications can be in the form of simulations, guided simulations and group activities. Group activities can encompass non

procedural skills such as documentation and care map activities. All applications and activities are designed to move from simple to complex learning. A clinical simulation experience is an active event in which students are immersed into a realistic clinical environment situation in the skills lab setting. Simulation experiences give the student an opportunity to demonstrate critical thinking, interpersonal and psychomotor skills. Students will be given the opportunity to achieve a satisfactory return demonstration of learned weekly skills in the laboratory experience. They must use the skills checklists as a guide in addition to instructor feedback. Students are expected to successfully pass all clinical application exercises. Students are still responsible to learn the other required nursing skills in this course even if they are not specifically evaluated in these clinical application exercises.

Laboratory/Clinical Assessment Method:

100% satisfactory completion and validation by a faculty member is required for all laboratory activities. These activities include weekly activities, simulations, and final validations. The following are specific evaluation criteria for the lab portion of this course.

- Students also need to reference and use the skills check lists which are psychomotor skills criteria to help students achieve specific skill competency.
- At the end of the term the students will participate in a formal clinical simulation in the skills lab. The student must achieve 100% satisfactory completion on this final simulation evaluation, which covers the course content. Two attempts are permitted to achieve satisfactory completion. Students are encouraged to continuously practice skills throughout the semester and seek feedback from lab instructors in order to fully prepare for this evaluation. If a student fails to achieve satisfactory completion of this final simulation by the second attempt, the student fails the course.
- The skills check lists, evaluation forms for weekly activities and final evaluations are posted on the course website and are in this syllabus.
- Drug-math calculations, nursing documentation and medical terminology may be a component of any evaluation.
- Students will be evaluated with the clinical evaluation tool at the end of their 3 days in the LTC facility and must meet the academic and professional standards of behavior that ensure patient comfort and safety in order to successfully complete the clinical portion of NUR 3056L.

Long Term Care Rotations

During the second half of the semester students will rotate into a clinical setting for 3 weeks at a long term care (LTC) facility (Westminster Oaks, Brynwood, CenterPoint and Miracle Hill). Students need to note that the times that they will attend clinical in the long term care facility will be different than their regular lab time. A long term care reflective journal will be posted in Blackboard within a week of the clinical rotation. Only 1 reflective

journal will be required during the 3 nursing home rotations. The student must receive a Satisfactory grade while in the LTC rotation.

Long Term Care Reflective Journal

Students must receive an S (satisfactory) grade in the Reflective Thinking Journal.

Reflective Thinking Journal Rubric

Criteria	Satisfactory	Unsatisfactory
Introduction	Includes an introductory paragraph about the issue/situation.	Situation/Issue not described.
Response to Question	Response to question is discussed clearly with one reference from professional literature that supports the rationale.	Discussion is limited and does not clearly answer the question.
Application of evidence-based literature	Two or more quality references from professional literature cited.	There is no professional article cited.
Mechanics	· Includes Title Page. · References properly cited within the paper. · Reference pages include all citations and are in APA format. · Evidence of spell and grammar check with fewer than three grammar and spelling errors. · Journal length meets the one page minimum requirement.	· Does not include a Title Page · References not properly cited within the paper. · Reference page does not include citations and is in APA format. · More than three grammar and spelling errors. · Journal length does not meet length requirement.

		(an Unsatisfactory in Mechanics is received if 4 of the 5 requirements in the mechanics section are unmet)
Timeliness	Journal is submitted within assigned timeframe.	Journal is submitted late.
Final Journal Grade	At least 4 of the 5 Satisfactory criteria are fully met.	Receives Unsatisfactory in 2 or more of the 4 criteria.

Reflective Thinking Journal Questions

Select one of the following questions to complete this assignment:

1. Describe a situation you have observed in your clinical experience where a client received effective nursing care.

a) What made the care effective?
b) Which components will you practice in your nursing practice and why?

2. Reflect on a long-term care visit or client home visit you have made this semester.

a) Identify the nursing skills and competencies you used as you provided care.
b) What did you expect of the visit, and how did the actual visit compare?

SBAR Assignment

During one of the LTC clinical day each student will be given the opportunity to obtain information from a patient's chart, subjective/objective information and assessment of a patient. This is to include the patient's medications (including dose, schedule) and

background/situational information. The student will complete an SBAR form (found in Course Library) and will verbally present the SBAR on their patient during post-conference. Feedback will be given by the student's peers and faculty. Failure for a student to participate in giving feedback to his/her peers during post-conference can result in a 5% deduction in the grade for the assignment.

Instructional Strategies

Self-directed learning modules, web based learning, Demo and return demonstrations, clinical applications, long term care clinical rotation, case studies, virtual clinical excursions, group learning, role playing, simulation based activities.

Course Content

I. FSU Laboratory Safety

- Rules/Protocols/Policies
- Clinical behaviors

II. Introduction to Nursing Practice

- Professional nursing defined
- The nursing process
- The Plan of Care (Care Mapping)

III. Accountability in Nursing Practice

- The role of standards and protocols in institutions
- Interactive communication skills – individual; vertical and horizontal
- Delegating to UAP
- HIPAA

IV. Patient Safety and Evidence Based Practice

☐ Patient safety and safe nursing care (Emphasizing QSEN initiatives and IOM report outcomes) in clinical scenarios ☐ The Link to Practice and Research o An introduction to evidence based practice

o The TeamSTEPPS approach to quality/safety in organizational care

V. Required Nursing Skills and Content:

The following nursing psychomotor skills/procedures will be taught by incorporating rationales for each action and providing evidence based examples of current nursing practice

- Patient identification
- Room/Patient Safety Assessment and Management
- Therapeutic Communication
- Nursing Documentation (paper and electronic charting)

        - Using SBAR and narrative charting
        - Interpreting physician orders and other notations
- Interpreting patient medical records and maintaining patient confidentiality
- Medication math calculations
- Applying restraints
- Managing the confused patient
- Fall Risk Assessment (Morse Scale)
- Pressure Ulcer Risk Assessment (Braden Scale)
- Patient Hygiene Care including oral and peri care
- Infection Control: Isolation practices and proper hand washing
- Bathing Patients
- Making an unoccupied and an occupied bed
- Using mobility devices (crutches, walkers)
- Positioning, transferring and ambulating patients, ROM exercises
- Nursing body mechanics
- Medication Administration (All routes)
- Non parenteral (oral, optic, otic, buccal, nasal, inhaled, topical, rectal)
- Parenteral (intradermal, subcutaneous, intramuscular, intravenous)
- IV management
        - Preparing and administering IV push, IV primary and IV secondary medications
        - Monitoring an IV (saline lock)

- Interpreting glycemic control order sets
        - correctional and nutritional insulin coverage
        - mixing insulin
- Nasogastric tube care
        - insertion, management, nutrition and medication administration
- Ostomy Care, enema administration and management
- Medical Asepsis verses Surgical Asepsis (review of rationale for utilizing each)
- Donning Sterile Gloves
- Sterile wound care
- Suture and staple removal
- Wound drainage devices
- Inserting and managing a urinary catheter
- Oxygen delivery systems (cannula, mask, tent)
- Antiembolism stockings (application and removal)
- SCD management

Course Requirements/Policies

Attendance

Lab attendance is required and students are expected to complete all lab preparation assignments prior to each lab session. All make-up sessions are to be arranged by the student and completed within one week following return to school. Make up sessions are allowed only for documented illness, death in the family, or grave circumstances at the instructor's discretion.

The lab faculty reserves the right to test laboratory content from the textbook, lectures in NUR 3056, videos, study guides/handouts, and any other teaching aids.
Students are expected to attend all of their scheduled university classes. The college reserves the right to deal at any time with individual cases of nonattendance. The effect of absences upon grades is determined by the instructor. Arranging to make up work missed because of legitimate class absence is the responsibility of the student. Lab courses (clinicals) are courses and fall under the class attendance policies.

With documentation, excused absences include documented illness, deaths in the immediate family and other documented crises, call to active military duty or jury duty, religious holy days, and official University activities. Accommodations for these excused absences will be made and will do so in a way that does not penalize students who have a valid excuse. Consideration will also be given to students whose dependent children experience serious illness. University policy requires that all registered students attend the first day of class. (See current FSU Bulletin at http://registrar.fsu.edu/bulletin/undergrad).

Professional Behavior Policy:
The College of Nursing strictly adheres to the Florida State University Academic Honor Code as stated and as delineated in the FSU General Bulletin. In addition, the following apply in the College of Nursing: the CON Academic Honesty Policy, the CON Plagiarism Policy, the Substance Abuse Policy and the Professional Critical Behaviors Policy.

Since each nursing student represents the College of Nursing, the University and the nursing profession, the faculty believes the following are the behaviors deemed to be critical for all nursing students in each learning environment throughout the program of study:

1. Abide by the FSU Academic Honor Code and the Student Conduct Code, the College of Nursing Academic Honesty Policy, Plagiarism Policy, and Professional Critical Behaviors Policy.

2. Exhibit professional nursing behaviors including, but not limited to the following:
   - Dress appropriately at all times when representing the College of Nursing such as adhering to the CON and Agency dress code for courses and clinical assignments.
   - Communicate using appropriate language and terms and demonstrate respect for others including addressing them by proper name and title.
   - Demonstrate ethical behavior including maintaining confidentiality.

- Resolve conflicts appropriately and follow appropriate lines of communication/chain of command.
- Deliver safe, effective nursing care including using appropriate judgment when making decisions; properly using and caring for equipment; and using correct techniques and cautions when delivering care,
- Adhere to the policies and protocols of the College of Nursing, affiliating agencies, the Florida Nurse Practice Act, and the legal mandates of society.

Note: An unsatisfactory in one or more of # 1 and # 2 will result in disciplinary action. This can include, but is not limited to the following:

a. Failing the course regardless of grades in other course requirements; and/or
b. Expulsion from the nursing program.

Individual courses or terms may have course-specific or term-specific behaviors with subsequent consequences. The nursing student is bound by the consequences of the course/term requirements as appropriate.

Late Policy

Due dates are clearly posted for examinations and activities. If you have emergent situations, do not hesitate to contact your lab instructor, and we'll arrive at a solution together. **However, students who miss the due date for an assignment and have not contacted the instructor prior to the due date, will receive a grade of zero.** If you are ill or have a serious problem that prevents you from submitting an assignment on the day it is due, please contact your professor prior to the deadline and we will arrange an alternative date if appropriate. An incomplete (I) will not be given except under extenuating circumstances that are discussed with me (your instructor) before final grades are assigned.

Communication

The Florida State University Bulletin states, "The official method of communication at Florida State University is your my.fsu.edu e-mail account. In order to stay informed and aware, you are required to set up and maintain your account and check it three times per week. If you choose to have your my.fsu.edu official account forwarded to another e-mail account, you are still held responsible for all information distributed by the University to your fsu.edu account". For more information (including how to set up an account) visit www.its.fsu.edu

FSU Academic Honor Policy

The Florida State University Academic Honor Policy outlines the University's expectations for the integrity of students' academic work, the procedures for resolving alleged violations of those expectations, and the rights and responsibilities of students and faculty members throughout the process. Students are responsible for reading the Academic Honor Policy and for living up to their pledge to ". . . be honest and truthful and . . . [to]

strive for personal and institutional integrity at Florida State University." (Florida State University Academic Honor Policy). The Florida State University Academic Honor Policy can be found at
http://fda.fsu.edu/Academics/Academic-Honor-Policy.

Additional CON policies regarding academic integrity can be found in the section regarding Professional Critical Behaviors. Each policy can be found on the College of Nursing website at: http://nurseapps.fsu.edu/policy.html.

Academic Penalties

In the FSU College of Nursing, students violating the Academic Honor Policy in any assignment, test, etc. will receive a minimum penalty of a grade of zero (0) for the assignment in question, will be reported to the Dean and the University Judicial Officer, and may receive an "F" for the course at the option of the instructor.

Americans with Disability Act:

Students with disabilities needing academic accommodation should:
(1) register with and provide documentation to the Student Disability Resource Center; and
(2) bring a letter to the instructor indicating the need for accommodation and what type. This should be done **during the first week of class**.
This syllabus and other class materials are available in alternative format upon request. For more information about services available to FSU students with disabilities, contact the:

Student Disability Resource Center
874 Traditions Way
108 Student Services Building
Florida State University
Tallahassee, FL 32306-4167
(850) 644-9566 (voice)
(850) 644-8504 (TDD)
Email: sdrc@admin.fsu.edu
Website: http://www.disabilitycenter.fsu.edu/

Clinical Clearance

For the health and safety of nursing students and the patients encountered in the nursing program, the FSU College of Nursing and participating agencies require current documentation of CPR, health status, immunizations, professional liability insurance, and health insurance. A copy of FSU College of Nursing Clinical Clearance policy can be found here: http://nurseapps.fsu.edu/pdf/policy/S-4%20Clinical%20Clearance.pdf

e. A faculty member or clinical instructor may request evidence of Clinical Clearance in order for a student to participate in a required clinical experience. Any lapse in Clinical Clearance may result in the student being dropped from courses**.**

Copyright Notice

This course website may contain copyrighted materials that are used in compliance with U.S. Copyright Law. Under that law, materials may not be saved to your computer, revised, copied, or distributed without permission. They are to be used in support of instructional activity as part of this course only and shall be limited to the duration of the course, unless otherwise specified by the instructor or owner of the material. You may only download or print materials at the direction of your instructor, who knows which materials, are copyrighted and which are not. Except for changes that substantially affect implementation of the evaluation (grading) statement, this syllabus is a guide for the course and is subject to change with advance notice. All changes will be done in writing and posted as announcement on the NUR 3056L Blackboard website.

NUR 3056L

Foundations of Nursing Practice Lab

Florida State University **College of Nursing**

Semester: _____ **Instructor:** _____ **Student:**_____

Clinical Evaluation Tool

- Students are expected to adhere to the CON mandatory clinical behaviors.

- The clinical evaluation tool records all activities that occur in the clinical setting.

- Course activities (simulation, lab, hospice, long term care, care map, etc) are incorporated into the clinical evaluation tool.

- A U in any category will initiate a learning contract.

- At the end of the clinical laboratory students must achieve S (satisfactory) or NA in all categories in order to meet the course objectives and pass the course.

Satisfactory: Consistent; may need minimal assistance. Student demonstrates all of the following: consistently follows established rules or protocols; independently incorporates principles and theory from courses; beginning to be self-directed in the majority of activities and skills for which content has been presented; begins to require only minimal assistance for appropriate performance of knowledge, skills, or behavior.

Unsatisfactory: Inconsistent; performance is unsafe. Student demonstrates <u>one or more</u> of the following: is inappropriate or in violation of established rules or protocols; does not associate or apply principles and theory from previous courses to current content and experience; shows limited understanding of rationale for interventions; requires continuous guidance to function safely; shows no or limited progress in skills, knowledge or behavior following instruction or counseling.

NUR 3056L
Foundations of Nursing Practice Lab

Clinical Performance _____(S/U)

SBAR Presentation _____(S/U)

Journal ____(S/U)

STRENGTHS	AREAS FOR IMPROVEMENT
Instructor/Student Comments	Instructor/Student Comments
_____ Instructor's Signature/Date	_____ Student's Signature/Date

OBJECTIVES	RATING	COMMENTS
Dress in accordance with CON requirements at all times when representing the College of Nursing such as adhering to the dress code In the classroom, clinical or community setting.		
Communicate using language and terms that demonstrate respect for others including addressing them by proper name and title.		
Demonstrate ethical behavior including maintaining confidentiality.		
Resolve conflicts by following defined lines of communication/chain of command.		

OBJECTIVES	RATING	COMMENTS
Deliver safe, effective nursing care using sound judgment according to professional standards of practice.		
Adhere to the polices and protocols of the College of Nursing, affiliating agencies, the Florida Nurse Practice Act and the legal mandates of society.		

Week	**Required/Recommended Taylor Videos**	**In Lab Activities**
Week 1 Aug 29- Sept 2nd	**Required with Quiz submission**: **Watch all videos in each module. Quizzes on modules, set # of questions at 10-test mode** Module 1: Asepsis Module 8: Hygiene Module 2: Vital signs **Recommended**: Module 7 Perioperative Nursing Module 10 Activity Module 11 Comfort Module 13 Urinary Elimination Laboratory orientation, review of syllabus, laboratory entry requirements	**NOTE: Lab Prep Work must be done BEFORE you come to lab each week. These prep instructions can be found on BB under Lab Prep tab, each weeks content will be included here:** **In Lab Activities**: Hand hygiene, Asepsis, Patient hygiene, Urinal, Condom Catheter, ADLs, Basic skin care, Braden Scale, Patient Safety, Positioning, Body Mechanics, Isolation, Bed making, Restraints, Ambulation, Crutches, TEDS, Patient Transfer, Fall Prevention (Morse Scale), Range-of Motion Exercises
Week 2 Sept 5-9	**Required Taylor's Clinical Skills Videos: with quiz submission. Quizzes on modules, set # of questions at 10-test mode** Module 9 Skin Integrity &Wound Care **Begin Assigned Open Lab Hours Docu Care Scavenger Hunt**	**In Lab Activities**: Sterile gloving, Sterile wound care, Suture and Staple Removal, Introduction to DocuCAre **Using Skills Checklists**: 23-3-Prepring sterile field 23-4 Putting on/removing sterile gloves 31-1 Cleaning a wound/applying dry dressing 31-2 Applying saline dressing 31-3 Performing wound irrigation 31-4 Caring for Jackson-Pratt 31-5 Caring for Hemovac 31-6 Collecting a wound Culture
Week 3 Sept 12-16	**Required Taylor's Clinical Skills Videos:** Module 5: Injectable Meds	**In Lab Activities**: Glucose Monitoring, Medication Errors Non-Parenteral Medications, SQ (Heparin,

	Module 4: Oral and Topical Meds **Required Quizzes: Quizzes on modules, set # of questions at 10-test mode** Module 4 and 5 only **Required: Open Lab Week 2 checklist**	Insulin), IM, , Medication Orders, PO, Optic, Otic Medication administration **Assessment: Hand hygiene, sterile gloving, wound care** **Using Skills Checklist:** SKILL 23-1: Performing Hand Hygiene SKILL 23-4 Putting on Sterile Gloves and Removing Soiled Gloves SKILL 23-3: Preparing a Sterile Field SKILL 31-2: Applying a Saline Moistened Dressing
Week 4 Sept 19-23	**Required Taylor's Clinical Skills Videos: with quiz submission** **Quizzes on modules, set # of questions at 10-test mode**. Module 7: Perioperative Nursing Module 16: Oxygenation **Recommended**: Module 2: Vital Signs Module 6: IV Medications: Watch only: Introducing Drugs through a medication and Drug Infusion lock Module 18: Watch only: Monitoring an IV site and infusion, unexpected situations, changing peripheral venous access dressing **Required: Open Lab Week 3 checklist**	In Lab Activities: O2 therapy, volume nebulizer, Incentive Spirometry, Inhalation medications, pulse oximetry, IV primary, IV secondary, IV push, **Assessment: Medication administration PO, IM, SQ** **Using Skills Checklist:** SKILL 28:1 Administering Oral Medications SKILL 28:2 Removing Medications from Ampule SKILL 28:3 Removing Medications From Vial SKILL 28:4 Mixing Medications From Two Vials in One Syringe SKILL 28:6 Administering Subcutaneous Injection SKILL 28:7 Administering Intramuscular Injection SKILL 28:8 Administrating Medications by IV Bolus or Push Through an IV Infusion
Week 5 Sept 26-30	**Required Taylor's Clinical Skills Videos:With Quiz submission**	In Lab Activities: Catheterization, Intake and

	Quizzes on modules, set # of questions at 10-test mode Module12: Nutrition Module 14: Urinary Catheterization **Recommended:** Module 13: Urinary Elimination Module 15: Bowel Elimination **Required: Open Lab Week 4 checklist**	Output Measurements, NGT Insertion (food and medication administration), Weights, Enemas, Colostomy Care
Week 6 Oct 3-7	Practice Skills prior to validation Introduction to SBAR Dysphagia Video **Required: Open Lab Week 5 & 6 checklist**	**Assessment: Foley catheterization,** **Using Skill Checklist:** SKILL 35:1 Inserting a NG tube SKILL 35:2 Administering a Tube Feeding SKILL 35:3 Removing a NG tube SKILL 36:5 Catheterizing the Female Urinary Bladder
Week 7 October 10-14 Homecoming 10/14-there **will** be clinical for AM clinical groups **Clinical Begins in Nursing Homes for:** **For AM lab groups: clinical will be 6:00-10:00am**	**Required: Open Lab Simulation I: Patient Transfer**	**Long Term Reflective Journal: Due within one week of clinical** **SBAR Assignment: completed in clinical**

For PM lab groups: clinical will be 11:00-3:00		
Week 8 October 17-21 **Clinical in Nursing Homes** **For AM lab groups: clinical will be 6:00-10:00am** **For PM lab groups: clinical will be 11:00-3:00**	**Required: Open Lab Simulation II: Unexpected Situations**	**Long Term Reflective Journal: Due within one week of clinical** **SBAR Assignment: completed in clinical**
Week 9 October 24-28 **Clinical-Nursing Home** **For AM lab groups: clinical will be 6:00-10:00am** **For PM lab groups: clinical will be 11:00-3:00**	**Required: Open Lab Simulation III: Glucose Alteration**	**Long Term Reflective Journal: Due within one week of clinical** **SBAR Assignment: completed in clinical**
Week 10 October 31-Nov 4	**Clinical Videos:** Module 2: Vital Signs Module 1: Asepsis Module 4: Oral/Topical Medications Module 5: Injectable Medications Module 9: Skin Integrity & Wound Care **Required: Open Lab-Begin Practicing for Final Skills Evaluations**	**Using Skill Checklist:** SKILL 23-4 Putting on Sterile Gloves and Removing Soiled Gloves SKILL 23-1: Performing Hand Hygiene SKILL 23-3: Preparing a Sterile Field SKILL 31-2: Applying a Saline Moistened Dressing SKILL 31-3: Performing Irrigation of a Wound SKILL 24-1 thru 24-4: Vital Signs SKILL 28-6: Administration of Subcutaneous injection SKILL 28-4 Mixing Medications from Two Vials in One Syringe

		SKILL 28-7: Administrating an Intramuscular Injection SKILL 28-1 Administering Oral Medications **Docu Care:** 1.Wound Care: Millie Delong 2. Blood Glucose Testing: Kevin Gargan
Week 11 November 7-11th No classes Friday 11/11-Veteran's Day	**Clinical Videos** Module 2: Vital Signs Module 6: Intravenous Medications Module 12: Nutrition Module 16: Oxygenation **Required: Open Lab-Begin Practicing for Final Skills Evaluations**	**Using Skill Checklist:** SKILL 36-1 Insertion of NG tube SKILL 36-2 Administering a Tube Feeding SKILL 40-2 Changing An IV Solution Container & Administration Set SKILL 40-3 Monitoring an IV site an Infusion SKILL 29-9 Administering a Piggyback Intermittent IV infusion SKILL 33-1 Applying/Removing Anti embolism Stockings SKILL 37-5 Catheterizing the Female Urinary Bladder SKILL 24-1 thru 24-4: Vital Signs **Docu Care:** Oxygenation: Joan McIntyre NGT: Marjorie Horn
Week 12 November 14-18th	**Clinical Videos** Module 2: Vital Signs Module 6: Intravenous Medications Module 14: Urinary Catheters **Required: Open Lab-Begin Practicing for Final Skills Evaluations**	**Using Skill Checklist:** SKILL 39-2 Monitoring an IV site an Infusion SKILL 32-1 Applying/Removing Graduated Compression Stockings SKILL 36-5 Catheterizing the Female Urinary Bladder

		SKILL 24-1 thru 24-4: Vital Signs **Docu Care:** 1. Foley: Esther Bailey
Week 13 November 21-25th **Thanksgiving Holiday 11/23-11/25- TUESDAY LABS 11/22 WILL HAVE CLASS (Evaluations)**	**Practice For Final Skills Validation** **Some Final Skills Validations can begin if ALL Docu Care Scenarios are Complete AND ALL clinical time/open lab is complete by the student** **FINAL EVALUATIONS 11/22: 8-3** **NUR 3056L Section 6 PARK /NUR 3065L Section 4 MCLARTY(KENDALL)** **NUR 3056L Section 5 MCLARTY/NUR 3065L Section 7 MCLARTY(KENDALL)**	**Practice For Final Skills Validation** **Some Final Skills Validations can begin if ALL Docu Care Scenarios are Complete AND ALL clinical time/open lab is complete by the student** **FINAL EVALUATIONS 11/22: 8-3** **NUR 3056L Section 6 PARK /NUR 3065L Section 4 MCLARTY(KENDALL)** **NUR 3056L Section 5 MCLARTY/NUR 3065L Section 7 MCLARTY(KENDALL)**
Week 14 November 28-December 2nd	**Required: Open Lab Week Practice For Final Skills Validation** **Some sections (FRIDAY Group) will need to complete Foley Docu- Care Scenarios** **Clinical Videos** Module 2: Vital Signs Module 6: Intravenous Medications Module 14: Urinary Catheters	**Required: Open Lab Week Practice For Final Skills Validation** **Some sections (FRIDAY Group) will need to complete Foley Docu- Care Scenarios** **Using Skill Checklist:** SKILL 39-2 Monitoring an IV site an Infusion SKILL 32-1 Applying/Removing Graduated Compression Stockings SKILL 36-5 Catheterizing the Female Urinary Bladder

	Some Final Skills Validations can begin if ALL Docu Care Scenarios are Complete AND ALL clinical time/open lab is complete by the student **FINAL EVALUATIONS 11/30: 8-3** **NUR 3056L Section4 WINTON/NUR 3065L Section 5 KENDALL** **NUR 3056L Section3 ABBOTT/NUR 3065L Section 8 MCLARTY**	SKILL 24-1 thru 24-4: Vital Signs **Docu Care:** 1. Foley: Esther Bailey **Some Final Skills Validations can begin if ALL Docu Care Scenarios are Complete AND ALL clinical time/open lab is complete by the studentPractice For Final Skills Validation** **FINAL EVALUATIONS 11/30: 8-3** **NUR 3056L Section4 WINTON/NUR 3065L Section 5 KENDALL** **NUR 3056L Section3 ABBOTT/NUR 3065L Section 8 MCLARTY**
Week 15 December 5-9	**Final Skills Validations** **FINAL EVALUATIONS 12/7: 8-3** **NUR 3056L Section7 WINTON /NUR 3065L Section1 KUNG** **NUR 3056L Section 8 BREWER /NUR 3065L Section3 KUNG** **FINAL EVALUATIONS 12/9: 8-3** **NUR 3056L Section 1 WHYTE / NUR3065L Section 6 KENDALL** **NUR 3056L Section2 BAMBER/NUR 3065L Section 2 GREENHALGH**	**Final Skills Validations** **FINAL EVALUATIONS 12/7: 8-3** **NUR 3056L Section7 WINTON /NUR 3065L Section1 KUNG** **NUR 3056L Section 8 BREWER /NUR 3065L Section3 KUNG** **FINAL EVALUATIONS 12/9: 8-3** **NUR 3056L Section 1 WHYTE / NUR3065L Section 6 KENDALL** **NUR 3056L Section2 BAMBER/NUR 3065L Section 2 GREENHALGH**
Week 16 December 12-16	**Finals Week**	**Finals Week**

NUR 3065 Health Assessment, Wellness and Prevention across the Lifespan

Fall 2016

Instructor Contact Information

Name: Jolynn Greenhalgh, DNP, ARNP
Address:
FSU College of Nursing, office # 445
Duxbury Hall
Tallahassee, Fl. 32306-4310
Fax: 850-644-7660

Office Hours: Mondays 11:00 am to 12:00 pm, 1:30 pm to 2:30 pm, or by appointment. Additional office hours will be announced as needed. Call me please.

Email: jgreenhalgh@fsu.edu
Phone: 850-510-9044 (cell), do not call my office number

Class Meeting Time & Location: CON 214, Mondays 2:30 pm to 5:15 pm.

Credit Hours and Prerequisites:

Credit Hours: 3 semester hours
Prerequisites: Admission to the Nursing Major
Co-Requisite: Semester I Nursing courses

Course Description:

This course introduces the nursing student to concepts and models of wellness and health promotion for individuals, families and communities. Included are communication and interview techniques in compiling a health history, technical skills in performing a physical exam, clinical reasoning skills in doing a health risk appraisal, formulating nursing diagnoses appropriate to identified problems, and understanding the role of the nurse in patient education. Client's cultural differences, development stage, family structure, economic situation, and health behaviors are considered when evaluating health status. In addition, the role of the nurse in patient education is emphasized.

Course Objectives:

Upon completion of this course, the student will:

1. Differentiate health promotion behaviors from health risk behaviors and their effects on individual health outcomes.
2. Relate various cultural values, beliefs, and practices to the health of individuals and their families.
3. Explain the use of selected psychomotor skills and procedures in performing a physical examination.

4. Differentiate among various communication techniques used in gathering and documenting health information.
5. Explore how politics and socio-economic issues impact resources available to individuals, families, and communities.
6. Explain the basic tenets of instruction when applied to patient education.

Course Materials Required:

Textbooks:

Jarvis, C. (2016). *Physical examination and health assessment (7th* ed.). St. Louis, MO: Saunders. (With accompanying on-line student access to textbook resources)

Other Required Reading:
Other required readings will be posted on the Blackboard Weekly Assignment.

Websites:
This course is Web- assisted course. Materials used for class can be found on the NUR 3065 course Blackboard website http://campus.fsu.edu.

Grading Scale:

A	930 - 1000
A-	900 - 929
B+	860 - 899
B	830 - 859
B-	800 - 829
C	750 - 799
D	600 - 749
F	below 600

Course Grade will be determined by:

Evaluation of the course is based on:

Assignment	Proportion of grade	Possible Points
Case Study Presentation	5%	50
Weekly Quizzes x10 (20 points each)	20%	200
Exam #1	25%	250
Exam #2	25%	250
Exam #3 - Final (Kaplan Standardized Exam)	25%	250
	100%	Total 1000

Student must achieve a 75% / 750 points in order to pass the course.

Case Study Presentations:

Case Study Learning Objectives:

1. Explore various abnormal health concerns encompassed in the course.
2. Describe subjective, objective, and assessment findings related to the problem.
3. Critically think through the assessment process discerning normal from abnormal outcomes.
4. Discuss patient/family teaching, risk reduction, and/or a health promotion recommendations related to specific health care needs.
5. Demonstrate effective communication, group work and participation.

Case Studies Instructions:

This is a group assignment. Each group will be given one health problem. Then build your case study with a hypothetical patient. Use initials as the name. Start with the reason for the patient visit (chief complaint) and progress through the history and focused physical exam to the problem or diagnoses. Critically think through the assessment process and formulate a health promotion recommendation for a patient with this problem. See the course calendar for the dates that each will be offered. See the CS schedule and group's student assignment chart.

Power Point presentation: Each group will design a concise Power Point presentation that represents the health problem assigned. It will be presented in the class by all the group members. Be prepared to lead group/class discussion and facilitate critical thinking. Please refer to the grading rubric for specific requirements. The maximum number of points for this portion = 30, and is assigned by the faculty.

References: List your references on a separate slide.
Use at least two sources- one may be your book and your audio/visual/images/video; more if needed. Use APA style for the references.

Participant Names: On the last slide, provide the names of your group members and their responsibilities toward the presentation.

Submit: Submit the group's PP to the appropriate Blackboard Discussion Board site prior to your Monday's class presentation. The due date and time is no later than Sunday at 10:00 p.m. the day before your scheduled presentation. Points will be deducted for late submission.

Participation: Each member of every group will complete the Student Peer Review Evaluation Form for Group Work/ Participation. Assign 0 to 4 points for each of the categories: responsibility, quality, timeliness, communication, and teamwork. The maximum number of points for this portion = 20, and these points are assigned by your peers.

Submit: Submit each Form under the Blackboard Assignment tab. The due date and time is no later than Friday at 10:00 p.m. (4 days) following your presentation. Points will be deducted for late submission.

Grading Rubric: See below
Student Peer Review Evaluation Form for Group Work/ Participation: See below

Quizzes:
There are ten weekly quizzes that are given on the same day as the class's content on that system. The quizzes have ten questions in multiple formats, including: fill in the blank, matching, labeling, sequencing, and choose all that apply. There also will be at least two Kaplan questions from the Kaplan system's practice questions. The Kaplan quiz questions are multiple choice, and are included to help familiarize students to the types and complexity of Kaplan questions. The student should prepare for the week's topic before class, review and reinforce content during class, verify answers following the quiz, and support your learning as you go into the lab. These quizzes have a maximum point score of 20, and count as 2% each toward your final grade. (10 quizzes X 20 points = 200 possible points / 20% of the total grade)

Exams:
There will be two multiple choice exams given during class time. They both have a maximum point value of 250 points and count as 25% of your grade each.
Kaplan Final Exam:
The final examination for the course is the Kaplan standardized examination. This exam will be administered on-line, at the FSU testing center and the CON computer center. This is a challenging exam which will test the cumulative content from the course. The exam is scored according to a 'raw score' that will be applied to a grading scale, which is posted below. The exam is a standardized examination with an established mastery score. The minimal mastery score will equilibrate to a grade of 80% for course grading purposes.

Raw Score	Assigned Grade (%)
75	100
74	100
73	100
72	100
71	100
70	100
69	99
68	98
67	97
66	96
65	95
64	94
63	93
62	92
61	91
60	90
59	89
58	88

57	87
56	86
55	85
54	84
53	83
52	82
51	81
50	80
49	79
48	78
47	77
46	76
45	75
44	74
43	73
42	72
41	71
40	70
39	69
38	68
37	67
36	66
35	65
34	64
33	63
32	62
31	61
30	60
29	59
28	58
27	57
26	56
25	55
24	54
23	53
22	52
21	51
20	50
19	49
18	48
17	47

Instructional Strategies:

Lecture, discussion, demonstration, case study power point presentations, audio-visual material, individual practices, group work, role play, readings, guest speakers, class attendance, quizzes, exams, and Kaplan resources utilization and final exam.

Course Content:

I. Health and Wellness across the Lifespan

- Disease prevention
- Levels of care
- Healthy People 2020
- Health policies, economic factors, and current trends

II. Family and Community

- Family theory, structure, roles and functions
- Group communication and dynamics
- Cultural variations, impact of population migration
- Genetic and environmental factors affecting health
- Resource availability and use

III. Health Assessment

- Physical, psychosocial and developmental assessment
- Interviewing and communication skills
- Health history
- Genogram
- Risk factors and health appraisal
- Nursing diagnosis
- Physical examination skills
- Documentation of health assessment findings

IV. Health Education

- Available Health education resources (Accuracy and Literacy Level)
- Principles of instruction
- Assessment of educational needs and readiness to learn

Course Requirements/Policies:

Attendance Policy:

Students are expected to attend all of their scheduled university classes. The college reserves the right to deal at any time with individual cases of nonattendance. The effect of absences upon grades is determined by the instructor. Arranging to make up work missed because of legitimate class absence is the responsibility of the student. Lab courses (clinicals) are courses and fall under the class attendance policies.

With documentation, **excused absences** include documented illness, deaths in the immediate family and other documented crises, call to active military duty or jury duty,

religious holy days, and official University activities. Accommodations for these excused absences will be made and will do so in a way that does not penalize students who have a valid excuse. Consideration will also be given to students whose dependent children experience serious illness. University policy requires that all registered students attend the first day of class. (See current FSU Bulletin at http://registrar.fsu.edu/bulletin/undergrad).

Note: for *Health Assessment* specifically- class attendance is required for this course. Students who are late for class, or who miss class without instructor approval, will not be allowed to take the weekly quiz on the date missed. Attendance will be monitored throughout the semester. Any student missing more than one class will receive a reduction of 1 to 5 points per subsequent absence from their final course grade. If an absence is necessary, prior arrangements must be made with the instructor in order to prevent a reduction in the final course grade. You must contact your instructor immediately if you know you will miss a class via phone or course e-mail. Documentation is required for excused absences.

Late Policy:

The dates listed for assignments may change as the semester progresses. If they do, you'll be notified through the course Announcements on Blackboard. However all assignments are expected to be completed on time. The standard policy regarding late assignments is 10% penalty for late assignments turned in within 1 week of due date and 10% penalty per week for assignments turned in thereafter until the end of the course (defined as the last regular class section). Any exceptions to this policy are made at the discretion of the instructor. If you have conflicts, or something unexpected arises, do not hesitate to contact your instructor. Students with incomplete assignments at the end of the course will be given the earned final grade. An incomplete (I) will not be given except under extenuating circumstances that are discussed with me (your instructor) before the final grades are assigned.

Note: for *Health Assessment* specifically- students who miss the due date for an assignment and have not contacted the instructor prior to the due date, will receive a grade of zero. If you are ill or have a serious problem that prevents you from submitting an assignment on the day it is due, please contact your instructor prior to the deadline and we will arrange an alternative date if appropriate.

Communication:

The Florida State University Bulletin states, "The official method of communication at Florida State University is your my.fsu.edu e-mail account. In order to stay informed and aware, you are required to set up and maintain your account and check it three times per week. If you choose to have your my.fsu.edu official account forwarded to another e-mail account, you are still held responsible for all information distributed by the University to your fsu.edu account". Students can go to http://fsu.edu/myfsu to confirm their settings or visit http://www.helpdesk.fsu.edu. For more information (including how to set up an account) visit www.its.fsu.edu.

FSU Academic Honor Policy:
The Florida State University Academic Honor Policy outlines the University's expectations for the integrity of students' academic work, the procedures for resolving alleged violations of those expectations, and the rights and responsibilities of students and faculty members throughout the process. Students are responsible for reading the Academic Honor Policy and for living up to their pledge to ". . . be honest and truthful and . . . [to] strive for personal and institutional integrity at Florida State University." (Florida State University Academic Honor Policy). The Florida State University Academic Honor Policy can be found at http://fda.fsu.edu/Academics/Academic-Honor-Policy

In addition, the following apply in the College of Nursing: the CON Academic Honesty Policy (S -10), the CON Professional Critical Behaviors Policy (S -13 Attachment 1), and the CON Substance Abuse Policy (S - 5). Each policy can be found on the College of Nursing website at: http://www.fsu.edu/~nursing/policy.html

Academic Penalties:
In the FSU College of Nursing, students violating the Academic Honor Policy in any assignment, test, etc. will receive a minimum penalty of a grade of zero (0) for the assignment in question, will be reported to the Dean and the University Judicial Officer, and may receive an "F" for the course at the option of the instructor.

Professional Critical Behavior Policy:
The College of Nursing strictly adheres to the Florida State University Academic Honor Code as stated and as delineated in the FSU General Bulletin. In addition, the following apply in the College of Nursing: the CON Academic Honesty Policy, the CON Plagiarism Policy, the Substance Abuse Policy and the Professional Critical Behaviors Policy.
POLICY: Since each nursing student represents the College of Nursing (CON), the university and the nursing profession, the faculty believes the communication skills, professional dress, conflict resolution, safe provision of care and adherence to policy and procedure deemed to be critical for all nursing students in each learning environment throughout the program of study.
Exhibit professional nursing behaviors including, but not limited to the following:

1. Dress in accordance with CON requirements at all times when representing the College of Nursing such as adhering to the dress code in the clinical or community setting.
2. Communicate using language and terms that demonstrate respect for others including addressing them by proper name and title.
3. Demonstrate ethical behavior including maintaining confidentiality.
4. Resolve conflicts by following defined lines of communication/chain of command.
5. Deliver safe, effective nursing care using sound judgment according to professional standards of practice.
6. Adhere to the policies and protocols of the College of Nursing, affiliating agencies, the Florida Nurse Practice Act and the legal mandates of society.

Classroom and Lab Civility:

Incivility in nursing education is defined as rude or disruptive behaviors which often results in physiological or psychological distress for people involved and if left unaddressed, may progress into a threatening situation (Clark, Farnsworth, & Landrom, 2008). Civility contributes to patient safety, student and faculty safety, patient satisfaction, and the learning environment. Civility includes behaviors of preparedness, respectfulness, and open-mindedness. I understand that civility incorporates teamwork, collaboration, and open effective communication. Faculty, staff, and clinical agencies will establish clear expectations of students, have respect for students, and provide feedback in an objective manor.

1. I will attend class on a regular basis, be on time, remain throughout the class, and stay attentive.
2. Dress in accordance with CON requirements at all times when representing the College of Nursing such as adhering to the dress code for courses and clinical assignments.
3. Communicate using language and terms that demonstrate respect for other including addressing them by proper name and title.
4. Demonstrate ethical behavior including maintaining confidentiality.
5. Resolve conflicts by following defined lines of communication/chain of command.
6. Deliver safe, effective nursing care using sound judgment according to professional standards of practice.
7. Adhere to the policies and protocols of the College of Nursing, affiliating agencies, the Florida Nurse Practice Act and the legal mandates of society.

Examples of uncivil behavior (not exclusive):

- Disrespect to other Students/Faculty including:
  - Demeaning, belittling or harassing others
  - Rumoring, gossiping about or damaging a classmate/professors reputation;
  - Habitually interrupting as others speak
  - Habitually arriving late to class
  - Yelling or screaming at instructors, peers, or clinical staff.
  - Questioning Faculty credibility
- Use of personal mobile devices during class or clinical without authorization of faculty or the clinical agency partners
- Neglecting to pay attention or listening to others who address you; not responding to email, letters, or voicemail in a timely fashion.
- Inappropriate emails or use of social media, such as those which are inflammatory in nature
- Speaking with a condescending attitude
- Knowingly withholding information or refusing help needed by a peer, instructor, or clinical staff.
- Discounting or ignoring solicited input from instructors/faculty regarding classroom and/or clinical performance or professional conduct.
- Overruling a decision without direct discussion and rationale

• Neglecting to share credit for collaborative work or not completing an equitable share of collaborative work assigned.
• Threatening others; this refers to physical threats, verbal/nonverbal threats, and implied threats.
• Displays of temper, tantrums
• Escalation to threatened or actual violence

Americans with Disability Act:

Students with disabilities needing academic accommodation should:

(1) register with and provide documentation to the Student Disability Resource Center; and

(2) bring a letter to the instructor indicating the need for accommodation and what type. This should be done during the first week of class.

This syllabus and other class materials are available in alternative format upon request. For more information about services available to FSU students with disabilities, contact the:

Student Disability Resource Center
874 Traditions Way
108 Student Services Building
Florida State University
Tallahassee, FL 32306-4167
(850) 644-9566 (voice)
(850) 644-8504 (TDD)
Email: sdrc@admin.fsu.edu
Website: http://www.disabilitycenter.fsu.edu/

Free Tutoring from FSU:

On-campus tutoring and writing assistance is available for many courses at Florida State University. For more information, visit the Academic Center for Excellence (ACE) Tutoring Services' comprehensive list of on-campus tutoring options - see http://ace.fsu.edu/tutoring or contact tutor@fsu.edu

Copyright Notice:

This course website may contain copyrighted materials that are used in compliance with U.S. Copyright Law. Under that law, materials may not be saved to your computer, revised, copied, or distributed without permission. They are to be used in support of instructional activity as part of this course only and shall be limited to the duration of the course, unless otherwise specified by the instructor or owner of the material. You may only download or print materials at the direction of your instructor, who knows which materials, are copyrighted and which are not.

Except for changes that substantially affect implementation of the evaluation (grading) statement, this syllabus is a guide for the course and is subject to change with advance notice. All changes will be done in writing and posted as announcement on the NUR 3065 Blackboard website.

(CON 05/12) (Greenhalgh, 8/2016)

Course Schedule

NUR 3065: Health Assessment Calendar Fall 2016 Jolynn Greenhalgh, DNP ARNP		
	Topic	**Required Reading/ Assignments**
Week 8/29	Introduction Kaplan resources, clinical documentation with DocuCare Interview, communication, culture **Core Unit** (Core concepts are testable on every course exam.) Health history, functional assessment Vital signs, pain, measurements	Jarvis chapters 2,3,4, 8, 9, 10, 27 Health History forms 1 & 2 **Review videos- weekly** **Practice- weekly** **Listen to audio classes- weekly prn** Quiz # 1
Week 2 9/5	**No Class- Labor Day** Examination of the integument- on-line PP on Blackboard (HA Lab - Complete a health history on a classmate)	Jarvis: chapters 12 Quiz # 2 during lab
Week 3 9/12	**Core Unit** The respiratory exam (HA Lab – show proficiency taking vital signs)	Jarvis: chapter 18 Quiz # 3 Case studies # 1 & 2
Week 4 9/19	**Core Unit** The cardiovascular exam Denise Tucker, PhD, RN	Jarvis: chapters 19, 20 Quiz # 4 Case studies # 3 & 4
Week 5 9/26	Rescuing the decompensating patient (HA Lab - cardiac/respiratory simulation)	Jarvis: chapter none, Whyte PP Quiz # 5 Case studies # 5 & 6
Week 6 10/3	Nutritional assessment Examination of the abdomen Examination of the musculo-skeletal system (HA Lab - Validate respiratory and cardiac/ peripheral circ. Exam)	Jarvis: chapter 11 Jarvis: chapter 21, 25 Jarvis: chapter 22 Quiz # 6 Case study # 7 & 8
Week 7 10/10	**Exam # 1**	Exam #1
Week 8 10/17	The mental status exam The neurological exam (HA Lab - Validate abdomen and musculo-skeletal exam)	Jarvis: chapter 5 & 23 Quiz # 7 Case studies # 9 & 10
Week 9 10/24	The HEENT exam (HA Lab - Validate mental and neuro exam)	Jarvis: chapter 13, 14, 15, 16 Quiz # 8

		Case studies # 11
Week 10 10/31	Examination of the eyes and ears Testing visual and auditory acuity	Jarvis: chapter 14, 15 Quiz # 9 Case studies # 12 & 13
Week 11 11/7	Examination of the genitourinary system- male and female Breast Exam (HA Lab - Validate HEENT)	Jarvis: chapter 24, 26, 17 Quiz # 10 Case study # 14- as needed & make-up
Week 12 11/14	Review bedside assessment (HA Lab - Environmental presentations)	Jarvis: chapter 29
Week 13 11/21	**Exam # 2** HA/Foundations Lab Final Evaluations - Tues. 11/22 (Sec. 4 & 7)	Exam # 2
Week 14 11/28	Examination of the neonate and infant Child development Mandy Bamber, PhD, RN HA/Foundations Lab Final Evaluations – Wed 11/30 (Sec. 5 & 8)	Jarvis: chapter 28
Week 15 12/5	Review full assessment- history and head-to-toe exam & final Lab Final Evaluations – Wed 12/7 (Sec. 1 & 3), Fri 12/9 (Sec. 6 & 2)	Jarvis: chapter 27 Course Evaluation
Finals Week	**Cumulative Final Exam** Tuesday 12/13/16, 7:30 to 9:30 am, FSU Testing Center & CON	Exam #3- Kaplan Final (Physical Assessment 113)

Grading Rubric: Health Assessment Case Study Presentation

Grading Rubric: Health Assessment Case Study Presentation			
Total possible points = 50			
Group Case Study Presentation of a Hypothetical Patient	Points Possible	Points Assigned	Comments
SUBJECTIVE DATA:			
Patient profile: age, occupation, gender- born, current	1		
Reason for seeking care / Chief Complaint	1		
History of the Present Illness: describe problem/symptoms: OPQRST, OLDCARTS, location, quality, quantity or severity, timing- onset, chronic or episodic, duration, frequency, setting, precipitating, aggravating or alleviating factors, and self-treatment. Be focused and concise.	5		
Past Medical History (major medical problems, chronic illness, and status of condition, allergies, immunizations, surgeries,	1		

hospitalizations/severe injuries, and tobacco, alcohol, and illicit drug use as needed to contribute to the case study			
Family History (focused and applicable to CC and HPI if needed)	S/U		
Psychosocial History (focused and applicable to HPI if needed)	S/U		
OBJECTIVE DATA:			
Physical Exam to support the problem or diagnosis	5		
Provide an audio and/or visual link, YouTube, images, etc. that represents the problem appropriately.	5		
ASSESSMENT:			
Diagnosis or problem identification and a brief definition	2		
MANAGEMENT PLAN:			
Discuss at least 1 of the following: patient/family teaching, risk reduction instructions, health promotion recommendations, etc.	5		
PRESENTATION:			
Power point presentation style	1		
Lead group discussion and facilitate critical thinking	2		
References- two or more sources, listed in APA format	2		
Group names and responsibilities	S/U		
Submit PP to the Blackboard DB thread. Due 1 day prior to presentation (Sunday at 10:00 p.m.)	S/U		
Failure to submit in a timely manner (per day)	-5		
Faculty assigned points possible	30		
PARTICIPATION:			
Each student will use the *Student Peer Evaluation Form for Group Work/ Participation* to calculate the total points you assign to each group member. The total points for each student will be averaged for an individual score. (0 to 20 possible points per peers)	0 - 20		
Each student will submit the *Form* to the Assignment tab. Due by 4 days following the presentation (Friday at 10:00 p.m.)	S/U		
Failure to submit in a timely manner (per day)	-5		
Total Points	**50**		

Student Peer Evaluation Form for Group Work/Participation

NUR 3065 Health Assessment Case Study Presentation
Student Peer Evaluation Form for Group Work/Participation
Fall 2016 Greenhalgh

Case Study Group # _____ Health Assessment Problem: _____

	Evaluation Criteria	Group Member #1- Your Name	Group Member #2	Group Member #3	Group Member #4	Group Member #5	Group Member #6
	For each student participant of the group, indicate a point value for each of the 5 criteria categories: **0** = inadequate/very poor, **1** = poor, **2** = adequate, **3** = good, **4** = very good You may add comments.						
1	Took **responsibility** for their portion of the group presentation (did the work).						
2	Produced work that met or exceeded the **quality** expected for the work.						
3	Completed the assigned task **on time.**						
4	**Communicated** effectively with others in the group- meeting attendance, availability, positive interactions, etc.						
5	Contributed to the **group/team** success with involvement, new ideas and/or information, organization, and cooperation.						
	(Max Possible Points = 20) **Total Points**						

Florida State University College of Nursing

Syllabus for NUR 3065L Health Assessment, Wellness and Prevention Across the Lifespan Lab

Fall 2016

Instructor Contact Information

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Class Meeting Time & Location

CON 212 Health Assessment Lab

Section	Day	Time	Faculty	Final Evaluation with Foundations (assigned times)
1	Tuesday	8-10	Kung	Wed. Dec. 7
2	Monday	9-11	Greenhalgh	Fri. Dec. 9
3	Tuesday	10:10-12:10	Kung	Wed. Dec. 7
4	Tuesday	1-3	McLarty	Tues. Nov. 22
5	Friday	9-11	Kendall	Wed. Nov. 30
6	Friday	1-3	Kendall	Fri. Dec. 9
7	Wednesday	1-3	McLarty	Tues. Nov. 22
8	Wednesday	3:05-5:05	McLarty	Wed. Nov. 30

Credit Hours and Prerequisites

Credit Hours: 1 semester hour = 2 hours of lab per week
Prerequisites: Admission to the Nursing Major

Co-Requisite: Semester I Nursing courses

Course Description

This course provides the application component of NUR3065. Under the guidance of lab
Instructors, the student is given opportunities to integrate theoretical knowledge from NUR3065 in practice sessions using demonstration; low, medium, and high fidelity simulation scenarios, deliberate practice, debriefing, and reflective instructional approaches.

Course Objectives

Upon completion of this course, the student will:

7. Use knowledge of health promotion behaviors versus health risk behaviors in planning care for individuals/families.
8. Relate various cultural values, beliefs, and practices to the health of individuals and their families.
9. Demonstrate selected psychomotor skills and procedures in performing a physical examination.
10. Use various communication techniques used in gathering and documenting health information.
11. Acquire knowledge of the basic tenets of learning and instruction in meeting patient/family education needs related to health.

Course Materials Required

Textbooks:

Jarvis, C. (2016). *Physical examination and health assessment (*7th ed.). St. Louis, MO: Saunders. (With accompanying on-line course)

Other Required Reading:
Other required readings will be posted on the Blackboard Weekly Assignment sheets for each week.

Websites:
This course is Web-assisted course. Materials used for class can be found on the NUR 3065L course Blackboard website http://campus.fsu.edu.

Taylor, C., et al. (2015). *Taylor's video guide to clinical nursing skills: Student set on thePoint.* (2nd ed.). Philadelphia: Lippincott Williams & Wilkins.

Agency for Healthcare Research and Quality, U.S. Preventive Services Task Force (USPSTF). (2016). Electronic Preventive Services Selector (ePSS) mobile application for preventive services. Retrieved from http://epss.ahrq.gov/PDA/index.jsp Download to your mobile device to use in patient teaching for lab.

Instructional Strategies

Discussion, demonstration, simulation experience, individual practices, group work, role play, audio-visual materials, readings, class attendance.

Course Content

I. Health and Wellness across the Lifespan

- Disease prevention
- Levels of care
- Healthy People 2020
- Health policies and economic factors

II. Family and Community

- Family theory, structure, roles and functions
- Group communication and dynamics
- Cultural variations
- Genetic and environmental factors affecting health
- Resource availability and use

III. Health Assessment

- Physical, psychosocial and developmental assessment
- Interviewing and communication skills
- Health history
- Genogram
- Risk factors and health appraisal
- Nursing diagnosis
- Physical examination skills
- Documentation of health assessment findings

IV. Health Education

- Available Health education resources (Accuracy and Literacy Level)
- Principles of instruction
- Assessment of educational needs and readiness to learn

Grading Scale Satisfactory or Unsatisfactory

Course Grade will be determined by:

Satisfactory (S) in all S/U assignments are required to pass the course.
Satisfactory is defined as weekly attendance, and satisfactory performance on the history taking, skills assessment, clinical simulation, environmental assessment, and the final evaluation. A score of "S" (satisfactory) for each component is required. Students who received more than one "U" (unsatisfactory) for any of the following components may result in a failure for this course. Assessment skills assessment will occur one time. Unsuccessful assessment of a system and/or the final evaluation will result in establishment of a remediation plan with assigned clinical faculty. This may include but is not limited to additional laboratory practice time, as well as simulations with assigned faculty member. Assessments and the Final Simulation Evaluation will allow 2 attempts; unsuccessful completion on the second attempt will result in unsuccessful completion of the course.

Assignment	Due on Lab Day	Scoring
I-Health History and Review of Systems (ROS)	See Course Calendar	S/U
II- Skills Assessments Respiratory Cardiovascular Abdominal Musculoskeletal Neurological HEENT	See Course Calendar and Lab Schedule by Section	S/U S/U S/U S/U S/U S/U
III-Clinical Simulation: Participation in the simulation activity, and Complete the assessment documentation in DocuCare	See Course Calendar	S/U
IV- Environmental Assessment Group Project/Presentation.	See Course Calendar and Lab Schedule by Section	S/U
V- Final Health Assessment/Foundations Evaluation	See Course Calendar	S/U

Course Requirements

Course Requirements

I-Health History and Review of Systems (ROS)-Students will bring a copy of their genogram to class in the second week. Each student will practice interview skills by taking a health history on a peer in class using the health history provided in the course syllabus. Include a summary of your findings. When complete, the student being interviewed does a peer review of the document to assure it is correct and areas are not omitted. The health history, review of systems, and summary is then uploaded onto the Blackboard Assignment.

II- Skills Assessments-Student will perform assessments for each of the system areas identified. The student will peer critique each of the assessment areas using weekly physical assessment criteria forms available on Blackboard. Faculty will supervise these activities during class time and provide deliberate practice feedback. Students are expected to practice these skills both **inside and outside of the** weekly class/lab setting in order to demonstrate mastery during scheduled assessments. Student will demonstrate their skills and show competence for scheduled assessments. Students are given two chances to successfully complete skills to receive a satisfactory grade. Remediation will result if unsuccessful in skills assessment at the first unsatisfactory attempt. More than one unsatisfactory systems skill assessment may result in an unsatisfactory for this course.

Refer to the Health Assessment Lab forms, as they are also used for student assessment. The forms are included in this syllabus and are posted on the Blackboard lab course site.

III- Clinical Simulation- There is one clinical simulation experience scheduled for the course. A clinical simulation experience is an active event in which students are immersed into a realistic clinical environment situation in the skills lab setting. Simulation experiences give the student an opportunity to demonstrate critical thinking, interpersonal and psychomotor skills. To prepare, review the “Setting the Stage” information related to the two patient scenarios to be done, and enroll in DocuCare using your section’s class code. Students will work in groups of 3-4 students. Each group will assess and provide care for two patients, and the group will give a verbal report (SBAR report) to the faculty on each patient seen. Each student will complete their own DocuCare documentation for both of the patients, and submit it to the link under the Assignments tab. Successful completion of this simulation activity requires participation and the submission of documentation.

IV- Environmental Assessment Group Project and Power Point Presentation-This is a group project with 2-3 students in each group. Each group will create a 5-10 minute PowerPoint presentation of an at risk client utilizing a student’s current living space by:

1. The project will be based on the need to transition an elder person from a hospital setting, to living independently in the home. The patient is 77 years old and lives alone. The patient has just suffered a stroke with residual hemiplegia. The following factors are to be considered: 1) the patient is ambulatory, but uses a walker. 2) While capable of independent toileting, the patient has trouble rising from a deep squat. 3) The patient has moderate visual impairment related to macular degeneration. 4) The patient fell once in hospital, not long before discharge when the walker became stuck in a doorway.
2. Conduct an environmental assessment utilizing one of the student’s living space.

3. Complete a photo-journal of this student's own living space including the entrance, living area, kitchen, and bathroom.
4. Identify factors present that may potentially place their client at risk.
5. Present the findings in class in a Power Point presentation that will be graded by the course faculty member.

Grading Rubric For Environmental Assessment		
Group Members:		
Component	Comments	Check if completed
Provides photos of the entrance, living area, kitchen and bathroom.		
For each of the above, list the possible dangers associated with the elements of each setting. Do so on a separate slide for each.		
Select and present 3 nursing diagnosis for the theoretical patient.		
Develop a plan to address each of the identified shortcomings. Do so on a separate slide for each of the living areas.		
Present the local area options for mass transit, including the distance to bus stops, etc.		

V- Final Evaluation-The final comprehensive evaluation will include a student's ability to perform a bedside physical examination. These skills will be performed during the formal clinical simulation of the combined Foundations/Health Assessment Lab's Final Evaluation. The student will be given a patient scenario and will review the chart. The student will assess and provide care for that patient with the Foundations faculty, and then will give an SBAR Report to the Health Assessment faculty. The SBAR report will communicate pertinent health status and nursing care information. The student must achieve satisfactory completion on this final simulation evaluation, which covers the course content. Two attempts are permitted to achieve satisfactory completion. If a student fails to achieve satisfactory completion of this final simulation by the second attempt, the student fails the course. Students are encouraged to continuously practice skills throughout the semester and seek feedback from lab instructors in order to fully prepare for this evaluation.

Health Assessment / Foundations Final Evaluation SBAR Report Form

SBAR Report Form
NUR 3056L Foundations Lab & NUR 3065L Health Assessment Lab
Before giving a Caregiver report:
1. This tool must be utilized when giving verbal or written report

2. Send current medication list if appropriate
3. Report must include a recent assessment
4. Report must allow for clarifications/questions
5. Only report on pertinent information related to the current patient situation
SITUATION
Admission Date¬_____ [ ] MRSA [ ] VRE [ ] C-Diff
Chief Complaint/Dx/OR Procedure:_____
Allergies:_____ _____ _____ _____
Consulting Physician/s:_____
Durable Power of Attorney [ ] Yes [ ] No [ ] On chart Code Status: [ ] Full Code [ ] No Code [ ] No Vent
Other
BACKGROUND (Be prepared to discuss any change from prior assessments)

( ) Asthma	( ) Glaucoma	( ) Kidney Disease	( ) MI	( ) ETOH Abuse
( ) Emphysema	( ) Diverticulitis	( ) Thyroid	( ) Cardiac Cath	( ) Smoker
( ) Arthritis	( ) Ulcer	( ) Stroke/TIA	( ) CABG/Bypass	
( ) Cancer	( ) Osteoporosis	( ) Angina	( ) Hyper/hypotension	
( ) Hepatitis	( ) Seizure	( ) Heart Disease (CAD)	( ) Mental Illness	
( ) Diabetes	( ) CHF	( ) Palpitations	( ) Dementia	

( ) Other_____
_____
_____

ASSESSMENT of the situation

VITAL SIGNS:	**ENDOCRINE:**
B/P_____ P_____ O2 SAT_____ T_____ RR_____ Pain Score_____ Comfort goal_____ Last pain med/intervention_____ Time _____ Post intervention score_____	BBG frequency_____ Diabetic teaching_____
NEUROLOGICAL:	**INTEGUMENTARY:**
Mental Status_____ Glasgow Coma Score_____ Behavior_____ Restraints ( ) Sitter ( ) Pupils_____ Facial droops ( ) Speech ( ) Arm drift ( )	Skin integrity_____ Turgor (Mucus membranes ( ) Wounds ( ) Incision ( ) Pressure ulcers ( ) Location(s) ( ) _____

RESPIRATORY: Lung sounds: Clear ( ), wheeze/rhonchi ( ), crackles Dyspnea ( ) Retractions ( ) Oxygen ( ) Liter flow _____ Aspiration precautions _____	**HEMATOLOGY/ONCOLOGY:** Neutropenia _____ Chemotherapy ( ) Radiation ( )
CARDIOVASCULAR: Heart sounds_____ Cardiac rhythm_____ Dysrhythmias ( ) Interventions ( ) Peripheral pulses_____ Peripheral edema ( ) Capillary refill_____ Cardiac monitor_____	**CHEST TUBES/DRAINS/TUBES:** Location/condition/incision appearance _____
GASTROINTESTINAL: Bowel sounds_____ Abdomen contour_____ Tenderness to palpitation ( ) Diet ( ) NPO ( ) Fluid restriction ( ) Tube feeding ( ) NGT ( ) Peg ( ) Duo tube ( ) Nausea ( ) Vomiting ( ) Incontinence ( ) Rectal tube ( )	**IV ACCESS:** Saline lock ( ) PICC ( ) CL location ( ) Site appearance_____ IV fluids ( ) Type _____ Rate ( ) Titrations ( ) Blood products ( ) IVPB( ) IV tubing: date to be changed_____
UROLOGICAL/GYNECOLOGICAL: Urine color ( ) Amount if needed_____ I & O ( ) Bladder distention ( ) Incontinence ( ) Foley ( ) Catheter ( ) CBI ( ) Dialysis ( )	**REPRODUCTIVE:** LMP_____ Pregnant ( ) Recent birth ( ) Breast feeding ( ) Menopausal ( )
MUSCOLOSKELETAL: Muscle strength_____ Hand grip ( ) Feet ( ) ROM ( ) Activity level_____ Fall precautions_____ Morse Fall Score _____	**Pertinent Medications:**

Pertinent Diagnostic Values:

PT/INR/PTT _____	K+ _____	EKG _____
PLT _____	Na _____	CXR _____
H & H _____	BUN _____	Other _____
WBC _____	Creatinine_____	_____

Vital Signs Frequency every _____ hours Latest Vital Signs: BP _____P _____ RR _____O2 Sat _____ T _____	**Pain** Free of pain ( ) Yes ( ) No Last Pain Medication_____ Time_____
Blood Sugars:	**Daily Weight:**

Special equipment/devices/protocol:				
IVs Solution _____	**PROTOCOLS**	**Tubes/Drains**	**Other Equipment**	**Assistive Devices**
( ) Saline Lock_____	( ) ETOH	( ) Foley	( ) Oxygen	( ) Glasses/Contacts
( ) Peripheral	( ) Heparin	( ) JP	( ) Sequential hose	( ) Dentures
( ) Central Line		( ) T-Tube	( )CPM	( ) Hearing Aid
( ) PICC		( ) NG		( )
Other_____				
( ) Med Port		( ) Tube feeding		
_____				
( ) PCA		( ) Chest tube		
_____				
RECOMMENDATION/REQUEST				
Anticipated discharge needs_____				
Specimens needed: ( ) Stool ( ) Urine ( ) Sputum		**Tests needed:** ( ) CXR ( ) ANG ( ) EKG ( ) CBC ( ) Other		
Other_____				
This form is only a tool to be used during patient's hospital stay and does not become part of the permanent record.				
Satisfactory _____ **Unsatisfactory** _____			Date:	
_____				
Faculty Signature:		Student Signature:		
rev 12/2015				

Course Policies

Attendance Policy

Students are expected to attend all of their scheduled university classes. The college reserves the right to deal at any time with individual cases of nonattendance. The effect of absences upon grades is determined by the instructor. Arranging to make up work missed because of legitimate class absence is the responsibility of the student (See current FSU Bulletin). Lab courses (clinicals) are courses and fall under the class attendance policies.

With documentation, **excused absences** include documented illness, deaths in the immediate family and other documented crises, call to active military duty or jury duty, religious holy days, and official University activities. Accommodations for these excused absences will be made and will do so in a way that does not penalize students who have a valid excuse. Consideration will also be given to students whose dependent children experience serious illness. University policy requires that all registered students attend the first day of class. (See current FSU Bulletin at http://registrar.fsu.edu/bulletin/undergrad).

Note: for *Health Assessment Lab* specifically- class attendance is required for this course. Students who are absent from a lab and have not contacted the instructor prior to the lab, will receive a grade of Unsatisfactory for that lab. If an absence is necessary, prior arrangements must be made with the instructor. You must contact your instructor immediately if you know you will miss a class via phone/text or course e-mail. Documentation is required for excused absences. Missed lab hours must be made up within 1 week. The student is responsible for contacting their assigned faculty for rescheduling missed lab time.

Late Policy

The dates listed for assignments may change as the semester progresses. If they do, you'll be notified through the course Announcements on Blackboard. However, all assignments are expected to be completed on time. Any exceptions to this policy are made at the discretion of the instructor. If you have conflicts, or something unexpected arises, do not hesitate to contact your instructor. Students with incomplete assignments at the end of the course will be given the earned final grade. An incomplete (I) will not be given except under extenuating circumstances that are discussed with me (your instructor) before the final grades are assigned.

Note: for *Health Assessment Lab* specifically- Timely completion and submission of all assignments are expected; no late assignments are accepted without prior approval (before the due date) unless unexpected, extenuating circumstances (subject to the approval by the instructor). Students who miss the due date for an assignment and have not contacted the instructor prior to the due date, will receive a grade of zero. If you are ill or have a serious problem that prevents you from submitting an assignment on the day it is due, please contact your instructor prior to the deadline and we will arrange an alternative date if appropriate.

Communication

The Florida State University Bulletin states, "The official method of communication at Florida State University is your my.fsu.edu e-mail account. In order to stay informed and aware, you are required to set up and maintain your account and check it three times per week. If you choose to have your my.fsu.edu official account forwarded to another e-mail account, you are still held responsible for all information distributed by the University to your fsu.edu account". Students can go to http://www.helpdesk.fsu.edu to confirm their settings. For more information (including how to set up an account) visit www.its.fsu.edu.

FSU Academic Honor Policy

The Florida State University Academic Honor Policy outlines the University's expectations for the integrity of students' academic work, the procedures for resolving alleged violations of those expectations, and the rights and responsibilities of students and faculty members throughout the process. Students are responsible for reading the Academic Honor Policy and for living up to their pledge to ". . . be honest and truthful and . . . [to] strive for personal and institutional integrity at Florida State University." (Florida State University Academic Honor Policy). The Florida State University

Academic Honor Policy can be found at http://fda.fsu.edu/Academics/Academic-Honor-Policy

The College of Nursing strictly adheres to the Florida State University Academic Honor Code as stated and as delineated in the FSU General Bulletin. In addition, the following apply in the College of Nursing: the CON Academic Honesty Policy (S-10), the CON Substance Abuse Policy (S-5) and the CON Required Professional Behaviors Policy (U-15).
Each policy can be found on the College of Nursing website at: http://nurseapps.fsu.edu/policy.html

Academic Penalties

In the FSU College of Nursing, students violating the Academic Honor Policy in any assignment, test, etc. will receive a minimum penalty of a grade of zero (0) for the assignment in question, will be reported to the Dean and the University Judicial Officer, and may receive an "F" for the course at the option of the instructor.

Required Professional Behaviors Policy

POLICY U-15 located at http://nurseapps.fsu.edu/policy.html

Since each nursing student represents the College of Nursing (CON), the university and the nursing profession, the faculty believes the communication skills, professional dress, conflict resolution, safe provision of care and adherence to policy and procedure deemed to be critical for all nursing students in each learning environment throughout the program of study.

Exhibit professional nursing behaviors including, but not limited to the following:

1. Dress in accordance with CON requirements at all times when representing the College of Nursing such as adhering to the dress code in the clinical or community setting.
2. Communicate using language and terms that demonstrate respect for others including addressing them by proper name and title.
3. Demonstrate ethical behavior including maintaining confidentiality.
4. Resolve conflicts by following defined lines of communication/chain of command.
5. Deliver safe, effective nursing care using sound judgment according to professional standards of practice.
6. Adhere to the policies and protocols of the College of Nursing, affiliating agencies, the Florida Nurse Practice Act and the legal mandates of society.

Clinical Clearance and Background Check

Students are expected to adhere to the College of Nursing Criminal Background Check Policy S-2 and the Clinical Clearance Policy S-4 located at http://nurseapps.fsu.edu/policy.html

POLICY S-4:	Clinical Clearance is required for a student to participate in a required clinical experience. Any lapse in Clinical Clearance may result in the student being dropped from courses.

RATIONALE: For the health and safety of nursing students and the patients encountered in the nursing program, the FSU College of Nursing and participating agencies require current documentation of CPR, health insurance, health status and currency in immunizations. Clinical Clearance will be issued when all documentation is complete.

PROCEDURE:

<u>For All Students Enrolled in College of Nursing Programs</u>:

1. It is the responsibility of each student to provide documentation for the following and upload this documentation to your clinical clearance account.
   - **College of Nursing Immunization Form**
     All students must provide proof of the following immunizations or titer results upon admission to the College of Nursing: polio, diphtheria, tetanus, MMR (measles, mumps, rubella), varicella (chickenpox), hepatitis B series. *(See Attachment #1 – Policy on Health Examination and Immunizations)*
   - **TB/PPD Test Results**
     All students must provide proof of a negative PPD test upon admission to the College of Nursing, which must be updated annually. *(See Attachment #1 – Policy on Health Examination and Immunizations)* Students who have positive results must provide documentation from a health care provider and submit an annual review of symptoms. *(See Attachment #2 – Positive PPD Test Results – Tuberculosis Symptom Questionnaire)*
   - **Influenza Vaccine**
     All students must provide documentation on having a current seasonal Influenza Vaccine during Fall Semester. For those students who cannot receive the flu vaccine documentation must be submitted from a healthcare provider explaining reason for not take the immunization and alternate clinical placement may be required. If an alternate clinical placement is not available, the student may not be able to progress in the nursing major.
   - **Essential Functions / Technical Standards Required of Nursing Students Form**
     All students have a complete physical examination and have an appropriate healthcare provider sign off on this form upon admission to the College of Nursing. *(See Attachments #3 and #4)* If you believe that you cannot meet one or more of the standards listed without accommodations or modifications, it is your responsibility to request appropriate assistance and guidance from the faculty and/or college administration *(See College of Nursing Policy S-3)*. It will be determined, on an individual basis, whether the necessary accommodations or modifications can be made reasonably.
   - **CPR Certification**
     All students must provide proof of CPR certification upon admission to the College of Nursing, which must be updated upon expiration. A copy of the certification card that includes expiration date must be uploaded to your clinical clearance account.
   - **Criminal History Background Check**
     All students must submit to a FDLE/FBI Level II Background Check upon admission to the College of Nursing, as well as a Certified Background Review, which includes the Patriot Act, Social Security Alert, Sex Offender Index, Employment Verification, Nationwide Healthcare Fraud & Abuse Scan, Residence History, Local Criminal Check based on county of residence for last 7 years. (See *College of Nursing Student Policy #S-2 – Criminal Background Check).*
   - **Affidavit of Good Moral Character**
     All students must submit this notarized form on an annual basis following the initial background screenings. *(See Attachment #5)*
   - **Personal Health Insurance**
     All students must provide proof of personal health insurance coverage upon admission to the program.
   - **10 Panel Drug Screen**
     All students must submit to a 10-panel drug urinalysis screening.
     (See College of Nursing Student Policy #S-5 – Substance Abuse)
   - **Current unencumbered Florida RN License**

Students enrolled in the graduate nursing program must provide proof of a current unencumbered Florida Registered Nurse license prior to enrollment in the program. Licensure must be active and unencumbered throughout enrollment in the nursing program.

2. This documentation must be on file and current to obtain clinical clearance. It is the responsibility of the student to provide updated information and to obtain clinical clearance prior to enrollment in a clinical course. It is the responsibility of each student to upload all documentation to your clinical clearance account.

3. Undergraduate nursing students must satisfactorily complete required Drug Math Tests and Clinical Skills Testing (*See College of Nursing Undergraduate Policy U-8 and U- 9*).

4. Students may be requested by a faculty member or clinical agency to provide evidence of clinical clearance in order for a student to participate in a required clinical experience.

Classroom and Lab Civility

Incivility in nursing education is defined as rude or disruptive behaviors which often results in physiological or psychological distress for people involved and if left unaddressed, may progress into a threatening situation (Clark, Farnsworth, & Landrom, 2008). Civility contributes to patient safety, student and faculty safety, patient satisfaction, and the learning environment. Civility includes behaviors of preparedness, respectfulness, and open-mindedness. I understand that civility incorporates teamwork, collaboration, and open effective communication. Faculty, staff, and clinical agencies will establish clear expectations of students, have respect for students, and provide feedback in an objective manor.

1. I will attend class on a regular basis, be on time, remain throughout the class, and stay attentive.
2. Dress in accordance with CON requirements at all times when representing the College of Nursing such as adhering to the dress code for courses and clinical assignments.
3. Communicate using language and terms that demonstrate respect for other including addressing them by proper name and title.
4. Demonstrate ethical behavior including maintaining confidentiality.
5. Resolve conflicts by following defined lines of communication/chain of command.
6. Deliver safe, effective nursing care using sound judgment according to professional standards of practice.
7. Adhere to the policies and protocols of the College of Nursing, affiliating agencies, the Florida Nurse Practice Act and the legal mandates of society.

Examples of uncivil behavior (not exclusive):

- Disrespect to other Students/Faculty including:
  - Demeaning, belittling or harassing others
  - Rumoring, gossiping about or damaging a classmate/professors reputation;
  - Habitually interrupting as others speak
  - Habitually arriving late to class
  - Yelling or screaming at instructors, peers, or clinical staff.
  - Questioning Faculty credibility
- Use of personal mobile devices during class or clinical without authorization of faculty or the clinical agency partners
- Neglecting to pay attention or listening to others who address you; not responding to email, letters, or voicemail in a timely fashion.
- Inappropriate emails or use of social media, such as those which are inflammatory in nature
- Speaking with a condescending attitude
- Knowingly withholding information or refusing help needed by a peer, instructor, or clinical staff.
- Discounting or ignoring solicited input from instructors/faculty regarding classroom and/or clinical performance or professional conduct.
- Overruling a decision without direct discussion and rationale

- Neglecting to share credit for collaborative work or not completing an equitable share of collaborative work assigned.
- Threatening others; this refers to physical threats, verbal/nonverbal threats, and implied threats.
- Displays of temper, tantrums
- Escalation to threatened or actual violence

Americans with Disability Act

Students with disabilities needing academic accommodation should:

(1) register with and provide documentation to the Student Disability Resource Center; and

(2) bring a letter to the instructor indicating the need for accommodation and what type. This should be done **during the first week of class.**

This syllabus and other class materials are available in alternative format upon request. For more information about services available to FSU students with disabilities, contact the:

Student Disability Resource Center
874 Traditions Way
108 Student Services Building
Florida State University
Tallahassee, FL 32306-4167
(850) 644-9566 (voice)
(850) 644-8504 (TDD)
Email: sdrc@admin.fsu.edu
Website: http://www.disabilitycenter.fsu.edu/

Free Tutoring from FSU

On-campus tutoring and writing assistance is available for many courses at Florida State University. For more information, visit the Academic Center for Excellence (ACE) Tutoring Services' comprehensive list of on-campus tutoring options - see http://ace.fsu.edu/tutoring or contact tutor@fsu.edu

Copyright Notice

This course website may contain copyrighted materials that are used in compliance with U.S. Copyright Law. Under that law, materials may not be saved to your computer, revised, copied, or distributed without permission. They are to be used in support of instructional activity as part of this course only and shall be limited to the duration of the course, unless otherwise specified by the instructor or owner of the material. You may only download or print materials at the direction of your instructor, who knows which materials, are copyrighted and which are not.

Except for changes that substantially affect implementation of the evaluation (grading) statement, this syllabus is a guide for the course and is subject to change with advance notice. All changes will be done in writing and posted as announcement on the NUR 3065L Blackboard website. (CON 05/12)

Course Schedule

NUR 3065L Health Assessment Lab Calendar Fall 2016 CON 212, Sections 1 – 8			
Week	**Date M-F**	**HA Theory Topic**	**Lab activities and Assignments**
1	8/29-9/2	Interview, health history, Vital signs, pain, measurements	Health History forms 1 & 2 Review HA videos- weekly (Taylor, the Point) Practice weekly ROS and five vital signs (TPR, BP, pain)
2	9/5-9/9	Examination of the skin (on-line, quiz in lab)	Practice interviewing, health history, ROS, vital signs, and integument Complete a health history on a classmate; Genogram due in class
3	9/12-9/16	The respiratory exam	Practice respiratory ROS and exam Show proficiency taking vital signs. Health History & ROS due.
4	9/19-9/23	The cardiovascular exam	Practice cardiac and peripheral circulation ROS and exam
5	9/26-9/30	Rescuing the decompensating patient	Simulation- cardiac and respiratory scenario
6	10/3-10/7	Exam of the abdomen Exam of the musculo-skeletal system	Practice abdomen and muscle ROS and exam Assessment: respiratory and cardiac/ peripheral circ. exam
7	10/10-10/14	HA Theory Exam #1	Practice abdomen and muscle ROS and exam (Foundations Lab clinicals week 1) (Sec. 6- no Lab - Homecoming)
8	10/17-10/21	The mental status exam The neurological exam	Practice mental, neuro and cranial nerves, ROS and exam Assessment: abdomen and musculo-skeletal exam (Foundations Lab clinicals week 2)
9	10/24-10/28	The HEENT exam	Practice head, face, neck, nodes, nose, mouth, throat ROS and exam Assessment: mental and neuro exam (Foundations Lab clinicals week 3)
10	10/31-11/4	Exam of the eyes and ears	Practice ears and eyes ROS and exam
11	11/7-11/11	Exam GU system, breast exam	Assessment: HEENT (Secs. 1-4, 7, 8) (Secs. 5 & 6 – no Lab - Veteran's Day)
12	11/14-11/18	Review bedside assessment	Practice bedside- resp., cardiac, abdomen, muscle, and neuro together Environmental presentations Assessment: HEENT (Secs. 5 & 6), Practice bedside exam in open lab (Sec. 5)
13	11/21-11/25	HA Theory Exam #2	Practice the bedside exam Practice giving report with the SBAR form

			Final HA/Foundations Evaluations (8:00 a.m. and 3:00 p.m.) **Tues. 11/22** NUR 3056L Sec. 6/NUR 3065L Sec. 4 (Kendall) NUR 3056L Sec. 5 (McLarty)/NUR 3065L Sec. 7 (Kendall) (Secs. 5,6,7,8 - no Lab this week – Thanksgiving)
14	11/28-12/2	Examination of the neonate and child	No HA Lab, continue open labs until final evaluations are completed Practice the bedside exam (Sec. 6) Final HA/Foundations Evaluations cont.– **Wed 11/30** NUR 3056L Section 4/ NUR 3065L Section 5 (Kendall) NUR 3056L Section 3/ NUR 3065L Section 8 (McLarty)
15	12/5-12/9	Review full assessment-history and head-to-toe exam	Final HA/Foundations Evaluations cont. **Wed 12/7** NUR 3056L Section 7/ NUR 3065L Section 1 (Kung) NUR 3056L Section 8/ NUR 3065L Section 3 (Kung) **Fri 12/9** NUR 3056L Section 1/ NUR3065L Section 6 (Kendall) NUR 3056L Section 2/ NUR 3065L Section 2 (Greenhalgh)
16	12/12-16	**Finals Week**	
*Weekly activity will vary by section due to holidays			

Weekly Lab Activities:

Students are responsible to do the following:

- Review the syllabus, course calendar and course requirements;
- Prepare for lab by reviewing and printing out the system health assessment form and watching the system exam video that corresponds to the assessment topic prior to class;
- Participate in supervised practice, simulation experiences, and practice on your own;
- Students not validating will engage in group work related to the assessment of the week;
- Provide appropriate documentation of findings;
- Practice communication through patient teaching and hand-off reports;
- Wear proper attire (as outlined by CON protocols) in the lab at all times.
-

FSU College of Nursing NUR 3065L Health Assessment, Wellness and Prevention Across the Lifespan Lab Lab Preparation Fall 2016			
Lab Units for HA	**Objectives**	**Preparation/Materials** **Jarvis (7th ed), 2016** **Taylor's video clips** **HAL=Health Assessment Lab** **Bb=Blackboard course site**	**In Lab Activities** **(2 hours per week)**
Subjective: Interview, communication, culture Health History and functional assessment **Objective:** Vital signs and measurements	Student will 1. Prepare prior to lab and practice each week in lab. 2. Complete on self the Health and Human Services (HHS) genogram through Bb resources and bring to class. 3. Complete a health history and Review of Systems (ROS) by interviewing a classmate. 4. Identify from the Health History and Review of Systems (ROS), 2-3 areas for health promotion and health teaching and 2-3	Jarvis: chapters 2, 3, 4, 8, 9, 10, 27 Bb resources Practice taking vital signs prior to lab. Health History (part 1) and Review of Systems (part 2) Forms (Bb) Complete electronic genogram on HHS website and bring to class. See Bb Resources for instructions. Bring paper copy of Health History (part 1) and Review of Systems (ROS) (part 2) in syllabus and on Bb. BP cuff & Stethoscope (each week) – put your name on each.	Practice Interviewing classmate with Health History and Review of Systems (ROS) paper form. Document findings throughout interview. Take height, weight, and calculate BMI. Practice taking Vital signs with classmates using standard and electronic equipment. Continue to practice. Next week perform

	health risks and or problems. 5. Assess height, weight, calculate BMI on classmate. 6. Assess vital signs (TPR, BP, Pulse Ox, pain) on classmate. 7. Verbalize normal ranges for each measurement. 8. Perform vital signs at the level of proficiency in second or third lab week.	**HAL Form:** Vital Signs, Pain, Measurements Assessments (include one with findings key) **Bb Video:** Multicultural Health **<u>Taylor's video clips:</u>** Module 3: Physical Assessment, , Videos: Introduction to Physical Assessment (1:18) Module 3: Physical Assessment, Videos: Beginning the Physical Assessment (3:48) Module 2: Vital Signs Videos: Introduction to Vital Signs (2:11) Module 2: Vital Signs Videos: Measuring Oral Temperature, Radial Pulse, Respiratory Rate, and Blood Pressure (8:22) Module 2: Vital Signs Videos: Measuring Oral Temperature, Radial Pulse, Respiratory Rate, and Blood Pressure : Unexpected Situations (2:41) Module 2: Vital Signs Videos: Assessing Bloor Pressure Using an Automatic Electronic Device (5:00) Module 11: Comfort: Introduction to Pain (9:42) Module 16: Oxygenation: Introduction (1:37) Module 16: Oxygenation: Measuring Pulse Ox (2:59) Module 16: Oxygenation: Measuring Pulse Ox: Unexpected Situations (1:53)	vital signs to demonstrate proficiency to faculty. Continue to practice vital signs in lab throughout the semester.

		Practice taking vital signs prior to lab.	
Integumentary (skin)	Student will 1. Prepare prior to lab and practice each week in lab. 2. Apply elements of skin assessment to all systems throughout the semester. 3. Identify one or more (≥ 1) self-care activities, health promotion or patient teaching interventions related to integumentary wellness. 4. Identify two (2) potential or actual health problems in the form of nursing diagnoses related to integumentary assessment.	Jarvis: chapter 12 Bb resources **HAL Form:** Integument Assessment Download ePSS onto laptop or mobile device (see syllabus websites for URL) BP cuff & Stethoscope **Bb Video:** Dr. Whyte's Integument Assessment (1:49) **<u>Taylor's video clips:</u>** (none specifically for this week – note skin as you view other systems) Using textbooks and other evidence-based resources, identify one or more (≥ 1) self-care activities, health promotion or patient teaching interventions related to integumentary wellness.	Practice skin assessment in class. Perform skin assessment along with each unit for validation.
Cardiac/Respiratory	Student will 1. Prepare prior to lab and practice each week in lab. 1. Verbalize normal ranges and findings for cardiac and respiratory systems using the HAL Forms.	Jarvis: chapters 18, 19, 20 Bb resources BP cuff & Stethoscope Review Simulation scenarios Set up patient in DocuCare using class codes provided. **HAL Forms:** Respiratory Assessment and Cardiac Assessment	Simulation practice in sim lab for one week. Discuss appropriate health care teaching. Practice in lab with faculty supervision. Establish system for assessing

	2. Perform assessment on peer using HAL Forms in syllabus and Bb. 3. Evaluate with peer group the simulated scenario. 4. Report simulated patient findings to faculty member using SBAR format. 5. Independently document in electronic health record (DocuCare) the assessment findings. 6. Identify one or more (≥ 1) self-care, health promotion, or patient teaching interventions related to each cardiac and respiratory system wellness. 7. Identify two (2) potential or actual health problems in the form of nursing diagnoses related to cardiac and respiratory assessment.	SBAR (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation) form in syllabus Practice respiratory and cardiac and assessments at home prior to labs to establish a system including IPPA (Inspection, Palpation, Percussion, Auscultation) sequence. **Bb Video:** Dr. Whyte's Respiratory Assessment **<u>Taylor's video clips:</u>** **Respiratory:** Module 3: Physical Assessment Videos: Assessing the Posterior and Lateral Thorax (2:51) Module 3: Physical Assessment Videos: Assessing the Anterior Thorax (2:31) Module 3: Physical Assessment Videos: Assessing Legs, Feet, and Toes Module 16: Oxygenation: Introduction (1:37) (repeat from Vital Signs as needed) Module 16: Oxygenation: Measuring Pulse Ox (2:59) (repeat from Vital Signs as needed) Module 16: Oxygenation: Measuring Pulse Ox: Unexpected Situations (1:53) (repeat from Vital Signs as needed) **Cardiac:**	Cardiac/Respiratory systems (IPPA) Assessment on Cardiac/Respiratory systems.

		Module 2: Vital Signs Videos: Measuring an Apical Pulse (2:25) Module 2: Vital Signs Videos: Measuring an Apical-Radial Pulse (3:57) Module 3: Physical Assessment Videos: Assessing the Heart (2:23) **Peripheral Circulation:** Module 3: Physical Assessment, Videos: Assessing the Arms, Hands, and Fingers (3:56) (Includes some skin; Range of Motion –ROM, Rapid Alternating Movements-RAMs; & sensation/proprioception) Module 3: Physical Assessment, Videos: Assessing the Legs, Feet, and Toes (2:47). (Includes some skin, pulses, and ROM) Using textbooks and other evidence-based resources, identify one or more (≥ 1) self-care activities, health promotion or patient teaching interventions related to each cardiac and respiratory wellness.	
Abdominal Musculoskeletal	Student will 1. Prepare prior to lab and practice each week in lab. 2. Verbalize normal ranges and findings for Abdominal and	Jarvis: chapters 11, 21, 22, 25 Bb resources **HAL Form:** Gastrointestinal System/Abdominal Assessment	Practice in lab with peers and faculty. Clarify questions. Discuss appropriate health care teaching.

	Musculoskeletal systems using the HAL Forms. 3. Safely and systematically perform a focused abdominal and musculoskeletal health assessment on a classmate using the HAL form provided in the syllabus and Bb. 4. Identify one or more (≥ 1) self-care, health promotion, or patient teaching interventions related to each abdominal and musculoskeletal wellness. 5. Identify two (2) potential or actual health problems in the form of nursing diagnoses related to diagnoses related to completed abdominal and musculoskeletal assessment.	**HAL Form:** Musculoskeletal Assessment BP cuff & Stethoscope **Bb Video:** Dr. Whyte's Abdominal Assessment **Taylor's video clips:** Module 2: Vital Signs Videos: Assessing the Abdomen Module 3: Physical Assessment Videos: Assessing the Musculoskeletal and Neurological Systems Using textbooks and other evidence-based resources, identify one or more (≥ 1) self-care activities, health promotion or patient teaching interventions related to abdominal and musculoskeletal wellness.	Assessment on abdominal and musculoskeletal system using the HAL form.
Neurological/mental status	Student will 1. Prepare prior to lab and practice each week in lab. 2. Verbalize normal ranges and findings	Jarvis: chapters 5, 23 Bb resources **HAL Form:** Neurological/Mental Status Assessment BP cuff & Stethoscope **Taylor's video clips :**	Practice in lab with peers and faculty. Clarify questions. Discuss appropriate health care teaching.

	Neurological/mental status using the HAL Forms. 3. Safely and systematically perform a focused Neurological/mental status health assessment on a classmate using the HAL form provided in the syllabus and Bb. 4. Identify one or more (≥ 1) self-care, health promotion, or patient teaching interventions related to neurological/mental status wellness. 5. Identify two (2) potential or actual health problems in the form of nursing diagnoses related to diagnoses related to completed neurological/mental status assessment.	Module 3: Physical Assessment Videos: Assessing the Musculoskeletal and Neurological Systems(same as with Musculoskeletal) (3:09) (includes sensation, proprioception, patellar reflex, gait, Romberg , finger/nose/finger; & spinal abnormalities) Using textbooks and other evidence-based resources, identify one or more (≥ 1) self-care activities, health promotion or patient teaching interventions related to neurological/mental status wellness.	Assessment on neurological system using the HAL Form
HEENT (Head, Eyes, Ears, Nose, Throat)	Student will 1. Prepare prior to lab and practice each week in lab.	Jarvis: chapters 13, 14, 15, 16 Head, Nose, Throat Eyes & Ears (chapters 14,15) Bb resources BP cuff & Stethoscope, **pen light**	Practice in lab with peers and faculty. Clarify questions. Discuss appropriate health care teaching.

	2. Verbalize normal ranges and findings for the HEENT using the HAL Forms. 3. Safely and systematically perform a focused HEENT health assessment on a classmate using the HAL form provided in the syllabus and Bb. 4. Identify one or more (≥ 1) self-care, health promotion, or patient teaching interventions related to HEENT wellness. 5. Identify two (2) potential or actual health problems in the form of nursing diagnoses related to diagnoses related to completed HEENT assessment.	**HAL Form:** HEENT Assessment **Bb Video:** Dr. Whyte's HEENT Assessment **<u>Taylor's video clips :</u>** Module 3: Physical Assessment, Videos: Assessing the Head (1:27) (this incorporates CN VII and CN V and temporal arteries.) Module 3: Physical Assessment, Videos: Assessing the Eyes (1:07) (this includes lashes & symmetry, pupillary constriction, accommodation) Module 3: Physical Assessment, Videos: Assessing the Ears (00:39) Module 3: Physical Assessment, Videos: Assessing the Nose and Sinuses (00:50) Module 3: Physical Assessment, Videos: Assessing the Mouth and Throat (1:01)-use tongue depressor and pen light – CN IX & CNX with tongue blade Module 3: Physical Assessment, Videos: Assessing the Neck (2:10) Using textbooks and other evidence-based resources, identify one or more (≥ 1) self-care activities, health promotion or patient teaching interventions related to HEENT wellness.	Assessment on neurological system using the HAL Form

Bedside Assessment & Synthesis	Student will 1. Prepare prior to lab and practice each week in lab. 2. Perform a bedside examination synthesizing the principles learned throughout the semester. 3. Report significant findings to faculty using the SBAR form provided.	Jarvis: chapters 27, 28 Module 3: Physical Assessment, Videos: Conclusion (00:33) Bedside Assessment Form SBAR form	Practice SBAR and Bedside Assessment for Final Evaluation to be applied with Foundations Evaluation.
Environmental	Student will, utilizing the instructions and grading rubric in the course syllabus: 1. Work cooperatively with a peer group 2. Assess environmental risk factors in the home environment 3. Utilize evidence-based literature. 4. Identify safety modifications in the home. 5. Present PowerPoint to peers in class setting.	See syllabus for instructions, grading rubric, and schedule for presentation. Establish groups early in semester and sign up with faculty.	Provide a 10-15 minute presentation in class with peers.

Health History Forms
Health History (part 1) and Review of Systems (part 2)
Corresponds to Jarvis (2016): Chapters 4 and 27 (Greenhalgh)
and the electronic Google Docs forms by Mandy Bamber, PhD

Subjective Data

Health History (part 1)

Biographical Data

Name (Initials for our use)
Phone #
Address
Birthdate
Birthplace
Age
Gender: Male Female
(Prefers not to answer, gender-born and/or currently)
Race/Ethnicity: White African American Asian Hispanic
(Choose not to answer)
Source and Reliability

Marital Status: Married
Single
Divorced
Separated
Occupation Health: Occupation
Employer

Reason for Seeking Care (this/these are written as quotes from the patient or family)

History of Chief Present Concern / **Present Health** / **History of Present Illness**
Additional Information not on the form (refer to Jarvis (2016) Chapter 4, pages 50, 51)
Symptoms description in chronologic order (symptoms are subjective data, signs are objective data)

PQRSTU

- **P**rovocative or palliative- precipitating, aggravating, alleviating, and associated factors- what makes the problem better or worse? What brings it on? Does this problem occur with anything else? (examples- medication, activity, food, season, cycle) Any self/home treatments used?
- **Q**uality/ Quantity- character of problem in descriptive terms- how does it look, feel, sound? How much?
- **R**egion or Radiation- location of the problem? Does it spread?
- **S**everity- how bad is it? Rate the problem on a 0 to 10 scale (include pain rating of ?/10)
- **T**iming- onset, duration, frequency, chronic/constant or episodic/intermittent, recurring, etc.
- **U**nderstanding- patient's perception of the problem, How is affective them? ADLs? Quality of life? What does the person think the problem is?

OLDCART: (not in the text book)

- Onset
- Location

- Duration & Frequency
- Characteristic Symptom
- Associated Manifestations
- Relieving/Exacerbating Factors
- Treatment/ Self-Treatment
- Unrelated conditions (possibly related)

Past Health History (Medical History)

Describe general health
Childhood Illnesses
Accidents or injuries: Include age/date
Serious or chronic illnesses (major medical problems and status of condition)
Hospitalizations: What for? Location?
Previous Surgical Procedures: Include name, age/date, and procedure
Obstetric History: Never been pregnant
Previous or current pregnancy/s
Gravida (# of Pregnancies)
Full Term (# of term pregnancies)
Preterm (# of preterm pregnancies)
Abortions (# of abortions)
Children living (# of living children)
Course of Pregnancies: Date of deliveries, length of pregnancies, length of labor, baby's weight, sex, type of delivery, any complications, and babys' conditions
Immunizations
Last exam date
Allergies: Include reaction
Current medications: Include route, dose, and frequency (daily, prn, current and recent, OTC, supplements, vitamins, herbals). Compare the current list to previous list-medication reconciliation. Check the Rx bottles.

Family Health History

Mark if a relative has or had any of the following:

Heart disease
High Blood pressure
Stroke
Diabetes
Blood Disorders
Cancer
Sickle Cell
Kidney disease
Tuberculosis
Allergies
Asthma
Arthritis
Obesity
Seizure Disorder
Mental Illness
Suicide
Alcoholism or drug addiction

You may be asked to do a family genogram.

<u>Functional Assessment</u> (Includes psycho-social history and Activities of Daily Living)

Self-Esteem and Self-Concept

Education: Last grade completed, other significant training, educational history
Financial Status: Income adequate for lifestyle and/or health concerns
Value-belief system: Religious practices and perception of personal strengths
Self-care behaviors

Activity and Rest

Daily profile, usual pattern of a typical day
Independent or needs assistance with ADL's, feeding, bathing hygiene, dressing, toileting, bed-chair transfer, walking, standing, climbing stairs
Leisure activities
Exercise pattern: Type, amount per day/week, method of warm-up session, method of monitoring body's response to exercise
Sleep and Rest: Sleep patterns, daytime naps, any sleep aids used

Nutrition and Elimination

24-hour diet recall
Is this menu pattern typical of most days?
Who buys food?
Who prepares food?
Finances adequate for food?
Who is present at mealtimes?
Other self-care behaviors

Interpersonal Relationships and Resources

Describe your role in your own family.
How do you get along with family, friends, co-workers, classmates, etc.
Who do you seek support from when problems present?
How much time do you spend alone daily?
Is this time pleasurable or isolating?
Other self-care behaviors

Coping and Stress Management

Describe the stresses in your life now.
Any changes in stress in the last year? If so, what and how?
What methods do you use to relieve stress?
Are these methods helpful?

Personal Habits

How much caffeine do you intake daily? (ie Coffee, tea, soda, chocolate, etc.)
Do you smoke?
    If so, number of pack per day

Daily use for how many years?
Age you started smoking?
Have you ever attempted to quit smoking?
Method used to attempt to quit and describe how it went.

Do you drink alcohol?
Date of last alcoholic drink
Amount of alcohol during that episode
During the last 30 days, how many days have you had alcohol?
Have you ever been told you have a drinking problem?

Any illicit drug use? Type? (street drugs and/or prescription drugs)
Drugs that you are currently using:
None
Marijuana
Cocaine
Crack cocaine
Amphetamines/meth amphetamines (ie ecstasy, meth, ADHD drugs, etc.)
Heroin
Prescription pain killers
Barbiturates
LSD

Have you ever been in treatment for drugs or alcohol?

Environment and Hazards

Housing and neighborhood: Type of structure, live alone, know neighbors, etc.
How safe is the area you live in?
How safe is the area you live in?
Do you have access to transportation?
Are you involved or take part in any community services?
Do you have any hazards at work or home?
Do you use your seatbelt? If so how often?
Do you travel or reside in any other countries on a regular basis?
Have you served in the military? If so what branch? How long? Any other countries?
Other self-care behaviors

Intimate Partner Violence

How are things at home? Do you feel safe?
Have you ever been emotionally or physically abused by your partner or someone important to you?
Have you ever been hit, slapped, kicked, pushed, or shoved, or otherwise physically hurt by your partner or ex-partner?
Has your partner ever forced you into having sex?
Are you afraid of your partner or ex-partner?

Occupational Health

Please describe your job.

Do you work with any health hazards? (ie asbestos, inhalants, chemical, repetitive motion)

Any equipment at work designed to reduce your exposure

Are there any work programs designed to reduce your exposure?

Do you have any health problems that you think are linked to your job?

What do you like and dislike about your job?

Perceptions of Own Health

How do you define health?

What is the view of your health at this time?

Do you have any concerns about your health?

What do you expect will happen to your health in the future?

What are your health goals?

What are your expectations of the nurses and physicians?

<u>Review of Systems (part 2)</u>

Systems reviews not included here are in the Health Assessment Lab Forms

(As you assess you patient, use the Health Assessment Lab forms for Review of Systems for units on Integument, HEENT, Respiratory, Cardiac/Peripheral Vascular System, Gastrointestinal System/Abdomen, Musculoskeletal System, Neurological/Mental status.)

General overall health state	
Weight gain	Tiredness/Malaise
Weight loss	Fever
Fatigue	Chills
Weakness	Sweats or Night sweats

Genitourinary System	
Frequency	**Gynecologic history**: Age at onset of menarche
Urgency	Last menstrual period
Nocturia	Menstrual cycle timing: regular/monthly, irregular, rare, none
Recent urinary changes	Breast self-exam performed, not performed
Dysuria	Date of last gynecological exam/ Pap test/ mammogram
Polyuria	Results of last Pap test
Oliguria	**Gynecologic problems**: Amenorrhea
Hesitancy or straining	Menorrhagia
Narrowed stream	Dysmenorrhea
Cloudy urine	Premenstrual pain
Hematuria	Vaginal discharge, itching, lesions

Incontinence
Kidney disease
Kidney stones
Urinary tract infections
Enlarged prostate
Pain in flank or low back
Pain in groin
Penile or testicular pain
Penile or testicular lesions
Penile discharge
Testicular lumps
Testicular self-exam performed, not performed
How many times awaken at night to void

Irregular bleeding- intermenstrual, post-menopausal
Post-menopausal age (if applicable), menopausal symptoms

Sexual Health Presently in a sexually active relationship
Dyspareunia
Erectile changes, ejaculation changes
Type of protection used
Type of contraceptive, regularity of use, method satisfaction
History of a sexually transmitted infection

Obstetrical history: not cover this area in this course

Health Promotion- ex. measures used to avoid UTI and use of Kegel exercises
Patient Teaching related to the kidneys, bladder, pelvic floor, reproductive organs, and sexual health

Endocrine System

Diabetes
Polyuria
Polydipsia
Polyphagia
Hyperthyroidism
Hypothyroidism
Heat or cold intolerance

Changes in skin pigmentation
Changes in skin texture
Excessive sweating
Abnormal hair distribution
Hormone therapy
Nervousness
Tremors

Health Promotion related to the endocrine system
Patient Teaching related to the endocrine system

Psychiatric History: Denies depression, nervousness, anxiety, visual/auditory hallucinations, or memory loss. Psychiatric care not covered in this course.

Summary:
From the Health History (including findings from the genogram) and Review of Systems (ROS), identify three (3) *self-care activities, health promotion, or health teaching topics with highest importance* (priority) for patient wellness.
1.
2.
3.

From the Health History (including findings from the genogram) and Review of Systems (ROS), identify three (3) *potential or actual health problems or health risk factors* of the individual.
1.
2.
3.

Using the subjective data from the history and review of systems and the initial summary, the student will proceed to collect objective data plus additional system specific subjective data using the Health Assessment Lab forms.

Health Assessment Lab Form				
Vital Signs, Pain, Measurements Assessment				
Assessment Technique	Performance Criteria	Evaluation Rating		
		Meets Expectations	Does not meet Expectations	Comments
SAFETY				
Hand Hygiene:	Performs proper hand hygiene			
Introduces Self:	Introduces self with name and role to patient			
Patient Verification:	Asks pt. to state their name, DOB & verify ID band			
Verifies Allergy:	Asks patient about allergies			
Communication:	Provides effective history taking and physical exam explanations			
HEALTH HISTORY / ROS				
PHYSICAL ASSESSMENT				
VS: BP _____ Pulse _____ Respirations _____ O2 Sat _____% Temp. _____˚F/C				Verbalize norms
BP _____ / _____	Right arm _____ Left arm _____			
Pulse Rate _____	Rhythm _____ Force _____			
Respiratory Rate _____	Rhythm _____ Resp. effort _____O2 Sat _____%			
Temp. _____˚F/C	Oral _____ Axillary _____ Temporal _____ Ear _____ Rectal - defer			
Measurements				
Height:	Feet/inches _____ cm _____			
Weight:	Pounds _____ kg _____			
	BMI _____ (wt. in kg/ ht. in meters or lbs/inches x 703) (18.5-24.9 normal)			
Pain _____/10	(Ask pt. to rate their pain on a 0 to 10 scale) (describe PQRSTU, OLDCART)			
HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention(s)			

PROBLEM IDENTIFICATION	Formulates two nursing diagnoses			
Student Signature Rev 8/2016	Evaluator Signature			Date:

Health Assessment Lab Form				
Integument Assessment				
Assessment Technique	Performance Criteria	Evaluation Rating		
		Meets Expectations	Does not meet Expectations	Comments
SAFETY				
Hand Hygiene:	Performs proper hand hygiene			
Introduces Self:	Introduces self with name and role to patient			
Patient Verification:	Asks pt. to state their name, DOB & verify ID band			
Verifies Allergy:	Asks patient about allergies			
Communication:	Provides effective history taking and physical exam explanations			
HEALTH HISTORY / ROS				
Skin History of skin disease Pigment or color change Change in moles Excessive dryness or moisture Pruritus Excessive bruising Rash Lesion Sun exposure estimate	**Hair** Recent hair loss/growth Change in texture **Nails** Change is shape Change in color Change in brittleness			
PHYSICAL ASSESSMENT				
VS: BP _____ Pulse _____ Respirations _____ O2 Sat _____% Temp. _____˚F/C				
Pain 0-10	Asks the pt. to rate their pain on a 0 to 10 scale			

INSPECT AND PALPATE				
Skin of face, trunk, bilateral upper and lower extremities:				
Color	Inspect color- even, pink, pale, erythema, jaundiced, mottled, cyanotic			
Temperature	Palpate temp.- warm, cool, cold, hot (Check temp with back of hand.)			
Moisture	Palpate skin for moisture- moist, dry, diaphoresis, dehydration			
Texture, turgor, thickness	Palpate- supple, smooth, firm, prompt return (pinch skin), thin, edema			
Condition	Inspect- skin intact, lesions, vascularity, wound, incision			
Describe any abnormalities	Inspect for abn. -inflammation, drainage, ecchymosis, piercings, tattoos			
Hair	Inspect and palpate hair- smooth, brittle, fine, coarse, evenly distributed, infestations, alopecia			
Scalp	Palpate scalp- mobile, no masses, masses, lesions, tenderness			
Nails- upper and lower extremities	Inspect for nail color- pink, pale, cyanotic, nail polish noted			
Condition	Inspect and palpate nails- smooth, firm, soft/spongy, pink, pale, cyanotic			
Shape	Inspect nails for shape and contour- rounded, clubbing			
Capillary refill	Palpate upper extremities and lower extremities' nails for capillary refill. Normal- less than 3 seconds. (blanch it, release, check color return)			
Braden Score	Pressure ulcer risk score: sensory perception, nutrition, mobility, activity, moisture, friction (low score ↑ risk, higher score 19 ↓ risk)			
HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention Sunscreen use and limit sun exposure Skin self-exam monthly Skin Cancer recognition with ABCDEs			
PROBLEM IDENTIFICATION	Formulates two nursing diagnoses			
DOCUMENTATION & REPORT	Records findings			
	Provides focused SBAR report			

ASSESSMENT RATING: Satisfactory ☐ Unsatisfactory ☐ Comments: (If needed)		
Student Signature	Evaluator Signature	Date:
Rev 8/2016		

Health Assessment Lab Form				
Respiratory Assessment				
Assessment Technique	Performance Criteria	Evaluation Rating		
		Meets Expectations	Does not meet Expectations	Comments
SAFETY				
Hand Hygiene:	Performs proper hand hygiene			
Introduces Self:	Introduces self with name and role to patient			
Patient Verification:	Asks pt. to state their name, DOB & verify ID band			
Verifies Allergy:	Asks patient about allergies			
Communication:	Provides effective history taking and physical exam explanations			
HEALTH HISTORY / ROS				
Asthma Emphysema Chronic bronchitis Pneumonia Tuberculosis Wheezing or noisy breathing Chest pain with breathing Shortness of breath How much activity produces SOB?	Chronic cough Sputum Hemoptysis Nasal Drainage Toxin or pollution exposure Resp. Methods: Room air ___ Nasal cannula L/min____ Face mask %____ CPAP ____ BiPAP ____ Inhaler ____ O2 treatment _____ Tracheostomy _____ Airway device ____ Mechanical device _____ Tobacco use: Smoke/Dip/Chew/Vapor How much?- PPD ____ Hx. _____			
PHYSICAL ASSESSMENT				
VS: BP _____ Pulse _____ Respirations _____ O2 Sat _____% Temp. _____˚F/C				

Pain 0-10	Asks the pt. to rate their pain on a 0 to 10 scale			
INSPECT:				
Respiratory Rhythm	Assess resp. rhythm- regular, irregular, quiet, labored, gasping, grunting, nasal flaring, use of accessory muscles, etc. Ex.- regular rate and rhythm. (Normal- Rhythm smooth & regular without use of accessory muscles.)			
General	Level of consciousness, skin and nail color for cyanosis and clubbing, pt. position needed for respiratory effort (relaxed, tripod)- report if abnormal			
Thoracic Expansion	Assess thoracic expansion by observing chest through inspiration and expiration. (Thoracic expansion is equal & symmetrical.)			
AP: Lateral Ratio	Assess anterior-posterior diameter compared to lateral/transvers diameter and give an estimated ratio. (place hand at pt.'s side for AP, then across pt.'s chest for transverse- normal about 1:2 or AP < transverse) (Barrel 1:1)			
Costal Angle	Assess Costal Angle. (estimate costal angle between xiphoid process and costal/rib margins- normal 90˚ or less) (increased angle indicates over-inflation of lungs, ex. emphysema) (Costal Angle less than 90 degrees.)			
PALPATE:				
Chest wall	Palpate the chest for skin temp., moisture, masses, tenderness, and any abnormalities. (Chest wall without tenderness or masses.)			
Lymph nodes	Palpate the Axillary & Epitrochlear lymph nodes for presence and tenderness. (axillary- underarm, epitrochlear inside elbow, other nodes with HEENT) (Lymph nodes nonpalpable and nontender.)			
PERCUSS:				
Lung fields	Percuss over anterior and posterior lung fields. (Resonance is normal; dull with consolidation, pneumonia; hyper with pneumothorax, emphysema) (Resonance noted throughout lungs fields.)			
AUSCULTATE:				
Breath sounds	Auscultate over anterior and posterior lung fields; identify vesicular, bronchovesicular, and bronchial/tracheal sounds. (move systematically, listen through inspiration and expiration, ant and post) (Normal- clear breath sounds bilat. without dyspnea and no adventitious breath sounds.)			

	Auscultate for adventitious breath sounds- Coarse, wheeze (rhonchi), crackles (rales), stridor, describe ant/post, RUL, LUL, RML, RLL, LLL, in/out			
May do additional assessments as needed- palpate chest expansion, palpate tactile fremitus, percuss diaphragmatic excursion, pt. uses spirometer and assess results, pt. need for O2 assistance- None or describe O2 L/min, %, etc.				
HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention(s) Date of last chest x-ray Smoking cessation if needed			
PROBLEM IDENTIFICATION	Formulates two nursing diagnoses			
DOCUMENTATION & REPORT	Records findings			
	Provides focused SBAR report			
ASSESSMENT RATING: Satisfactory ☐ Unsatisfactory ☐ Comments: (If needed)				
Student Signature Evaluator Signature Date: Rev 8/2016				

Health Assessment Lab Form				
Cardiovascular and Peripheral Vascular Assessment				
Assessment Technique	Performance Criteria	Evaluation Rating		
		Meets Expectations	Does not meet Expectations	Comments
SAFETY				
Hand Hygiene:	Performs proper hand hygiene			
Introduces Self:	Introduces self with name and role to patient			
Patient Verification:	Asks pt. to state their name, DOB & verify ID band			
Verifies Allergy:	Asks patient about allergies			
Communication:	Provides effective history taking and physical exam explanations			
HEALTH HISTORY / ROS:				
Cardiovascular System ROS	**Peripheral Vascular System ROS**			

Precordial or retrosternal pain Palpitations Cyanosis Dyspnea on exertion Orthopnea Paroxysmal nocturnal dyspnea Nocturia Anemia Edema History of heart murmur Hypertension Coronary artery disease High cholesterol Cardiac medications _____ Cardiac surgery history Date of last ECG (if applicable) List any other cardiac tests Additional cardiac risks- personal hx. of disease, MI, diabetes, obesity, sedentary lifestyle, age, family hx., etc.	Coldness Pain, numbness and/or tingling Swelling of legs/edema Discoloration of hands or feet Varicose veins Intermittent claudication Thrombophlebitis History of deep vein thrombosis Ulcers Use of support hose Occupation that requires long-term sitting or standing Tobacco use: Smoke/Dip/Chew/Vapor PPD How much? How often? Hx. _____			
PHYSICAL ASSESSMENT				
VS: BP _____ Pulse _____ Respirations _____ O2 Sat _____% Temp. _____˚F/C				
Pain 0-10	Asks the pt. to rate their pain on a 0 to 10 scale			
INSPECT and PALPATE:				
Point of Maximal Impulse (Apical Impulse)	Inspect PMI at 5th ICS LMCL (5th Intercostal space Left Midclavicular line). Normal- PMI without heaves. (Apical/apex/mitral valve area)			
	Palpate PMI. Normal – PMI without thrills. (Chart without heaves or thrills.)			
AUSCULTATE:				
Apical Pulse	Auscultate apical pulse, assess rate & rhythm. May compare to radial. (reg.)			
Valve areas	Auscultate over valves. Use the diaphragm and bell. Assess S1 and S2 and the rhythm- regular/irregular. Then assess for S3, S4, murmurs,			

	rubs, or gallops. (RRR, _ bpm, S1- S2 present, no S3, S4, extra sounds or murmurs)			
	Aortic (2nd ICS RSB—2nd Intercostal Space Right Sternal Border)			
	Pulmonic (2nd ICS LSB)			
	Erb's Point (3rd ICS LSB)			
	Tricuspid (5th ICS LSB or epigastric area)			
	Mitral (5th ICS LMCL)			
INSPECT, PALPATE, AND AUSCULTATE Pulses				
Pulses- All	Palpate pulses for: rate, rhythm, force/amplitude (0 is absent, 1+ weak, 2+ normal, 3+ bounding), compare symmetry (do both sides simultaneously), and indicate any thrills.			
Pulses- Neck	Inspect the Jugular Veins with pt. supine, then raise to 45°. Assess for jugular venous distention (JVD); normal is none. (At 45°, the jugular venous pulse does not rise more than 1-2 cm above the level of the manubrium.) (defer measurement)			
	Inspect, palpate, and auscultate Carotid Arteries. Normal- 2+, regular and equal bilaterally without thrill, no bruit on auscultation. (Do 1 at a time.)			
Pulses- Peripheral (Upper & Lower Extremities)	Palpate arteries: Temporal (temples), Brachial (inner elbow), Radial (wrist), Femoral (groin-defer), Popliteal (back of knee), Posterior Tibial (inner ankle), and Dorsalis Pedis (top of foot). Normal- pulses 2+, regular, & equal bilaterally.			
INSPECT and PALPATE Upper and Lower Extremities				
Upper Extremities	Inspect and palpate- symmetry, skin color, and moisture (appropriate, pale, cyanotic, diaphoretic), nails for color and shape (pink, rounded, clubbing), and capillary refill (< 3 seconds is normal, > 3 seconds abnormal)			
Lower Extremities	Inspect and palpate- symmetry, skin, nails, capillary refill, edema (absent edema is normal, 1+, 2+, 3+, 4+, pitting), varicosities, ulcers, and Homan's sign (normal is negative- no calf pain with dorsiflexion; pos. indicates DVT)			
HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention(s)			
PROBLEM IDENTIFICATION	Formulates two nursing diagnoses			
DOCUMENTATION & REPORT	Records findings			

	Provides focused SBAR report			

ASSESSMENT RATING: Satisfactory ☐ Unsatisfactory ☐ Comments: (If needed)

Student Signature Evaluator Signature Date:

Rev 8/2016

Health Assessment Lab Form				
Gastrointestinal System /Abdomen Assessment				
Assessment Technique	Performance Criteria	Evaluation Rating		
		Meets Expectations	Does not meet Expectations	Comments
SAFETY				
Hand Hygiene:	Performs proper hand hygiene			
Introduces Self:	Introduces self with name and role to patient			
Patient Verification:	Asks pt. to state their name, DOB & verify ID band			
Verifies Allergy:	Asks patient about allergies			
Communication:	Provides effective history taking and physical exam explanations			
HEALTH HISTORY / ROS				
*Refer to the functional assessment for nutritional information Changes in appetite- anorexia, weight loss or gain Food intolerance Dysphagia Pyrosis/ Heartburn Epigastric pain / GERD Other abdominal pain Nausea and/or vomiting Hematemesis/ Vomiting blood Stomach/Intestinal ulcers Liver disease Gallbladder disease Jaundice Appendicitis Colitis Flatulence and/ or belching Constipation Diarrhea Black stools Rectal bleeding Hemorrhoids Fissures Fistula Describe current bowel habits, any changes? Describe current stool characteristics, changes? Use of laxatives and/or antacids Alcohol use How often? _____How much? ____				

Tubes-Nasogastric, orogastric, gastric, rectal, peg, duo /Ostomy				
PHYSICAL ASSESSMENT				
VS: BP _____ Pulse _____ Respirations _____ O2 Sat _____% Temp. _____˚F/C				
Pain 0-10	Asks the pt. to rate their pain on a 0 to 10 scale			
INSPECT:				
Abdomen contour	Inspect abdomen contour- symmetric, flat, round, scaphoid, protuberant, distended (Contour flat/slightly rounded is normal.)			
Pulsations/movements	Inspect movements- no pulsations, slight aortic pulse, peristalsis. (any seen?)			
AUSCULTATE:				
Bowel sounds	Auscultate bowel sounds in all 4 quadrants- present, hyperactive, hypoactive, absent, audible # of sounds/min. Normal is 5 to 30/min. (active, present, audible sounds/min)			
Vascular sounds	Auscultate vascular sounds over aorta and renal arteries, assess for bruits. Normal- no bruit. (No aortic or renal bruit heard.)			
PERCUSS:				
All 4 quadrants	Percuss in all 4 quadrants. Tympany is the normal sound.			
Liver	Percuss liver- move down the right mid-clavicular line. Dullness over liver is normal. (Lung resonance down to dull liver, about 5th intercostal space, then bowel tympany up to dull, about ribs, measure for span if needed; liver span 6-12 cm is normal) (Normal- no hepatomegaly.)			Don't need to measure liver but know where to percuss.
Costovertebral Angle	Percuss the CVA regions, posterior bilat., using indirect/blunt method, normal is neg. (Use fist over flat hand, post. 12th rib; positive may indicate UTI) (No CVA tenderness.)			
PALPATE:				
Light palpation	Palpate superficially in all 4 quadrants- soft, firm, rigid, non-distended, distended, nontender, tender, guarding, fluid wave assoc. with ascites, etc. (Normal- soft, no tenderness, masses or hernias, no inguinal lymphadenopathy.)			
	Palpate lightly for organ enlargement, masses, hernia, inguinal nodes (none is normal)			
	Palpate superficially over the aorta, assess for pulsations (nonpalpable is normal)			

Deep palpation	Palpate deep- edge of the liver with inhalation at right costal/rib margin, liver may not be palpable (Normal- no organomegaly)			
	Palpate deep- spleen and kidneys. Normal- kidneys/ spleen nonpalpable			
	Palpate deep and release assessing for rebound tenderness, negative is normal. (Pos. rebound pain may indicate appendicitis.) Palpate liver when pt. inhales deeply (Murphy's sign), neg./no pain is normal. (Positive may be gallbladder related.)			
DIET- tolerance and ordered	Regular, NPO, fluid restricted, ADA, low Na+, soft, clear/ full liquid, TPN, etc.			
HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention(s)			
PROBLEM IDENTIFICATION	Formulates two nursing diagnoses			
DOCUMENTATION & REPORT	Records findings			
	Provides focused SBAR report			
ASSESSMENT RATING: Satisfactory ☐ Unsatisfactory ☐ Comments: (If needed)				
Student Signature Evaluator Signature Date:				

Rev 8/2016

Health Assessment Lab Form				
Musculoskeletal Assessment				
Assessment Technique	Performance Criteria	Evaluation Rating		
		Meets Expectations	Does not meet Expectations	Comments
SAFETY				
Hand Hygiene:	Performs proper hand hygiene			
Introduces Self:	Introduces self with name and role to patient			
Patient Verification:	Asks pt. to state their name, DOB & verify ID band			
Verifies Allergy:	Asks patient about allergies			
Communication:	Provides effective history taking and physical exam explanations			
HEALTH HISTORY / ROS:				
Arthritis Gout Joint pain Joint stiffness Joint swelling Deformity Limited range of motion in joint Noise with joint motion Walker/Cane or other mobility aid used (cast, sling, boot, crutches, wheelchair, prosthesis, etc.) Daily activities limited by ROM- describe	Muscle cramps Muscle pain Muscle weakness Gait or problems with coordination Back pain Back stiffness Limited ROM in back Disk disease			
PHYSICAL ASSESSMENT:				
VS: BP _____ Pulse _____ Respirations _____ O2 Sat _____% Temp. _____˚F/C				
Pain 0-10	Asks the pt. to rate their pain on a 0 to 10 scale			
INSPECT:				
Overall muscles, bones, and joints	Muscles, bones, & joints are symmetrical, shoulders and hips aligned (normal)			

	Assess for scoliosis, lordosis, or kyphosis (None is normal.)			
INSPECT & PALPATE:				
Joints- each bilaterally	Inspect for ↑size, color change, swelling, masses, deformities (none)			
	Palpate joints for warmth, tenderness, crepitus, edema, or deformity (none)			
Shoulders	ROM: flexion (swing forward and up), extension (downward), abduction (side up), adduction (side down), internal rotation (bend behind back) & ext. rotation (up at neck), elevation (up), depression (down), circumduction (around) (Normal- no heat, swelling, tenderness, crepitus, and full ROM bilat.)			
Elbows	ROM: flexion (bend up), extension (back), pronation (palm down), supination			
Wrists & hands	ROM: wrist- extension (up), flexion (palm down), pronation (palm down), supination (palm up), ulnar deviation (out), radial deviation (in), fingers- extension (flat), flexion (bend down), hyperextension (up), abduction (spread out), adduction (fist), move thumb (full ROM)			
Hips	ROM: flexion (bend leg up), extension (flat, straight), hyperextension (standing, move back), abduction (out), adduction (in), int. rotation (rotate toward other leg), ext. rotation (out, away from other leg) (full ROM)			
Knees	ROM: flexion (bend), extension (flat, straight), may squat or walk (full ROM)			
Ankles & feet	ROM: ankle- dorsiflexion (bend foot up), plantar flexion (point toes down), inversion (turn sole of foot in with big toe up), eversion (sole out, little toe up), feet- (flex and straighten toes) (full ROM)			
Cervical spine/neck	ROM: flexion (chin to chest), extension (straight), hyperextension (backward, chin up), lateral bending (ear to shoulder), rotation (chin to shoulder) (full)			
Spine	ROM: flexion (bend forward), extension (straight), hyperextension (bend backward), lateral bending (sideways), rotation (twist shoulders) (full)			
PALPATE:				

Muscle strength	Shoulders (shrug), deltoids (pt. holding arms straight out, push arms down), biceps (pull flexed arm against resistance), triceps (push), hands (grip), quadriceps (pt. to push up against resistance), hamstrings (push down), and calves (flex knee, pull back against resist.) (normal- equal strength bilat., 5/5)			
HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention(s)			
PROBLEM IDENTIFICATION	Formulates two nursing diagnoses			
DOCUMENTATION & REPORT	Records findings			
	Provides focused SBAR report			
ASSESSMENT RATING: Satisfactory ☐ Unsatisfactory ☐ Comments: (If needed)				
Student Signature Evaluator Signature Date: Rev 8/2016				

Health Assessment Lab Form				
Neurological and Mental Assessment				
Assessment Technique	Performance Criteria	Evaluation Rating		
		Meets Expectations	Does not meet Expectations	Comments
SAFETY				
Hand Hygiene:	Performs proper hand hygiene			
Introduces Self:	Introduces self with name and role to patient			
Patient Verification:	Asks pt. to state their name, DOB & verify ID band			
Verifies Allergy:	Asks patient about allergies			
Communication:	Provides effective history taking and physical exam explanations			
HEALTH HISTORY / ROS				
History of seizure disorder Stroke	Recent memory disorder Distant memory disorder			

Fainting Blackouts Weakness Tic or tremor Paralysis Paresthesia Coordination problems	Disorientation Hallucinations Nervousness Depression Mood changes Mental health diagnosis			
PHYSICAL ASSESSMENT				
VS: BP _____ Pulse _____ Respirations _____ O2 Sat _____% Temp. _____˚F/C				
Pain 0-10	Asks the pt. to rate their pain on a 0 to 10 scale			
Sedation Level	if needed (Normal is 0- fully awake, 4 is unconscious) (LOC- 1 alert to 5 coma)			
Glasgow Coma Score	if needed (best responses for verbal, motor, and eye) (normal = 15)			
Mental Assessment	Assess cognition (alert, oriented to person, time, place, and situation)			
	Assess short term memory: (ask pt. to remember 3 words) (correct recall)			
	Behavior: appropriate, calm, anxious, agitated, fearful, depressed, confused			
Neurological Physical				
Cranial Nerves I Olfactory	Sensory: Smell (whiff scent) (able to correctly identify odor with eyes closed)			
CN II Optic	Sensory: Visual acuity (use Snellen chart) (20/20 per Snellen Chart) (also peripheral fields, test by confrontation, wiggle fingers out to in, cover 1)			
CN III, IV, VI: Oculomotor, Trochlear, & Abducens	Motor: Extraocular Muscles (EOM's - test -follow in an H or Vs) (intact in 6 cardinal fields of gaze). (Gaze is conjugate- simultaneous movement of both eyes, without nystagmus- normal) (CN III-EOM, CN IV- up, down and inward movements, CN VI- lateral movements). Parasympathetic: Pupil size and constriction (pupillary light reflex test- penlight from the side, check same eye-direct and other eye- consensual/simultaneous pupil constriction or reaction to light & accommodation test- focus far away to dilate, then bring finger close, check for pupils to constrict and converge- axes move in, CN III).			

	(Pupils, Round, React to Light and Accommodation (PERRLA) with consensual response)			
CN V: Trigeminal	Motor: Jaw muscle strength (clench jaw muscles, chew) (strength equal bilat., TMJ without pain or crepitus) Sensory: Facial sensation (Correctly identifies touch to areas of the face)			
CN VII: Facial	Motor: Movement (smile, frown, raise eyebrow, puff cheeks symmetrically) Sensory: Taste (identify sweet, salty, sour, bitter on ant. 2/3 of tongue)			
CN VIII: Acoustic	Sensory: Hearing (whisper word at 2 feet- correctly identifies is normal)			
CN IX & X: Glossopharyngeal & Vagus	Motor: Talking and swallowing (say 'ahh'- uvula rises midline on phonation) Sensory: Taste and gag reflex (CN IX: taste on post 1/3 tongue) (defer gag)			
CN XI: Spinal	Motor: Shoulder shrug & head movement (5/5 strength against resistance)			
CN XII: Hypoglossal	Motor: Tongue movement (tongue extends midline without deviation)			
Assess Sensation	Assess sharp and dull on bilateral upper and lower extremities (touch with cotton ball and stick) (correctly discriminates sharp and dull)			
	Assess proprioception (move fingers and toes up and down, and ask for pt. to identify the position) (intact sensation)			
Assess Cerebellar Function	Gait- (assess walking, coordination, balance) (smooth and steady)			
	Tandem walk- (maintains a heel toe walk along a straight line with balance)			
	RAM's- (alternating supination and pronation of hands on knees, and fingers to thumb) (smooth, quick and rhythmic)			
	Eye-Hand Movements- (finger to nose, finger to the nurse's finger) (performed with accuracy, coordination and rapidity)			
	Romberg test-(pt. stands, closes eyes, holds position, maintains balance) (neg.			
Assess for **S&S** of Disease/Stroke	Prn Facial asymmetry, speech change, abn. pupil response, arm drift (absent)			
Assess Deep Tendon Reflexes	Biceps (int. elbow/forearm), Triceps (above elbow), Brachioradialis (wrist, thumb up), Patellar (knee), Achilles (post. ankle)			

	(DTRs- 0 is absent, 2+ is normal, 4+ is hyper; check for clonus- neg. is normal)			
	Babinski (stroke sole, toes curl down/plantar flex= normal/ neg. after 2 years)			
HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention(s)			
PROBLEM IDENTIFICATION	Formulates two nursing diagnoses			
DOCUMENTATION & REPORT	Records findings			
	Provides focused SBAR report			

ASSESSMENT RATING: Satisfactory ☐ Unsatisfactory ☐ Comments: (If needed)

Student Signature Evaluator Signature Date:

Rev 8/2016

Health Assessment Lab Form				
HEENT Assessment				
Assessment Technique	Performance Criteria	Evaluation Rating		
		Meets Expectations	Does not meet Expectations	Comments
SAFETY				
Hand Hygiene:	Performs proper hand hygiene			
Introduces Self:	Introduces self with name and role to patient			
Patient Verification:	Asks pt. to state their name, DOB & verify ID band			
Verifies Allergy:	Asks patient about allergies			
Communication:	Provides effective history taking and physical exam explanations			
HEALTH HISTORY / ROS				
Head Frequent or severe headaches Head Injury Dizziness/syncope **Neck** Pain Limited ROM Lumps or swelling Enlarged or tender nodes Goiter **Mouth and Throat** Mouth pain or toothache Bleeding gums Lesions in mouth or tongue Frequent sore throats Hoarseness or voice change	**Nose and Sinuses** Discharge Unusual frequent or severe colds Sinus pain Nasal obstruction Nosebleeds Allergies Changes in sense of smell **Ears** Earaches Infections Discharge Tinnitus Vertigo Wears hearing aids Coping with hearing loss	**Eyes** Blurring Decreased acuity Blind Spots Floaters Halos Eye Pain Diplopia Redness or swelling Watering or discharge Glaucoma Cataracts Wears glasses or contacts Date of last eye exam Coping with loss of vision			

Dysphagia Altered tastes Wears dentures Date of last dental exam _____ Hx. ____	Exposure to environmental noise Method of ear cleaning **<u>Tobacco use</u>:** Smoke/Dip/Chew/Vapor How much?- PPD			
PHYSICAL ASSESSMENT				
VS: BP _____ Pulse _____ Respirations _____ O2 Sat _____% Temp. _____˚F/C				
Pain 0-10	Asks the pt. to rate their pain on a 0 to 10 scale			
INSPECT & PALPATE: Head, Face, Neck, Nose, Mouth, Throat, Ears and Eyes				
Skull & Scalp	Palpate head. (Rounded, normocephalic and symmetrical, and nontender; scalp is smooth with uniform consistency; absence of nodules or masses.)			
Face	Palpate temporal arteries. (Normal- 2+, regular, equal bilaterally)			
	Inspect face. (Normal- features symmetric with no droop, movements are symmetrical, no involuntary movements, skin tone even, no edema)			
	Inspect facial movements. (Ask pt. to puffs cheeks, smile, frown, and raise eyebrows.) CN VII: Facial (intact) CN V: Facial sensation- with neuro			
Nose & Sinuses	Inspect nose. (Normal- symmetric and straight, no flaring)			
	Inspect and palpate nasal cavity using a nasal speculum. (Normal- nasal mucosa pink & moist, no drainage; no septal deviation, nontender)			
	Inspect and palpate nares for nostril patency. (occlude each, check patency)			
	CN I: Olfactory -assess smell with eyes closed. (Normal- able to identify smells correctly, CN I intact.)			
	Palpate Frontal & Maxillary sinuses. (Frontal palpated midline above eye sockets, Maxillary palpated midline and cheekbones, use thumb or fingertips; normal- no tenderness or crepitus)			
Mouth & Pharynx	Inspect lips, gums, oral mucosa, palate, pharynx, and tongue. (Normal- pink & moist without lesions or exudates)			
	Inspect teeth and salivary ducts. (Wharton's and Stenson's). (teeth without dental caries); (Stenson's duct- opening to parotid gland,			

	upper 2nd molar, Wharton's duct- or submandibular, base of tongue) (salivary ducts patent)			
	Inspect tonsils. (Tonsils pink, moist, grade 0-4+ , without exudates)			
	CN VII and CN IX- assess taste. (ask pt. if they can taste accurately) (sweet, salty, sour, bitter on ant. 2/3 of tongue, and on post 1/3 tongue- defer)			
	CN IX & X: Glossopharyngeal & Vagus- inspect palate and uvula rise midline on phonation. (soft palate intact, uvula midline; ask pt. to swallow, say 'ahh', use tongue blade, uvula rises (CN IX & X intact). (Gag reflex- defer)			
	CN XII: Hypoglossal- inspect tongue when extended. (ask pt. to stick out their tongue, check position, midline without deviation) (CN XII intact).			
	CN V: Trigeminal- Palpate TMJ. (ask pt. to clench teeth or chew, check jaw muscle strength) (strength equal bilat., TMJ without pain or crepitus)			
Neck	CN XI: Spinal- palpate muscle strength with head/neck movement and shoulder shrug. (5/5 bilaterally as client moves against resistance. (CN XI intact.)			
	Inspect: trachea (midline), jugular veins (no JVD distention), ROM (full)			
	Inspect and palpate the thyroid gland. (Normal- not visible; no thyromegaly and without nodules or tenderness.) (may use ant. or post. approaches)			
	Palpate lymph nodes. (pre-auricular, post-auricular, occipital, tonsillar (or jugulodigastric), submandibular, submental, superficial cervical, deep cervical chain, posterior cervical, and supraclavicular without tenderness or swelling) (No lymphadenopathy.)			
	Inspect, palpate, and auscultate carotid arteries. (2+, regular and equal bilaterally without thrill, no bruit on auscultation.)			
Ears	Inspect and palpate the external ears- auricle/ pinna, tragus, lobule, mastoid process and the canals. (symmetrical, auricle is aligned with the outer canthus of the eye, move the pinna, gently push on the tragus- firm, mobile, non-tender; canal without redness, swelling, lesions, foreign bodies, obstruction or drainage; slight amount of cerumen.)			

	Inspect canal and tympanic membranes using an otoscope. (adult- pull pinna up and back, child- down, gently and slowly insert otoscope's speculum) (Normal- TM should be pearly gray, intact; cone of light and bony prominences/landmarks present, no perforations)			
	CN VIII: Acoustic- assess hearing acuity. (whisper word at 2 feet) (Normal- voice sounds were audible and words correctly identified)			
Eyes	CN II Optic- inspect visual acuity (use Snellen chart) (20/20 per Snellen Chart)			
	CN II Inspect visual fields- peripheral vision tested by confrontation. (When looking straight ahead, wiggle fingers out to in, cover 1, ask when the moving object is spotted) (Normal- visual fields intact by confrontation.)			
	CN III, IV, VI: Oculomotor, Trochlear, & Abducens- inspect extraocular muscles function using the diagnostic positions test. (EOM's - test - follow in an H or Vs) (EOMs intact in 6 cardinal fields of gaze). (Gaze is conjugate (simultaneous movement of both eyes) without nystagmus- normal) (CN III-EOM, CN IV- up, down and inward movements, CN VI- lateral movements).			
	CN III, IV, VI: inspect pupil size and constriction. Assess pupil size. (equal in size, normal adult resting size is 3 to 5 mm) Assess pupillary light reflex test- (penlight from the side, check same eye-direct and other eye- consensual/simultaneous pupil constriction or reaction to light) and accommodation test- (focus far away to dilate pupils, then bring finger close to pt.'s nose 4 inches, check for pupils to constrict and converge- axes move in, CN III). (Pupils Equal, Round, React to Light and Accommodation (PERRLA) with consensual response)			
	Inspect eyebrows, eyelashes, eyelids. (Brows and lashes full and evenly distributed.) (Lids without discoloration, lesions or ptosis.)			
	Inspect and palpate lacrimal ducts. (Lacrimal ducts without discharge, edema, tenderness, or tearing.)			
	Inspect conjunctiva, sclera, iris, cornea, and lens. (Conjunctiva pink & moist, sclera white, iris color evenly distributed; using a penlight- cornea is transparent, smooth and shiny, and the lens is transparent.			
	Inspect the ocular fundus using an ophthalmoscope. May defer.			

HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention(s) Last exams- dental _____eye _____ Use of nasal spray? Ear cleaning technique? Smoking cessation teaching as needed.			
PROBLEM IDENTIFICATION	Formulates two nursing diagnoses			
DOCUMENTATION & REPORT	Records findings			
	Provides focused SBAR report			

ASSESSMENT RATING: Satisfactory ☐ Unsatisfactory ☐ Comments: (If needed)

Student Signature Evaluator Signature Date:

Rev 8/2016

Health Assessment Lab Form	
Bedside Assessment	
Assessment Technique	**Performance Criteria**
SAFETY	
Hand Hygiene:	Performs proper hand hygiene
Introduces Self:	Introduces self with name and role to patient
Patient Verification:	Asks pt. to state their name, DOB & verify ID band (use 2 identifiers-name, DOB
Verifies Allergy:	Asks patient about allergies (check armbands for allergies, fall precautions, etc.
Communication:	Provides effective history taking and physical exam explanations
HEALTH HISTORY refer to the chart/ ROS do with the system if able: Subjective	
PHYSICAL ASSESSMENT: Objective	
General Survey	Overall first impression of pt. Categories: Physical appearance, mental status, m behavior
Room Survey	Room- bed (position and height, side rails up), call bell in reach, IVs, pumps (IV, nutrition), devices (SCD), machines (suction, etc.), isolation precautions, fall pre allergies, other signs (DNR, BPs on 1 arm only)
Neuro - LOC/ Sedation Level	Observe/inspect LOC/ sedation level (Normal is 0- fully awake, 4 is unconscious coma)
Neuro - Glasgow Coma Score	Calculate GCS if needed (best responses for verbal, motor, and eye) (normal = 1
Vital Signs	BP _____ Pulse _____ Respirations _____ O2 Sat _____ _____˚F/C
Pain	Subjective- ask pt. to rate their pain on a 0 to 10 scale (or use a faces scale for a
	Assess pain medications if needed- ordered, used, last dose, response to pain m
General, Pain, Neuro	Observe nonverbal signs - body position (supine, sitting, relaxed, tense, holding and facial expression (appropriate, tense, grimacing, blank)
Respiratory ROS	Subjective- SOB, dyspnea, asthma, wheezing, emphysema, chronic bronchitis, c any cancer
Respiratory - Effort	Observe resp. effort- (quiet, labored, gasping, grunting, nasal flaring, use of acc distress, etc.) Pt. position needed for breathing (relaxed, tripod)
Respiratory - Rhythm	Observe resp. rhythm- regular, irregular (normal- rhythm smooth & regular wit muscles, regular rate and rhythm.)

Skin - Color	Observe overall color- even, pink, pale, erythema, jaundiced, mottled, cyanotic
Respiratory - Breath sounds	Auscultate over anterior and posterior lung fields- (listen through inspiration an and posterior) (Normal- clear breath sounds bilat. without dyspnea and no adve sounds.)
Respiratory - Breath sounds	Auscultate for adventitious breath sounds- Coarse, wheeze (rhonchi), crackles (ant/post, RUL, LUL, RML, RLL, LLL, in/out
Respiratory- Interventions	Pt. need for O2 assistance (if needed) (None or describe O2 L/min, %, mask, car respirator, etc.) Pt. use of inhaler or resp. treatment (if needed), Pt. use of a spirometer and assess results (if needed), turn, cough, and deep bre Assess mucous, sputum if cough is productive(if needed)- (color, amount, purul (hemoptysis), frothy)
Cardiac ROS	Subjective- HTN, CAD, CHF, MI, angina, palpitations, MVP; cardiac meds, treatm needed)
Cardiac- Apical Pulse	Auscultate apical pulse- assess rate & rhythm. Compare to palpated radial. (reg abnormal- arrhythmia, bradycardia, tachycardia)
Cardiac- Valve areas	Auscultate: Aortic (2nd ICS RSB), Pulmonic (2nd ICS LSB), Erb's Point (3rd ICS LSE LSB or epigastric area), and Mitral (5th ICS LMCL) (S1 and S2 are present, no S3, S4, murmurs, rubs, or gallops), (auscultate with t
Cardiac- Interventions	Pt. use of a cardiac monitor, ECG, pacemaker, cardiac med infusions, heparin, e periph.)
Abdomen ROS	Subjective- diet, any abd. pain, N&V, constipation, diarrhea, rectal bleeding, gas hepatitis, liver disease, jaundice, unexplained weight changes (loss or gain), etc. surgery (if needed) (colonoscopy, cholecystectomy, appendectomy, etc.); descr needed).
Abdomen	Inspect abdomen contour- non-distended, indicate more if needed (symmetric, protuberant, distended) (Contour flat/slightly rounded is normal)
Abdomen	Auscultate bowel sounds in all 4 quadrants- (present, hyperactive, hypoactive, a sounds/min.) (Normal is 5 to 30/min. audible sounds) (Bowel sounds active or p quadrants.)
Abdomen	Palpate superficially in all 4 quadrants- (soft, firm, rigid, non-distended, distend guarding), and for organ enlargement (if needed) (masses, hernia) (Abdomen was soft, non-distended, and non-tender on palpation.)
Abdomen	Assess diet- tolerance and ordered (if needed)- (regular, NPO, fluid restricted, A clear/ full liquid, TPN, lipids, vitamins, probiotics, tube feeding, peg, etc.)
Genitourinary ROS	Subjective- ability to void, any urinary problems/symptoms (pain, frequency, ur incontinence, hematuria); any genital problems (if needed) (lesions, discharge, menses, surgery, cancer)
Genitourinary	Assess ability to void- voiding qs (q 4-6 hours, amount at least 30cc/hr); calculat Urine- color and clarity (pale yellow, dark yellow, amber, bloody, clear, cloudy) Use of a catheter (if needed) (foley, condom) Urinary abnormal S&S- (bladder retention, pain, frequency, urgency, hesitation, tenderness)

Genitourinary	Palpate the bladder- (non-palpable, non-distended, filling, full, distended, non-t
Endocrine ROS	Subjective- any DM, thyroid, or hormone changes/ problems (if needed) (last BI treatment)
Neuro ROS	Subjective- any HAs, migraines, seizures, stroke, TIA, weakness, tremor, paralys coordination/balance changes Any changes in the senses or facial movements (if needed) (CNs, eyesight, heari Any mental health problems (if needed) (depression, anxiety, bipolar, ADHD, m dementia, etc.)
Neuro - mental throughout	Assess cognition: (alert, oriented to person, time, place, and situation)
Neuro - mental throughout	Assess behavior: (appropriate, calm, anxious, agitated, fearful, depressed, confu
Neuro and HEENT throughout	Assess speech during care: (clear, articulate, appropriate, no presence of aphas
	Assess general vision and hearing during care: observe and note if needed- (nor responses and facial expression to speaking, noises; ability to acknowledge othe watch TV, etc.)
Neuro and HEENT	Assess pupil size and response to light (right and left eyes compared, normal is
	Inspect face- (symmetric, asymmetric, drooping, ptosis, flat affect, unresponsive
Neuro and HEENT and Abdomen	Assess the ability to swallow (potential risk for aspiration)
Cardiac/Peripheral circulation ROS	Subjective- any edema, pain, numbness, tingling, varicose veins, or discoloratio hx. of DVT
Musculo-skeletal ROS	Subjective- joint pain, stiffness, or swelling; arthritis, RA, gout, osteoporosis, no ROM; muscle pain, weakness, cramping; gait or coordination problems; able to in ADLs
Skin ROS	Subjective- Hx of skin disease; change in moles; excessive bruising, dryness, or r lesions
Resp. and Cardiac and Skin Upper and Lower Extremities	Inspect and palpate- skin color and symmetry (even, appropriate, pink, pale, cya jaundiced)
	Inspect and palpate- nails for color and shape (pink, rounded, clubbing), Assess capillary refill (< 3 seconds is normal, > 3 seconds abnormal)
Cardiac/Peripheral circulation Upper Extremities	Palpate peripheral pulses- rate, rhythm, force/amplitude (0 is absent, 1+ weak, bounding), compare symmetry (do both sides simultaneously)- Radial (wrists, m with apical pulse)
Muscle and Neuro- Upper Extrem.	Assess hand grips strength bilaterally (normal- equal strength bilat., 5/5)
	Assess for pronator/arm drift (if needed)
Cardiac/Peripheral Lower Extremities	Palpate peripheral pulses- Posterior Tibial (inner ankle), and Dorsalis Pedis (top (Normal- pulses 2+, regular, & equal bilaterally)
	Inspect and palpate- edema (absent edema is normal, 1+, 2+, 3+, 4+, pitting)
Cardiac/Peripheral and Neuro Lower Extremities	Inspect and palpate- Homan's sign (normal is negative- no calf pain with dorsifle DVT), and clonus (normal is negative)
Muscle and Neuro- Lower Extrem.	Assess strength of lower leg and feet (push down) (normal- equal strength bilat

Neuro Lower Extrem. DTRs	Assess patellar (knee) Deep Tendon Reflexes (if needed) (0 is absent, 2+ is norm
Muscle and Neuro	Assess activity and mobility- (ambulatory- tolerance, distance, gate and balance devices(cane, walker), able to sit in a chair, able to stand, needs to use a wheelc needed, bedrest ,immobile, able to do ROM exercises)
	Assess Morse Fall Score for risks of falling (scale with 6 variables- hx. of falls, sec ambulatory aid, IV or saline lock, gait and transferring, and mental status) (Tota falls, <25= low risk, 25-45= moderate risk, and >45= high risk)
	Assess for restraints (if needed)
Cardiac/Periph. and Skin	Inspect and palpate IV and IV site(s) (if needed)- patent, solution to be infused- mainline, type and rates for piggybacks, using gravity and/or pump(s), compare assess IV site(s) (location, intact, without redness, swelling or tenderness, infiltr check the dates- IV site, bag and tubing
Pain, Skin, Cardiac, Neuro, Resp.	Inspect- if a PCA or PCE pump is in use (location, site, level of use, response, cor dosing)
Skin	Palpate temperature (warm, cool, cold, hot) (Check temp with back of hand), m diaphoresis, dehydration), texture, turgor, thickness (supple, smooth, firm, pron pinching skin, thin)
	Inspect mucous membranes (pink, pale)
	Inspect and palpate skin condition/ integrity and abnormalities (intact, vascular lesions, wound, incision, inflammation, ecchymosis, drainage) (note location, siz REEDA- (redness, ecchymosis, edema, drainage, approximated)
	Inspect skin condition – wound and incisional types of dressings; skin around- d chest, NG, etc., trach, ostomy, use of air/egg crate/specialized bed (if needed)
	Inspect for pressure ulcers (if needed)
	Braden Score (if needed)- Pressure ulcer risk score: sensory perception, nutritio moisture, friction (low score ↑ risk, higher score 19 ↓ risk)
HEALTH PROMOTION & TEACHING	Identifies ≥1 self-care, health promotion, or pt. teaching intervention(s)
PROBLEM IDENTIFICATION	Formulates two nursing diagnoses
DOCUMENTATION & REPORT	Records findings
	Provides focused SBAR report
ASSESSMENT RATING: Satisfactory ☐ Unsatisfactory ☐ Comments: (If needed)	
Student Signature	**Evaluator Signature**
Rev 8/2016	

M E M O R A N D U M

2D

FROM: Cheyenne Redd, MSN, RN
Director of Licensure & Certification
Maryland Board of Nursing
TO: The Board
DATE: March 22, 2017
IN RE: Request for Approval of Nurse Refresher Program-Faculty

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The following nurse faculty has been reviewed and have satisfied all criteria as outlined in COMAR 10.27.01.15 (B) for Faculty in a nurse refresher course in the State of Maryland:

Hagerstown Community College is seeking approval of Ms. Susan K. Lyons to teach in the nurse refresher program. Ms. Lyons has an active RN in Maryland. She obtain her Bachelor of Science degree in Nursing from Shepard University in 1991 and her MSN, Acute Care Nurse Practitioner from University of Southern Indiana in 2011. She has taught in several arenas. Most recently, Ms. Lyons has taught for Meritus Medical Center in the "New Grad Nurse Residency Program".

Susan K. Lyons, BSN, MA, MSN, ACNP-BC

Education:

- 1991 BSN, Shepherd University, Shepherdstown, West Virginia, magna cum laude, vice president of nursing class
- 2004 MA, Thanatology, Hood College, Frederick, Maryland
- 2011, MSN, Acute Care Nurse Practitioner, University of Southern Indiana, Evansville, Indiana
- 2013-2014: Physician Leadership Academy, ACPE
- *Certifications:* 1995-2011: CCRN; 1999-2010: ACLS Instructor; CHPN, 2006-2011; 2011-Present: ACNP-BC, Acute Care Nurse Practitioner, Board Certified

Teaching Experience:

- 2000 – 2010 -ACLS Instructor - I taught ALL ACLS case stations and mega code. I taught 2-4 sessions every year. This was done through American Heart Association ACLS provider affiliated with Washington County Hospital.
  Contact: Donna Carey, Education, Meritus Medical Center
- December, 2013 – Present - Maryland MOLST Trainer - I have taught the Maryland MOLST program content at least 15 times all over the state of Maryland. This training is done through the Office of Attorney General and Office of Health Care Quality.
  Contacts: Paul Ballard, Assistant Attorney General and Dr. Trisha Nay, Director, Office of Health Care Quality
- April 17, 2013 -AACN Instructor –MNA District 8 "Challenging Pain- Management and Interventions". Meritus Medical Center.
- October 8, 2013 – AACN Instructor – Fall Trauma Update-"Ethical and End of Life Dilemmas of Trauma and Critical Care." Meritus Medical Center.
- 05/04/2015 – AACN Instructor –"Beyond the Bedside, Expanded Roles for Nurses in a Hospital Setting," Meritus Medical Center. AACN approved contact hour courses for nurses. Contact: Tamara Yeager and Lynn Waldron, Meritus Medical Center
- Quarterly Conversations in Ethics", a one hour CME offering for multidisciplinary staff on common or current news event ethical issues in health care. Contact: Sheree Martin, Meritus Medical Center
- September/2013 – February/9/2017 - - Instructor – "New Grad Nurse Residency Program" (spring and fall cohorts) two hour course. Topics include: "Hospital Based Palliative Care,"" Ethics," and "Communication." Contact: Lynn Drury, Meritus Medical Center.
- September, 2015, Guest Speaker, "Partnership for Care Transformation" Premier, Inc., Springfield, Massachusetts. Contact: Dr. Mimi Huizinga.
- June 2017, Presenter- Maryland Health Education Institute (MHEI) Palliative Care conference
  Contact: Alison Burrows

Work Experience:

- February 1990-Present: employee Meritus Medical Center, Hagerstown, Maryland (formerly Washington County Hospital).
- 2013-Present: Medical Director of Health Home, Family Services, Inc. for clients with primary persistent psychiatric disorders who qualify for Health Home services.

- 2011-Present: Outpatient Trauma Clinic NP; post discharge assessment and evaluation of healing and readiness to return to routine activities or continued need for multidisciplinary follow-up. Perform minor wound care and suture/staple removal.
- 2002-Present: Palliative Care Program Coordinator; develop, coordinate and implement palliative care delivery model that prioritizes care based on patient and family education and preferences, early and appropriate integration of services, seamless transition from curative model to palliative model of care. Provide education and support to interdisciplinary staff.
- 1999-2002: Clinical Manger Progressive Care Unit; supervising and supporting daily operations of twenty-tree bed cardiac and intensive care step-down unit. During three years as manager, lower than hospital average falls and hospital acquired skin breakdown rate. Patient satisfaction scores significantly better than hospital average as measured by Press-Ganey.
- 1999-2010: PRN Administrative Nursing Supervisor (off-shift nursing supervisor).
- 1991-1999: Staff RN, Progressive Care Unit; Resource Nurse, preceptor for experienced and novice nurses, summer student nurse intern preceptor, skills validator for RNs, CNAs, schedule negotiator, Chair Professional Practice Council for Cardiology Services, PRN ICU staffing.

Professional Roles, Responsibilities and Areas of Interest:

- Co-Chair, Institutional Review Board since 2012
- 2007- Present: Chair, Ethics Committee, member since 1998
- Designated Donor Requestor for Living Legacy Foundation of Maryland
- Founding member, Washington County CARES, community based coalition dedicated to improving the care, access, resources and education and support for individuals with advanced illnesses. Authored successful grant from Robert Wood Johnson Rallying Points program to develop community education models (2004).
- Chair, Code Blue Committee 1996-2013; hospital-wide multidisciplinary committee that reviews statistics, protocols, standards, outcomes, equipment and educational needs relating to resuscitation attempts.
- Strong functional knowledge of Joint Commission standards and elements of performance, scoring and survey process, team leader for Provision of Care standards; scribe for physician hospital surveyor.
- Multiple ad-hoc and ongoing team memberships and presentations including root cause analysis, grand rounds, patient safety, shared governance design, planning for conferences and professional symposiums, public education, pastoral care advisory team, strategic planning for division of nursing, patient family advisory committee liaison, etc.
- Community education: Multiple appearances on hospital sponsored radio call in program, Health Matters; hospital sponsored local cable program, Contemporary Retirement; small and large group Advance Directive and Maryland MOLST workshops per request for local church groups, senior clubs, parish nursing, etc.
- Multiple peer and management acknowledgments of outstanding service including President's Award, Nurse of the Year, Employee of the Month, Shining Star, Customer Service Star, Pillar of Excellence, Nurse's Choice Advance Practice Provider.
- Coordinate and present quarterly Conversations in Ethics CME program.
- Maryland MOLST Certified Trainer; presenter of health care decision making training activities of the Office of Health Care Quality and the Office of Attorney General throughout the State of Maryland.
- Community Foundation of Frederick County, Maryland; scholarship committee.

MEMORANDUM

2.E

FROM: Cheyenne Redd, MSN, RN
Director of Licensure & Certification
Maryland Board of Nursing
TO: The Board
DATE: February 22, 2017
IN RE: CNA Advisory Committee-Long Term Care Nursing Assistant (Camello David)

Camello David has been an active CNA/GNA in Maryland since 2004. Ms. David has a vast knowledge in the scope of practice of a nursing assistant in the long-term care, mental health, and home health settings. Ms. David has an expressed interest in the protection of the public. She was made aware of the duties expected of a member of the CNA Advisory Committee set forth in Maryland Annotated Code, Health Occupations Article, section 8-6A-13(f). She is being considered for the long term care nursing assistant designation noted in Maryland Annotated Code, Health Occupations Article, section 8-6A-13(b).

Ms. Camello K. David CNA, GNA, MHA

Objective:

To obtain employment in the healthcare, field, where I am able to use my diverse experience and compassionate nature to help enrich and improve the quality of life for others.

Work History:

Mental Health Technician/ Unit Secretary September 2010-Current

Frederick memorial Hospital, Frederick, MD

- Assist in therapeutic activities,
- Ensure that patients take their medications
- Facilitate and design therapeutic groups to teach daily living skills, enhance the patient's social skills and provide recreational therapy.
- Communicate effectively with mentally ill and emotionally disturbed people. While interacting with patients,
- Identify behavior and statements that require intervention by the psychiatric staff.
- Keeping records, entering patient data and transporting patients to activities or appointments.
- Listen and provide emotional support and encouragement to psychiatric patients.
- Complete physical checks and monitor patients to detect unusual or harmful behavior and report observations treatment team
- Restrain or aid patients as necessary to prevent injury.
- Complete administrative tasks, such as entering orders into computer, answering telephone calls, or maintaining medical or facility information.

Personal Job Coach/ Home Health Assistant March 2009-September 2010

Arch of the Chesapeake region, Adamstown MD

- Monitor patient condition by observing physical and mental condition intake and output, and exercise.
- Supports patients by providing housekeeping and laundry services; shopping for food and other household requirements; preparing and serving meals and snacks; running errands.
- Assisted individuals with disabilities to learn and accurately carry out job duties.
- Provide one-on-one training tailored to the needs of the employee.
- Job analysis to identify the job duties
- Developed specific plans as to how they can best train the employee to work more and more on his/her own until completely self-sufficient and able to perform job duties accurately and effectively without assistance.

CNA/GNA October 2007- March 2009

Northampton Manor nursing & rehab, Frederick, MD

- Assist elderly patients with handling daily tasks such as grooming, bathing, toileting and dressing.
- Assist patients with mobility and encourage them to walk independently when possible
- Reposition and turn patients on a constant basis to ward of possibilities of bedsores
- Measure and record patient's' vitals such as temperature, blood sugar, blood pressure and pulse
- Prepare or assist in preparing appropriate food items for elderly patients by ensuring that they conform to doctors' orders
- Set up and operate equipment such as oxygen pumps, irrigation bottles and x-ray machines
- Perform emergency services such as First Aid and CPR

Work History Cont.:

CNA/ Home Health Aid January 2003-October 2007

Montgomery General Hospital. Olney, MD.

- Monitor patient condition by observing physical and mental condition, intake and output, and exercise.
- Supports patients by providing housekeeping and laundry services; shopping for food and other household requirements; preparing and serving meals and snacks; running errands.
- Assist with activities of daily living
- Provide companionship to patients, such as reading to them, playing games, going on walks

Education:

R.N. degree in progress

2003 CNA/GNA certification

1998 High School Graduate Seneca Valley high School, Germantown MD

Current First Aid and CPR Certified

References available upon request

STATE OF MARYLAND

MARYLAND BOARD OF NURSING
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BALTIMORE, MARYLAND 21215-2254

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4 a

To: Maryland Board of Nursing

From: Patricia Kennedy, Director of Education

Date: March 22, 2017

Re: Wor-Wic Community College, Department of Nursing welcomed Kris Brown, BSN, RN as part-time clinical faculty

Ms. Brown recently earned a MS in Health Service Administration. She has worked as a RN for 36 years as a nurse administrator, performed ophthalmology procedures and clinically taught bachelor students as well as courses for Certified Nursing Assistants and physical therapy students.

Ms. Kris Brown meets the qualifications for clinical nurse faculty (COMAR 10.27.03C(1)(a)-(d)).

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Dr. Murray K. Hoy

February 8, 2017

Dr. Patricia Kennedy
Director of Education Research
Maryland Board of Nursing
4140 Patterson Avenue
Baltimore, Maryland, 21215-2254

Dear Dr. Kennedy:

The Department of Nursing at Wor-Wic Community College in Salisbury, Maryland has recently welcomed a new part-time clinical faculty member, Ms. Kris Brown, MS in Administration, BSN, RN. Ms. Brown has been approved as a part-time clinical faculty member by Dr. Stephen L. Capelli, Senior Vice President for Academic Affairs.

Ms. Brown has experience in critical care and trauma nursing as an emergency department staff RN, and she is still employed in the clinical arena. She has also cared for pre- and post-operative patients for a surgical eye center. Ms. Brown has taught part-time in the clinical setting for Salisbury University, and she is currently a participant in the Eastern Shore Faculty Academy and Mentorship Initiative, which is funded by a Nurse Support Program II grant partnership agreement among Salisbury University, Wor-Wic Community College and Chesapeake College.

Ms. Brown will be teaching clinical experiences in the acute care setting for our NUR 111: Adult and Mental Health Nursing students this spring semester. She will also assist the full-time nursing faculty member with the skill laboratories for the course.

Attached you shall find Ms. Brown's resume, as well as, proof of licensure as registered nurse in the state of Maryland. Thank you for your time. Should you have questions or concerns, feel free to call the Department of Nursing, at 410-572-8700.

Sincerely,

Brenda J. Mister

Brenda J. Mister, EdD, MS, RN
Department Head and Professor of Nursing
Wor-Wic Community College
32000 Campus Drive
Salisbury, MD 21804

RECEIVED
2017 FEB 13 PM 3:39
MARYLAND
BOARD OF NURSING

Kris A. Brown

Career Objective: To teach as a nursing instructor. Considering obtaining my doctorate degree.

Summary of Qualifications: Experienced registered nurse; I love nursing and teaching nursing; detailed oriented.

Professional Experiences:

- Nursing Clinical Adjunct at Salisbury University
- Preceptor in Emergency Room at Nanticoke Memorial Hospital for numerous Salisbury and Delaware Technical Nursing students
- Wor-Wic Community instructor for Certified Nursing Assistant courses
- University of Maryland Eastern Shore instructor for Cardiology class/EKG's for post-graduate PT students

Education:

Central Michigan University, Mt. Pleasant, MD 48859 attended at Andrews Airforce Base, Clinton, MD – Master of Health Service Administration Fall

Hartwick College, One Hartwick Drive, Oneonta, NY 13820 – Bachelor of Science in Nursing with Spanish minor 1981

Board of Cooperative Educational Services (BOCES), HB Ward Technical Center, Griffing Avenue, Riverhead, NY – Licensed Practical Nurse 1977

Additional Skills: Taught at: Salisbury University BSN students as Nursing Clinical Adjunct at PRMC, Wor-Wic Community College CNA students, UMES post graduate Physical Therapy students Cardiology/EKG class. Certified as a CEN (Certified Emergency Nurse), also in Basic Life Support, Advanced Cardiac Life Support, Pediatric Advanced Life Support, TNCC, and Nonviolent Crises Intervention. Also skilled with IV's, NG tubes, assisting with chest tubes and intubations, triage, nursing assessments, patient teaching, preop/postop cataract and Laser surgery nurse; CPR instructor at PRMC.

Employment History:

- Salisbury University, 1101 Camden Avenue, Salisbury, MD 21801 410-543-6000 Supervisor Jeff Willey; 7/2016-12/2016 as a Nursing Clinical Adjunct bringing students to PRMC.
- Nanticoke Memorial Hospital, 801 Middleford Rd., Seaford, DE 19973 302-629-6611 Supervisor Lisa Wile; 11/2006, still working 4-5 days/month as ER staff nurse.
- Peninsula Eye Center, 101 Milford St., Salisbury, MD 21804 410-729-9290 Manager Karen Weidema; 2/2013 - 10/2016. Performed preop/post/op for cataract surgeries and Laser procedures.
- Peninsula Regional Medical Center, 100 E. Carroll St., Salisbury, MD 21801 410-546-6400 Manager Maria Mulinos; 2/1988-10/2006. Staff RN in ER and 2 years as Clinical Coordinator of Satellites.
- Wor-Wic Community College, 32000 Campus Dr., Salisbury, MD 21804 410-334-2895 Hired by Mr. Scarborough to teach Certified Nursing Assistants.
- Wicomico County Board of Education, 520 S. Pinehurst Ave., Salisbury, MD 21801 410-677-4400 Hired by Allan Brown and David Churchman for School Nurse at Parkside High School/Alternative School /Vocational Technology
- University of MD Eastern Shore, 11868 Academic Oval, Princess Anne, MD 21853 410-651-2200 Taught post graduate Physical Therapy student a Cardiology/EKG class.
- Southern Maryland Hospital Center, 7503 Surratts Rd., Clinton, MD 20735 301-868-8000; 1985 - 2/1988 Staff nurse in ER.

References supplied upon request.

Licensee Details

Demographic Information

Full Name:	KRIS ANNE BROWN	Home State:	Compact State

License Information

Lic #:	R081790	Profession:	Nursing	Type:	REGISTERED NURSE
Status:	Active	Issue Date:	5/4/1983	Expiration Date:	11/28/2017
Date Renewed:	10/23/2015				
Obtained by:	Endorsement US - Active	State:			

Education Information

School:	Out of State	
Profession:	Nursing	MASTER'S IN OTHER FIELD
Specialty:		
Type:	EITHER	
School:		
Profession:	Nursing	BACCALAUREATE IN NURSING
Specialty:		
Type:	RN	
School:		
Profession:	Nursing	MASTER'S IN OTHER FIELD
Specialty:		
Type:	RN	

Employment Information

No Employment Information

License CSR Information

No License CSR Information

CheckList Information

No CheckList Information

Public Orders

No Related Documents

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4 a

To: Maryland Board of Nursing

From: Patricia Kennedy, Director of Education

Date: March 22, 2017

Re: Wor-Wic Community College, Department of Nursing welcomed Kris Brown, BSN, RN as part-time clinical faculty

Ms. Brown recently earned a MS in Health Service Administration. She has worked as a RN for 36 years as a nurse administrator, performed ophthalmology procedures and clinically taught bachelor students as well as courses for Certified Nursing Assistants and physical therapy students.

Ms. Kris Brown meets the qualifications for clinical nurse faculty (COMAR 10.27.03C(1)(a)-(d)).

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4 b

To: Maryland Board of Nursing

From: Patricia Kennedy, Director of Education

Date: March 22, 2017

Re: Wor-Wic Community College, Department of Nursing welcomed Jeannette Elliot, BSN, RN as part-time clinical faculty

Ms. Elliott's 21 years as a RN includes functioning in a variety of medical-surgical critical care roles, middle management and informatics. She is currently enrolled in a DNP program.

Ms. Jeanette Elliot meets the qualifications for clinical nurse faculty (COMAR 10.27.03C(1)(a)-(d)).

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Dr. Murray K. Hoy

February 16, 2017

Dr. Patricia Kennedy
Director of Education Research
Maryland Board of Nursing
4140 Patterson Avenue
Baltimore, Maryland, 21215-2254

Dear Dr. Kennedy:

The Department of Nursing at Wor-Wic Community College in Salisbury, Maryland welcomes a new part-time clinical faculty member, Ms. Jeanette Elliott, BSN, RN. Ms. Elliott is a 1997 ADN alumnus of Wor-Wic Community College, and she earned her BSN from Wilmington University in 2015. She is currently enrolled in Capella University's DNP program.

She has been employed with Peninsula Regional Medical Center since 1996, and she has a strong background in medical-surgical and critical care nursing. Ms. Elliott also completed the grant funded Eastern Shore Faculty Academy and Mentorship Initiative (ES-FAMI) in 2016. Wor-Wic Community College, Chesapeake College and Salisbury University are partnering institutions in the ES-FAMI grant efforts.

Ms. Elliott will be teaching clinical experiences in the acute care setting for our NUR 101: Nursing Fundamentals students this spring semester.

Attached you shall find Ms. Elliott's resume, as well as proof of licensure as registered nurse in the state of Maryland. Thank you for your time. Should you have questions or concerns, feel free to call the Department of Nursing, at 410-572-8700.

Sincerely,

Brenda J. Mister

Brenda J. Mister, EdD, MS, RN
Department Head and Professor of Nursing
Wor-Wic Community College
32000 Campus Drive
Salisbury, MD 21804

2017 FEB 22 AM 8:24
MARYLAND
BOARD OF NURSING

JEANETTE V. ELLIOTT RN, BSN, CCRN-CSC

PROFESSIONAL SUMMARY

Registered Nurse

- Highly skilled and caring professional with more than 21 years' experience in areas of medical oncology, cardiac and medical telemetry, medical and surgical critical care, cardiovascular thoracic surgery. Specialize but not limited to, recovering patients post operative open heart, lung, and vascular surgeries. Skills include and are not limited to intra-aortic balloon pump therapy, continuous renal replacement therapy, ventilator management, hemodynamic monitoring, and intracranial device monitoring.
- Administrative charge nurse in ICU, charge nurse rotation in CTICU. Skills included but not limited to running code blue and rapid response situations, assigning patients based on acuity, working closely with staff, physicians, patients, and families.
- Chair of Education Committee, as well as active member of Healthy Work, Peer/Orientation, Holistic modalities, and Shared Leadership committees in CTICU.
- Member of Nursing Informatics support team at PRMC.(Team Red)
- DMAIC/Leadership training completed.
- Co-Nursing Champion for Epic Implementation. Facilitate Clinical Informatics Council, BCA (downtime) Patient care services sub-committee, MEWS committee, and handoff/worklist committees. Participated in validation of education materials used for Epic training. Coordinated Patient Care Service super user scheduling and assisted with leading daily huddles. Provided education and elbow supports to end users for the implementation of Pericalm fetal heart rate system, Nurse Call systems, and Epic.
- Winner of 2016 Ed Urban Quality and Safety Award and Honorable mention from Baxter recognizing Hospital Pharmacies for Excellence in lean Practices and safety Initiatives for Scheduled Medication Administration Times- "Giving Nurses the Gift of Time"

CREDENTIALS

CALS Certified	2013
REIKI 1 Certified	2012
ACLS Certified	2016
BLS Certified	2015
CSC	2012
CCRN	2009
Bachelors Science in Nursing	2015
Registered Nurse Licensure, State of Maryland	1997
Licensed Practice Nurse Licensure, State of Maryland	1995

EXPERIENCE

Registered Nurse/ Informatics — 7-2015-present
Peninsula Regional Medical Center, Salisbury, Maryland

Registered Nurse/CTICU — 2010-2015
Peninsula Regional Medical Center, Salisbury, Maryland

Registered Nurse/MCICU-ICU — 2007-2010
Peninsula Regional Medical Center, Salisbury, Maryland

Registered Nurse/Flex — 2005-2007
Peninsula Regional Medical Center, Salisbury, Maryland

Registered Nurse/Critical Care Float — 2001-2005
Peninsula Regional Medical Center, Salisbury, Maryland

Registered Nurse/5 East — 1997-2001
Peninsula Regional Medical Center, Salisbury, Maryland

Licensed Practical Nurse/ Transitional Care Unit — 1996-1997

Peninsula Regional Medical Center, Salisbury, Maryland

Licensed Practical Nurse/ Skilled Nursing Home 1995-1996

EDUCATION

DNP current
Capella University

Bachelors of Science Degree, Nursing 2015
Wilmington University, Wilmington, Delaware

Associate of Science Degree, Nursing
1997
Wor-Wic Community College, Salisbury, Maryland

Licensed Practical Nurse Degree 1995
Wor-Wic Community College, Salisbury, Maryland

AFFILIATIONS

American Nurse Informatics Association-Co-chair education 2015- Current

American Association of Critical Care, Delmarva Chapter 2007-Current

Certification Coordinator of Delmarva AACN Chapter 2014-Current

Certification Ambassador for AACN 2014-2016

REFERENCES

Roxie Shortt-Lewis, RN	410-603-7764
Kendra Baldwin, BSN, CCRN-CSC	443-880-3297
Donna Logan, NP	410-476-7764

Licensee Details

Demographic Information

Full Name:	JEANETTE VICTORIA ELLIOTT	Home State:	Compact State

License Information

Lic #:	R135257	Profession:	Nursing	Type:	REGISTERED NURSE
Status:	Active	Issue Date:	7/16/1997	Expiration Date:	11/28/2017
Date Renewed:	11/20/2015				
Obtained by:	Application - Active (5004)	State:	MD		

Education Information

School:	WOR-WIC COMM COLLEGE-AD	
Profession:	Nursing	DIPLOMA
Specialty:	Diploma	
Type:	RN	

Employment Information

No Employment Information

License CSR Information

No License CSR Information

CheckList Information

No CheckList Information

Public Orders

No Related Documents

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STATE OF MARYLAND

MARYLAND BOARD OF NURSING
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BALTIMORE, MARYLAND 21215-2254

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(410) 585-1978 AUTOMATED VERIFICATION
1-888-202-9861 TOLL FREE

4 c

To: Maryland Board of Nursing
From: Patricia Kennedy, Director of Education
Date: March 22. 2017
Re: Carroll Community College, Associate Degree Nursing Program granted NLN Commission for Nursing Education Accreditation (CNEA) pre-accreditation status

The pre-accreditation period runs from February 17, 2017 to February 16, 2020. The Nursing Program has three (3) years to complete the accreditation process. The Nursing Program is eligible to apply for initial program accreditation at any time within the three year pre-accreditation candidacy window. Programs choosing to publically disclose their pre-accreditation status, must use the following public statement:

"The Carroll Community College Associate Degree Nursing Program holds pre-accreditation status from the National League for Nursing Commission for Nursing Education Accreditation, located at 2600 Virginia Avenue, NW, Washington, DC, 20037. Holding pre-accreditation status <u>does not</u> guarantee that initial accreditation by NLN CNES will be received."

NLN

Commission *for* Nursing Education Accreditation

February 23, 2017

Nancy Perry, DNP, RN, CNE
Nursing Program Director
Carroll Community College
1601 Washington Road
Westminster, MD 21157

Dear Dr. Perry:

The National League for Nursing Commission for Nursing Education Accreditation (NLN CNEA) Board of Commissioners met on February 16-17, 2017 to review the pre-accreditation candidacy applications received during the December 2016 submission cycle.

We are pleased to inform you that the NLN CNEA Board of Commissioners voted that pre-accreditation status be **granted** for the following program:

Carroll Community College, Associate Degree Nursing Program

The pre-accreditation status is effective for three years, beginning February 17, 2017 and terminating February 16, 2020.

This action was taken based upon evidence supporting a reasonable conclusion that the program will be able to demonstrate full compliance with the standards within the allotted three year pre-accreditation time frame. As stated in the NLN CNEA's Pre-Accreditation Candidacy Policy, the granting of pre-accreditation status **does not guarantee that a program will be accredited by the NLN CNEA**. Upon application for initial accreditation by NLN CNEA, programs will be expected to demonstrate full compliance with the NLN CNEA Standards of Accreditation.

The program will have a **maximum of three years within which to complete the accreditation process (including Board of Commissioner action) and achieve initial accreditation with the NLN CNEA. Failure to complete the process within the three year window outlined in this letter may result in termination of the program's pre-accreditation status**. Programs may voluntarily withdraw from NLN CNEA pre-accreditation status upon formal request from the chief academic nurse administrator.

As per NLN CNEA policy, the NLN CNEA reserves the right to terminate the pre-accreditation status of any program under the following conditions:

1) Accreditation status of the governing institution changes;
2) Accreditation status of the program as granted by another nursing accrediting body changes;
3) State regulatory status of the nursing program changes; or
4) Other substantive institutional or program changes occur affecting the stability of the nursing program.

NLN CNEA requires that programs notify NLN CNEA **within sixty days of the change in status**; if any of the above conditions occur. Failure to notify NLN CNEA of program changes of the nature listed above and within the stipulated time frame may also lead to termination of the program's pre-accreditation status.

Programs may choose to publicly disclose their NLN CNEA pre-accreditation status. For programs choosing to publicly disclose their pre-accreditation status, they must use the following public statement:

"The Carroll Community College Associate Degree Nursing Program holds pre-accreditation status from the National League for Nursing Commission for Nursing Education Accreditation, located at 2600 Virginia Avenue, NW, Washington, DC, 20037. Holding pre-accreditation status does not guarantee that initial accreditation by NLN CNEA will be received."

Programs holding NLN CNEA pre-accreditation status are eligible to apply for initial program accreditation with NLN CNEA. Initial accreditation may be pursued at any time within the three year pre-accreditation candidacy window of opportunity but must be timed so that all steps of the accreditation process, including CNEA Board of Commissioner action, are completed within the three year timeline. It is the responsibility of the chief academic nurse administrator to determine the appropriate time for the program(s) to pursue initial accreditation based upon a program self-assessment which indicates the capacity to demonstrate compliance with the NLN CNEA Standards of Accreditation. The program should notify NLN CNEA of its intent to proceed with seeking initial accreditation between 6 and 12 months prior to the time of scheduling an on-site program evaluation visit. Please review the NLN CNEA Initial Accreditation Policy for further details and contact NLN CNEA staff for any additional information on applying for initial accreditation.

Congratulations on achieving pre-accreditation status with NLN CNEA. If you have any questions about the accreditation process, please feel free to contact me.

Sincerely,

Judith A. Halstead

Judith A. Halstead, PhD, RN, ANEF, FAAN
Executive Director

Cc: James Ball, EdD, President, Carroll Community College
Mary Kay Goetter, Executive Director, Maryland Board of Nursing
Elizabeth H. Sibolski, President, Middle States Commission on Higher Education
Cathleen Shultz, PhD, RN, FAAN, Chair, NLN CNEA Board of Commissioners

M E M O R A N D U M

6

FROM:	Cheyenne Redd, MSN, RN Director of Licensure & Certification Maryland Board of Nursing
TO:	The Board
DATE:	March 22, 2017
IN RE:	Request to Approve Blended Nurse Refresher Course

Montgomery College would like to request approval of a blended nurse refresher course. Montgomery College is would like to offer web-based online learning for a portion of the face-to-face instruction. Students would have 100 hours of online learning and face to face learning, 60 hours of clinical and 8 hours of skills lab. Students would be required to view online materials (journals, case studies, and videos), actively participate in online discussion board (minimum of three times a week), and have weekly online chats with peers and instructor.

There have been multiple requests from nurses for on online format for the Nurse Refresher course. These requests incited the college to devise such a program. This course will allow Montgomery College to remain current with the trend of online learning.

8.a.

M E M O R A N D U M

FROM: **Shirley A. Devaris RN, JD**
Director of Legislation
TO: **The Board**
DATE: **March 22, 2017**
IN RE: **Amendments to COMAR 10.27.22 – Regulations for Nurse Licensure Compact – Request for approval to publish.**

In September, 2016, the Board responded to National Council of State Boards of Nursing (NCSBN) that we would amend the regulations for the Multistate Nurse Licensure Compact (NLC) when the new Enhanced Nurse Licenure Compact was adopted. After further discussion this month in response to the NCSBN request to adopt model rules the Directors decided not to wait, for what could be a two year period, before updating the existing regulations to reflect the model rules promulgated by NCSBN.

Following are the amended regulations that reflect the model rules for the NLC.

10.27.22.01-.04 - March 6, 2017

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Board" means the regulatory body responsible for issuing nurse licenses.

[(2) "Compact" means the Nurse Multistate Licensing Compact.**]**

[(3)**]***(2)* "**[**Coordinated Licensure Information System (CLIS)" means an integrated process for collecting, storing, and sharing information on nurse licensing and enforcement activities related to nurse licensing laws, which is administered by a nonprofit organization composed of and

controlled by state nurse licensing boards**]** *Information System" means the coordinated licensure information system.*

[(4) "Home state" means the party state that is the nurse's primary state of residence.**]**

[(5)**]***(3)* "Primary state of residence" means the state of an individual's declared, fixed, and permanent **[**residence**]** *home for legal purposes; domicile*.

[(6)**]***(4)* "Public" means **[**an**]** *any* individual or entity other than designated staff or representatives of party state boards or the National Council of State Boards of Nursing, Inc.

.02 Issuance of a License [in] *by* a Compact Party State.

A. **[**A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. This evidence shall include a declaration signed by the licensee. Further evidence that may be requested includes but is not limited to:**]**

As of July 1, 2005, no applicant for initial licensure will be issued a compact license granting a multi-state privilege to practice unless the applicant first obtains a passing score on the applicable NCLEX examination or any predecessor examination used for licensure.
[A.**]** *B. (1) A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence.*
(2) Such evidence shall include a declaration signed by the licensee.

(3)Further evidence that may be requested may include but is not limited to a:

[(1)**]***(a)* Driver's license with a home address;

[(2)**]** *(b)* Voter registration card displaying a home address; **[**or**]**

[(3)**]** *(c)* Federal income tax return declaring the primary state of residence*;*

(d) Military Form No. 2058, State of Legal Residence Certificate; or

(e) W2 form from the United States government or any bureau, division, or agency thereof indicating the declared state of residence.

C. A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license will be issued by the party state.

D. A license issued by a party state is valid for practice in all other party states unless clearly designated as valid only in the state which issued the license.

E. (1) When a party state issues a license authorizing practice only in that state and not authorizing practice in other party states the license shall be clearly marked with words indicating that it is valid only in the state of issuance.

(2) A license that is only valid for the party state is called a single state license.

[B.**]** *F.* A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed 90 days.

[C.**]***G.*The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance, and the 90-day period in §**[**B**]** *F* of this regulation shall be stayed until resolution of the pending investigation.

[D.**]** *H.* The former home state license is not valid upon the issuance of a new home state license.

[E.**]** *I.* If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within 10 business days, and the former home state may take action in accordance with that state's laws and regulations.

.03 [Multistate Licensure Privilege Limitations] ***Limitations on Multistate Licensure Privilege - Discipline.***

A. *(1)* Home state boards shall include, in all disciplinary orders or agreements that limit practice or require monitoring, the requirement that the licensee subject to the order or agreement shall limit the licensee's practice to the home state during the pendency of the disciplinary order or agreement.

[B.**]** *(2)* The requirement referred to in §A *(1)* of this regulation may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and other party state boards.

(3) An individual who had a license which was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence, may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by any prior state where there was an adverse action.

(4) Once eligible for licensure in the prior state, a multistate license may be issued.

.04 Information System.

A. Levels of Access.

(1) Public access to nurse licensure information shall be limited to:

(a) The licensee's name;

(b) Jurisdictions of licensure;

(c) Licensure expiration date;

(d) Licensure classification and status;

(e) Public emergency, summary, and final disciplinary actions, as defined by contributing state authority; and

(f) The status of multistate licensure privileges.

(2) Non-party state boards shall have access to all **[**CLIS**]** *Information System* data except current significant investigative information and other information as limited by contributing party state authority.

(3) Party state boards shall have access to all **[**CLIS**]** *Information System* data contributed by the party states and other information as allowed by contributing non-party state authority.

B. Right to Review.

(1) The licensee may request, in writing, to the home state board to review data relating to the licensee in the **[**CLIS**]** *Information System*.

(2) If a licensee asserts that any data relating to the licensee is inaccurate, the burden of proof is on the licensee to provide evidence substantiating that claim.

(3) Within 10 business days, the Board shall correct information that it finds to be inaccurate in the **[**CLIS**]** *Information System*.

C. Changes in Disciplinary Data.

(1) Within 10 business days, the Board shall report to the **[**CLIS**]** *Information System*:

(a) Disciplinary action, agreement, or order requiring participation in alternative programs or which limit practice or require monitoring unless the agreement or order relating to participation in alternative programs is required to remain nonpublic by the contributing state authority;

(b) Dismissal of the complaint; and

(c) Changes in status of disciplinary action, or licensure encumbrance.

(2) The Board shall delete current significant investigative information from the **[**CLIS**]** *Information System* within 10 business days after:

(a) A *report of a* disciplinary action;

(b) An agreement or order requiring participation in alternative programs;

(c) An agreement or agreements which limit practice or require monitoring; or

(d) Dismissal of a complaint.

(3) The **[**CLIS**]** *Information system* administrator shall make changes to licensure information in the **[**CLIS**]** *Information system* within 10 business days upon notification by a board.

8.b.

M E M O R A N D U M

FROM: **Shirley A. Devaris RN, JD**
Director of Legislation
TO: **The Board**
DATE: **March 22, 2017**
IN RE: **Amendments to COMAR 10.27.07.02 – Repeal Bee sting Program – Request for approval to publish.**

This program was repealed by legislation. The DHMH program authorized CRNPs to certify individuals for administering emergency Epinephrine by Epi Pen. The Department has transferred this requirement to Youth Camps who will be responsible for training staff at their expense.

Following are the amendments.

10.27.07.02 (January 9, 2017)

.02 Nurse Practitioner — Scope and Standards of Practice.

A. A nurse practitioner may independently perform the following functions:

(1) –(5) (text unchanged)

[(6) In accordance with Health General Article, §*§*13-*701*-704, Annotated Code of Maryland, conduct education and training to certify individuals for the Insect Sting Emergency Treatment Program;**]**

(7)*(6)* – (16)*(15)* (text unchanged)

8.c.

M E M O R A N D U M

FROM: **Shirley A. Devaris RN, JD**
Director of Legislation
TO: **The Board**
DATE: **March 22, 2017**
IN RE: **House Bill 1623 – Public Health – Certificates of Birth- Birth Outside and Institution.**

This is an emergency bill meaning that it takes effect as soon as it is signed. The bill is designed to extend the same requirements for completing a birth certificate in a hospital or birthing center to a home birth attended by a licensed provider.

According to the Maryland Academy of Nurse Midwives, until November 2016, nurse midwives were completing the birth certificates and filing them within 5 days for their home births. In December, the Department of Vital Statistics, by way of a memo, required that hence forth all certificates for a home birth will have to be verified and filed by local health departments. This has created another layer of bureaucracy and confusion. There is no uniform policy in place for local health departments. This new policy has caused delays in registration, hardship to the parents, and is not necessary.

We could find no other state that requires filing a birth certificate with a local health department. Most states require filing with a department of vital statistics, a county clerk, or a local court. The licensed provider who attended the birth is responsible for verifying the information on the birth certificate.

We supported this legislation because our licensed independent practitioners who have a patient relationship with the birth mothers and are present at the birth should be able to verify the birth, complete the birth certificates, and file them with vital statistics. Many of our nurse midwives have an electronic program for filing the birth certificates or have someone file it electronically for them, just as is done in a hospital or birthing center. It is expected that the direct entry midwives will also be able to file electronically if they chose to do so.

The bill was heard on March 16, 2016.