NR 509 Shadow Health Respiratory Physical Assessment Assignment

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Shadow Health Respiratory Assessment Pre Brief

Tina had an asthma episode 2 days ago. At that time she used her albuterol inhaler and her symptoms decreased although they did not completely resolve. Since that incident she notes that she has had ten episodes of wheezing and has shortness of breath approximately every four hours.

Tina presents with continued shortness of breath and wheezing. Be sure to ask pertinent questions during the interview about related body systems. This case study will provide the opportunity to carefully assess lung sounds during the physical examination. Be sure to appropriately document your findings using correct medical terminology.

Reason for visit: Patient presents complaining of a recent asthma episode that is not fully resolved.

SAMPLE Shadow Health Respiratory Assessment

Model Documentation

Subjective

HPI: Ms. Jones is a pleasant 28-year-old African American woman who presented to the clinic with complaints of shortness of breath and wheezing following a near asthma attack that she had two days ago. She reports that she was at her cousin's house and was exposed to cats which triggered her asthma symptoms.

At the time of the incident she notes that her wheezes were a 6/10 severity and her shortness of breath was a 7-8/10 severity and lasted five minutes. She did not experience any chest pain or allergic symptoms.

Social History: She is not aware of any environmental exposures or irritants at her job or home. She changes her sheets weekly and denies dust/mildew at her home. She uses a hypoallergenic pillow cover and her mattress is one year old. She denies current use of tobacco, alcohol, and illicit drugs. She did smoke marijuana for 5 or 6 years, her last use was at age 21 years. She does not exercise.

Reports allergies to cats which triggered her asthma symptoms
Asthma exacerbation are aggravated by exposure to cats

Diagnosed with asthma at 2.5-years-old, She frequented hospital visits including five hospitalizations before she was 16-years-old. Since then she hasn't been hospitalized. Pt. denies spirometry inhaler, peak flow meter use, as well as any other asthma medication use.

Pt. doesn't keep asthma records of exacerbations and triggers; denies asthma medication usage except for albuterol rescue inhaler.

Pt. not currently being managed by a pulmonologist or someone for her allergies. Pt. denies using a vaporizer or nebulizer at home.

PMH:

Pt. reports Type 2 Diabetes, possible borderline hypertension (no actual dx).

Allergies:CONT.

Cats: Develops itchy, watery eyes; an itchy, "runny nose"; an itchy, sometimes a sore throat, and often an asthma exacerbation – SOB, DOE, wheezing, coughing, and chest tightness.

Dust: Develops a rash, no itching.

Penicillin: "Rash, like, hives."

HPI: CONT.

Since that incident she notes that she has had 10 episodes of wheezing and has shortness of breath approximately every four hours. Her last episode of shortness of breath was this morning before coming to the clinic. She notes that her current

symptoms seem to be worsened by lying flat and movement and are accompanied by a non-productive cough. She awakens with night-time shortness of breath twice per night. She complains that her current symptoms are beginning to interfere with her daily activities.

Respiratory | Completed | Shadow Health 7/26/18, 2)20 PM

https://chamberlain.shadowhealth.com/assignment_attempts/3664486

Medications:

Rx: Provenal 90 mcg/spray, 2 puffs, for asthma.

OTC: Acetamet:aphen 1000 mg for occasional headaches related to reading for prolonged periods of . Ibuprofen OTC

Social History:

Family History: Pt. My sister has a history of asthma and hay fever.

Surgical History: Pt. denies previous surgeries. NR 509 Shadow Health Respiratory Physical Assessment Assignment

ROS:

General: … **cont.**

Review of Systems:**CONT.**

General: Denies changes in weight, fatigue, weakness, fever, chills, and night sweats.

• Nose/Sinuses: Denies rhinorrhea with this episode.

Denies stuffiness, sneezing, itching, previous allergy, epistaxis, or sinus pressure.

• Gastrointestinal: No changes in appetite, no nausea, no vomiting, no symptoms of GERD or abdominal pain

• Respiratory: Complains of shortness of breath and cough as above. Denies sputum, hemoptysis, pneumonia, bronchitis, emphysema, tuberculosis.

She has a history of asthma, last hospitalization was age 16, last chest XR was age 16.

https://www.coursehero.com/file/32326524/W2-SH-Dr-Documentation-ASTHMA-Respiratory-Completed-Shadow-Healthpdf/

Respiratory | Completed | Shadow Health 7/26/18, 2)20 PM

https://chamberlain.shadowhealth.com/assignment_attempts/3664486

Objective

Tina is an obese 28-year-old African American woman who does not seem to be in any acute distress. Alert and oriented, sitting upright, maintains appropriate eye contact, is conversational, and answers questions appropriately.

Respiratory: … **CONT.**

Muffled words bilaterally with prominent expiratory wheezes in the posterior lower lobes only.

Spirometry yielded FVC 3.91, FEV/FVC ratio

80.56%, SaO2 97% on room air, HR 89, RR 20, BP

General: … **CONT.**

140/81, Temperature 98.5 degrees Fahrenheit.

Assessment

Mild-Persistent Asthma with Exacerbation. Mild-persistent asthma with exacerbation

Plan

Diagnostics: Obtain oxygen saturation and baseline spirometry and peak flow readings.

Medication: NMI at the office one time. Continue albuterol rescue inhaler. Initiate step up inhaled corticosteroid.

Education: … **CONT.**

Orders: … **CONT.**

Follow-Up: Return to clinic in 3 weeks for follow-up evaluation regarding course of illness, medication use and needs, as well as medication effectiveness.

Diagnostics

• … **CONT.**

Education

… **CONT.**

•

Referral/Consultation

• Refer to allergy specialist for evaluation and testing

Follow-up Planning … **CONT.**

Review of Systems: … CONT.

Objective

General: Ms. Jones is a pleasant, obese 28-year-old African American woman in no acute distress. She is alert and oriented and sits upright on the exam table. She maintains eye contact throughout the interview and examination.

- Respiratory: Chest expansion is symmetrical with respirations. Normal fremitus, symmetric bilaterally. Chest resonant to percussion; no dullness. Bilateral expiratory wheezes in posterior lower lobes. Bilateral muffled words with notable expiratory wheezes in posterior lower lobes. No crackles. In office spirometry: FVC 3.91 L, FEV1/FVC ratio 80.56%. SpO2: 97%.

Assessment

Mild-persistent asthma with exacerbation

Plan

Diagnostics

… **CONT.**

- NR 509: Shadow Health Respiratory Physical Assessment Assignment

Education

- Encourage Ms. Jones to continue … **CONT.** NR 509: Shadow Health Respiratory Physical Assessment Assignment

Referral/Consultation

- Refer to allergy specialist for evaluation and testing

Follow-up Planning

- Order PFTs to be completed after exacerbation to have baseline available for future comparison
- Instruct Ms. Jones on when to seek emergency care including episodes of chest pain or shortness of breath unrelieved by rest, worsening asthma symptoms or wheezing, or the sense that rescue inhaler is not helping
- Revisit clinic in 2-4 weeks for follow up and evaluation.

Tina's second cousin was diagnosed with asthma at age 5. What would be included in your treatment plan? What factors might concern you related to compliance?

The treatment plan for this child would be to treat the airways of inflammation using medication to prevent asthma attacks. Further, short-acting drugs will be used to treat

asthma attacks. Also, the child will have to avoid triggers of asthma. Lastly, the child will be advised to maintain normal activity levels.

Consider that Tina's uncle is now 68 years old and has smoked heavily every day since he was fifteen. What would you expect to find in his respiratory assessment? How would this affect your oxygenation goals for this patient?

Common significant deviations …**CONT.**

In the respiratory assessment of this patient, … **CONT.**

- If Tina had mentioned that she was just diagnosed with pneumonia, what would you have expected to find during percussion?
- If the results of Tina's pulse oximetry had been 97%, which of the following would have been true?
- Suppose that, during your lung exam on Tina, you had heard bronchial breath sounds in the left lower lung posteriorly. What would you have suspected based on this finding?
- Suppose that while auscultating, you assessed a few scattered expiratory wheezes. Why would this be an expected finding for a patient with Tina's history.
- When you observe a patient like Tina throughout an exam, there are many ways to determine whether a patient is experiencing respiratory distress. Identify one indicator of respiratory distress that can be assessed through observation alone.
- Describe how you would assess Tina for dyspnea

Dyspnea can be assessed …**CONT.**

- Explicitly describe the tasks you undertook to complete this exam.

The examination was … **CONT.**

- Explain the clinical reasoning behind your decisions and tasks.

The various tasks and decisions undertaken here were to inform … **CONT.**

- Identify how your performance could be improved and how you can apply "lessons learned" within the assignment to your professional practice.

My performance could be improved by seeking more history from the patient. In terms of lessons learned, the present analysis will allow me to become even more aware of the nitty-gritties of respiratory assessment for future practice.

NR 509 Week 1 Shadow Health History Assignment

Pre-Brief

Obtaining an accurate history is the critical first step in determining the etiology of a patient's problem. A large percentage of the time, you will actually be able to make a diagnosis based on the history alone. The value of the history, of course, will depend on your ability to elicit relevant information.

Your sense of what constitutes important data will grow exponentially as you practice your interviewing skills and through increased exposure to patients and illness. Interviewing patients is an art and should remain an essential skill for successful practice.

In this activity, you will interview Tina Jones to collect data to assess Ms. Jones' condition. You will also have the opportunity to educate and empathize with Tina to engage in effective therapeutic communication; create a problem list using evidence from the data you collected; prioritize the identified problems to differentiate immediate from non-immediate care; plan how to best address the most important concern with further assessment, interventions, and patient education; and compare your documentation to model documentation.

Ms. Jones is a pleasant, 28-year-old obese African American single woman who presents to establish care and with a recent right foot injury. She is the primary source of history. Ms. Jones offers information freely and without contradiction. Her speech is clear and coherent and she maintains eye contact throughout the interview.

Reason for visit: Patient presents for an initial primary care visit today complaining of an infected foot wound.

- | Overview
- | Transcript
- | Subjective Data Collection
- | Objective Data Collection
- | Education & Empathy
- | Documentation / Electronic Health Record
- | Information Processing

- | Lab Pass: Certificate of Completion.

N 518 Module 2: THE GENERAL SURVEY AND HEENT

Module 2: Discussion Question

Start by reading and following these instructions:

- You are responsible for at least 3 posts for each question in your discussion boards; your initial post and reply to two of your classmates. Your initial post(s) should be your response to the questions posed in the discussion question. You should research your answer and cite at least one scholarly source when appropriate, and always use quality writing.
- The discussion board is never a place to use text language or emoticons. You will also be asked to respond to your classmates. This is designed to enhance the academic discussion around the topic.
- It is all right to disagree with something posted by another, however your responses should always be thoughtful and respectful and reflect your opinions professionally.

Discussion Question:

- In your professional opinion, what is the difference between chronic and acute pain? How is the assessment for each type of pain different? What must you keep in mind when assessing acute pain? What must you keep in mind when assessing chronic pain? Reflect upon a time when you assessed a patient in pain.

- What did you do well? What points could you have improved upon? How did the pain impact the patient? What specific treatments could have lessened the impact of the pain on the patient?

Your initial posting should be 200 to 300 words in length and utilize at least one scholarly source other than the textbook. Please reply to at least two classmates. Replies to classmates should be at least 100 words in length. To properly “thread” your discussion posting, please click on REPLY.

When you are ready for the discussion, do the following:

- Click on the discussion link above.
- Start your answer by clicking the “Start a New Thread” button with the title of your answer and the body of text following the guidance above.
- To properly post your answer, please click on the “Post” button.
- After posting your contribution, you must read what others have posted, reply to at least two of those posts, and respond (when appropriate) to those you have responded to you.

To reply to a classmate’s post:

- Click on the title of another student’s post.
- Click “Reply to Thread” and type your response to the student.
- Click the “Post” button to post your reply.

N 581 Module 2: Assignment

Remember to submit your work following the file naming convention FirstInitial.LastName_M01.docx. For example, J.Smith_M01.docx. Remember that it is not necessary to manually type in the file extension; it will automatically append.

Start by reading and following these instructions:

- Quickly skim the questions or assignment below and the assignment rubric to help you focus.
- Read the required chapter(s) of the textbook and any additional recommended resources. Some answers may require you to do additional research on the Internet or in other reference sources. Choose your sources carefully.
- Consider the discussion and any insights you gained from it.
- Create your Assignment submission and be sure to cite your sources, use APA style as required, check your spelling.

Assignment:

Exercises

- Complete the Shadow Health HEENT assessment.

Professional Development

- Write a reflection essay of your experience with the Shadow Health virtual assessment. At least two scholarly sources in addition to your textbook should be utilized. Please be sure to address each of the following prompts:
    - What went well in your assessment?
    - What did not go so well? What will you change for your next assessment?

- What findings did you uncover?
- What questions yielded the most information? Why do you think these were effective?
- What diagnostic tests would you order based on your findings?
- What differential diagnoses are you currently considering?
- What patient teaching were you able to complete? What additional patient teaching is needed?
- Would you prescribe any medications at this point? Why or why not? If so, what?

How did your assessment demonstrate sound critical thinking and clinical decision making? What could you change to make it better?

N 581: SHADOW HEALTH ASSIGNMENT

Subjective HPI: Ms. Jones is a 28 year old African American woman who is presented to the clinic with complaints of soreness, … Social History: patient is unaware of any environmental exposure / irritants . … **CONT.** Review systems : General – denies changes in weight, fever and chills. … **CONT.**	HPI: Ms. Jones is a pleasant 28-year-old African American woman who presented to the clinic with complaints of sore, itchy throat, itchy eyes, and runny nose for the last week. Social History: She is not aware of any environmental exposures or irritants at her job or home. She changes her sheets weekly and denies dust/mildew at her home. She denies use of tobacco, alcohol, and illicit drugs. She does not exercise. Review of Systems: General: Denies changes in weight, fatigue, weakness, fever, chills, and night sweats. … **CONT.** ● Head: Denies history of trauma or headaches. ● Eyes: She does … **CONT.** ● Ears: Denies hearing loss, tinnitus, vertigo, discharge, or earache. ● Nose/Sinuses: Denies rhinorrhea prior to this episode. Denies stuffiness, sneezing, itching, previous allergy, epistaxis, or sinus pressure. ● Mouth/Throat: Denies bleeding gums, hoarseness, swollen lymph nodes, or wounds in mouth. No sore throat prior to this episode. ● Respiratory: She denies shortness of breath, wheezing, cough, sputum, hemoptysis, pneumonia, bronchitis, emphysema, tuberculosis. ● She has a history of asthma, last hospitalization was age 16 for asthma, last chest XR was age 16. Her current inhaler use has been her baseline of 2-3 times per week.

Objective patient c/o 4/10 pain in her throat, … **CONT.** Nares appear to be swollen, patient denies difficulty breathing, … **CONT.**	General: ● Head: Head is normocephalic and atraumatic. Scalp with no masses, normal hair distribution. ● Eyes: Bilateral eyes with equal hair distribution, no lesions, no ptosis, … **CONT.** ● Ears: Ear shape equal bilaterally. External canals without inflammation bilaterally. Tympanic membranes are pearly grey and intact with positive light reflex bilaterally. Rinne, Weber, and Whisper test normal bilaterally. ● Nose: Septum is midline, nasal mucosa is boggy and pale bilaterally. No pain with palpation of frontal or maxillary sinuses. ● Mouth/Throat: ● Neck: ● Respiratory: **CONT.**
Assessment Patient was assessed for sore throat and runny nose …	Allergic Rhinitis
Plan Refer patient for … **CONT.**	

Shadow Health Physical Assessment Rubric		
Criteria	**Ratings**	**Pts**

This criterion is linked to a Learning OutcomeSubjective Data, Organization, Communication,and Summary (DCE Score or transcript)	25.0 pts Above Average- DCE Score greater than or equal to 93; Comprehensive introduction with expectations of exam verbalized; questions worded in a non-judgmental way; professional language exercised; questions well-organized; appropriate closing with summary of findings verbalized to patient.	21.0 pts Average- DCE Score greater than or equal to 86-92; Adequate introduction; some questions worded in a non-judgmental way; professional language mostly exercised; questions generally organized; somewhat complete closing.	10.0 pts Below Average- DCE Score greater than or equal to 80-85; Incomplete introduction; many questions worded in a judgmental way; some professional language exercised; questions somewhat organized; incomplete closing.	0.0 pts Unsatisfactory- DCE Score less than or equal to 79; Introduction missing; questions worded in a judgmental way; little professional language; questions unorganized; closing missing. NR 509 Shadow Health Respiratory Physical Assessment Assignment	25.0 pts

This criterion is linked to a Learning OutcomeObjective Data, Physical Examination, Interpretation of Findings, Assessment, and Documentation	20.0 pts Above Average- Physical assessment documentation includes all relevant body systems; all pertinent normal and abnormal findings identified; documentation reflects professional language; treatment plan includes each of the following components: diagnostics, medication, education, consultation/referral, and follow-up planning. NR 509 Shadow Health Respiratory Physical Assessment Assignment	16.0 pts Average- Physical assessment documentation lacks sufficient details pertaining to one or two relevant body systems; or identifies ≥ 50% of the pertinent normal and abnormal findings; or documentation lacks professional language; or treatment plan lacks one or two components (diagnostics, medication, education, consultation/referral, or follow-up planning).	8.0 pts Below Average- Physical assessment documentation lacks sufficient details pertaining to three or more relevant body systems; or identifies < 49% of the pertinent normal and abnormal findings; or documentation includes unprofessional language; or treatment plan lacks three or more components (diagnostics, medication, education, consultation/referral, or follow-up planning).	0.0 pts Unsatisfactory- No physical assessment documentation or no treatment plan.	20.0 pts

This criterion is linked to a Learning OutcomeSelf-Reflection	5.0 pts Above Average-Responds to three of the three reflection post questions; and provides analysis of performance; and reflection posts written using professional language; and reflection posts demonstrate insight.	3.0 pts Average-Responds to two of the three reflection post questions; or provides limited self-analysis of performance; or reflection posts are somewhat unclear related to the assignment and the student's experience; or reflection posts lack insight.	2.0 pts Below Average-Responds to one of the three reflection post questions; or does not provide self-analysis of performance; or reflections are not related to the assignment and the student's experience; or does not provide insight	0.0 pts Unsatisfactory-No reflection posts for the assignment.	5.0 pts
Total Points: 50.0					

Shadow Health Respiratory Transcript

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304

1/23

Respiratory Results | Turned In

Advanced Health Assessment – Chamberlain, NR509-April-2018

Return to Assignment

Your Results Labb Pass

Started: May 11, 2018 | Patient Exam Time: 168 min

Greet 05/11/18 12:39 PM CDT

Question 05/11/18 12:39 PM CDT

Question NR 509 Shadow Health Respiratory Physical Assessment Assignment 05/11/18 12:39 PM

CDT

Question 05/11/18 12:40 PM CDT

- Overview
- Transcript
- Subjective Data Collection
- Objective Data Collection
- Education & Empathy
- Documentation
- Student Pre-Survey
- Lifespan
- Review Questions NR 509 Shadow Health Respiratory Physical Assessment Assignment
- Self-Reflection

Greet 05/11/18 12:39 PM CDT

Hello my name Sara an FNP student and I will be interviewing you

today.

Tina Jones: Hey.

Question 05/11/18 12:39 PM CDT

Can you please state your name for me?

Tina Jones: Tina Jones.

Question NR 509 Shadow Health Respiratory Physical Assessment Assignment 05/11/18 12:39 PM

CDT

Your date of birth?

Tina Jones: February 17th.

Question 05/11/18 12:40 PM CDT

Year of birth please? (Clarified to What year were you born.)

Tina Jones: I was born in . . . [Ms. Jones reports correct birth year.] [AUDIO COMING SOON]

Question 05/11/ 12:40 PM CDT NR 509 Shadow Health Respiratory Physical Assessment Assignment

Question 05/11/ 12:41 PM CDT

Question 05/11/ 12:42 PM CDT

Empathize 05/11/18 12:42 PM CDT

Question 05/11/ 12:43 PM CDT

Question 05/11/ 12:53 PM CDT

Question 05/11/ 12:53 PM CDT

… **CONT.**

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 3/23

Question 05/11/18 12:53 PM CDT

Empathize 05/11/18 12:56 PM CDT NR 509 Shadow Health Respiratory Physical Assessment Assignment

Question 05/11/18 12:56 PM CDT

Question 05/11/18 12:57 PM CDT

Question 05/11/18 12:57 PM CDT

Question 05/11/18 1:00 PM CDT

Question 05/11/18 1:02 PM CDT

I don't know if I'd call it an asthma attack, … **CONT.**

CONT.

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 8/23

Exam Action 05/11/18 1:53 PM CDT NR 509 Shadow Health Respiratory Physical Assessment Assignment

Exam Action 05/11/18 1:53 PM CDT

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Exam Action NR 509 Shadow Health Respiratory Physical Assessment Assignment 05/11/18 1:56 PM CDT

Exam Action 05/11/18 1:56 PM CDT

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CONT.

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 9/23

Exam Action 05/11/18 1:56 PM CDT

Exam Action 05/11/18 1:56 PM CDT

Exam Action 05/11/18 1:56 PM CDT NR 509 Shadow Health Respiratory Physical Assessment Assignment

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Auscultated … **CONT.**

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 10/23

Exam Action

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CONT.

5/11/2018 Respiratory | Completed | Shadow Health

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Exam Action

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CDT

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Ninety-nine.

CONT.

5/11/2018 Respiratory | Completed | Shadow Health

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Exam Action

05/11/18 2:02 PM

CDT

Exam Action

05/11/18 2:08 PM

CDT

Exam Action

05/11/18 2:08 PM

CDT

Exam Action

05/11/18 2:12 PM

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Exam Action

05/11/18 2:15 PM

CDT

Educate

05/11/18 2:16 PM

CDT

Question

05/11/18 2:16 PM

CDT

Educate

05/11/18 2:17 PM

CDT

Educate

05/11/18 2:17 PM

CDT

Educate

05/11/18 2:18 PM

CDT

CONT.

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 13/23

Question

05/11/18 2:19 PM

CDT

Question

05/11/18 2:20 PM

CDT

Question

05/11/18 2:20 PM

CDT

Question

05/11/18 2:21 PM

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Question

05/11/18 2:21 PM

CDT

Question

05/11/18 2:22 PM

CDT

Question

05/11/18 2:22 PM NR 509 Shadow Health Respiratory Physical Assessment Assignment

CDT

CONT. [Nurse confirmed with Pharmacy: albuterol 90mcg/spray MDI]

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 14/23

Educate

05/11/18 2:22 PM

CDT

Question

05/11/18 2:23 PM

CDT

Question

05/11/18 2:24 PM

CDT

Question

05/11/18 2:24 PM

CDT

Question

05/11/18 2:25 PM

CDT NR 509 Shadow Health Respiratory Physical Assessment Assignment

Question

05/11/18 2:26 PM

CDT

Question

05/11/18 2:27 PM

CDT

CONT.

When did your recent asthma problems start? (Clarified to What started your recent asthma problems? .)

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 15/23

Question

05/11/18 2:27 PM

CDT

Question

05/11/18 2:28 PM

CDT

Empathize

05/11/18 2:28 PM

CDT

Question

05/11/18 2:28 PM

CDT

Question

05/11/18 2:30 PM NR 509 Shadow Health Respiratory Physical Assessment

Assignment

CDT

Question

05/11/18 2:30 PM

CDT

Question

05/11/18 2:31 PM

CDT

CONT.

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 16/23

Educate

05/11/18 2:32 PM

CDT

Question

05/11/18 2:50 PM

CDT

Question

05/11/18 2:50 PM

CDT

Question

05/11/18 2:51 PM

CDT

Question

05/11/18 2:52 PM

CDT NR 509 Shadow Health Respiratory Physical Assessment Assignment

Question

05/11/18 2:53 PM

CDT

Question

05/11/18 2:54 PM

CDT

CONT.

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 17/23

Question

05/11/18 2:54 PM

CDT

Question

05/11/18 2:55 PM

CDT

Educate

05/11/18 2:57 PM

CDT

Question

05/11/18 2:57 PM

CDT

Educate

05/11/18 2:57 PM

CDT

Question

05/11/18 2:58 PM

CDT

Educate

05/11/18 2:59 PM NR 509 Shadow Health Respiratory Physical Assessment Assignment

CDT

Question

05/11/18 3:00 PM

CDT

I've heard of that, but no, I don't do it.

Do you use a nebulizer?

No, but I have before.

We may consider a nebulizer for home treatments.

That makes sense.

Also a way to track your asthma symptoms and episodes. (No matching questions found.)

Also a way to track your asthma symptoms and episodes.

OK, I understand.

Sending you home with a peak flow meter and document regularly. NR 509 Shadow Health Respiratory Physical Assessment Assignment

I've heard of that, but no, I don't do it.

We will also teach you how to use nebulizer at home.

Sure, I think I understand what you mean.

How often do you change your sheets?

I change my bedding once a week, I'd say.

Question

05/11/18 3:01 PM

CDT

Empathize

05/11/18 3:01 PM

CDT

Educate

05/11/18 3:02 PM

CDT

Question

05/11/18 3:02 PM

CDT

Empathize

05/11/18 3:02 PM

CDT

Question

05/11/18 3:03 PM NR 509 Shadow Health Respiratory Physical Assessment Assignment

CDT

Educate

05/11/18 3:03 PM

CDT

CONT.

Question

05/11/18 3:04 PM

CDT

Question

05/11/18 3:06 PM

CDT

Educate

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Question

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Question NR 509 Shadow Health Respiratory Physical Assessment Assignment

05/11/18 3:09 PM

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Question

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Question

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CONT.

5/11/2018 Respiratory | Completed | Shadow Health

https://chamberlain.shadowhealth.com/assignment_attempts/3498304 20/23

Empathize

05/11/18 3:13 PM

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Educate

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Question

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Question

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05/11/18 3:14 PM NR 509 Shadow Health Respiratory Physical Assessment Assignment

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Question

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Question

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CONT.

5/11/2018 Respiratory | Completed | Shadow Health

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Question

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Question

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Question

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Question

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Educate

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Question NR 509 Shadow Health Respiratory Physical Assessment Assignment

05/11/18 3:20 PM

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Question

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Question

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CONT.

5/11/2018 Respiratory | Completed | Shadow Health

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Question

05/11/18 3:27 PM

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Question

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Question

05/11/18 3:29 PM

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Question

05/11/18 3:30 PM

CDT NR 509 Shadow Health Respiratory Physical Assessment Assignment

Question

05/11/18 3:31 PM

CDT

Question

05/11/18 3:34 PM

CDT

Question

05/11/18 3:35 PM

CDT

Question

05/11/18 3:35 PM

CDT

No, my nose has been fine.**CONT.**

Question

05/11/18 3:36 PM

CDT

Question

05/11/18 3:37 PM

CDT

CONT.

Comments

If your instructor provides individual feedback on this assignment, it will appear here.

SAMPLE Shadow Health Respiratory Assessment

Model Documentation

Subjective

HPI: Ms. Jones is a pleasant 28-year-old African American woman who presented to the clinic with complaints of shortness of breath and wheezing following a near asthma attack that she had two days ago. She reports that she was at her cousin's house and was exposed to cats which triggered her asthma symptoms.

At the time of the incident she notes that her wheezes were a 6/10 severity and her shortness of breath was a 7-8/10 severity and lasted five minutes. She did not experience any chest pain or allergic symptoms.

At that time she used her albuterol inhaler and her symptoms decreased although they did not completely resolve. Since that incident she notes that she has had 10 episodes of wheezing and has shortness of breath approximately every four hours.

Her last episode of shortness of breath was this morning before coming to clinic. She notes that her current symptoms seem to be worsened by lying flat and movement and are accompanied by a non-productive cough. She awakens with night-time shortness of breath twice per night.

She complains that her current symptoms are beginning to interfere with her daily activities and she is concerned that her albuterol inhaler seems to be less effective than previous. Currently she states that her breathing is normal. Diagnosed with asthma at age 2.5 years.

She has no recent use of spirometry, does not use a peak flow, does not record attacks, and does not have a home nebulizer or vaporizer. She has been hospitalized five times for asthma, last at age 16.

She has never been intubated for her asthma. She does not have a current pulmonologist or allergist.

SAMPLE Shadow Health Respiratory Assessment

Model Documentation

Subjective

Social History: She is not aware of any environmental exposures or irritants at her job or home……

Review Of Systems:

- General: Denies changes in…
- Nose/Sinuses:
- Gastrointestinal:
- Respiratory:

Objective

- General: Ms. Jones is pleasant….
- Respiratory: Chest expansion is….

Assessment

- Mild-persistent….

Plan

Diagnostics

- Obtain office….

Education

- Encourage Ms. Jones to continue t….

Referral/Consultation NR 509 Shadow Health Respiratory Physical Assessment Assignment

- Refer to…..

Follow-Up Planning

- Order ….

    - Instruct Ms. Jones
    - Revisit
- Tina's second cousin was diagnosed with asthma at age 5. What would be included in your treatment plan? What factors might concern you related to compliance?

The treatment plan for this child would be to….

- Consider that Tina's uncle is now 68 years old and has smoked heavily every day since he was fifteen. What would you expect to find in his respiratory assessment? How would this affect your oxygenation goals for this patient?

Common significant deviations … **CONT.**

In the respiratory assessment of this patient, … **CONT.**

- If Tina had mentioned that she was just diagnosed with pneumonia, what would you have expected to find during percussion?
- If the results of Tina's pulse oximetry had been 97%, which of the following would have been true?
- Suppose that, during your lung exam on Tina, you had heard bronchial breath sounds in the left lower lung posteriorly. What would you have suspected based on this finding?
- Suppose that while auscultating, you assessed a few scattered expiratory wheezes. Why would this be an expected finding for a patient with Tina's history

- When you observe a patient like Tina throughout an exam, there are many ways to determine whether a patient is experiencing respiratory distress. Identify one indicator of respiratory distress that can be assessed through observation alone.
- Describe how you would assess Tina for dyspnea

Dyspnea can be assessed both

- Explicitly describe the tasks you undertook to complete this exam.

The examination

Explain the clinical reasoning behind your decisions and tasks.

- Identify how your performance could be improved and how you can apply "lessons learned" within the assignment to your professional practice.

My performance could be improved by seeking more history from the patient…..

NR 509 Week 1 Shadow Health History Assignment

Pre-brief

Obtaining an accurate history is the critical first step in determining the etiology of a patient's problem. A large percentage of the time, you will actually be able to make a diagnosis based on the history alone. The value of the history, of course, will depend on your ability to elicit relevant information.

Your sense of what constitutes important data will grow exponentially as you practice your interviewing skills and through increased exposure to patients and illness.

Interviewing patients is an art and should remain an essential skill for successful practice.

In this activity, you will interview Tina Jones to collect data to assess Ms. Jones' condition. You will also have the opportunity to educate and empathize with Tina to engage in effective therapeutic communication; create a problem list using evidence from the data you collected; prioritize the identified problems to differentiate immediate from non-immediate care; plan how to best address the most important concern with further assessment, interventions, and patient education; and compare your documentation to model documentation.

Ms. Jones is a pleasant, 28-year-old obese African American single woman who presents to establish care and with a recent right foot injury. She is the primary source of history. Ms. Jones offers information freely and without contradiction. Her speech is clear and coherent and she maintains eye contact throughout the interview.

Reason for visit: Patient presents for an initial primary care visit today complaining of an infected foot wound.

- | Overview
- | Transcript
- | Subjective Data Collection
- | Objective Data Collection
- | Education & Empathy
- | Documentation / Electronic Health Record
- | Information Processing

- | Lab Pass: Certificate of Completion

NR 509 Week 2 Alternate Writing Assignment: Respiratory Summer

Purpose

As a family nurse practitioner, you must possess excellent physical assessment skills. This alternative writing assignment mirrors the discussion content of the debriefing session and will allow the student to expand their knowledge of physical health assessment principles specific to the advanced practice role.

Course Outcomes Expected in NR 509: Shadow Health Respiratory Physical Assessment Assignment

This assignment is guided by the following Course Outcomes (COs):

- Apply advanced practice nursing knowledge to collecting health history information and physical examination findings for various patient populations. (PO 1, 2)
- Differentiate normal and abnormal health history and physical examination findings. (PO 1, 2)
- Adapt health history and physical examination skills to the developmental, gender-related, age-specific, and special population needs of the individual patient. (PO 1, 2)

The purposes of this assignment are to: (a) identify and articulate advanced assessment health history and physical examination techniques which are relevant to a focused body system (CO 1), (b) differentiate normal and abnormal findings with regard

to a disease or condition that impacts the body system (CO 2), and (c) adapt advanced assessment skills if necessary to suit the needs of specific patient populations (CO 4).

NOTE: You are to complete this alternative writing assignment only if you had not participated or do not plan to participate in a debriefing session for the given week.

Due Date: This alternative written assignment is due no later than the **Sunday of the week in which you did not attend the weekly debriefing session**. The standard MSN Participation Late Assignment policy applies to this assignment.

Preparing The Paper:

- Select a focused body system from the weekly lesson which corresponds with the week of the written assignment.
- Carefully read and review the selected body system in your course textbooks.
- Incorporate at least **one scholarly** peer-reviewed journal article that relates to the body system. It may be useful to identify an article that relates to a disease that impacts the body system.
- The paper must clearly articulate the relevance of advanced physical assessment skills, techniques, application of advanced practice knowledge, and assessment modification (when necessary) to accommodate specific patient populations.
- Provide concluding statements that should summarize key points of the overall assignment content.
- In-text citations and reference page(s) must be written using proper APA format (6th edition).

NR 509 Shadow Health Respiratory Physical Assessment Assignment Week 2 Quiz

- A mother bringing her two month old daughter in for an examination says “my daughter rolled over against the wall and now I have noticed that she has a spot soft on the top of her head, is there something terribly wrong?” The FNP's best response would be:
- During percussion the FNP knows that a dull percussion note elicited over a lung lobe. This most likely results from:
- The patient is unable to differentiate between sharp and dull stimulation to both sides of her face. The FNP suspects Damage to:
- When examining the face, the FNP is aware that the two pairs of salivary glands that are accessible to examination are the _____ glands
- A patient comes to the clinic complaining of neck and shoulder pain and is unable to turn her head. The FNP suspects damage to cranial nerve ____ and proceeds with the examination by____
- When examining a patient’s cranial nerve function, the FNP remembers that the muscles in the neck that are innervated by CN XI are the:
- The patient’s laboratory data reveal an elevated thyroxine level. The FNP would proceed with an examination of the _____ gland
- A patient says that she has recently noticed a lump in the front of her neck below her “Adam's apple” that seems to be getting bigger. During the assessment, the finding that leaves the FNP to suspect that this may not be a cancerous thyroid nodule is that the lump:

- The FNP notices that the patient's submental lymph nodes are enlarged. In an effort to identify the cause of the node enlargement, the FNP would assess the patient's:
- The FNP is aware that the four areas in the body where lymph nodes accessible are the:
- A 52-year-old patient describes the presence of occasional floaters or spots moving in front of his eyes. The FNP should know that floaters are usually not significant and are caused by:
- The FNP is preparing to assess the visual acuity of a 16-year-old patient. How should the FNP proceed?
- A patient's vision is recorded as 20/30 when the Snellen eye chart is used. The FNP interprets these results to indicate that:
- A patient is unable to read even the largest letters on the Snellen chart. The FNP should take which action next:
- A patient's vision is reported as 20/80 in each eye. The FNP interprets this finding to mean that
- When performing the corneal light reflex assessment, the FNP notes that the light is reflected at 2 o'clock in each eye.
- The FNP is performing the diagnostic positions test. Normal findings would be which of these results?
- During an assessment of the sclera of an African-American patient, the FNP would consider which of these an expected finding?

- A 60-year-old man is at the clinic for an examination. The FNP suspects that he has ptosis of one eye. How should the FNP check for this?
- The FNP is doing an assessment on a 21-year-old patient and notices that his nasal mucosa appears pale gray and swollen. What would be the most appropriate question to ask the patient?
- The FNP is palpating the sinus areas. If the findings are normal, then the patient should report which sensation?
- During an oral assessment of a 30-year-old African-American patient, the FNP notices bluish lips and a dark line along the gingival margin. What would the FNP do in response to these findings
- During an assessment of a 20-year-old patient with a three day history of nausea and vomiting the FNP notices dry mucous and deep vertical fissures on the tongue. These findings are reflective of:
- The FNP is reviewing the technique of palpating for tactile fremitus with a new graduate. Which statement by the graduate FNP reflects a correct understanding of tactile fremitus?
- The FNP student is reviewing physical assessment findings of the HEENT system associated with pregnancy. Which statement by the graduate FNP reflects a correct understanding of expected HEENT changes associated with pregnancy? During pregnancy:

NR 509 Week 2 Quiz Review – (Jarvis 8,9,13,14,15,16,18), (Swartz 4,6,7,8,9,10)

- A mother bringing her two month old daughter in for an examination says “my daughter rolled over against the wall and now I have noticed that she has a soft spot on the top of her head, is there something terribly wrong?” The FNP‘s best response would be:
- During percussion the FNP knows that a dull percussion note elicited over a lung lobe. This most likely results from:
- The patient is unable to differentiate between sharp and dull stimulation to both sides of her face. The FNP suspects Damage to:
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- The FNP notices that the patient's submental lymph nodes are enlarged. In an effort to identify the cause of the node enlargement, the FNP would assess the patient's:
- The FNP is aware that the four areas in the body where lymph nodes accessible are the:
- A 52-year-old patient describes the presence of occasional floaters or spots moving in front of his eyes. The FNP should know that floaters are usually not significant and are caused by:
- The FNP is preparing to assess the visual acuity of a 16-year-old patient. How should the FNP proceed?
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NR 509 Week 2 Quiz Review – (Jarvis 8,9,13,14,15,16,18), (Swartz 4,6,7,8,9,10)

1. What does dullness when percussing lung fields: Jarvis pg 427

2. Facial sensation controlled by which CN: Jarvis 283,
3. Know what two salivary glands are accessible during exam
4. What CN is … when pt shrugs shoulders Jarvis 646
5. What muscles are …. when …. CN 11 (spinal accessory nerve)
6. Concern for malignant nodules versus benign lymph nodule
7. Know what you'd do next if you palpated a submental lymph node: Jarvis pg 253
8. Define visual acuity
9. Know what to do if your patient can't read the largest number on the Snellen chart: Jarvis 289
10. Example of good visual acuity : Jarvis 289
11. Example of poor visual acuity: Jarvis 289
12. What is …. with corneal light reflex-
13. Know normal variances of sclera : Jarvis 283
14. Know how to check for Ptosis: Jarvis 292
15. What does ptosis indicate: Jarvis 292
16. Nasal fissure of pt with chronic allergies : Jarvis 271
    - Acute allergies : Jarvis p 363 .
17. What is an abnormal palpation of sinuses: Jarvis 362
    - Normal palpation of sinuses
18. Know normal variations in gingival margin
19. Know what a dehydrated oral cavity will look like: Jarvis 387
20. What is tactile fremitus, how do you test for it and what does it indicate? Jarvis 425

N 518 Module 2: THE GENERAL SURVEY AND HEENT

Module 2: Discussion Question

Start by reading and following these instructions:

You are responsible for at least 3 posts for each question in your discussion boards; your initial post and reply to two of your classmates. Your initial post(s) should be your response to the questions posed in the discussion question.

You should research your answer and cite at least one scholarly source when appropriate, and always use quality writing.

The discussion board is never a place to use text language or emoticons. You will also be asked to respond to your classmates. This is designed to enhance the academic discussion around the topic. It is all right to disagree with something posted by another, however your responses should always be thoughtful and respectful and reflect your opinions professionally.

Discussion Question:

- In your professional opinion, what is the difference between chronic and acute pain? How is the assessment for each type of pain different? What must you keep in mind when assessing acute pain?
- What must you keep in mind when assessing chronic pain? Reflect upon a time when you assessed a patient in pain. What did you do well? What points could

you have improved upon? How did the pain impact the patient? What specific treatments could have lessened the impact of the pain on the patient?

- Your initial posting should be 200 to 300 words in length and utilize at least one scholarly source other than the textbook. Please reply to at least two classmates. Replies to classmates should be at least 100 words in length. To properly "thread" your discussion posting, please click on REPLY.

When you are ready for the discussion, do the following:

- Click on the discussion link above.
- Start your answer by clicking the "Start a New Thread" button with the title of your answer and the body of text following the guidance above. NR 509 Shadow Health Respiratory Physical Assessment Assignment
- To properly post your answer, please click on the "Post" button.
- After posting your contribution, you must read what others have posted, reply to at least two of those posts, and respond (when appropriate) to those you have responded to.

To reply to a classmate's post:

- Click on the title of another student's post.
- Click "Reply to Thread" and type your response to the student.
- Click the "Post" button to post your reply.

N 581 Module 2: Assignment

Remember to submit your work following the file naming convention FirstInitial.LastName_M01.docx. For example, J.Smith_M01.docx. Remember that it is not necessary to manually type in the file extension; it will automatically append.

Start by reading and following these instructions:

1. Quickly skim the questions or assignment below and the assignment rubric to help you focus.

2. Read the required chapter(s) of the textbook and any additional recommended resources. Some answers may require you to do additional research on the Internet or in other reference sources. Choose your sources carefully.

3. Consider the discussion and any insights you gained from it.

4. Create your Assignment submission and be sure to cite your sources, use APA style as required, check your spelling.

Assignment:

Exercises:

- Complete the Shadow Health HEENT assessment.

Professional Development

- Write a reflection essay of your experience with the Shadow Health virtual assessment. At least two scholarly sources in addition to your textbook should be utilized. Please be sure to address each of the following prompts:
- What went well in your assessment?
- What did not go so well? What will you change for your next assessment?

- What findings did you uncover?
- What questions yielded the most information? Why do you think these were effective?
- What diagnostic tests would you order based on your findings?
- What differential diagnoses are you currently considering?
- What patient teaching were you able to complete? What additional patient teaching is needed?
- Would you prescribe any medications at this point? Why or why not? If so, what?
- How did your assessment demonstrate sound critical thinking and clinical decision making? What could you change to make it better?

N 581: SHADOW HEALTH ASSIGNMENT

Shadow Health Physical Assessment Rubric

Criteria Ratings

Pts

- This criterion is linked to a Learning Outcome Subjective Data, Organization, Communication, and Summary (DCE Score or transcript) NR 509 Shadow Health Respiratory Physical Assessment Assignment **25.0 pts**

Above Average

DCE Score greater than or equal to 93; Comprehensive introduction with expectations of exam verbalized; questions worded in a non-judgmental way; professional language exercised; questions well-organized; appropriate closing with summary of findings

verbalized to patient.NR 509: Shadow Health Respiratory Physical Assessment Assignment **21.0 pts**

Average

DCE Score greater than or equal to 86-92; Adequate introduction; some questions worded in a non-judgmental way; professional language mostly exercised; questions generally organized; somewhat complete closing. **10.0 pts**

Below Average

DCE Score greater than or equal to 80-85; Incomplete introduction; many questions worded in a judgmental way; some professional language exercised; questions somewhat organized; incomplete closing.**0.0 pts**

Unsatisfactory

DCE Score less than or equal to 79; Introduction missing; questions worded in a judgmental way; little professional language; questions unorganized; closing missing. **25.0 pts**

- This criterion is linked to a Learning Outcome, Objective Data, Physical Examination, Interpretation of Findings, Assessment, and Documentation **20.0 pts**

Above Average

Physical assessment documentation includes all relevant body systems; all pertinent normal and abnormal findings identified; documentation reflects professional language;

treatment plan includes each of the following components: diagnostics, medication, education, consultation/referral, and follow-up planning. **16.0 pts**

Average

Physical assessment documentation lacks sufficient details pertaining to one or two relevant body systems; or identifies ≥ 50% of the pertinent normal and abnormal findings; or documentation lacks professional language; or treatment plan lacks one or two components (diagnostics, medication, education, consultation/referral, or follow-up planning). **8.0 pts**

Below Average

Physical assessment documentation lacks sufficient details pertaining to three or more relevant body systems; or identifies < 49% of the pertinent normal and abnormal findings; or documentation includes unprofessional language; or treatment plan lacks three or more components (diagnostics, medication, education, consultation/referral, or follow-up planning). **0.0 pts**

Unsatisfactory

No physical assessment documentation or no treatment plan. **20.0 pts**

- This criterion is linked to a Learning Outcome Self-Reflection 5.0 pts

Above Average

Responds to three of the three reflection post questions; and provides analysis of performance; and reflection posts written using professional language; and reflection posts demonstrate insight. **3.0 pts**

Average

Responds to two of the three reflection post questions; or provides limited self-analysis of performance; or reflection posts are somewhat unclear related to the assignment and the student's experience; or reflection posts lack insight. **2.0 pts**

Below Average

Responds to one of the three reflection post questions; or does not provide self-analysis of performance; or reflections are not related to the assignment and the student's experience; or does not provide insight **0.0 pts**

Unsatisfactory

No reflection posts for the assignment. **5.0 pts**

Total Points: 50.0