

PLA Application for Credit

Please complete all information below before submitting the application for credit.

Name: Jane Doe	VSU ID: 870 – 555 – 555
<small>(first) (middle) (last)</small>	
Major: Nursing	Academic Advisor: Gayle Taylor
	<small>(first) (last)</small>
VSU Email: janedoe@valdosta.edu	Date: 05/05/2008
Address: 555 Happy Road	Telephone: (H) 229-555-5555 (C) 229-444-4444
<small>(street, apartment, box)</small>	<small>(home) / (cell)</small>
Valdosta, Ga. 31602	Best times to call: After 5:00 pm
<small>(city, state, zip)</small>	

Information about the course for which you are seeking credit:

Course prefix & number: NURS 4060	
Course Title: Advanced Health Assessment	
Is this course required for your major?	Yes
Have you satisfied prerequisites (or equivalents) for this course?	Yes
Is this course a prerequisite for other courses in your major?	No
Will you need to transfer credit for this course to another university?	No
Area: A, B, C, D, E, or F?	N/A
Notes - add any other information about the course	

Please describe the work or volunteer experience, training, courses, or other things you have done that you believe have met the requirements of the course listed above.

- Completed an Associate Degree in Nursing
- Have six years of clinical experience in nursing
- Completed a Paramedic Degree
- Have four years of clinical experience as a Paramedic
- Have been an certified instructor of First Aid/CPR for six years
- Worked as a lead supervisor for medical-surgical unit for four years
- Completed a 15 hour course in Adult Health Assessment
- Hold a National Certification in Adult Health Nursing

List each of the course outcomes for the course for which you are seeking credit. After the objective, identify any artifacts (documents, Web pages, audio or video files, or other materials) that correspond to the objective support your application for credit. For each of the artifacts that provide support for your prior learning, write a caption that will briefly describe the connections between the artifacts and the objectives:

Outcome 1	Perform a comprehensive physical, psychosocial, developmental, occupational, and cultural assessment in a concise and systematic manner;
Artifact	Physical Assessment Check-Off
Caption	Assessment observed by Mrs. Taylor and check-off sheet successfully completed
Outcome 2	Analyze history, physical examination, diagnostic procedures, and laboratory data to formulate a diagnostic hypothesis;
Artifact	Completed a Health History
Caption	Utilized information from health history to analyze and formulate a care plan.
Outcome 3	Document health assessment data in a concise, accurate, and logical manner;
Artifact	Completion of Health History notations
Caption	Assessed for complete notations that convey problems to be addressed and the actions and evaluations to follow.

Outcome 4	Skillfully perform selected diagnostic and laboratory procedures;
Artifact	Health History
Caption	Assessed for completion of documented lab procedures and the actions and evaluations that follow those results.
Outcome 5	Analyze ethical, legal, and socio-cultural issues associated with advanced health assessment issues.
Artifact	Formal Paper on a Disease Process Examination (Essay Questions)
Caption	Assessed understanding of issues related to a health problem. Examination answers were assessed for understanding of ethical, legal, and socio-cultural issues related to certain health problems.

JANE DOE

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912-555-5555

janedoe@valdosta.edu

PROFESSIONAL SUMMARY

Registered Nurse

- Highly skilled career professional with more than 5 years of hospital experience
- Established a Congestive Heart Failure support group that met once a month that included counseling, education regarding etiology, management, and treatment of congestive heart failure. Provided a resource for people and families to come and gain knowledge and share thoughts regarding congestive heart failure
- Trained in administering moderate sedation
- Trained in radiation safety with knowledge of a C-Arm
- Trained in External Counter Pulsation Therapy
- Trained in Intra-Aortic Balloon Pump safety
- Employee of the month April 2006 Satilla Regional Medical Center
- Charge nurse over a 21 bed medical surgical unit for 3 years

CREDENTIALS

Georgia Board of Nursing**License NO: RN555555**

2002

EXPERIENCE

Cardiovascular Nurse/Cath Lab Nurse

2004-present

*Satilla Regional Medical Center
Waycross, GA***Cardiovascular Nurse/ Congestive Heart Failure Coordinator**

2004-2006

*Satilla Regional Medical Center
Waycross, GA***Medical/Surgical Nurse/ Charge Nurse**

2002-2004

*Satilla Regional Medical Center
Unit- 3main***Nurse Intern**

2000-2001

*Satilla Regional Medical Center
Unit 3-main, CCU*

EDUCATION

Bachelor of Science of Nursing

Present-2008

*Valdosta State University
College of Nursing (presently enrolled)*

Associate Degree of Nursing <i>South Georgia College</i> Douglas, GA	2002
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Associate Degree of Science	1998
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CERTIFICATIONS

Advanced Cardiovascular Life Support	2006- present
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CPR	1997- present
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References available upon request

Advanced Health Assessment

Nursing 4060

Head-To-Toe Adult Health Assessment

Jane Doe

EVALUATION OF PHYSICAL EXAM

GENERAL INFORMATION

1. Bring your check-off sheet
2. You are responsible for the following equipment/supplies:
 - a. Stethoscope
 - b. Penlight
 - c. Taste and smell items (2of each)
 - d. Reflex hammer
 - e. Towel
 - f. Button, coin, paper clip, cotton swabs/balls, tongue blades, etc.
 - g. Gloves
 - h. Index Card
 - i. Pen
 - j. tape measure
 - k. drinking cup
3. There will be an ophthalmoscope/otoscope, BP cuff and tuning fork in class room.

PRE-EXAM

1. Assemble equipment necessary for exam (Snellen chart / news print, BP cuff ophthalmoscope, otoscope, nose/ear speculums, tuning fork, tongue blade, penlight, glove, stethoscope, eye cover (card), cup of water, etc.)
2. Introduce self and explain procedure/confidentiality. Obtain health history (to be done prior to exam).
3. Have client dress for exam.

EXAMINATION

1. Develop a personal routine, perform examination procedures systematically and efficiently using a system that requires the fewest number of client position changes, and prevents the examiner moving back and forth between body systems during the exam.
2. Ask pertinent questions related to personal and family medical history.
3. Explain each part of examination to client as it is performed.
4. Demonstrate consideration for client's privacy.
5. Observe general appearance: grooming, emotional status, body language, speech pattern, motor ability, etc.

POST-EXAMINATION

A one hour time limit will be granted per check-off. All areas must be satisfactory. The student will have three (3) opportunities to successfully complete assessment criteria. If unsuccessful after three attempts, the clinical portion of the course will be considered unsatisfactory and this will constitute a course failure.

PHYSICAL ASSESSMENT CHECK OFF

OBJECTIVE: To illustrate the incorporation of the separate body system examination into one complete integrated physical examination.

I. Evaluation of Physical Assessment	S-	U-	Comments---
A. Introduction	---	---	-----
1. Explain exam to client	-S	-	-
2. Explain clients right to refuse and confidentiality	-S	-	-
B. Balance/Motor Coordination	---	---	-----
1. Romberg	-S	-	-
2. Heal to toe walking (tandem walking)	-S	-	-
3. Single foot balance	-S	-	-
4. Hopping in place	-S	-	-
5. Knee bends	-S	-	-
C. Back	---	---	-----
1. Inspect back	-S	-	-
2. Check for scoliosis	-S	-	-
3. Palpate spine	-S	-	-
4. Palpate back muscles	-S	-	-
5. Bend side to side and twist	-S	-	-
D. Integumentary (Upper)	---	---	-----
1. Skin, nails	-S	-	-
E. Extremities (Upper) (Sitting)	---	---	-----
1. Inspection	-S	-	-
2. Pulses (Ulnar, Radial, Brachial)	-S	-	-
3. Sensory (light/deep, sharp/dull)	-S	-	-
4. ROM of joints	-S	-	-
5. Palpation of all joints (Hands, Arms, Shoulder, TMJ)	-S	-	-

6. Stereognosis (times 2 bilaterally)	-S	-	-
7. Graphesthesia	-S	-	-
8. Vibration (times 2 bilaterally)	-S	-	-
9. Two point discrimination	-S	-	-
10. Reflexes a. Biceps b. Triceps c. Brachial	-S	-	-
11. Motor/coordination(Specify heel to shin, finger to thumb/touch nose)	-S	-	-
F. Head	-	-	-
1. Inspect vision placement (Far/near) and symmetry	-S	-	-
2. Inspect scalp	-S	-	-
3. Palpate scalp	-S	-	-
G. Eyes	-	-	-
1. Inspect placement and symmetry	-S	-	-
2. Inspect conjunctiva	-S	-	-
3. Puncta	-S	-	-
4. Inspect sclera & cornea & iris	-S	-	-
5. Alignment (cover/uncover)	-S	-	-
6. E.O.M.	-S	-	-
7. Accommodation	-S	-	-
8. Direct light reaction	-S	-	-
9. Consensual light reaction	-S	-	-
10. Visual fields	-S	-	-
11. Corneal reflex	-S	-	-
12. Fundoscopic - 1. Position, 2. Approach 3. Anterior chamber	-S	-	-
13. Vision (far/near)	-S	-	-
H. Cranial Nerves not covered previously	-	-	-
1. Trigeminal - Sensory of forehead, face,jaw (Closing of jaw)	-S	-	-
2. Facial - raise eyebrows, wrinkle forehead, show teeth, smile, puff cheeks,	-S	-	-
3. Accessory - shrugging shoulders head to shoulder, resist head to hands	-S	-	-
I. Ears	-	-	-
1. Inspect outer ear, symmetry	-S	-	-

2. Inspect/palpate pinna	-S	-	-
3. Gross hearing, whisper test	-S	-	-
4. Weber, Rinne	-S	-	-
5. Otoscopic Exam: Describe land marks.(Cone of light, malleus, umbo)	-S	-	-
J. Nose	-	-	-
1. Inspect: mucosa, septum deviation, symmetry, turbinates	-S	-	-
2. Assess patency of nose	-S	-	-
3. Palpate (external nose, sinuses, frontal & maxillary)	-S	-	-
4. Test sense of smell	-S	-	-
K. Mouth and Pharynx	-	-	-
1. Inspect mouth: Mucosa, gums and teeth	-S	-	-
2. Inspect Tongue (sublingual also)	-S	-	-
3. Tongue: motor/deviation	-S	-	-
4. Inspect pharynx, Uvula/palate movement on phonation.	-S	-	-
5. Sense of Taste	-S	-	-
L. Neck	-	-	-
1. Inspect neck (inc. R.O.M/strength)	-S	-	-
2. Palpate trachea position	-S	-	-
3. Palpate thyroid	-S	-	-
4. Auscultate carotid	-S	-	-
M. Lymph Nodes	-	-	-
1. Occipital	-S	-	-
2. Post auricular / pre-auricular	-S	-	-
3. Tonsillar	-S	-	-
4. Submaxillary/Submandibular	-S	-	-
5. Submental	-S	-	-
6. Ant./Posterior cervical chains	-S	-	-
7. Supraclavicular/Infraclavicular	-S	-	-
8. Axillary	-S	-	-
N. Posterior Thorax and Lungs (Sitting)	-	-	-
1. Inspect (contour, pattern, etc.)	-S	-	-
2. Respiratory pattern	-S	-	-
3. Palpate for respiratory expansion	-S	-	-
4. Palpate fremitus-compare sides	-S	-	-

5. Percuss lung fields	-S	-	-
6. Percuss for diaphragmatic excursion	-S	-	-
7. Auscultate lung fields	-S	-	-
8. Costalvertebral rebound	-S	-	-
O. Anterior, Thorax and Lungs (Sitting)	-	-	-
1. Inspect	-S	-	-
2. Palpate for fremitus	-S	-	-
3. Percuss lung fields	-S	-	-
4. Auscultate lungs	-S	-	-
P. Heart (Sitting)	-	-	-
1. Palpate for lifts, heaves or thrills, PMI	-S	-	-
2. Auscultate (Bell/Diaphragm)	-	-	-
a. aortic (murmur)	-S	-	-
b. pulmonic	-S	-	-
c. Erb's point	-S	-	-
d. tricuspid	-S	-	-
e. mitral (count heartbeat)	-S	-	-
Q. Heart (Supine)	-	-	-
1. (Observe JVD)Inspect for heaves/pulsations/thrills	-S	-	-
2. Auscultate (Bell/Diaphragm)	-	-	-
a. aorta	-S	-	-
b.pulmonic	-S	-	-
c. Erb's point	-S	-	-
d. tricuspid	-S	-	-
e. mitral (murmur)	-S	-	-
R. Abdomen	-	-	-
1. Inspect	-S	-	-
2. Auscultate all four quadrants for Bowel sounds	-S	-	-
3. Auscultate arteries (Aorta, Renal, Femoral)	-S	-	-
4. Percuss: all four quadrants	-S	-	-
5. Percuss spleen	-S	-	-
6. Percuss liver	-S	-	-
5. Palpate all four quadrants (Light/deep)	-S	-	-
6. Palpate Liver	-S	-	-
7 Palpate Spleen	-S	-	-

8. Palpate Kidneys	-S	-	-
9. Palpate Aorta	-S	-	-
10. Palpate Femoral Pulse	-S	-	-
11. Abdominal Reflex	-S	-	-
S. Extremities (lower supine)			
1. Inspection/general	-S	-	-
2. Palpate Pulses	-S	-	-
a. Popliteal	-S	-	-
b. Dorsalis Pedis	-S	-	-
c. Posterior Tibial	-S	-	-
3. Sensory (light/deep, sharp/dull)	-S	-	-
4. ROM of joints, position sense	-S	-	-
5. Palpation of all joints	-S	-	-
6. Strength	-S	-	-
7. Reflexes	-S	-	-
a. Achilles	-S	-	-
b. Babinski	-S	-	-
c. Patella	-S	-	-
d. Homan's sign	-S	-	-
e. Clonus	-S	-	-
II. Organization (For more detailed explanation, Use Recommendations)			
A. Uses correct vocabulary	-S	-	-
B. Maintains privacy	-S	-	-
C. Uses appropriate sequence	-S	-	-
D. Examines thoroughly	-S	-	-
E. Uses organized approach	-S	-	-

III. Recommendations

Work on explaining to the patient the procedures as you perform them.

STUDENT: Jane Doe
 FACULTY: Gayle Taylor
 GRADE : **Pass**

Advanced Health Assessment

Nursing 4060

Complete Health History

HEALTH HISTORY

Biographical Data

Name: G. H.

Birth date: 12/16/1980

Address: 35 Center Street

Birthplace: Albany, Georgia

Marital Status: Divorced

Race: African American

G. is a 27-year-old, divorced, black, female patient care technician at Phoebe Putney Memorial Hospital of Albany.

Source: G. H.; appears reliable.

Reason for Seeking Care: "I need help with my crack cocaine addiction."

History of Present Illness: First "hit" of crack cocaine, age 22. Smoking ten to twenty dollars worth of cocaine daily. Attending Albany State University classes every day, but grades slipping from A+ average to C-average. At age 25, smoking "fifty dollar pieces" of cocaine daily and about two hundred dollar worth every weekend. At age 26, entered a long-term treatment program in Columbus, GA. After three months of treatment, left program against medical advice. Used a "hundred dollar piece" of cocaine the same day. During this year, experience chest pain, failed attempts to stop using cocaine, being physically sick, not eating or sleeping properly and being unable to control the urge to purchase cocaine once obtaining paycheck. Also, started having sex with numerous of men in exchange for cocaine or money. Notice sores around vaginal area this year.

Past Health

Childhood Illness: Chicken pox at age 8. No measles, mumps, croup, pertussis. No rheumatic fever, scarlet fever or polio.

Accidents: Denies.

Chronic Illnesses: None.

Hospitalizations: At 21, total abdominal hysterectomy surgery due to uterine cysts.

Obstetric History: Gravida 0/ Para 0/ Abortion 0.

Immunizations: Childhood immunization up to date. Tetanus 1999. TB skin test 2/05.

Last Examination: Yearly pelvic at OB/GYN since age 22, told “normal.” Last dental exam 6/03. Last vision exam for driver’s license age 18, never had ECG, chest x-ray study.

Allergies: No known allergies

Current Medications: Birth control pills, one per day, for eight years. Motrin 400mg PRN. Tylenol 650mg PRN. No other prescription or over-the-counter medications.

Family History

G. is the oldest with one sister who is 15-years-old and “healthy.” Her mother is 48-years-old and is “healthy.” Her father is 45-years-old and has a history of “crack cocaine” abuse. G. has “not spoken to them for a year.” G. has no children.

Review of Systems

General Health: Reports overall health: “Okay, if those sores around my vagina didn’t bother me.” Lost 18 pounds within the last month. Denies fatigue, weakness, fever, sweats.

Skin: No change in skin color, pigmentation, or nevi. No rash, pruritus, bruises. Have “painful” sores around vagina area. Consumes Motrin for pain. Denies any other lesions. No history of skin disease. Hair, no loss, changes in texture. Nails, no change.

Head: No head injury, dizziness, syncope, or vertigo. Reports occasional frontal headaches that are relieved by Tylenol.

Eyes: No difficulty with vision or double vision. No eye pain, inflammation, discharge, lesions. No history of glaucoma or cataracts. Wears no corrective lenses.

Ears: Denies any discharge, pain, or buzzing. Denies problem with balance. Describes hearing as “excellent.” Denies ear infections.

Nose: No nasal drainage, congestion, or sinus problems. Denies epistaxis or allergies. Last cold “about two years ago.”

Mouth and Throat: No mouth pain, bleeding gums, toothache, sores or lesions in mouth. Denies dysphagia, hoarseness, or sore throat. Self care: Brush teeth once a day. Denies flossing.

Neck: No pain, limitation of motion, lumps, or swollen glands.

Breast and Axilla: No pain, lump, nipple discharge, rash, swelling, or trauma. No history of breast disease in self, mother, or sister. No surgery. Self care: Monthly self breast exams. Never had mammogram exam.

Respiratory: No past history of lung disease. Denies dyspnea, wheezing, or chest pain when breathing. Occasional early morning cough, nonproductive. Smokes cigarettes 1 PPD X5 years. Never tried to quit. Smoke “crack” cocaine daily, “twenty to fifty dollars pieces.” Attempted treatment program to quit but “checked-out” against medical advice at age 26.

Cardiovascular: Reports having chest pain on two separate occasions after taking a “hit” of cocaine. “Sharp pain in my chest and went down my left shoulder.” Denies going to the emergency room or urgent care services. “It went away after 15-20 minutes.” No palpation, cyanosis, fatigue, dyspnea with exertion, orthopnea, paroxysmal nocturnal dyspnea, nocturnal, edema. No history of heart murmur, hypertension, coronary artery disease, or anemia.

Peripheral Vascular: No pain, numbness or tingling, swelling in legs. No coldness, discoloration, varicose veins, infections, or ulcers. No past history of vascular problems.

Gastrointestinal: Appetite is “poor.” Weight has decreased by eighteen pounds due to cocaine habit. Denies any food intolerances, heartburn, indigestion, pain in abdomen, nausea, or vomiting. No history of ulcers, jaundice, appendicitis, colitis, or liver or gallbladder diseases. Bowel movement every other day. Describes as soft, brown and is without pain or bleeding. Self care: denies use of vitamins, laxatives, antacids. Diet: see Functional Assessment.

Urinary: Denies frequency, urgency, nocturia, hesitancy, or straining. Reports pain during urination, “it burns.” No pain in flank, suprapubic region. Has pain in groin area due to “sores around vagina area.” Urine yellow, no history of kidney disease.

Genitalia: Menarche age 12. Last menstrual period April 12. Cycle usually every 29 days, duration 5 to 7 days, flow moderate, no dysmenorrhea. Currently has “several red itchy, painful sores are vagina area.” Reports “brownish-color vaginal discharge.” Denies any physician examination or treatment at this time. Denies lesions.

Sexual Health: In relationship for three months that includes intercourse. This has not been her only partner during this time frame, had four to five other partners. Uses birth

control pills to prevent pregnancy, partner uses no condoms. Possible STD contact due painful red sores in vaginal area. Never been tested for AIDS. Past history of sexual abuse by father at age 15, abuse included sexual intercourse. G. is unwilling to discuss further at this time.

Musculoskeletal: No past history of arthritis, gout, joint pain, deformities, or limitation of motion. No muscle pain or weakness. No history of trauma. Self care: denies bone density exam.

Neurological: no history of seizure disorder, stroke, fainting. No weakness, tremors, paralysis, problems with coordination, difficulty speaking or swallowing. No numbness or tingling. Denies memory or mood changes, depression, or nervousness. Had counseling for sexual abuse in the past. Denies any suicidal or homicidal ideation or intent during adolescent years or now.

Hematologic: No bleeding problems in skin, excessive bruising. Not aware of exposure to toxins, never had blood transfusion. Denies ever using needles to inject drugs.

Endocrine: No increase in hunger, thirst, or urination. No problems with hot or cold environments. No changes in skin, or nervousness. Has "poor" appetite due smoking cocaine.

Functional Assessment

Self Concept: Graduated from Albany Technical College with a certification in nurse assistant. Currently employed part-time at Phoebe Putney Memorial Hospital of Albany as a patient care technician, which she enjoys. Perceive she does not have enough of money for daily living. Lives with boyfriend in an apartment. Denies any participation in a specific religion but considers herself a spiritual person. Believes self to be "truthful, compassionate." Believes limitations are "smoking cigarette and crack cocaine, weight."

Activity-Exercise: Typical day: arises 7:00 am, go to work, spend time smoking cocaine, with friends, bedtime 2:00 am. No sustained physical exercise. No problem in bathing dressing, cooking, household tasks, mobility, driving a car, or work as a patient care technician. No mobility aids. Hobbies are reading, spending time with friends, and fishing.

Sleep-Rest: Bedtime 2:00 a.m. Sleeps 4-5 hours per night. Denies use of sleep aids.

Nutrition: 24-hour recall: breakfast, none; lunch, ham sandwich, soda; dinner, none. Typically eats one very small meal per day and one snack, sometimes. Denies food allergies.

Cocaine. See present illness. Cigarettes, smokes 1 PPD X5 years. Never tried to quit.

Interpersonal Relationships: Client has not spoken with parents for a year and chooses not to discuss this further. Has a strong relationship with younger sister. Describes relationship with live-in-boyfriend as “okay.” G. has “many” friends but does not get to see them as often as she would like due to her work schedule and drug habit. Denies and history of domestic violence.

Coping and Stress Management: Believes housing adequate, adequate heat and utilities, and neighborhood safe. Believes home has no safety hazards. Does use seat belts. States friends are supportive.

Identifies current stresses to be smoking crack cocaine, financial management, possible STD, weight.

Perception of Health

G. identifies “crack” cocaine as a health problem for herself, feels “depressed” that she is at “this point” again. She states she needs to not only focus on her treatment for her drug addiction but her overall general health. “It’s time for me to take control over my life.” Expects to stay at this facility for two month, “Then I will seek more long-term drug treatment if I need to.”

Assessment

History of Substance Abuse

STD

Chest pain due to cocaine abuse

Molested as a child

Depression

Nursing Diagnoses

Risk for trauma R/T cocaine abuse AEB chest pain and multiple sex partners

Risk for suicide R/T depressed mood AEB verbal statement of depression

Rape Trauma Syndrome R/T sexual abused AEB cocaine abuse and multiple sex partners

Risk of Infection R/T multiple sex partner AEB sores around vagina area

Acute pain R/T cocaine abuse AEB chest pain and sores around vagina area

Deficient knowledge R/T lack of interest in learning AEB abuse of cocaine

Ineffective coping R/T dysfunctional family system AEB sexual abuse and alcoholism

Deficient knowledge about balance diet R/T denial of risk involved with cocaine AEB continuous abuse of cocaine

Imbalance nutrition: less than body requirements R/T lack of interest in food AEB loss of weight

Sleep Deprivation R/T cocaine abuse AEB sleeping pattern

Advanced Health Assessment

Nursing 4060

Jane Doe

PLA Examination

**VSU College of Nursing
Nursing 4060
Advanced Health Assessment
PLA Examination**

Answer each of the four questions. Each answer should be at least one page in length. Return the finished document as an attachment by the due date.

1. Name three diagnostic procedures that have improved the healthcare system in the last 20 years.

Magnetic resonance imaging (MRI) is a medical imaging technique primarily used in radiology to visualize the structure and function of the body. It provides detailed images of the body in any plane. MRI provides good contrast between the different soft tissues of the body, making it especially useful in neurological, musculoskeletal, cardiovascular, and oncological imaging. MRI procedure is safe, radiation free, and poses no side effects. This is helpful when educating children and elderly patients.

Esophagogastroduodenoscopy (EGD) with biopsy, also known as upper endoscopy, is a procedure usually performed by a gastroenterologist. This test involve passing an endoscope, a long flexible black tube with a light and video camera on one end, through the mouth to examine the esophagus, stomach and the first part of the small intestine called the duodenum. The advantages of this test are that the lining of the upper digestive tract can be directly viewed by the doctor and very small abnormalities seen.

Endoscopic treatments can be performed at the time of the procedure. Examples of such treatments include dilation of an esophageal stricture (stretching an pieces of tissue) of any abnormality may also bee done directly

through the endoscope including biopsy of suspected duodenal, stomach ulcers, and the evaluation of GERD.

EGD is very safe one of the most frequently performed endoscopic procedures. Endoscopic biopsies are superficial, taking only the very top layer of the esophagus. Therefore, significant bleeding from the biopsies is at a minimum and the biopsies do not scar the esophagus.

Colonoscopy is a procedure that enables an examiner (usually a gastroenterologist) to evaluate the appearance of the inside of the colon (large bowel). This is accomplished by inserting a flexible tube that is about the thickness of a finger into the anus, and then advancing it slowly, under visual control, into the rectum and through the colon. It is performed with the visual control of either looking through the instrument or with viewing a TV monitor.

Colonoscopy is done for a variety of reasons. Most often it is done to investigate the finding of blood in the stool, abdominal pain, diarrhea, a change in the bowel habits, or an abnormality found on colon x-ray or CT scan. Certain individuals with previous history of polyps or colon cancer and certain individuals with family history of particular malignancies or colon problems may be advised to have periodic colonoscopies because they are at a greater risk of polyps or colon cancer.

2. Discuss socio-cultural issues that may impact a thorough health assessment.

Gender norms in many societies tend to make men macho, women passive, and marginalize transgender people-making all of them vulnerable in different ways and inhibits access services. For example, men may associate masculinity with taking risks in their sexual relations which expose them to HIV and sexual transmitted diseases, and may be reluctant or too embarrassed to seek out appropriate health information and care (these are often focused on women).

Women who are financially, materially or socially dependent on men may have limited power to exercise control in relationships, such as negotiating the use of condoms during sex. Social expectations about how women should behave can place women in subordinate roles and increase their risk of being sexually assaulted; contracting sexual transmitted diseases and having unwanted pregnancies. In many societies, women health concerns are often considered less important than those of men and children, and household responsibilities can prevent them from spending time visiting a clinic.

Issues around sex and sexuality are taboo in many cultures, and perceived stigma and embarrassment can lead to a reluctance to discuss and address sexual health issues. Taboos are even more pronounced for people who do not conform to socially accepted norms of behavior such as

adolescents who have sex before marriage and men who have sex with men.

Unmarried adolescent girls are routinely denied or have limited access to health care services without parents being present with the consequences of early sexual experiences including unwanted pregnancy, sexual transmitted diseases and unsafe abortions.

Racial differences in health often persist even at “equivalent” socioeconomic levels. Individual and institutional discrimination, along with the stigma of inferiority, can adversely affect health. Racism can also directly affect health in multiple ways. Residence in poor neighborhoods, racial bias in medical care, the stress of experiences of discrimination and the acceptance of the societal stigma of inferiority can have deleterious consequences for health.

3. Discuss occupational health assessments and how they may be used.

Occupational health is a cross-disciplinary area concerned with protecting the safety, health and welfare of people engaged in work or employment. A secondary effect, it may also protect co-workers family members, employers, customers, suppliers, nearby communities, and other members of the public who are impacted by the workplace environment.

Occupational health should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in the occupational environment adapted to his physiological and psychological capabilities; and, to summarize, the adaptation of work to man and of each man to his job.

Occupational health assessment should be carried out prior to making an intervention. The assessment should identify the hazards, identify all affected by the hazard and how, evaluate the risk and identify and priorities the required actions. The calculation of risk is based on the likelihood or probability of the harm being realized and the severity of the consequences. The assessment should be recorded and reviewed periodically and whenever there is a significant change to work practices. In addition, the assessment needs to include practical recommendations to control the risk.

Occupational health can address sitting posture, desktop and equipment layout, vision and glare issues, work patterns, breaks and stress management. Occupational individualized assessments encourage a healthy attitude, which has a very positive impact on the well being of staff, by reducing the number of repetitive strain injuries in the work environment. It can also increase workforce morale.

4. Discuss the history of health assessment and how it has improved in this century.

Health assessment is the gathering of information about a patient's physiological, psychological, sociological, and spiritual status. Health assessment started in the history of Nurse Florence Nightingale.

Assessment is the first stage of the nursing process in which the nurse should carry out a complete and holistic nursing assessment of every patient's needs, regardless of the reason for the encounter. Usually, an assessment framework, based on nursing model is used.

The purpose of this stage is to identify the patient's nursing problems. These problems are expressed as either actual or potential. For example, a patient who has been rendered immobile by a road traffic accident may be assessed as having the "potential for impaired skin integrity related to immobility."

Taking a nursing health history prior to the physical examination allows a nurse to establish a rapport with the patient and family. This may make the patient comfortable in discussing their problems/issues. Also, the patient will possibly give more details information.

A health assessment includes a physical examination: the observation or measurement of signs, which can be observed or measured, or symptoms such as nausea or vertigo, which can be felt by the patient. Techniques have improved through the years to include: inspection, palpation, auscultation and percussion in addition to the "vital signs" of temperature, blood pressure, pulse and respiratory rates. Furthermore,

these assessments are documented in the patient's medical or nursing records, which may be on paper or electronically. Many hospitals have gone paperless over the years to documenting information electronically in completing health assessments.

Advanced Health Assessment

Nursing 4060

Formal Paper

Jane Doe

RUNNING HEAD: What is Known About Genital Herpes

What Is Known About Genital Herpes
NURS 4060
Advanced Health Assessment
Jane Doe

Abstract

Genital herpes, usually caused by herpes simplex virus type 2 (HSV-2), is the most common cause of genital ulceration. The primary episodes of genital herpes are generally the most painful. Subsequently recurrences are generally milder and localized. Pregnant women who have a history of genital herpes or recent primary infections often deliver by caesarean section in the presence of genital lesions to prevent transmission to the infant. Diagnosis is made clinically, but should be confirmed by cultures or serology. Management includes antiviral drug therapy-acyclovir, valacyclovir, or famciclovir, as well as an analgesic. In addition, patient counseling and education is vital. Antiviral treatment decreases the severity and duration of primary genital herpes and of recurrences, and it may be used as a continuous suppressive therapy to decrease the incidence of recurrence.

What Is Known About Genital Herpes

Genital herpes is a sexually transmitted disease (STD). It is one out of the three most prevalent STDs in the United States, with Chlamydia and human papillomavirus infection. According to the Centers of Disease Control and Prevention, one out of every five American teenagers and adults is infected with genital herpes. Genital herpes is caused by genital infection with HSV type 1 (HSV-1) or herpes simplex virus type 2 (HSV-2), although, genital herpes is most common in HSV-type 2(CDC, 2006).

HSV type 1 most commonly infects the mouth and lips, causing cold sores known as fever blisters or cold sores. HSV-1 infection of genitals can be caused by genital-to-genital or oral-genital contact with a person who has HSV-1 infection. So having oral sex with a person who has a cold sore can cause genital herpes through shedding (the time during which the virus can be transmitted to a partner) or transmission. HSV-1 outbreaks recur less regularly than genital HSV-2 outbreaks (ACOG, 2008).

HSV type 2 is the usual cause of genital herpes, but it also can infect the mouth. This virus spreads through sexual contact and skin-to-skin contact. HSV-2 is very common and highly contagious whether or not visible sores are present. Generally, a person can only get HSV-2 infection during sexual intercourse with someone who has a genital HSV-2 infection (Corey & Wald, 1999). Also, transmission can occur even if the person does not know of being infected.

Someone with genital herpes may first notice itching or pain followed by sores appearing a few hours or days later. The sores appear on the vagina, penis, scrotum, buttock, or anus. They start as small red bumps that soon become red, watery blisters. The sores may be open, oozing fluids or blood. Healing usually take place within the next two to four weeks (CDC, 2006). Furthermore, the entire genital area may be very painful, and tender. Sometimes, there is a crack or raw area or some redness without pain, itch or tingling. Other symptoms that may accompany the first outbreak of genital herpes are fever, headache, muscle aches, flu-like symptoms, painful or difficult urination, vaginal discharge, and swollen glands in the groin area (Dorlin & Mandell, 2000).

In most people, the virus can become active and cause outbreaks several times a year. This is called recurrence, and infected people can have symptoms. Symptoms from recurrences might include itching, tingling, and burning feeling or pain in genital or anal area. HSV remains in certain nerve cells of the body for life. When the virus is triggered to be active, it travels along the nerve of the skin (Dorlin & Mandell, 2000). There, it makes more virus and sometimes, new sores near the site of the first outbreak. Recurrences are generally milder than the first outbreak of genital herpes; however, they are less common over time (CDC, 2006).

Women who have a first outbreak of genital herpes near the time of delivering their baby are at risk of transmitting herpes to their newborn. Women who acquire genital herpes before becoming pregnant are not likely to pass the virus to the baby.

However, it is possible for this to happen, particularly if the mother has symptoms of pain or burning, or has active lesions at the time of delivery (ACOG, 2008).

A caesarean delivery is usually recommended in women who experience an outbreak of symptoms at the time of labor. Genital herpes also increases the risk of human immunodeficiency virus (HIV) infection. This is because HIV can enter the body more easily whenever there's a break in the skin (such as a sore) during unprotected sexual contact (CDC, 2006).

Genital herpes can be diagnosed by examinations and visual inspections of the lesions. There are two main laboratory methods to diagnose the virus: culture and serology. A culture is done when a health care provider uses a swab to obtain and study the material from a patient's sore. The culture determines if herpes simplex virus is present on the skin and in secretions from the urinary and genital tracts. Studies have shown a patient can still have genital herpes, however, even if the culture is negative (CDC, 2006). In addition, a blood test called type-specific test can tell whether a patient is infected with HSV-1, HSV-2 or both. The blood test can detect antibodies (proteins that are produced by the body in response to a foreign substance) to HSV-1 and HSV-2 (Corey & Wald, 1999). Having a positive test for these antibodies indicates that an individual has been infected with the virus at some time in the past, although it is not possible to know from whom the virus was transmitted (CDC, 2006).

Although there is no cure for genital herpes, the infection can be managed with antiviral drug therapy and self-care measures. Several antiviral drugs are used to treat

genital herpes. Antiviral medications can shorten and prevent outbreaks during the period of time the person takes the medication. In addition, episodic therapy and suppressive therapy for symptomatic herpes can reduce the transmission to partners.

Episodic therapy is treatment with antiviral drugs as soon as the symptoms of genital herpes begin. The medication is stopped after seven to ten days. Antiviral medications can alleviate pain, reduce the healing time of ulcers, and shorten the duration

of viral shedding. Episodic therapy is usually recommended for individuals who have fewer than six recurrences each year (CDC, 2006). Episodic treatment does not eliminate the frequency of recurrences. Antiviral treatment of recurrent episodes is most likely to be effective if started within twenty-four hours of the first symptoms (ACOG, 2008).

Suppressive therapy refers to the continuous use of antiviral drugs, even when there are no symptoms. Suppressive therapy increases the time between recurrences, decreases the number of recurrences, shortens the duration of symptoms during a recurrence, and can reduce the risk of transmission of HSV to an uninfected partner (Corey & Wald, 1999). Suppressive therapy is recommended for HSV-positive individuals who have six or more recurrences each year and those with a weakened immune system due to HIV, use of immune-suppressing drugs, or other factors (CDC, 2006).

Three antiviral medications are used to treat genital herpes: acyclovir, famciclovir, and valacyclovir. These medications are primarily taken by mouth. Acyclovir is the oldest and least expensive antiviral medication (ACOG, 2008). It requires more frequent dosing than famciclovir and valacyclovir. This medication is available in pill, liquid, and injection form (CDC, 2006). Famciclovir is taken two or three times per day. Moreover, valacyclovir is taken one to two times per day. Patient teaching should include: take the antiviral medication as prescribed, even after feeling better, avoid sexual contact while visible lesions are present and the medication does not eliminate or cure herpes. Headache, nausea, vomiting, malaise and dizziness are common side effects of antiviral medications (Dorlin & Mandell, 2000).

In addition to antiviral medications, other treatments may be used to relieve the pain of a herpes outbreak. Sitting in a few inches of cool water (called a sitz bath) can temporarily decrease pain. This can be done in a clean bathtub. Tylenol or advil may also be helpful in relieving the pain of genital ulcers. Soaps and bubble baths should be avoided. It is essentially important to keep the genital area clean and dry, and to avoid tight underwear and clothing.

Although genital herpes is a treatable condition, it can cause feelings of shame, fear, and distress. Therefore, education is important for infected individuals and their partner to know what to expect and how to protect themselves. Counseling is helpful in dealing with the issue because many individuals may have difficulty understanding the impact of the disease, especially in the absence of physical signs (Corey & Wald, 1999).

Genital Herpes 8

Because all sexually active persons are at some risk of acquiring genital herpes, it is important to communicate with a sexual partner before the first sexual encounter. Discussing herpes can be uncomfortable and embarrassing, but it ensures that both partners understand the possibility of transmitting the infection through sexual activity. Regular testing for sexually transmitted diseases is also recommended, especially if one or both partners have other sexual partners (CDC, 2006).

After being diagnosed with genital herpes, it is still possible to have safe and healthy sex life; however, it is important to take precautions. Use of latex condoms with every sexual encounter can reduce the risk of herpes. Sex should be avoided any time genital ulcers are present. Meanwhile, the only sure way to prevent genital herpes is abstinence.

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