NURS-FPX4015 Assessment 5

Comprehensive Head-to-Toe Assessment on a Volunteer - Distinguished-Level Video Script and Clinical Rationale

Selected simulated patient: Ivy Jackson, 61-year-old African American woman with major depressive disorder and hypertension. **Estimated spoken length:** 12-14 minutes, excluding pauses for positioning and examination.

Important: This PDF is a complete model script for a recorded demonstration. A real submission still requires the learner's own adult volunteer, authentic Assessment 1 waiver, visible performance of the techniques, and Kaltura recording with captions.

0:00-0:45 | Introduction, consent, safety, and preparation

Student: "Hello, Ms. Jackson. My name is Jordan Lee, and I am the nursing student completing your assessment today. I verified your identity using your name and date of birth from the fictional scenario. Before we begin, I have reviewed the signed waiver. This is an educational head-to-toe assessment, not a real diagnosis or treatment visit. I will explain each step, protect your privacy, and ask permission before touching you. You may pause or stop at any time. Are you comfortable proceeding?"

Patient: "Yes."

Student: "Thank you. I have performed hand hygiene. I have a stethoscope, blood-pressure cuff, thermometer, pulse oximeter, penlight, reflex hammer, and watch. I will begin with a general survey and vital signs."

0:45-1:45 | General survey, vital signs, pain, and immediate safety

Student: "I observe that you are awake, alert, dressed appropriately, and able to sit without assistance. Your posture is slightly slumped, your facial expression is subdued, and your speech is soft but clear. I do not see acute respiratory distress, cyanosis, or uncontrolled pain. Your temperature is 98.4°F, pulse 78 and regular, respirations 16 and unlabored, oxygen saturation 98% on room air, and blood pressure 148/92 in the right arm while seated. I would repeat the blood pressure after five minutes and confirm the correct cuff size. On a zero-to-ten scale, do you have pain?"

Patient: "No pain."

Student: "Because mood symptoms are part of your scenario, I also need to ask directly about safety. Have you had thoughts of hurting yourself, wishing you were dead, or making a suicide plan?"

Patient: "I sometimes feel hopeless, but I do not have a plan or intent."

Student: "Thank you for telling me. I will continue to assess safety and make sure you receive appropriate support. Any active intent, plan, inability to stay safe, or rapidly worsening symptoms would require immediate escalation."

1:45-2:45 | Mental status and neurological assessment

Student: "Please tell me your full name, where we are, today's date, and why we are meeting." The patient is oriented to person, place, time, and situation. "I notice your mood appears low and your affect is constricted but appropriate to the conversation. Your thought process is logical and goal directed. I do not observe hallucinations, delusions, or pressured speech. Concentration is mildly reduced, which fits the reported depression and poor sleep."

“I will now examine neurological function. Your pupils are equal, round, and reactive to light. Please follow my finger through the six cardinal fields of gaze.” Extraocular movements are intact without nystagmus. Facial movement is symmetrical, speech is clear, shoulder shrug is equal, and the tongue is midline. Hand grips and foot pushes are 5/5 bilaterally. Sensation to light touch is intact in all extremities. Finger-to-nose testing is smooth, gait is steady, and deep tendon reflexes are 2+ and symmetrical. These findings do not suggest an acute focal neurological deficit.”

2:45-3:45 | Head, eyes, ears, nose, mouth, and neck

Student: “I inspect the scalp and face and see no lesions, swelling, or asymmetry. The conjunctivae are pink, sclerae are white, and there is no drainage. The external ears are intact, and you respond appropriately to normal conversation. The nose is midline with no visible drainage. Oral mucosa is moist and pink, dentition is intact, and the tongue and uvula are midline. Please swallow.” Swallowing is intact.

“I palpate the neck gently. The trachea is midline, and I do not detect enlarged cervical lymph nodes or thyroid enlargement. Please move your neck up, down, and side to side.” Range of motion is full without pain. “These findings are within expected limits. Dry mouth or appetite changes can sometimes occur with depression, dehydration, or medication effects, so I would continue to ask about nutrition, fluid intake, and oral health.”

3:45-5:00 | Respiratory assessment

Student: “I inspect the chest. Respirations are regular, the chest expands symmetrically, and there is no accessory-muscle use. I will place my hands on your back to compare expansion. Please take a deep breath.” Expansion is equal. “Now I will listen to lung sounds from side to side on the back, sides, and front. Please breathe slowly through your mouth each time I move the stethoscope.” Breath sounds are clear in all fields without wheezes, crackles, or diminished areas.

“Your oxygen level, breathing pattern, and lung sounds are normal in this demonstration. This matters because shortness of breath, fatigue, and sleep problems can overlap with depression but may also indicate cardiopulmonary disease. If I heard crackles, wheezing, or reduced airflow, or if your oxygen saturation were low, I would investigate those findings rather than attributing fatigue only to mood.”

5:00-6:30 | Cardiovascular and peripheral vascular assessment

Student: “I inspect the precordium and do not see visible heaves. I palpate the point of maximal impulse in the expected location. I will listen at the aortic, pulmonic, Erb’s point, tricuspid, and mitral areas.” Heart sounds S1 and S2 are regular with no audible murmur in this sample. The apical pulse is 78 and regular.

“I palpate radial, posterior tibial, and dorsalis pedis pulses; they are 2+ and equal. Capillary refill is under two seconds. The extremities are warm, with no edema, calf tenderness, or unilateral swelling. Your blood pressure, however, is elevated at 148/92. One reading does not establish control by itself, so it should be repeated and compared with home or clinic readings. Persistent hypertension increases strain on blood vessels and raises the risk of stroke, heart disease, kidney injury, and cognitive decline. Depression can also make adherence, activity, sleep, and follow-up more difficult, so both conditions should be managed together.”

6:30-7:40 | Abdomen, nutrition, and elimination

Student: “I inspect the abdomen before touching it. It is flat and symmetrical with no visible distention. I listen for bowel sounds in all four quadrants; they are active. I then listen over the abdominal aorta and renal arteries and do not hear a bruit in this sample. I lightly and then deeply palpate all quadrants. The abdomen is soft and

nontender, with no guarding or palpable mass."

"Have you noticed nausea, constipation, diarrhea, appetite change, or unplanned weight change?" The patient reports reduced appetite and a five-pound weight loss over two months. "Reduced appetite can occur with MDD, but the finding still deserves assessment of nutrition, medication adverse effects, thyroid disease, malignancy risk, and food access. I would document intake, weight trend, hydration, bowel pattern, and any red-flag symptoms such as persistent vomiting, blood in stool, severe pain, or rapid weight loss."

7:40-8:50 | Musculoskeletal, skin, and functional assessment

Student: "I inspect the skin on exposed areas. It is warm, dry, and intact, with even color for the patient's baseline and no rash, pressure injury, or concerning lesion. Skin turgor is appropriate. I examine the hands and feet and see no wounds. Range of motion is full in the shoulders, elbows, wrists, hips, knees, and ankles. Strength is 5/5 bilaterally. The patient rises from the chair without using the arms, walks with a steady gait, turns safely, and returns to the chair."

"Although the physical findings are normal, the patient reports low energy and reduced activity. In MDD, fatigue and psychomotor slowing may reduce exercise and self-care. I would ask how symptoms affect bathing, cooking, work, medication management, and social contact. Functional impact helps determine severity and creates measurable goals, such as walking for ten minutes three times this week or completing one valued daily activity."

8:50-10:00 | Diagnosis and explanation of assessment findings

Student: "Ms. Jackson, most of your physical examination is within expected limits. Your lungs are clear, heart rhythm is regular, neurological function is symmetrical, abdomen is nontender, and strength and gait are intact. The main concerns are an elevated blood pressure, reduced appetite and weight, poor sleep, low energy, impaired concentration, depressed mood, and hopelessness without a current suicide plan."

"These findings are consistent with the scenario diagnosis of major depressive disorder and coexisting hypertension. MDD is diagnosed from a pattern of symptoms, duration, functional impairment, and exclusion of other causes; it is not diagnosed by a single laboratory test. I would also review thyroid function, anemia risk, medication effects, substance use, grief, and any past manic symptoms. Your blood pressure should be confirmed with repeated properly measured readings. I would explain that depression is a real health condition affecting brain function, stress systems, sleep, energy, thinking, and the body, not a personal failure."

10:00-11:15 | Pathophysiology explained in patient-centered language

Student: "Depression does not come from one simple chemical imbalance. Current evidence suggests that genetics, stressful experiences, inflammation, the body's stress-response system, brain-network function, and neuroplasticity can interact. Those changes can affect mood, motivation, sleep, appetite, concentration, pain perception, and energy. That is why depression can feel both emotional and physical. If symptoms progress, a person may withdraw more, stop eating or sleeping normally, struggle to take medication, or develop suicidal thinking."

"Hypertension means the pressure inside the arteries stays too high over time. The heart must work harder, and the blood-vessel lining can be damaged. High blood pressure may cause no symptoms, but uncontrolled pressure can harm the brain, heart, kidneys, and eyes. Managing sleep, stress, activity, diet, medication, and follow-up can support both mood and cardiovascular health."

11:15-12:40 | Pharmacological needs, benefits, drawbacks, and teaching

Student: “Treatment decisions belong to you and the licensed prescriber. For moderate major depression, evidence-based options include cognitive behavioral therapy, a second-generation antidepressant, or sometimes both. An SSRI such as sertraline is commonly considered because it is effective for many adults and generally safer than older antidepressants. Benefits may take several weeks. Early effects can include nausea, headache, sleep change, restlessness, or sexual dysfunction. Important risks include worsening suicidal thoughts, serotonin syndrome, low sodium, and increased bleeding risk, especially with certain other medicines. The patient should not stop the drug suddenly and should report severe agitation, confusion, fever, muscle rigidity, rash, or suicidal intent.”

“For hypertension, a prescriber considers repeated blood pressure readings, cardiovascular risk, kidney function, other conditions, and current medicines. Common options include thiazide-type diuretics, ACE inhibitors or ARBs, and calcium-channel blockers. Each has benefits and drawbacks. For example, a thiazide can lower blood pressure but may affect sodium or potassium; an ACE inhibitor can protect the heart and kidneys but may cause cough, elevated potassium, or rare angioedema. Medication reconciliation is essential before any change.”

12:40-13:50 | Clinical reasoning and prioritized plan of care

Student: “My first priority is safety because hopelessness can progress even when there is no current plan. I would complete a structured suicide assessment, identify protective factors, create a collaborative safety plan, provide crisis instructions, and arrange timely behavioral-health follow-up. The second priority is confirming and managing hypertension through repeated readings, home monitoring if available, medication reconciliation, and primary-care follow-up. The third priority is restoring treatment engagement and function: review antidepressant adherence and adverse effects, support psychotherapy, monitor sleep, appetite, weight, and activity, and identify barriers such as cost, transportation, culture, or stigma.”

“The plan is evidence based because current guidance supports psychotherapy or a second-generation antidepressant for moderate-to-severe MDD, individualized through shared decision-making. Current blood-pressure guidance emphasizes accurate measurement, lifestyle support, and treatment to reduce cardiovascular risk. I would coordinate rather than treat each condition in isolation.”

13:50-14:30 | Teach-back, collaboration, and closing

Student: “To make sure I explained this clearly, please tell me the two main concerns we identified and what you would do if suicidal thoughts became active.” The patient states that the concerns are depression and elevated blood pressure and that she would use the safety plan and seek immediate help if she developed intent or a plan.

“Exactly. Before we finish, what is one goal that feels realistic?” The patient chooses to call the behavioral-health clinic and measure blood pressure twice this week. “That plan respects your priorities. I will document the assessment, repeat the blood pressure, communicate concerns to the appropriate licensed provider, and make sure you understand follow-up and urgent warning signs. Thank you for participating. I will perform hand hygiene and ensure you are comfortable before ending the recording.”

Model Assessment Findings and Clinical Reasoning

Domain	Sample finding	Clinical interpretation / action
General / vital signs	Alert; subdued affect; T 98.4°F; HR 78; RR 16; SpO2 98%; BP 148/92	No acute distress. Repeat BP with correct technique; confirm trends and cardiovascular risk.
Mental status / safety	Oriented x4; depressed mood; constricted affect; mild concentration difficulty; hopelessness; no current plan or intent	Complete structured suicide assessment and collaborative safety plan; escalate immediately if intent, plan, or inability to remain safe emerges.
Neurological	PERRL; EOM intact; cranial nerves grossly intact; strength 5/5; sensation intact; reflexes 2+; steady gait	No focal deficit in this sample. Continue to evaluate medical causes if cognition or neurological findings change.
HEENT / neck	Moist mucosa; no lymphadenopathy; thyroid not enlarged; full neck ROM	Expected findings. Assess nutrition, oral health, hydration, and thyroid symptoms because they may overlap with depression.
Respiratory	Symmetrical expansion; clear breath sounds; no accessory-muscle use	Normal findings reduce concern for a pulmonary explanation of fatigue at this time.
Cardiovascular / vascular	Regular S1/S2; pulses 2+; capillary refill <2 sec; no edema; elevated BP	Hypertension requires confirmation and follow-up even when the patient is asymptomatic.
Abdomen / nutrition	Soft, nontender; active bowel sounds; reduced appetite; 5-lb unplanned loss	Monitor weight and intake; assess medication effects, thyroid disease, food access, and other medical causes.
Skin / musculoskeletal / function	Skin intact; full ROM; strength 5/5; steady gait; low energy and reduced activity	Physical capacity is intact, but depressive symptoms impair function. Use graded, patient-selected activity goals.

Distinguished-Criterion Alignment

Criterion	How the sample reaches the distinguished expectation
Comprehensive and professional assessment	Uses a systematic sequence, verbally explains techniques and findings, protects privacy, obtains permission, and identifies both normal and abnormal findings.
Diagnosis and findings	Explains what was found, how findings support the scenario diagnosis, what alternative causes require evaluation, and why repeated BP measurement matters.
Pharmacological needs	Discusses evidence-based options, benefits, drawbacks, adverse effects, comorbidity considerations, medication reconciliation, and shared decision-making.
Pathophysiology	Explains how MDD and hypertension affect body systems and what progression may look, sound, and feel like in patient-centered language.
Clinical reasoning	Combines physical findings, safety assessment, pathophysiology, and medication knowledge to establish evidence-based priorities.
Professional communication	Uses clear terminology, teach-back, respect, collaboration, autonomy, and direct safety questions without judgment.

References

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Medical-safety note: This model is educational and does not replace clinical judgment, local policy, emergency procedures, medication prescribing, or a licensed clinician’s evaluation. Any person with active suicidal intent or an inability to stay safe requires immediate emergency assessment.

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