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Fall 9-1-2005

NUR 155.01: Meeting Adult Physiological Needs I

Michele Sare
The University Of Montana

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College of Technology
The University of Montana - Missoula
Course Syllabus

HEALTH PROFESSIONS DEPARTMENT
PRACTICAL NURSING

COURSE NAME AND TITLE: NUR 152 & 155 Principles of Nursing Practice (Previously; Introduction to Nursing & Adult Physiologic Needs)

DATE REVISED: August 15, 2005

SEMESTER CREDITS: 7

Course Design:

Lecture Hours per week: 4
Lab Hours per week: 12 hours per week - *weeks 1-4*
Lab Hours per week: 4 (+ 4 optional) per week – *weeks 5-14*

Clinical/Internship hours per week *(beginning week 5*): **weeks 5-14:** 8 hours per week on Thu and Fri from 6:15 a.m. – 10:30 p.m.
(beginning R September 29, 2005)

PREREQUISITES: Successful completion of Core program: Coreq. NUR 151/154

INSTRUCTOR NAME: Michele Sare, R.N., MSN
E-MAIL ADDRESS: Michele.Sare@mso.umt.edu
PHONE NUMBER: (406) 396-5155 ***(emergency*** – home: 288-0022 & cell: 544-7620)
OFFICE LOCATION: Stanahan Building – North Reserve, Rm. 155
OFFICE HOURS: By Appointment

RELATIONSHIP TO PROGRAM(S):
Provides foundation in nursing theory, knowledge, and skill with application to the clinical setting. Also sequences skills from basic to complex (advanced in NUR 252).

COURSE DESCRIPTION:
Introduction to the fundamental concepts of nursing theory, knowledge, and skill development – lecture, lab, and clinical experiences. On-campus lab and off-campus clinical experiences are included**.**
*** **Clinical** is the last 12 weeks from 6:15 am – 10:30 on Thurs. & Friday **or** 6:45am – 10:45*

STUDENT PERFORMANCE ASSESSMENT METHODS AND GRADING PROCEDURES:

1. Unit exams
2. Final exams.
3. Laboratory demonstrations, either performed live or peer review
4. Instructor evaluation of students, utilizing evaluation form for course and based on instructor observation of supervised clinical practice.
5. Written nursing care plans for assigned client.
6. Participation in pre- and post-clinical conferences.
7. Completion of critical thinking activities in student journal.
8. Completion of a case study & a pathophysiology paper
9. Theory ***and*** the clinical component must ***both*** be passed in order to pass NUR 152. (Clinical is pass/fail only.)
10. Failure of the theory component will result in the earned letter grade.
11. Failure of the clinical component will result in a failing grade for the course.

* 12. This course may only be ***attempted*** twice and if not successfully completed, removal from the program occurs.

13. Two percent off of final course grade for ***each*** 24-hours late for turning in assignments.
14. Grading scale:

90 – 100	A
80 – 89	B
70 - 79	C
60 - 69	D
59 and below	F (plus & minus grades will be calculated)

15. All courses must be completed with a "B" or greater in order to matriculate and graduate.

ATTENDANCE POLICY AND TESTING POLICY
Regular timely attendance is expected. If a student misses more than three classes or labs, their final course grade will be reduced by one full letter grade, and will go down an additional grade for each absence thereafter. If the student misses a class or lab, it is the **student's responsibility** to make up for the absence. Tests are to be taken on the day they are scheduled. Make-up tests will be taken on ***the first day the student returns to class***. 5% per day will be subtracted for each day thereafter and a failing (0) grade after 5 days. The only exceptions will be at the instructor's discretion. All make-up tests will automatically have a 5% reduction in score unless there have been extenuating circumstances – at the instructor's discretion. There will be no extra credit questions included. Students are responsible for makeup tests through the ASC on the main COT campus. Assignments will not be accepted after their due date without consent of instructor.

Students must attend every agency clinical experience. In the case of an unavoidable absence on an assigned day, the student must call the assigned unit at least 30 minutes **prior** to the assigned arrival time. Students are allowed **one** personal leave day for clinical for this course. Tardiness is defined as up to 30 minutes late for an assignment. Chronic tardiness past two occurrences will be considered an absence. A

student contract will be formulated with a student with attendance and punctuality problems. Personal appointments made during scheduled clinical hours will be considered as absences.

OTHER POLICIES:
Refer to the Practical Nursing program student handbook for information about uniforms, health requirements, phone calls, liability coverage, etc.

Disability Services: Eligible students with disabilities will receive appropriate accommodations in this course when requested in a timely way. Please speak with me after class or in my office. Please be prepared to provide a letter from your DSS Coordinator.

For students planning to request testing accommodations, be sure to bring the form to me in advance of the two-day deadline for scheduling in the ASC.

CHEATING: Any student found cheating will fail this course and be dismissed from the program.

HOW VARIOUS ASSESSMENT METHODS WILL BE USED TO IMPROVE THE COURSE:

1. Student course evaluations each semester (and weekly – as this is a new offering).
2. Advisory committee input relative to expectations of employers for entry-level skills.
3. Change to scope of practice as made by the Board of Nursing in the statutes and rules.
4. Collaboration between classroom and clinical instructors to maintain clinical currency in theory classes.
5. Student performance evaluations clinically.
6. Students will keep a learning journal.

REQUIRED TEXT:
Fundamentals of Nursing, (6th ed.) Potter and Perry (2005), Mosby
Foundations of Adult Health Nursing, (2nd ed.) White (2005), Thomson Delmar
The Story of My Life An Afghan Girl On The Other Side Of The Sky, Ahmedi, (2005), Simon & Schuster

SUGGESTED REFERENCE MATERIALS:
Medical Dictionary – either Mosby's or Taber's
Nurses's Pocket Guide, Dongenes and Moorhouse, F.A. Davis (current edition).
Nursing Procedures, P.A. Springhouse (current edition)

SUPPLIES:
Uniform for the Practical Nursing program – See student handbook
Duty shoes – See student handbook
Name tag – See student handbook
Watch with sweep second hand
Kit of supplies for use in campus laboratory procedures – purchased as a course fee
Journal
BP cuff & a stethoscope

COURSE OUTLINE:

There are three 'tracks' that the learner will follow:

Track 1: Nursing Skills, Knowledge, & Concepts
Track 2: Systems (musculoskeletal, GI, GU, integumentary, & endocrine)
Track 3: Medication administration & meds. appropriate to systems(NUR 151/54)
(see NUR 151/54 syllabus for Track 3)

Track 1:

Unit 1 - (4 weeks) Foundational Skills & Concepts in Nursing I:

Module 1: Nursing practice & the Healthcare Delivery System
Module 2: Ethics & Values in Nursing
Module 3: Community Based Nursing & Health & Wellness
Module 4: Nursing Theory & Research
Module 5: Spirituality, Loss & Grief, & Coping
Module 6: Culture & Ethnicity, Developmental Theories, & Communication
Module 7: The Older Adult

Track 2: Module 8: Concepts of Care – Musculoskeletal System

Track 1:

Unit II - (1 weeks) Applying Foundational Skills, Knowledge, & Concepts in Nursing I:

Module 1: Legal Considerations in Nursing
Module 2: Documentation
Module 3: Infection Control

Begin Clinical in this unit:

Module 4: Clinical Orientation
Module 5: Care of the Environment & Vital Signs (skill)
Module 6: HIPAA & Confidentiality
Module 7: Activity/ROM
Module 8: Applying a Learned Concept (Farah Ahmedi)

Track 2: (none…beginning clinical is enough☺)

Track 1:

Unit III – (1 week) Applying Foundational Skills, Knowledge, & Concepts in Nursing II:

Module 1: Physical Assessment
Module 2: Critical Thinking
Module 3: Nursing Assessment
Module 4: Nursing Diagnosis
Module 5: Planning & Implementation
Module 6: Evaluation of Care
Module 7: Develop a Plan of Care (POC) for Farah

Track 2: Module 8: Beginning Concepts in GI Care

Track 1:

Unit IV – (2 weeks) Human Physiologic Needs I

Module I: Safety
Module 2: Hygiene
Module 3: Sleep & Comfort
Module 4: Sexuality
Module 5: Nutrition
Module 6: Diabetes Mellitus – Principles in Nutrition

Track 2: Module 7: Continuing Concepts in GI Care

Track 1:
Unit V – (2 weeks) Human Physiologic Needs II
Module 1: Fluid & Electrolytes
Module 2: Basic Cardiac Function & Fluid Dynamics
Module 3: Clinical orientation to Acute Care Settings
Module 4: Clinical – Care in an Acute Setting
Track 2: Module 5: Concepts in GU Care
Module 6: Continuing Concepts in GU Care

Track 1:
Unit VI – (2 weeks) Clients with Special Needs in Acute Care Settings I
Module 1: Skin Integrity & Wound Care
Module 2: Concepts in Caring for Surgical Clients (pre-op)
Module 3: Care of the Middle Adult
Module 4: Clinical Care – Wounds
Module 5: Dressings
Module 6: Concepts in Caring for the Surgical Client (post-op)
Track 2: Module 7: Concepts in Integumentary Care

Track 1:
Unit VII – (2 weeks) Clients with special needs in Acute Care Settings II
Module 1: Hazards of Immobility
Module 2: Review Pressure Ulcers
Module 3: Basics of Sensory Perception/Loss
Module 4: Clinical – Holistic Application of Concepts, Skills, & Knowledge
Track 2: Module 5: Concepts in Endocrine Care
*Please note – the lab time will require time outside of normal class time – approximately 2 extra hours per student per week.

COURSE OUTLINE – *CLINICAL PHASE*:
There are 2 hands-on, supervised clinical phases to this course. 1]. Care is provided in a long-term setting with elderly clients during weeks 5 - 8 of the semester, for 8 hours each week (4 hours on R & F). 2]. The second clinical experience will be in acute care settings – both a hospital setting and a sub-acute unit in a long term care setting – rotating learners every 3 weeks so that all learners receive comparable experience. This is also a R & F rotation of 4 hours each day for weeks 9-14. The clinical time will require that you research your client outside of regular class time – anticipate at least 2 hours every Wed. p.m. during the clinical weeks.

General Work Design Long Term Care (LTC) Clinical:

Week 1-	Orient to facility, documentation, and facility search, P&P, unit purpose/clientele, body mechanics & ROM, & transfers + mobility equipment Basic infection control. Basic hygiene.
Week 2 -	Vital signs, care of the environment, thorough hygiene, and therapeutic communication. Continue with above as from week. Begin medication administration.
Week 3-	PA + all of the above + team collaboration
Week 4 -	Complete care of 1 client + assist at least one other student with their cares.

- ***Students are responsible for all policies and information in the Student Handbooks of the PN Program and the UM.***

Course Calendar Fall 2005:

Lab focus – 4 weeks:

Weeks 1-4: Unit I (Aug. 29 – Sept. 23)

LTC Clinical – 3 weeks:

Week 5: Unit 2 (Sept. 26 – 30) (begin LTC clinical)

Week 6: Unit 3 (Oct. 3 – 7) (week 2 of LTC)

Weeks 7-8: Unit 4 (Oct. 10-21) (1 week of clinical as 20 & 21 off)

Acute Care Rotations Begin – 7 weeks (minus Thanksgiving holiday):

Weeks 9-10: Unit 5 (Oct. 24 – Nov. 4) (begin acute care)

Weeks 11-12:Unit 6 (Nov. 7-18) (2 weeks of acute)

****Learners rotate after week 3 - between LTC Sub-acute & Community Medical Center (CMC) - 3 weeks in each setting**

Weeks 13-14:Unit 7 (Nov. 21 – Dec. 9) (11/24 & 25 off clinical)

UNIT I: Foundational Skills & Concepts in Nursing I (4 weeks)

CENTRAL OBJECTIVES: This is a heavily skills laden unit comprised of 8 modules. The overall objective is to prepare the learner to be ready to purposefully and safely interact with clients by week 5 of the semester. Basic conceptual foundations that underlie the profession of nursing, and the University of Montana College of Technology Practical Nursing program, such as nursing philosophy, health, illness, wellness, human needs, professional practice issues, standards of care, and continuity of care will be explained as the learner discovers the meaning of nursing practice and its position in today's healthcare environment. The learner will demonstrate an understanding of concepts of coping & stress, grief processes, and spirituality. Further, the learner will express understanding of ethnicity and culture care competence. The pathophysiology of the musculoskeletal system and nursing care will be discovered. The developmental stage of the older adult will be a learning focus area. This unit will lay the foundation that allows the learner to advance from novice to intermediate nursing student by the semesters completion.

Week 1: Module 1: Nursing Practice & the Healthcare Delivery System (Chapts. 1 & 2 Potter/Perry)
Module 2: Ethics & Values in Nursing (Chapts. 21 & 7 Potter & Perry)
Skills: P, N, O, G, B, A, K, C, Q, U
Ahmedi: pgs. V-12

Week 2: Module 3: Community Based Nursing & Health & Wellness (Chapts. 3 & 6 P/P)
Module 4: Nursing Theory & Research (Chapts. 4 & 5 P/P)
Module 5: Spirituality, Loss, & Coping (Chapts. 28, 29, & 30 P/P)
Skills: D, I, M, G, E, C, J, H, Y
Ahmedi: pgs. 13-26

Week 3: Module 6: Cultural Care, Communication, & Developmental Theories (Chapts. 8,10, & 23 P/P)
Module 8: Musculoskeletal System (White pgs. 250-260)
Skills: F, G, Z, W, X, Q, L, T
Ahmedi: pgs. 27-41

Week 4: Module 6: Self Concept (Chapt. 26 P/P)
Module 7: The Older Adult (Chapts. 13 – P/P& White Chapt 20)
Module 8: Musculoskeletal con't. (White pgs. 261-272)
Skills: R, V, S, G
Ahmedi: pgs. 42-52

Skill List:

A. VS – pain assessment – SAO2 + documentation
B. Hand hygiene
C. Care of the environment – use of & bed making
D. Basics of infection control
E. Introduction to documentation
F. ROM/activity
G. Terminology/abbreviations
H. Body mechanics, transfers, devices, gates, & gait belts
I. Restraints
J. Bed positions & positioning
K. RACE, O2 safety, fire extinguishers
L. Bathing – bed, shower, tub, chair – hair, nails, oral, pericare

M. Basic communication
N. Personal & professional attributes in nursing
O. Confidentiality – HIPAA
P. History & culture of nursing
Q. I & O
R. Specimen collection
S. Examination positions
T. Assisting w/ elimination
U. Ht., wt., anthropometrics
V. Glucometer
W. Foleys
X. Ostomies & enemas
Y. Post-mortem care
Z. Application of heat & cold

Crucial Components to Any Client Centered Skill

1. **Check** appropriate order (take necessary supplies).

2. **Knock** --- Identify self.

3. **Identify client.**

4. **Wash** hands.

5. **Explain** procedure --- secure permission.

6. **Gather** appropriate supplies.

7. **Assess** what part – if any – client can perform independently or participate in (again, explain clearly).

8. **Assure** for safety and comfort.

9. **Assure** for privacy (door, curtain, cover, etc.)

10. **After** procedure completed all away, clean, measured, proper disposal.

11. **Assure** for safety and comfort.

12. **Call light!!**

13. **Wash hands.**

14. **Document.**

UNIT II: (1 week) Applying Foundational Skills & Knowledge in Nursing I – The Beginning Clinical Experience

CENTRAL OBJECTIVES: The overall objectives of this unit are; 1]. Mastery of the psychomotor skills learned in Unit I 2]. Application of those skills 3]. Understanding the legal concepts of nursing and documentation 4]. Demonstrating understanding concepts of nursing care that ensure client safety and comfort by preventing/controlling the spread of microorganisms 5]. Organizing client care in a clinical setting based on learned principles and skills 6]. Demonstrating understanding of the nursing process and 7

Week 5: Module 1: Legal Considerations in Nursing (Chapt. 22 P/P)
Module 2: Documentation (Chapt. 25 P/P)
Module 3: Infection Control (Chapt. 33 P/P)
Skills: review A-Z…seeking mastery ☺
Clinical Week 1: R = orientation….*Module 4*
Clinical Week 1: F = care of the environment….*Module 5*
HIPAA in a LTC care setting….*Module 6*
Activity & mobility in a care setting….*Module 7*
Compare Farah's care to a learned concepts (team project)….*Module 8*

Ahmedi: (learned concept – application team project☺) pgs. 53-69

Unit III: (1 week) Applying Foundational Skills, Knowledge, & Concepts in Nursing II – Long Term Care Clinical Experience

Central Objectives: The overall objective is to apply care competence of foundational skills and knowledge in a care setting. The learner will construct a POC based on the NP. Employing a nursing assessment the learner will demonstrate beginning understanding of the PA process. The learner will explore the GI system and demonstrate a beginning understanding of pathologic conditions, and their treatment.

Week 6: Module 1: VS & Physical Assessment (Chapt. 31 & 32 P/P & Appen. A)
Module 2: Critical Thinking (Chapt. 14 P/P)
Module 3: Nursing Assessment (Chapt. 15 P/P)
Module 4: Nursing Diagnosis (Chapt. 16 P/P)
Module 5: Planning & Implementation (Chapts. 17 & 18P/P)
Module 7: Begin GI (White pgs. 177-188)

Ahmedi: re-read pgs. 42-69 – develop a POC
Skills: PA, VS, POC/CP, NP
Clinical: complete client care for one client applying previous knowledge & skills – begin PA and develop a POC for your client and the case study (Mrs. Brown)

APPENDIX A

PHYSICAL ASSESSMENT GUIDE -- SYSTEMS APPROACH

I. SKIN
The skin assessment is continuous as one does the total body assessment.

A. Temperature/moisture
1. Warm, dry, cool, diaphoretic, moist

B. Turgor
1. State of hydration (dehydration, over hydration, hydration)
2. Elastic, tenting

C. Color
1. Pink
2. Cyanotic
3. Pale
4. Mottled
5. Ruddy

D. Texture

E. Hair
1. Distribution, loss, balding areas

F. Nail Beds
1. Pink, cyanotic pale, smooth or grooved
2. Mottled (with white blotches)
3. Clubbing

G. Circumoral
1. Pallor, cyanosis

H. Capillary refill
1. Nail beds blanch and refill (return to normal pink color in number of seconds)

I. Ears
1. Redness, discharge, use of aids

J. Abnormalities
1. Rashes, moles, wheals, leukoplakia
2. Striae, silver; old skin stretching (stretch marks); purplish-pink fine network (Cushing=s syndrome)
3. Angiomas, spider from waist to head, when pressed will blanch, usually found on chest (liver disease or pregnancy)
4. Scars: surgical or accidental, location
5. Redness to ulcerations at pressure points

6. Loss of hair on extremities (seen especially in men); poor circulation
7. Brown pigmentation changes (extremities) with poor circulation
8. Bruising, petechiae

K. Intravenous therapy
1. Sites, redness, swelling, infiltration, pain

L. Ostomy sites
1. Excoriation, appliance

M. Incisions/wounds; appearance, odor
1. Dressing/drains; intact, dry

N. Turn patient to assess posterior areas

II. NEUROLOGICAL

A. Mental status/level of consciousness
1. Alert, awake, lethargic, stuporous, coma, response to pain appropriate
2. Oriented to person, place, time
3. Responds to commands, appropriate conversation, speech clear, aphasia
4. Emotional status: calm, cooperative, anxious

B. Pupils
1. Equal, react to light, fixed, dilated, constricted

2. Estimated pupil size in millimeters using pupil chart

1 2 3 4 5 6 7 8

C. Grasps
1. Equal, strong, weak, uni or bilateral

D. Motor Control
1. Fine; touch first finger to thumb
2. Gross; push self to sitting position from lying position or reaching for objects

E. Facial symmetry
1. Smile
2. Eyebrow lift, forehead wrinkle
3. Sticks out tongue

F. Coordination: steady, unsteady ambulation

G. Sensation: tingling, numbness present

III. CARDIOVASCULAR

A. Rate, beats per minute

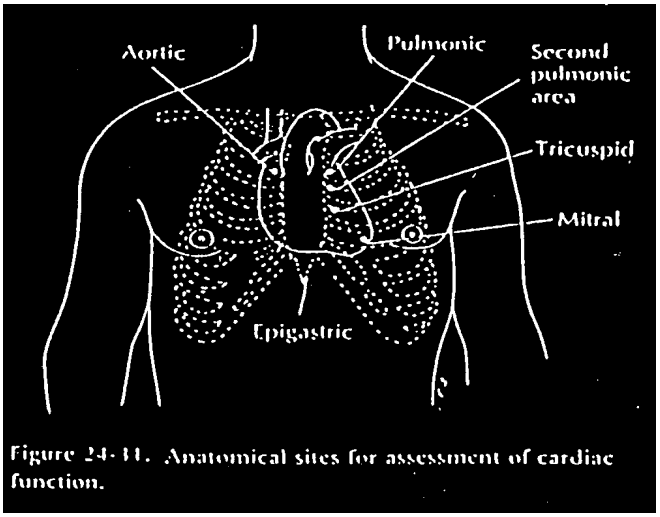
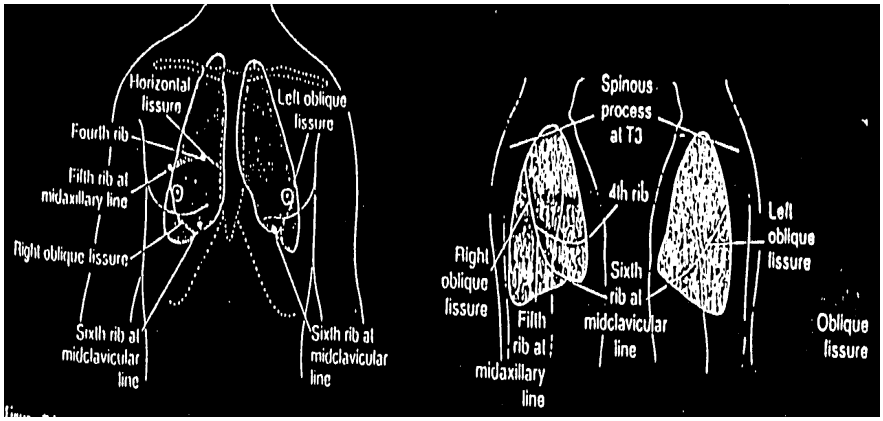


Figure 24-11. Anatomical sites for assessment of cardiac function.

B. Always apical pulse
   1. Midclavicular line left, fifth intercostal space

C. Rhythm; regular, irregular

D. Edema
   1. Nonpitting ι
   2. Pitting
      a. 0-1/4 inch; mild -
      b. 1/4 - 2 inch; moderate +2
      c. ½ - 1 inch; severe +3



E. Pulses: absent ι, weak +1, Normal +2, bounding +3, and equality when applicable
   1. Pedal
   2. Radial
   3. Femoral
   4. Brachial
   5. Popliteal
   6. Carotid

IV. RESPIRATORY

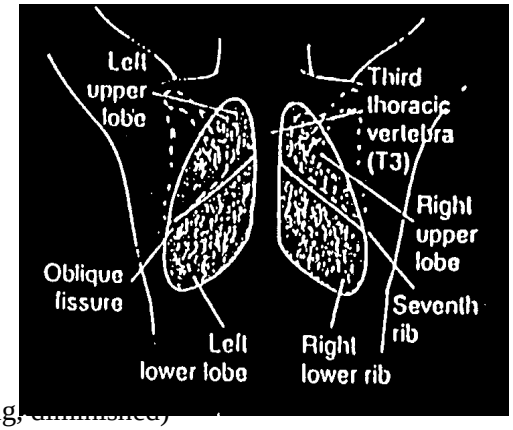
A. Nose, drainage, redness, deformity

B. Terms
   1. Eupneic; normal (quiet, effortless)
   2. Dyspneic; difficult (short of breath)
   3. Orthopneic; sitting to breathe – or stand to breathe
   4. Tachypneic; fast (more than 20 per minute for adults)
   5. Bradypneic; slow (less than 12 per minute for adults)

C. Excursion
   1. Full; full expansion on both sides`
   2. Unequal expansion

D. Depth; deep shallow, normal

E. Rhythm; regular, irregular



F. Breath sounds
   1 . Hear inspiration and expiration (clear, bubbling, crackling, wheezing, diminished)
   2. Systematic assessment
      a. Anterior
      b. Posterior
      c. Lateral

. Secretions: color, amount, thickness, cough

V. GASTROINTESTINAL

A. Mouth; mucous membranes, teeth, tongue, roof, check under tongue

B. Abdomen
   1. Soft, firm, obtunded, rigid, flat, scaphoid (sunken), distended
   2. Masses (herniations, tumors)
   3. Peristaltic waves
   4. Scars; location
   5. ***Light*** palpation ***only*** for bladder distention; skin depression of no more than one-half inch, normally soft and non-tender

C. Bowel sounds
   1. May take up to five minutes before a bowel sound is heard, especially in immediate post-op intestinal surgery. Listen to right lower quadrant.
   2. Rate of bowel sounds, usually 5 - 35 bowel sounds are heard per minute (more than that hyperactive; less than that hypoactive).

D. NG tubes, ostomy, wound drains: drainage color, amount consistency, patency.

VI. MUSCULO-SKELETAL

A. Extremities
   1. Any deformities, discoloration, hair loss, ulcerations, varicose veins, loss of toes, thickened toenails, temperature

B. Joints
   1. Range of motion of joint, full or limited ROM
   2. Deformities; arthritis, stiffness (morning) pain, inflammation, swelling, and/or accumulation of fluid around joint

C. Calf tenderness
   1. Homan=s sign, pain experienced in calf when foot is dorsiflexed. Positive thrombophlebitis
   2. Signs of inflammation (reddened calf, red streak along vein); increased warmth of affected calf

D. Tone
   1. Flaccid
   2. Spastic
   3. Normal

E. Posture/Gait

F. Use of assistive devices, prothesis

VII. GENITOURINARY

A. Breast (optional or prn)
   1. Size, symmetry
   2. Contour, shape

3. Nipple, areola
4. Retraction
5. Palpation for lungs

B. Normal genitalia

C. Menses, if applicable

D. Bladder
1. Palpate for distention, fullness, landmarks, percussion
2. Catheters: assess drainage, patency
3. Voiding: color, frequency
4. Amount 30 cc/hr at least

E. Rectum
1. Excoriation
2. Stools: color and consistency

Case Study – Mrs. Brown

Mrs. Brown is a 70-year old white female who was transferred to a nursing home for rehabilitation. Her nursing history states that she weighs 200 pounds and had a stroke two weeks ago. Mrs. Brown has left-sided weakness. Mrs. Brown is a widow and mother of adult children, all living out of state ☹.

At morning report you receive the following nursing Orders:

Complete bed bath
Denture care
Bedpan prn
Turn q two hours and reposition
Observe skin for signs of breakdown
Up in chair t.i.d. (dangle before transferring)

Answer the following scenario questions and be prepared to discuss responses in class:

1. Prioritize the order of care as you will deliver it and <u>state your rational for that order</u>.

2. What objective assessment data would you want to observe during the bath?

3. During Mrs. Brown's bath you observe an open draining wound on her sacrum. What universal precautions are appropriate based on that observation? Why?

4. Mrs. Brown falls to the left as you are transferring her to a chair. What safety precautions should you have anticipated when preparing to transfer your client to a chair?

Document all pertinent observations and nursing care on appropriate form. (**next page.**)

TIME	Problem No. (POC)	**NURSES PROGRESS REPORT**

Patient or Significant Other Teaching

ADDRESSOGRAPH 24 hr. Summary

MISCELLANEOUS FLOW SHEET		Addressograph		
ASSESSMENT		**7-3**	**3-11**	**10-8**
Psycho	i.e. attitude, anxiety			
Social	coping, sociability			
Neuro	orientation			
Pulmonary	Resp. pattern			
	Cyanosis/Ruddy			
	Breath Sounds			
	Cough, quality			
	Sputum			
	Supplemental support			
	IPPB			
Cardiovascular	Pulses: radial R/L			
	pedal R/L			
	Rhythm (reg., irreg.)			
	Skin color, temp.			
	Skin integrity/Turgor			
	Edema			
G.I.	Abdomen			
	Bowel sounds			
	NG			
G.U.	Urine – color/character			
	Foley			
	Menses			

	7-3	**3-11**	**10-8**		**7-3**	**3-11**	**10-8**
AM/HS Care				Tube Feeding Bag △			
Bed/Bath (type)							
Oral/Shave							
Peri Care				O_2 (Type – Liters)			
Foley/Catheter △							
Support Stockings On				Dressing △			
- Off 30”/shift				Incision Care			
				Staples Removes			
Cough & Deep Breath							
				Specimen Sent			
Turn & Reposition							
ROM:				Special Skin Care			
A = Active P = Passive				Special Mattress			
R = Right L = Left				Special Bed			
U = Upper Extremity							
L = Lower Extremity				PROCEDURES DONE:			
				X-ray			
				CT Scan			
Dangle/Chair				ECG			
				EEG			
Ambulation:				Echo			
Independent							
Walker				EXTRA SAFETY MEASURES			
Crutches				Call light within reach			
With Assistance				Bed position			
Phs. Therapy				Ambu alarm			
CT Speech							
Uninterrupt Sleep							
				SIGNATURE			

POC – Nursing Care Plan

Assessment	Diagnosis	Plan	Implementation	Evaluation

Formats for Recording

PIE: Acronym for Problem, Intervention, and Evaluation. Problem-oriented system in which progress notes are written based on a list of identified problems and detailed data may be entered by any member of the health care team. For example:

P: Problem – Client states, "I am dreading this surgery because last time I had a terrible reaction to the anesthesia and had such terrible pain when they made me get out of bed." Noted muscle tension and loud, agitated voice.

I: Intervention – Notified anesthesiologist, Dr. Moore of experience. Discussed alternatives for anesthesia and pain-control options. Stressed importance of activity for circulation and healing. Encouraged to keep nurses informed of pain level and need for medication and told client that pain usually is present, but manageable.

E: Evaluation – Client stated she was "very relieved." Stated she would tell the nurses about pain.

SOAP: Acronym for Subjective data, Objective data, Assessment or Analysis, and Plan. Usually based on a numbered list of problems or nursing diagnoses. For example:

S: Subjective data – The client's statements regarding the problem. (e.g. Client states, "I am dreading this surgery because last time I had a terrible reaction to the anesthesia and had such terrible pain when they made me get out of bed.")

O: Objective data – Observations that support or are related to subjective data. (e.g. Noted muscle tension and loud, agitated voice.)

A: Assessment/Analysis – Conclusions reached based on data. Intense fear related to pain/anesthesia.

P: Plan – The plan for dealing with the situation. (e.g. Notified anesthesiologist, Dr. Moore, of experience. Discussed alternatives for anesthesia and pain-control options. Stressed importance of activity for circulation and healing. Encouraged to keep nurses informed of pain level and need for medication and told client that pain usually is present, but manageable.)

Focus Charting: A way to organize progress notes to make them more clear and organized. For example:

D: Data – Client states, "I am dreading this surgery because last time I had a terrible reaction to the anesthesia and had such terrible pain when they made me get out of bed." Noted muscle tension and loud, agitated voice.

A: Action – Notified anesthesiologist, Dr. Moore, of experience. Discussed alternatives for anesthesia and pain-control options. Stressed importance of activity for circulation and healing. Encouraged to keep nurses informed of pain level and need for medication and told client that pain usually is present, but manageable.

R: Response – Client stated she was "very relieved." Stated she would tell the nurses about pain.

Narrative Note: Describes client data in a narrative paragraph. For example:

> Client states, "I am dreading this surgery because last time I had a terrible reaction to the anesthesia and had such terrible pain when they made me get out of bed." Noted muscle tension and loud, agitated voice. Notified anesthesiologist, Dr. Moore, of experience. Discussed alternatives for anesthesia and pain-control options. Stressed importance of activity for circulation and healing. Encouraged to keep nurses informed of pain level and need for medication and told client that pain usually is present, but manageable.

Unit IV (2 weeks): Basic Human Physiologic Needs I – Meeting Needs in a LTC Setting

Central Objectives: In this two week unit the learner will discover the concepts of safety and comfort. They will explore the principles and skills of hygiene, need for and assisting with sleep, sexuality, nutrition. They will express an understanding of DM and principles of nutrition and drug management. The learner will continue to develop their understanding of the diseases, injury, and treatment of GI disorders.

Track 1:

Week 7: Module 1 – Safety (Chapt. 37 P/P)
Module 2 – Hygiene (Chapt. 38 – P/P)
Module 3 – Sleep & Comfort (Chapts. 41 & 42 – P/P)
Module 4 – Sexuality (Chapt. 27 P/P)
Module 5 – Nutrition (Chapt. 43 P/P)
Skills: PA, safety/devices, positioning/comfort, hygiene, NGT, suctioning, NPO, diets/assisting
w/ nutrition, feeding pumps, rectal tubes, enemas
Ahmadi: 70-87

Track 2:

Module 6 – GI continued (pgs. 186-201 White – to hemorrhoids☺)
Clinical (only 1 week in this unit – as 10/20 & 10/21 are MEA conference dates)

Track 1:

Week 8: Module 7 – GI (Chapt. 45 P/P)
Skills: ostomies, enemas, review enteral feeding, TPN
Ahmadi: 88-113

Track 2:
Module 8 – GI continued (pgs. 201-216 White)

Unit V (2 weeks): Basic Human Physiologic Needs II - Transitioning from LTC to Acute Care Settings

Central Objectives: The learner will continue to apply learned theory as well as demonstrate an increased level of skill competence as he/she acquires integrated knowledge and skills. The client care setting change demands an increased understanding of the complexity of care modalities and scenarios encountered as the learner transitions from providing care in a LTC setting to acute care. Building on previous learning the student will demonstrate understanding of basic concepts and principles of fluid and electrolyte balance, diseases of the GU system, and will demonstrate beginning competence with skills involving the GU system.

Track 1:

Week 9: Module 1 – Fluid & Electrolytes (pgs. 1135-1160 P/P)
Module 2 – Cardiac Output & CHF (pgs. 1069 & 1078 [para 5-7] P/P)
Skills: IVs, I/O, (suctions/drains), foleys, all previous skills, lab tests, urostomy
Ahmadi: 114-124

Track 2:

Module 3 – GU System (Chapt. 8 – pgs. 218-227 White)
Module 4 – Orient to acute care
Module 5 – Complete client care + meds. + environment + IV + documentation

Track 2:

Week 10: Module 6 – Continue GU (Chapt. 8 pgs. 228-246 White)
Ahmadi: pgs. 125-149
Module 7 – Clinical – apply knowledge & skills to date – seek new learning
Skills: IV increased proficiency

UNIT VI (2 weeks): Clients with Special Needs in Acute Care Settings I

Central Objectives: After completion of this unit the learner will demonstrate beginning proficiency with common medical surgical skills in a clinical setting. They will be able to demonstrate understanding of the basic concepts and principles of skin integrity and wound care and will have a basic understanding of the special needs of surgical clients.

Track 1:

Week 11: Module 1 – Skin Integrity & Wound Care (Chapt. 47 P/P)
Module 2 – Surgical Clients (Chapt. 49 P/P)
Module 3 – Middle Adult (Chapt. 12 - pgs. 226-232 P/P)
Skills: wound vacs., IV pumps, gastric suction, dressings, traction
Ahmadi: re-read pgs. 46-52, 53-56, & 150-165

Track 2:

Module 4 – Integumentary System (Chapt. 15 pgs. 453-473)
Module 5 – Clinical – complete care of a surgical client w/ IV, wound, or assist other

Track 1:

Week 12: Module 6 – Dressings (Chapt. 47 – pgs. 1528-1561 P/P)
Module 7 – Post-op Care (Chapt 49 – pgs. 1631-1642 P/P)
Skills: PCAs + previous skills
Ahmadi: pgs. 166-193

Track 2:

Module 8 – Integumentary continued (Chpat. 15 – pgs. 474-489 – White)

Unit VII (2 weeks): Clients with Special Needs in Acute Care Settings II

Central Objectives: The overall objective is to facilitate the learner's integration of skill and knowledge at a competent novice level of all body systems, treatments, diseases, and equipment taught in this semester and inclusive of concepts from their core program. The learner will demonstrate basic mastery of previously learned skills in an acute care setting and will be able to provide complete care within the scope of practice of a PN for all personal care, care of the environment, care of GU, skin, & GI devices and assist with elimination, provide competent wound care, administer IV therapy within the scope of practice, and safely pass medications. The learner will express understanding of the concepts and principles of the hazards of immobility. The learner will demonstrate an intermediate knowledge of care modalities presented in their coursework of this semester through a holistic approach. These capstone two weeks offers the learner the opportunity to integrate and assimilate previous learning in preparation for matriculation into their final PN semester. The learner will demonstrate beginning comprehension of the diseases of the endocrine system and their affects on well-being.

Track 1:

Week 13: Module 1 – Immobility (Chapt. 46 P/P)
Module 2 – Review Pressure Ulcers (Chpat 47 P/P)
Module 3 - Sensation (Chapt 48 – pgs. 1567-68 P/P

Skills: positioning review, CDB, spirometry, review DM
Ahmadi: 194-227

Track 2:

Module 4 – Endocrine System (Chapt. 12 – pgs. 350-70 – to DM – White)

Track 1:

Week 14: Module 1 – Review Immobility (Chapt. 46 P/P)

Module 2 – Review Pressure Ulcers (Chapt. 47 P/P)
Ahmadi: pgs. 228-249

Track 2:

Module 4 – Endocrine continued (Chapt. 12 – pgs. 371-87 – White)
Module 5 – Completion of clinical experience – holistic cares of client + case study
(Thursday only – Friday = clinical evaluations & case studies)

UNIT V: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS

CENTRAL OBJECTIVE: Describe and demonstrate basic nursing measures that assist in meeting the nutritional and elimination needs of clients at various developmental levels, using the nursing process as a problem-solving tool.

Student Objectives:	Learning Experiences:
A. EXAMINE:	
1. The six categories of nutrients and explain why each is necessary for nutrition.	**80% on unit test ☺**
2. The importance of a balance between energy intake and output.	
3. The end products of carbohydrate, protein, and lipid metabolism.	
4. The significance of saturated, unsaturated, and polyunsaturated lipids in nutrition.	
5. The basic food groups (including the food pyramid) and their value in planning meals for good nutrition.	**Read: Chapter 31, Potter and Perry, Basic Nursing Essentials for Practice, (2003), Mosby Read: Chapter 34, Potter and Perry, Basic Nursing Essentials for Practice, (2003), Mosby.**
6. Recommended daily allowances (RDAs).	**Look up definitions for all key words at the end of the chapter, using your medical dictionary.**
7. USDA dietary guidelines and explain their importance in health promotion.	
8. The major areas of nutritional assessment.	**Videos as selected by instructor.**
9. Three major nutritional problems and describe clients at risk for these problems.	**Campus Lab: Demonstrate:**
10. The goals of total parenteral nutrition.	**1. Measures to collect urine specimens**
11. The procedure for initiating and maintaining total parental nutrition.	**2. Determine specific gravity of urine**
	3. Use of bedpan, urinal, and commode
	4. Insertion of urinary indwelling catheters.
B. DESCRIBE AND DISCUSS:	
1. The function of each organ in the urinary system.	**Videos as selected by instructor.**
	Practicum #2 as found in syllabus.

2. The process of urination. **3. Factors that commonly influence urination.** **4. Common alterations in urination.** **5. Physical assessment techniques used to assess urine elimination.** **6. Characteristics of normal and abnormal urine.** **7. Nursing implications of common diagnostic tests of the urinary system.** **8. Nursing measures to assist the client with urinary elimination.** **9. Nursing measures to control incontinence.** **10. Nursing measures to reduce urinary tract infections.** **11. Basic principles in urinary catheter selection.** **12. The procedure to apply or insert an external or indwelling catheter.**	**Look up definitions for all key words at the end of the chapter, using your medical dictionary.** **Read: Chapter 32, Potter and Perry, Basic Nursing Essentials for Practice, (2003), Mosby.** **Campus Lab: Demonstrate:** **1. Measures to promote regular emptying of feces from colon, e.g.** **- suppository** **- rectal catheter** **- enema** **Videos as selected by instructor** **Look up definitions for all key words at the end of the chapter, using your medical dictionary.** **Read: Critical Thinking Activity.#2 and #3 on page 821 of Potter and Perry**
C. EXAMINE: **1. The role of gastrointestinal organs in digestion and elimination.** **2. Four functions of the large intestine** **3. The physiology of normal defecation.** **4. Psychological and physiological factors that influence the elimination process.** **5. Common physiological alterations in elimination.** **6. Methods to assess a client=s elimination pattern.** **7. Method of performing a guaiac test**	

	for occult blood.	
8.	**Nursing implications for common diagnostic examinations of the gastrointestinal tract.**	
9.	**Nursing diagnoses related to alterations in elimination.**	
10.	**Nursing measures aimed at promoting normal elimination and defecation.**	
11.	**Technique for administering an enema.**	

Date _____

TIME	Problem No.	**NURSES PROGRESS REPORT**

Patient or Significant Other Teaching

ADDRESSOGRAPH 24E Summary

MISCELLANEOUS FLOW SHEET		Addressograph		
ASSESSMENT		**7-3**	**3-11**	**10-8**
Psycho	i.e. attitude, anxiety			
Social	coping, sociability			
Neuro	orientation			
Pulmonary	Resp. pattern			
	Cyanosis/Ruddy			
	Breath Sounds			
	Cough, quality			
	Sputum			
	Supplemental support			
	IPPB			
Cardiovascular	Pulses: radial R/L			
	pedal R/L			
	Rhythm (reg., irreg.)			
	Skin color, temp.			
	Skin integrity/Turgor			
	Edema			
G.I.	Abdomen			
	Bowel sounds			
	NG			
G.U.	Urine – color/character			
	Foley			
	Menses			

	7-3	**3-11**	**10-8**		**7-3**	**3-11**	**10-8**
AM/HS Care				Tube Feeding Bag △			
Bed/Bath (type)							
Oral/Shave							
Peri Care				O_2 (Type – Liters)			
Foley/Catheter △							
Support Stockings On				Dressing △			
- Off 30”/shift				Incision Care			
				Staples Removes			
Cough & Deep Breath							
				Specimen Sent			
Turn & Reposition							
ROM:				Special Skin Care			
A = Active P = Passive				Special Mattress			
R = Right L = Left				Special Bed			
U = Upper Extremity							
L = Lower Extremity				PROCEDURES DONE:			
				X-ray			
				CT Scan			
Dangle/Chair				ECG			
				EEG			
Ambulation:				Echo			
Independent							
Walker				EXTRA SAFETY MEASURES			
Crutches				Call light within reach			
With Assistance				Bed position			
Phs. Therapy				Ambu alarm			
CT Speech							
Uninterrupt Sleep							
				SIGNATURE			

Date _____

TIME	Problem No.	**NURSES PROGRESS REPORT**

Patient or Significant Other Teaching

ADDRESSOGRAPH 24E Summary

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	Supplemental support			
	IPPB			
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	pedal R/L			
	Rhythm (reg., irreg.)			
	Skin color, temp.			
	Skin integrity/Turgor			
	Edema			
G.I.	Abdomen			
	Bowel sounds			
	NG			
G.U.	Urine – color/character			
	Foley			
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	7-3	**3-11**	**10-8**		**7-3**	**3-11**	**10-8**
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Bed/Bath (type)							
Oral/Shave							
Peri Care				O_2 (Type – Liters)			
Foley/Catheter △							
Support Stockings On				Dressing △			
- Off 30”/shift				Incision Care			
				Staples Removes			
Cough & Deep Breath							
				Specimen Sent			
Turn & Reposition							
ROM:				Special Skin Care			
A = Active P = Passive				Special Mattress			
R = Right L = Left				Special Bed			
U = Upper Extremity							
L = Lower Extremity				PROCEDURES DONE:			
				X-ray			
				CT Scan			
Dangle/Chair				ECG			
				EEG			
Ambulation:				Echo			
Independent							
Walker				EXTRA SAFETY MEASURES			
Crutches				Call light within reach			
With Assistance				Bed position			
Phs. Therapy				Ambu alarm			
CT Speech							
Uninterrupt Sleep							
				SIGNATURE			

NURSING FUNDAMENTALS CLINICAL PRACTICUM #2

Student Objectives:

To perform the listed nursing skills and demonstrate basic problem solving ability.

Universal Precautions

Foley catheter

Sterile specimen collection

Medication preparation and administration

Sterile gloving

Care of client in isolation

Documentation

Reading Resources:

Read: Potter and Perry. Basic Nursing Essentials for Practice, (2003) Mosby.

Gloria D. Pickar. Dosage Calculations: A ratio/Proportion Approach. (1999) Delmar.

Audio/visual aides as appropriate

Equipment required for Practicum Exam:

One surgical mask

One pair sterile gloves

One pair unsterile gloves

Foley catheter kit

Isolation gown

Medication preparation equipment as appropriate

CASE HISTORY #2

Mrs. Camille Jones is a 28-year-old school teacher who is being admitted for possible abdominal surgery for appendicitis. Her past medical history states she has had Diabetes Mellitus Type II for five years.

Upon receiving the client on the unit, you and the R.N. you are assigned with, obtain the following nursing assessment:

Subjective: AI haven=t been able to keep anything down for four days,@ and complaining of thirst. C/- LRQ abdominal pain.

Vital Signs: B/P = 110/70; P = 110; R = 28; T = 37.3C (99.2F)

Skin: Warm, excessively dry, with poor turgor. Face is flushed.

Neuro: Lethargic but oriented to person, place, and time. Able to move all extremities but is weak.

Cardiovascular: Pulse rate is regular. Radial and pedal pulses are equal bilaterally. No peripheral edema.

Respiratory: Respirations are deep but breath sounds are clear to the bases. No cough.

Gastrointestinal: Abdomen is flat and soft with bowel sounds present.

Genitourinary: Urine clear, dark yellow.

Answer all scenario questions in writing and turn in responses with videotape.

List abnormal signs and symptoms from above data. Turn in.

Which of the following is the **first priority** nursing diagnosis? ***Why?***

1. Nutrition, altered: less than body requirements
2. Family processes, altered
3. Fluid volume deficit
4. Anxiety, acute

What assessment techniques would you use in assessing the abdomen?

The physician has written the following orders:

NPO

Intake and output

Routine vital signs

Glucosan blood check every four hours

Sliding scale regular Humulin Insulin SQ as follows:

Blood glucose less than 80 = call physician

80 - 180 = 0 units

181 - 240 = 4 units

241 - 280 = 8 units

281 - 320 = 10 units

Blood glucose greater than 320 = call physician

Ambulatory ad lib

Tylenol 600 mgm, rectal suppository prn for headache

Foley catheter to down drain

Send urine specimen for culture and sensitivity

If you insert a Foley catheter and no urine returns in the tubing, what would you do for each of the following possible causes?

The catheter is in the vagina.

There is no urine in the bladder.

Insert the Foley catheter and obtain the urine specimen. ***(on video-please use zoom)***

Mrs. Jones turns on her call light and you find that she has vomited in the emesis basin.
She is also complaining of a severe headache.

Empty the emesis basin. ***(on video)***

Prepare, administer, and document the medication for headache. ***(on video)***

The RN has checked Mrs. Jones' blood sugar. She instructs you to give the appropriate amount of insulin.

Obtain the glucosan results from your instructor, "the RN," and prepare, administer, and document the medication. ***(on video-please use zoom for closeups)***

Mrs. Jones turns on her light and states she is "feeling funny." You suspect she is having an insulin reaction.

What would you do? **State rationale for interventions.**

Mrs. Jones is complaining of nausea. You pass her physician in the hall and he states: "I have ordered a one time injection for her nausea, it's on her chart."

Obtain from the instructor the new physician order. Prepare, administer, and document the medication.
(on video-please use zoom for closeups)

Mrs. Jones is to have an appendectomy. After surgery, Mrs. Jones returns to her room with the following physician post-operative orders:

Ambulate q.i.d. and prn
Sterile dressing change daily
Cleanse wound
TDB (turn and deep breathe) q two hours
Record intake and output
Ted hose

Two days post-operatively, you enter Mrs. Jone's room and observe that she has a runny nose and a slight fever. You notice that she also has small pustules on her neck and underarms. When you ask her about allergies to tape, she states that she has never been allergic before. On further questioning, she relates that two weeks ago a student had come to school with chicken pox and that to her knowledge she had not had chicken pox as a child.

What specific type of isolation is required to prevent transmission of highly contagious or virulent infections spread by air or contact?

List the equipment required to care for a patient in this category of isolation.
On the second post-operative day, Mrs. Jones has for breakfast:

one glass of orange juice
scrambled eggs with bacon
toast
one cup coffee

For lunch she eats:
one bowel of soup
one carton of milk
potatoes
meat loaf
jello
two glasses of water

She was assisted to the toilet two times:
voided 350 cc
voided 100 cc
one soft brown stool
Collect your equipment and deliver the following assigned nursing care:

1. Demonstrate the correct attire to enter an isolation room.
2. Demonstrate the disposal of soiled linen.

3. Remove and dispose of protective clothing.
4. Document your care and observations on the appropriate forms (attached).

UNIT VI CRITICAL THINKING AND THE NURSING PROCESS

CENTRAL OBJECTIVE: Describe and explain components of the nursing process.

Student Objectives:	**Learning Experiences:**
A. EXAMINE: 1. The components of a critical thinking model for nursing judgment. 2. Critical thinking skills used in nursing practice. 3. The relationship between clinical experience and critical thinking. 4. How professional standards influence a nurse=s clinical decisions. 5. The relationship of the nursing process to critical thinking. 6. Assessment as the first component of the nursing process. a. Purpose of initial and ongoing nursing assessments. b. Skills necessary to conduct a basic nursing assessment. 1. Nursing knowledge 2. Communication, 3. Psychomotor skills 4. Techniques of physical assessment c. Differentiate between objective and subjective data. d. Describe the purpose of nursing observation, interview, physical assessment, and the nursing history. e. Differentiate between comprehensive, problem-oriented, and focused assessments. f. Purpose and techniques for validation of assessment data. 7. The components of a nursing diagnosis: a. Differentiate between medical and nursing diagnosis. b. Differentiate between nursing diagnosis and collaborative, problem. c. NANDA approved categories and components of categories. d. Criteria and format for a nursing diagnosis. e. Differentiate between actual, potential, and possible diagnoses f. How defining characteristics and the etiological process individualizes a nursing diagnosis.	**Read:** Chapter 5, Potter and Perry, Basic Nursing Essentials for Practice, (2003), Mosby. Look up definitions for all key words at the end of chapters 4, 5, 6, 7, 8, and 9, using your medical dictionary. **Read:** Chapter 6, Potter and Perry, Basic Nursing Essentials for Practice, (2003), Mosby. **Complete:** Critical Thinking Activity # 4 and #5 on page 98 of Potter and Perry and turn in to instructor when requested. **Complete:** A Nursing Care Plan assigned by instructor. Turn in when instructor requests. (This will be a part of the unit test) Unit test – receive an 80%

g. Methods to prioritize a list of nursing diagnoses. 8. Purpose and benefits of planning: a. Describe how client goals and nursing orders are derived from nursing diagnoses. b. Differentiate between a goal and an expected outcome. c. The three types of interventions, i.e. dependent, interdependent and independent. d. Purpose of critical pathways. e. Similarities and differences between nursing care plans and critical pathways. f. The seven guidelines of a written outcome statement. 9. Implementation and documentation as components of the nursing process. a. The five implementation methods used by nurses. b. Describe components of a correctly stated intervention. c. Differences between standing orders and protocols. 10. Evaluation: Purpose and relation to other steps in the nursing process. a. Describe use of client responses to the plan of care to modify the plan as needed. b. Value self-evaluation as a critical element in developing the ability to deliver quality nursing care. c. Describe when nursing care plans are discontinued, revised or modified based on evaluation results. d. The relationship between expected outcomes and goals of care and evaluation of care.	

UNIT VII: IMMOBILITY

CENTRAL OBJECTIVE: Immobility occurs when a client is unable to move/change positions independently. Each body system is at risk for impairments when immobilized. The student will learn ways to minimize or alleviate the hazards of immobility.

Student Objectives:	**Learning Experiences:**
A. Examine: 1. Define key terms – immobility. 2. Benefits vs. hazards of bed rest. 3. Metabolic changes - immobility. 4. Musculoskeletal changes – immobility. 5. Pressure ulcers and stages. 6. Psycosocial and developmental effects of immobilization. 7. Phases of wound healing. 8. Wound complications. 9. Factors that impair or provide wound healing. **B. Practice:** 1. Positioning. 2. Braden scale assessment. 3. Wound cultures. 4. Assessing/describing wounds. 5. Apply wet-dry dressing.	1. Read Chapter 33, Potter and Perry, Basic Nursing Essentials for Practice, (2003) Mosby. 2. Look up definitions for all key words at the end of the chapter. 3. Read Chapter 34, Potter and Perry, Basic Nursing Essentials for Practice, (2003) Mosby. 4. Videos and research as assigned in class. Read Critical Thinking #1 and 2, pg 840. And # 1, 2, and 3 pg. 883. Write response and rationale. 5. 80% on unit test

UNIT VIII: DEATH, DYING, LOSS AND GRIEF

CENTRAL OBJECTIVE: Discuss nursing care of clients and families throughout the dying process.

Student Objectives:	**Learning Experiences:**
A. DESCRIBE/DISCUSS:	**Read:** Chapters 17 and 22 Potter and Perry, Basic Nursing Essentials for Practice, (2003) Mosby. Look up definitions for all key words at the end of the chapter, using your medical dictionary. Videos as selected by instructor. Classroom assignments as per instructor. Read Ch. 21, Potter and Perry, Basic Nursing Essentials for Practice, (2003) Mosby. 500 wd. Paper on the grieving process (this is the unit 8 'test')

GUIDELINES FOR CAMPUS CLINICAL/PRACTICUM

PURPOSE: The student will demonstrate competence in critical skills in a simulated setting prior to clinical performance of the skill. The scenario situations include basic decision-making questions in addition to the psychomotor skills to be performed. These simulations intend to provide a Asafe@ and Aless stressful@ environment to the student prior to clinical performance at an agency.

1. There are two simulations to be completed for NUR152. Written information on scenarios follows in the syllabus.

2. The **student** will take responsibility to **practice** and be **prepared** for the simulation.

3. The student is responsible to schedule their simulation time and follow that scheduled time. Be respectful of other student's scheduling of equipment.

4. The simulations will be performed by the student Alive@ as the instructor evaluates. There is a students= self-evaluation as well as the instructor evaluation. Repeats of unsuccessful performance are evaluated Alive@ by the instructor. Video presentations are optional.

5. ***Successful completion of critical skills is based on Pass/Fail***

   Pass
   - Demonstrated competency in each skill ***in the allotted time***
   - Demonstration of pertinent observations and the skill/interventions
   - Appropriate answers to the decision-making questions

   Fail
   - Incompetence of the demonstrated skill:
   - evidence of being unprepared (prompting needed, unorganized, unfamiliar with equipment)
   - unsafe practice
   - miss/tardy for scheduled time (late such that the instructor believes the procedure will be compromised and/or interfere with another student=s schedule)
   - not meeting the critical requirements
   - Inappropriate responses without rationale
   - ***Two percent off of total course grade for each 24-hours late!!***

6. ***Unsuccessful completion of a module:***
   The student will be provided a second opportunity to demonstrate competency of the failed component. This will be scheduled according to faculty convenience. Failure of the second attempt constitutes failure of the course.

7. **NOTE**: Extraneous persons observing are known to increase the stress and anxiety of the student=s performance. Please be respectful. Students are not to observe another student during a scheduled simulation, whether it is live or video, unless they are the video operator or role-playing client.

8. It is the student=s responsibility to secure a role playing client or to be assured that the mannequin is fully functional/appropriate. Role playing client may not assist.

9. A competency check-list will be completed on each scenario.

10. An evaluation checklist will be completed by one fellow student as peer review. This student will be chosen at random by instructor.

NUR 152T CLINICAL LAB OBJECTIVES
WEEK 1: VITAL SIGNS, BASIC ASSESSMENT, AND THERAPEUTIC COMMUNICATION

CENTRAL OBJECTIVES: Utilize beginning nursing assessment skills and communication techniques in interactions with elderly clients.

STUDENT OBJECTIVES:

1. ***Prior to the experience***:
   a. Review effective communication techniques, Chapter 8, Potter and Perry.
   b. Review procedure for assessing vital signs, including age related changes Chapter 11, Potter and Perry.

2. ***In preconference setting***:
   a. Verbally review plan for day=s activities with instructor.
   b. Verbalize concerns and anxieties, as well as verbal recognition of own feelings towards elderly.
   c. Review professional and ethical conduct in nurse-client interactions.

3. During experience:
   a. Determine temperature, pulse, blood pressure, and respiratory rate on at least three residents, utilizing staff and/or instructor as resources.
   b. Report vital sign readings to appropriate agency staff, and after approval of staff and/or instructor, record readings per agency policy.
   c. Meet assigned resident, introduce self and interact in a therapeutic professional manner for a minimum of 20 minutes.
   d. Assess assigned resident=s general appearance, grooming, hygiene, orientation in all spheres, nonverbal behaviors, language spoken, posture, range of motion (joints), hand grip, muscle firmness, gait, and equilibrium during communication.
   e. Report pertinent observations and any nursing actions taken to the appropriate staff member, and record per agency policy after approval by staff and/or instructor.
   f. Complete a Fall Risk and Pressure Ulcer Risk assessment on at least two (2) clients each day and turn in to instructor on Friday.
   g. Locate and read the posted list of Resident=s Rights.

4. Evaluation of experience (post conference):
   a. Discuss setting in which conservation was held.
   b. Compare and contrast client=s and student=s verbal and nonverbal behavior.
   c. Discuss student=s feelings and attitudes about the elderly and geriatric nursing in a long term care setting.
   d. Discuss student and client concerns about initial assessment and vital sign determination.
   e. Compare and contrast physical observations and vital sign values of each resident
   f. Discuss the role of the nurse in communicating observations.
   g. Complete appropriate sections of gerontics screening examination and turn in to instructor before leaving facility each day.
   h. Describe resident=s rights and the role of the L.P.N. in protecting residents.

WEEK 2-5: HEAD-TO-TOE ASSESSMENTS
MEDICATION ADMINISTRATION
TREATMENTS

CENTRAL OBJECTIVE: Apply the principles of physical assessment and medication administration techniques to the care of an elderly client in a long-term care setting.

1. ***Prior to the experience***:
   a. Review Unit III, NUR 152, Physical Assessment Techniques.
   b. Review NUR 151, Medication Administration Principles units.

2. ***In pre-conference setting***:
   a. Verbally review plan for day=s activities with instructor.
   b. Review verbally the physical assessment techniques of inspection, palpation, and auscultation, including modifications for the elderly.
   c. Verbalize the three check system and the five rights of medication administration to insure safety in administration.
   d. Discuss verification of identity when administering medication.
   e. Discuss agency S.O.P. for documentation of medications.

3. ***During the experience***:
   a. Perform a ***complete***, thorough and accurate ***head-to-toe*** physical assessment, including vital signs, of assigned resident, utilizing format provided ***EACH DAY***.
   b. Document the physical assessments on the form provided to be turned in to the instructor on the last clinical day.
   c. Report pertinent observations to agency staff and document per agency S.O.P. after approval by staff and/or instructor.
   d. Write one nursing diagnosis for assigned resident, utilizing format from Unit IV, NUR 152, to include approved diagnoses, defining characteristics, client centered goals, nursing interventions, and evaluation criteria, to be turned in to the instructor on the last clinical day.
   e. Write brief statement of assigned residents successful or unsuccessful completion of Eric Erickson=s developmental task of the elderly, to be turned in with care plan.
   f. Be prepared to discuss with instructor medication information such as: use, actions, usual dosage, and nursing implications. Turn in medication cards/sheets to instructor on the last clinical day.
   g. Identify information about a patient that may affect medication administration.
   h. Identify any changes, such as additions or deletions of entries on the medication record.
   i. Prepare medications in a well-lighted area.
   j. Check the label of the drug container three times to ensure safety and accuracy.
   k. Check the expiration dates on medications prior to pouring/preparing.
   l. Prepare medications in the order in which they will be delivered to the resident.
   m. Transport drugs from the area of preparation to the patient carefully and safely.
   n. Allow enough time to assist patients who will require help with taking medications.
   o. Keep all prepared medications in sight to ensure that the drugs will not be disturbed or taken by others.
   p. Identify the patient by checking the resident=s identification bracelet or photograph, if available. Also, ask the resident to state his/her name when able and check allergies.

Wound complications.

9. Factors that imparri q. Remain with the resident as he takes the medication. If there are several medications, offer each separately to resident.
   r. Help the resident swallow medications without aspiration by keeping the head in a neutral or flexed position.
   s. Avoid leaving medications at the bedside for the resident to take at later time.
   t. Omit giving medication if the resident has symptoms suggesting an undesirable reaction to a previous administration of the drug. Report the observation immediately.
   u. Avoid giving a drug if the resident states that he is allergic.
   v. Report immediately when a resident refuses a drug so that necessary adjustments can be made.
   w. Document administration on agency medication forms.

4. ***Evaluation of experience (post-conference):***
   a. Discuss resident and student reactions to physical assessment and medication administration.
   b. Discuss age-related changes noted on physical assessment.
   c. Discuss age-related nursing considerations when administering medications.

GERONTICS SCREENING EXAMINATION FORMAT

General appearance, grooming, hygiene_____

Oral mucous membranes (color, moistness, lesions _____

Teeth: Dentures _____ Cavities _____ Missing _____

Reads newsprint _____ Glasses _____ Hears whisper _____

Pulse (rate) _____(rhythm) _____ Blood pressure _____

Respirations(rate) _____ (depth) _____ (rhythm) _____ Breath Sounds _____

Hand grip _____Can pick up pencil _____

Range of motion (joints) _____Muscle firmness _____

Skin: Bony prominences _____Lesions _____Color Changes _____

Posture _____ Gait _____ Absent body part _____

Orientation _____

Language spoken _____Voice and speech pattern _____

Nervous or relaxed (rate from 1 to 5 with 1 being relaxed)_____

Assertive or passive (rate from 1 to 5 with 1 being passive) _____

Interaction with family member, guardian, other (if present) _____

Summarize available support system for your client in the areas of housing, transportation, health care, finances, spiritual, safety, and social. _____

_____

_____

_____

_____

_____

BEFORE clinical, research the following information for ALL the client's medication (routine and PRN)				
Trade and Generic Name	**Dose Route Frequency**	**Classification and Action**	**Primary Nursing Implications**	**Common Side Effects and *Life Threatening Adverse Reactions**
Lasix Furosemide	80 mg IV QD	Loop Diuretic Prevents reabsorptionof Na	Assess UOP to determine effectiveness Assess electrolytes to prevent dysrhythmias	Dysrhythmias d/t *HypoKalemia Hypotension d/t dehydration
IV Solution	**Additive (Compatible?)**	**Rate**	**Calculations**	

Medication	**What side effects (if any) does this client exhibit?**	**Why is this client receiving this medication/IV?**	**What does the client know/say about this medication?**	**What have you observed that shows that this medication/IV is <u>effective</u> for this client?**
Lasix	Poor skin turgor	Decrease workload of the heart – heart failure	"That's my water pill"	Intake 1875 Output 2100 Decreased crackles in lung bases according to history.
List the priority action that you took to keep the				

client safe (Safety Need)	
List one thing the client does to be healthy (Health Promotion)	
List the client's priority need for education (Health Teaching)	
What services does the client need to care for self at home (Discharge Planning)	

Nursing Diagnosis	**Clinical Findings**	**Outcomes**	**Nursing Interventions**	**Rationale**	**Evaluation of Outcomes**
What is my PRIMARY physiological concern about this client based on the data that I have collected? (P.E.	Subjective and Objective data that support this Nursing Diagnosis S.)	Ideally, my client will achieve this outcome because of my interventions (list the outcomes)	What Nursing Interventions can I do to help the client achieve the outcome?	This is the research upon which my intervention is based.	Did my interventions work? Were the outcomes achieved? What modifications should I make?

University of Montana – Missoula
College of Technology
Nursing Education
Clinical Worksheet

Student _____ Date _____

<table>
<tr><td colspan="6">Age</td><td colspan="5">M/F</td></tr>
<tr><td colspan="6">Admitting Diagnosis and Presenting Signs and Symptoms:</td><td colspan="5">Medical/Surgical History:</td></tr>
<tr><td colspan="6">Surgery:</td><td colspan="5" rowspan="2">Erickson’s Developmental Stage:

Supportive Data:</td></tr>
<tr><td colspan="6">Allergies:</td></tr>
<tr><td colspan="6" rowspan="4">Vital Signs
<table><tr><td></td><td>T</td><td>P</td><td>R</td><td>BP</td><td>Pain</td></tr><tr><td>Baseline</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Current</td><td></td><td></td><td></td><td></td><td></td></tr></table></td><td colspan="5" rowspan="4">Physician’s Orders (Chart and Kardex)</td></tr>
<tr><td colspan="3">Diet</td><td colspan="3">24° Intake and Output</td></tr>
<tr><td colspan="3"></td><td>I =
O=</td><td colspan="2">Balance
(+) (-)</td></tr>
<tr><td colspan="11"></td></tr>
<tr><td colspan="11">ORGANIZATIONAL PLAN</td></tr>
<tr><td>Day 1</td><td colspan="3">Preconference</td><td>Day 2</td><td colspan="3">Preconference</td><td colspan="3">Notes</td></tr>
<tr><td>0650-0730</td><td colspan="3"></td><td>0650-0730</td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>0730-0800</td><td colspan="3"></td><td>0730-0800</td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>0800-0900</td><td colspan="3"></td><td>0800-0900</td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>1000-1100</td><td colspan="3"></td><td>1000-1100</td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>1100-1130</td><td colspan="3"></td><td>1100-1130</td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>1200-1250</td><td colspan="3">Postconference</td><td>1200-1250</td><td colspan="3">Postconference</td><td colspan="3"></td></tr>
</table>

From San Diego City College, 2003

University of Montana – Missoula
College of Technology
Nursing Education
Case Study

Student _____ Date _____

Age	Gender	Date of Admission	
Code status/Advanced Directive		**Allergies** & Effects	
Chief Complaint/Admitting Diagnosis		Current Diagnoses	
Date/Type Procedure			
Medical/Surgical History		24° Intake & Output	
		I= O= Balance (+) (-)	
		Vitals	
		Baseline Current	
Pathophysiology of Current Diagnoses			

Current Physician's Orders from Kardex and Chart			
Date	Order	Date	Order

From San Diego City College, 2003

Name _____ Term _____

Instructor _____ Date _____

NUR 152 Fundamentals of Nursing
Clinical Evaluation Instrument

Note: Permission to use this from HCC in Florida, Prof. S. Henderson.
From Hillsborough Community College, Division of Nursing 2002.

This course addresses the health care of clients experiencing deficits of cardiac, respiratory, hematological, burns and trauma. Independent performance is encouraged. It is expected that the student is competent in performing previously learned nursing skills. Students are to schedule time in the nursing skills lab to practice procedures. Observational experiences are at the discretion of the clinical instructor.

There are 68 criteria on the clinical evaluation instrument. In order to achieve a **SATISFACTORY** clinical evaluation, 80% (54) criteria must be satisfactory. In addition, ALL critical (*) elements must be satisfactory.

An **UNSATISFACTORY** clinical evaluation (less than 54 satisfactory criteria or **unsatisfactory critical element(s)** will result in an "F" for the course regardless of the theory grade.

KEY: SATISFACTORY

1 = Minimally meets standard criteria, requires frequent verbal and occasional physical cues to perform skill.
2 = Consistently meets minimal criteria, requires rare cures to perform skill
3 = Proficient in performing skills without supporting cues

US = UNSATISFACTORY Does not meet minimal criteria

SL = Performed only in skills laboratory

Attach documentation regarding **UNSATISFACTORY EVALUATION**.

I. PROVIDE DIRECT CLIENT CARE					
CRITERION	SATISFACTORY Competency Levels			US	SL
	1	2	3		
* A. Performed skills taught in previous courses and applied theoretical knowledge to related skills.					
* B. Utilized prior knowledge in the care of clients and families.					
* C. Applied principles of medical asepsis.					
* D. Applied principles of surgical asepsis.					
* E. Prepared to provide nursing care and perform the following procedures correctly: 1. Respiratory assessment 2. Cardiovascular assessment 3. Apply oxygen devices					

	4. Administer subcutaneous heparin 5. Apply elastic stockings					
F.	Developed means to care for clients of varied cultures, languages and developmental levels.					
* G.	Administered medications to a minimum of three to four adult clients (PO, SQ, IM, G-tube, etc.) 1. Researched drugs before administration. 2. Stated critical nursing implications for each drug. 3. Performed required nursing action appropriate for specific drugs. 4. Followed the "5 Rights" when administering medications 5. Calculated correct dosages of medications prior to administration (oral, NG, G-tube, injections).					
H.	Analyzed and adapted nutritional needs related to client care.					
* I.	Maintained client safety following hospital protocol.					
* J.	Provided client privacy.					

COMMENTS:

II. THE NURSING PROCESS (Minimum grade 80%)						
CRITERION		SATISFACTORY Competency Levels			US	SL
		1	2	3		
A.	Performed complete and accurate head to toe assessments daily.					
B.	Used appropriate data collection tool correctly.					
C.	Used multiple sources to collect data regarding client status including computer generated data.					
D.	Followed protocol for nursing care plan.					
E.	Identified all applicable nursing diagnoses for assigned client(s) using NANDA list.					
F.	Prioritized nursing diagnoses based on developmental level, assessment and pathophysiological process.					
G.	Identified short and long term expected outcomes.					
H.	Implemented appropriate nursing actions.					
I.	Evaluated effectiveness of care provided to client(s).					
J.	Modified Nursing Care Plan as needed.					
K.	Integrate community-based resources in planning care for clients with health problems related to course content.					

COMMENTS:

III. COMMUNICATE EFFECTIVELY: VERBAL AND WRITTEN						
CRITERION	SATISFACTORY Competency Levels			US	SL
	1	2	3		
* A. Followed verbal and written instructions.					
* B. Reported relevant information to appropriate person.					
* C. Used proper nursing documentation format. 1. Followed hospital documentation guidelines. 2. Used appropriate medical terminology, including correct grammar and spelling. 3. Recorded all pertinent data in a timely manner.					
D. Used effective interpersonal skills. 1. Presented data actively in clinical conferences related to theoretical concepts. 2. Interacted with members of the health care team on a professional level.					
E. Communicated with clients and families appropriately according to their level of understanding.					
F. Evaluated verbal and n on-verbal forms of communication when caring for clients, and when communicating with the client's significant others, health care team members and HCC Nursing Faculty.					

COMMENTS:

IV. UTILIZE PRINCIPLES OF TEACHING/LEARNING					
CRITERION	SATISFACTORY Competency Levels			US	SL
	1	2	3		
* A. Assessed client(s) learning needs.					
B. Planned teaching according to client's level of understanding.					
C. Utilized various teaching/learning materials.					
* D. Implemented appropriate teaching based on client needs (including information on medications, nutrition, treatments, etc.)					
* E. Documented teaching plan according to institutional policy.					
F. Revised teaching plan as needed.					
G. Identified a minimum of one learning objective for each observational clinical area assigned.					

COMMENTS:

V. MANAGE CARE FOR MINIMUM OF TWO CLIENTS						
CRITERION		SATISFACTORY Competency Levels			US	SL
		1	2	3		
A.	Organizes time effectively.					
B.	Completed assignments within time allotted.					
*C.	Provide total care including medications, treatments and teaching. Including psychosocial support, age and developmental considerations.					
* D.	Evaluated effectiveness of time management.					
* E.	Began to delegate nursing care to the appropriate nursing personnel as necessary.					

COMMENTS:

VI. PARTICIPATES AS A MEMBER WITHIN THE NURSING PROFESSION						
CRITERION		SATISFACTORY Competency Levels			US	SL
		1	2	3		
* A.	Prepared for clinical assignments.					
* B.	Adhered to policies stated in Nursing Student Handbook.					
* C.	Maintained client/family confidentialilty.					
* D.	Completed daily written assignments as specified by clinical objectives and clinical instructor.					
* E.	Completed a minimum of one nursing care plan.					
* F.	Completed a minimum of one pathophysiology paper for a client.					
G.	Sought new or additional learning experiences on the clinical unit.					
H.	Identified a minimum of one learning objective for each clinical unit assigned.					
* I.	Related theoretical concepts to clinical practice.					
J.	Documented clinical/theoretical rationales according to APA format.					
K.	Arranged conference with instructor if needed.					
L.	Accepted constructive criticism and adjusted behaviors/performance accordingly.					
M.	Worked effectively with peers, members of the health care team and Nursing Faculty.					
N.	Recognized improper technique in performance of client care.					
O.	Discussed an ethical/legal issue pertinent to client care and delivery of care.					
P.	Evaluated self orally and in writing during clinical evaluation conferences.					
Q.	Followed protocol for notifying clinical unit and instructor of lateness or absences. LATE: _____ ABSENCES: _____					

COMMENTS:

AREAS FOR DEVELOPMENT	ACTION PLAN

STUDENT RESPONSE TO EVALUATION

PRINT STUDENT NAME: _____

STUDENT SIGNATURE: _____ DATE: _____

FACULTY SIGNATURE: _____ DATE: _____

Revised August 2003

University of Montana – Missoula
College of Technology
Nursing Education
Student Evaluation of Clinical Instructor

Clinical Agency _____ Instructor _____

Semester/Year: _____ Nursing Education _____ Date _____
From San Diego City College, 2003
Directions: Please rate your instructor on each of the following statements. Circle the letter of the answer which best describes the instructor's performance in the clinical area.

(a) Outstanding (b) More than satisfactory (c) Satisfactory
(d) Less than satisfactory (e) Not applicable

		a	b	c	d	e	ADDITIONAL COMMENTS
1.	The instructor made the objectives and criteria of the clinical rotation clear.						
2.	The instructor planned assignments which promoted learning.						
3.	The instructor treated students with respect, fairness and confidentiality.						
4.	The instructor was available to work with individual students during assigned clinical hours.						
5.	The instructor demonstrated competency in her/his field of knowledge.						
6.	The instructor encouraged students to apply theory to the clinical situation.						
7.	The instructor used pre/post conference time effectively by stimulating problem solving and critical thinking.						
8.	The instructor allowed students sufficient time to prepare for assignments.						
9.	The instructor encouraged students, including those who were experiencing difficulty, or needed to strengthen weak areas.						
10.	The instructor made specific, useful comments and/or corrections on case studies, and other student work via anecdotal notes or in private conversations.						
11.	The instructor gave an adequate orientation to the clinical facility.						

12.	The instructor encouraged critical thinking by asking appropriate questions of students.						
13.	The instructor was available to help students in preparation of case studies and care plans.						
14.	The instructor was supportive of the students when dealing with staff personnel at the clinical facility.						
15.	The instructor assisted the students to feel comfortable when discussing problems that may have impeded their learning.						
16.	The instructor was enthusiastic.						
17.	Assigned papers were corrected and returned promptly to facilitate the learning and role growth process, as well as having specific, useful comments.						