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NUR 195T.01: Fundamentals of Nursing

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The University of Montana College of Technology
Missoula
Course Syllabus

HEALTH PROFESSIONS DEPARTMENT
PRACTICAL NURSING



COURSE NAME AND TITLE: NUR 195T – Fundamentals of Nursing

DATE REVISED: September 12, 2006

SEMESTER CREDITS: 3

Course Design:

Didactic – online = 2 credits

Campus Clinical plus LTC Clinical & Affiliate Clinicals = 1 credit

PREREQUISITES: Coreq.: NUR 155, 151, & 154

INSTRUCTOR NAME: Rosemary Lynch, MA, BSN, RN, NHA

E-MAIL ADDRESS: Rosemary.lynch@mso.umt.edu

PHONE NUMBER: (406) 360-4140 (*emergency* – home: 721-3814)

OFFICE Hours: Thursday afternoons or by appointment

OFFICE Location: GD 2

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 conducted in Missoula & at Rural affiliate facilities*

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 195T.
(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.

Methods of Evaluation:

- Weekly Mini-Exams – 25% (5 points (pts) per week)
- Final Exam – 10% (100 pts total)
- Mid-term - 10% (50 pts total)
- Journal Topics – 10% (2 pts per week)
- Case Studies – 10% (Includes a pathophysiology paper☺)(case studies 10pts each, patho-paper 50 pts)
- Presentation – 10% (100pts)
- On-Line Discussions- 10% (10pt per week)
- Campus Clinical Lab Tests - 15% (based on weekly objectives in clinical)

Both the theory and clinical component must be passed in order to pass NUR 155. Failure of the theory component will result in the earned letter grade. Failure of clinical will result in a failing grade for NUR 155 ☹

ATTENDANCE POLICY: Regular on-line attendance is expected. On-line attendance is asynchronous and is monitored by the instructor. Attendance for the on-line course includes a minimum of one substantive five days a week. Substantive postings can include but are not limited to responding to discussion questions, posting case studies, and/or taking on-line quizzes. Lack of attendance will adversely affect final grades. Students will be evaluated weekly through a points system. Points will be given weekly based on attendance to the required assignments/posting for the on-line component. Absenteeism **greater than one day in clinical** will result in failure of the clinical portion of the course. Tests are to be taken by the required date. (copyright – LeAnne Ogilvie)

- ** All nursing courses must be completed with a "B" or greater in order to matriculate and graduate.
- ***Students are responsible for all policies and information in the Student Handbooks of the PN Program and the UM.***

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.

Both the theory and clinical component must be passed in order to pass NUR 195T. Failure of the theory component will result in the earned letter grade. Failure of clinical will result in a failing grade for NUR 195T ☹

WRITTEN WORK

1. Pathophysiology – assignment is to be done on standard size paper and typed on one side. **APA format is REQUIRED.** The pathophysiology paper will require you to discuss:

- a. a brief client history
- b. signs and symptoms of disease/condition
- c. pathophysiology of disease/condition
- d. usual treatment/patient treatment
- e. expected outcomes
- f. nursing implications
- g. reference information - APA

The pathophysiology paper is due the last week of class. Work is to be handed in on the assigned date. No work will be accepted late without prior permission from the instructor. Late assignments will be penalized. If assignments (either patho paper or care plans) are late three times in one semester, the student may fail the course based on instructor discretion.

2. Care Plan – A weekly care plan will be turned in for each week to your clinical instructor case study. Papers are to be turned in on Monday of the following week. Plans submitted should meet the format discussed in NUR 155 &/or 195. The care plan should include:

- a. clinical prep form
- b. medication sheets
- c. nursing care plan
- d. clinical objectives form

Written work that is turned in to clinical instructors in the hospital settings will be graded on a Pass/Fail basis. If a student receives a grade of "Fail" on a written assignment, the work will be returned to the student, completed, and returned to the instructor within one week. Unsatisfactory written work will result in completion of a Student Contract. Unsatisfactory completion of a Student Contract by the scheduled completion date may result in failure of the course.

3. On-line Discussion Postings – Discussion questions will be posted weekly. The purpose of discussion areas is to create a forum for idea exchange; there is not typically a "right" or "wrong" response as long as there is data and thought behind it. Students are required to respond to the discussion questions with a substantial, researched (when applicable) response to the question. Unacceptable responses include but are not limited to the following examples: "yeah, I agree", "you are so right", "great thought", or "I do not agree". In addition to posting a response to the question, students must also post a thoughtful, substantial posting to at least one

other student's response to the discussion topic. Unacceptable responses include the as above.

4. Journaling – Journal entries will be submitted in a typed online paper that will not be shared with the class. Journal entries are to be one typed page (double-space) in length (minimally). Journal topics will be posted throughout the course allowing the students the opportunity to reflect on their learning experiences. There is not a right or wrong answer, students will be graded on thought content and timeliness in submissions (get them turned in on time). This **DOES NOT** have to be in APA format.

5. Mini-Quizzes, Mid-term and Final Exams – Weekly – as assigned by instructor. Final will cover all course content covered throughout the course with 70% of the exam dedicated to the last half of the semester. Mid-term and final exams will consist of multiple choice and/or short answer questions. Quizzes, mid-term and final may be timed exams on Blackboard.

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
The Story of My Life An Afghan Girl On The Other Side Of The Sky, Ahmed, (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 & 154)

(see NUR 151 & 154 syllabus for Track 3)

Track 1:

- Unit 1 - 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 - 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)
(none...beginning clinical is enough☺)

Track 2:

Track 1:

Unit III – 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 –

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 – 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 – 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 – 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 2]. The second clinical experience will be in acute care. This is also a W & R rotation of 8 hours each day. **The clinical time will require that you research your client outside of regular class time – anticipate at least 2 hours every Tues. p.m. during the clinical weeks.**

General Work Design Clinical:

Beginning Clinical

Orient to facility, documentation, and facility search, P&P, unit purpose/clientele, body mechanics & ROM, & transfers + mobility equipment Basic infection control. Basic hygiene.

Vital signs, care of the environment, thorough hygiene, and therapeutic communication. Continue with above as from week. Begin medication administration.

Continuing Clinical

PA + all of the above + team collaboration

Complete care of 1 client + assist at least one other student with their cares.

UNIT I: Foundational Skills & Concepts in Nursing I

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.

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

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

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

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: 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

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 ☺

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

Unit III: Applying Foundational Skills, Knowledge, & Concepts in Nursing II

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.

Module 1: VS & Physical Assessment (Chapt. 31 & 32 P/P & Appendix 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)

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
- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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
- B. Always apical pulse
1. Midclavicular line left, fifth intercostal space

- C. Rhythm; regular, irregular

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

- E. Pulses: absent -, weak +1, Normal +2, bounding +3, and equality when

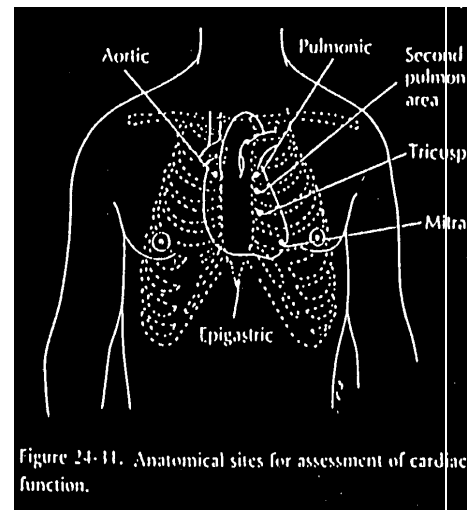


Figure 24-11. Anatomical sites for assessment of cardiac function.

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

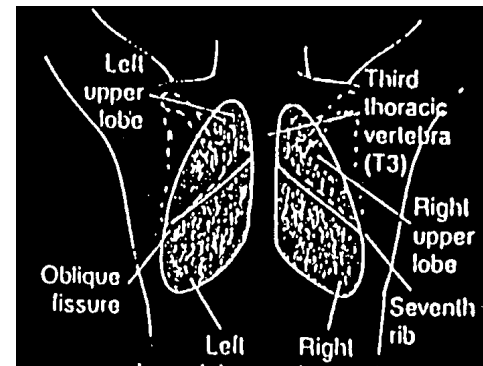
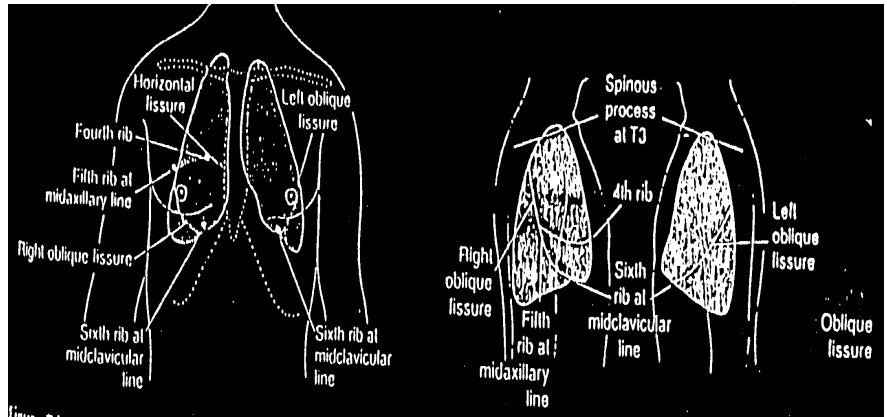
A. Mouth; mucous membranes, teeth, tongue, roof, check under tongue

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, prosthesis

VII. GENITOURINARY

A. Breast (optional or prn)

1. Size, symmetry
2. Contour, shape
3. Nipple, areola
4. Retraction
5. Palpation for lumps

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 state your rational for that order.
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.**)

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: 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:

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

Track 1:

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: 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:

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 – acute care

Module 5 – Complete client care + meds. + environment + IV + documentation

Track 2:

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: 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:

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:

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: 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:

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:

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)

YEE-Haw!!!.....that's all folks.....

