



## **Good Work Ethics Should Lead to Career Success**

*Cape Fear Community College and employers recognize the importance of good work ethics. The standards that govern the conduct of persons in the workplace are known as work ethics. More specifically, a person's conduct, such as punctuality, honesty, motivation, reliability, cooperation, thoroughness, and creativity, pertains to values, abilities, and behaviors that he or she brings to the job. Studies show that employees' lack of ability to do a job accounts for only 15 percent of fringes and dismissals. Of the other 85 percent, employers often give the following reasons for "letting employees go".*

- *Frequent absences from work*
- *Habitual laziness*
- *Inability to get along with other workers*
- *Dishonesty*
- *Lack of reliability*
- *Failure to use resources properly*

*CFCC instructors want you to be prepared for further education and success in the workplace: therefore, they have classroom and shop/lab rules and standards. Below is a check list for assessing your commitment to school/work success.*

- *I understand the importance of quality of doing a school / job assignment right the first time.*
- *I am motivated, and I accept responsibility without close supervision.*
- *I am receptive to new ideas, methods, and processes, and I pursue emerging technologies.*
- *I speak and write effectively in a clear, concise, and professional manner.*
- *I function in a "team" environment that requires working for the "good of the whole."*
- *I am dependable and reliable at school/work, reporting to my classes/work on time and completing assignments within the required time.*
- *I am honest in my dealings with instructors, supervisors, students, and co-workers, and I display a cooperative and supportive attitude.*
- *I dress appropriately for school and the workplace and maintain a neat clean appearance.*
- *I manage my time effectively and look for ways to be more efficient at school and on the job.*
- *I maintain a clean, orderly school/work space and leave it ready for use by others.*

**Cape Fear Community College**  
**Associate Degree Nursing**  
**NUR-110**  
**Nursing I**

Prerequisites: Acceptance to Cape Fear Community College ADN Program  
Co-requisites: None  
Fall Semester: First Year  
Instructors: Brenda Holland, R.N., MSN, ADN Director, Shawne Llewellyn, R.N., MSN, ADN Coordinator, Mary Murray, R.N., MSN, ADN Coordinator Julie Harris, R.N., BSN, ADN Program Faculty, and Pat Simpson, R.N., BSN, ADN Program Faculty

CONTACT HOURS:      Class:      5  
                                 Lab            3  
                                 Clinical:    6  
                                 CREDIT:    8

**Course Description:**

This course introduces concepts basic to beginning nursing practice. Emphasis is placed on introducing the nurse's role as provider of care, manager of care, and member of the discipline of nursing. Upon completion, students should be able to demonstrate beginning competence in caring for individuals with common alterations in health.

The clinical portion of this course is planned to allow the student to apply and expand on basic nursing concepts and skills. Patient care assignments and observational experiences in acute care adult medical-surgical settings provide students with opportunity to assist adults in reaching their optimal level of wellness.

**Teaching Strategies:**

- Guest Speakers
- Lecture
- Discussion
- Role Play
- Audio Visuals, CAI
- Handouts
- Clinical Observation Rotations
- Clinical Scenarios / Case Studies
- Journal Entries
- Other active learning strategies

**Evaluation:**

Theory:      Unit Tests \*    75%  
                         Final Exam       25%

Clinical:    (S) Satisfactory  
                  (U) Unsatisfactory

The student must pass a test on math medication calculations, achieving a minimal grade of 90%. Three opportunities will be provided for the student to demonstrate competency in math computation. Students who fail to achieve a minimum of 90% after three attempts will not be allowed to continue in clinical. This will result in the student receiving a WF.

Care plans and other clinical paperwork will not receive a numerical grade but will be a part of clinical evaluation.

Students are required to take all competency testing as scheduled i.e., NLN Test, Assess Test, etc.

Students receiving final grades below a "C" in nursing courses and below a "C" in related courses in the ADN curriculum must repeat the course and receive at least at "C" in nursing courses and a "C" in related courses before progressing to the next semester.

**A = 92-100**  
**B = 84-91**  
**C = 76-83**

**Safety:** Students who willfully disregard safety instructions or procedures are subject to dismissal.

### **Evaluation of Clinical Simulation**

Mastery of clinical objectives must be demonstrated by a "S" Satisfactory. Students who do not achieve a "S" on clinical objectives will receive an "F" for the course. A student whose clinical performance reflects behavior which conflicts with safety essential to nursing practice may be asked to exit the ADN program at any point during the quarter and receive a "WF."

Alternative methods for clinical makeup will be allowed only in the event of absence and in accordance with departmental attendance policies.

Clinical performance will be discussed with the students on an ongoing basis. Final clinical evaluation conferences will be held with each student.

Each student is expected to come to the clinical area prepared to give nursing care to the assigned patients.

### **Laboratory:**

An instructor in the nursing lab will demonstrate psychomotor skills. Students are scheduled time to practice and return psychomotor skills. Laboratory time also will be used for role-play, case studies, interactive video, CAI, videos, and class discussion.

All students are required to purchase an ADN Lab Kit from the bookstore.

## **Skill Sheets for Lab Returns**

1. The purpose of the skill sheet is to establish the student's competence in clinical skills each semester. The skill sheet will be utilized throughout the program to prepare student assignments. It is not required to complete all skills in one semester, but the student is encouraged to become competent in each skill by the end of the nursing program.
2. Each student will bring their skill sheet for lab returns and to their clinical areas each day. Do not turn in the Skill Sheet with your clinical paperwork. You will be unable to be signed off on the lab return if you do not have your skill sheet.
3. After an instructor signs off your lab returns, you can perform those tasks with an instructor's supervision. You must perform the task for the required number of times before performing the task in the clinical setting on your own (after instructor approval).
4. Your instructor may suggest returning to the simulation lab if they feel you need more practice. You then must make an appointment with an available instructor for sign off again. If you pass, you will be signed off again, but will have to restart your required number of check offs before performing the procedure on you own. If you do not pass again, you will then make another appointment for the lab return until the skill is successfully completed.
5. You do not have to get more than the number of signatures required per semester. Your next clinical instructor may continue to sign off on your skill sheet at their discretion. Hand in your skill sheet with that week's paperwork. The skill will be dated and signed only if performed perfectly without any prompting or assisting.

LAB	# OF SIGNATURES	LAB RETURN SIGNATURE	INITIAL & DATE	INITIAL & DATE	INITIAL & DATE	INITIAL & DATE	INITIAL & DATE
Vital Signs	1						
<b>Asepsis:</b>							
Sterile Gloves	1						
Sterile field	2						
O <sub>2</sub> Admin & Sat	1						
Wound Drain	1						
Isolation Tech	1						
Hemoccult	1						
<b>Medications:</b>							
PO	2						
SQ	2						
IM	3						
PR	1						
NG/PEG	2						
SW Flush	2						
Sterile Wound & Care	2						
Bed Making	1						
IV Start	3						
IV D/C	1						
<b>Foley Insert:</b>							
Male	1						
Female	2						
Foley D/C	1						
Trach Care	2						
SXN – Oro & Naso	2						
NG Insert	2						
NG D/C	1						
Restraints	1						
Removing Staples	1						
Cultures	1 each						
Accucheck	1						
Enema	1						
Physical Assessment	2						
Total Bed Bath (1 Male and 1 Female)	2						



## SAMPLE TEST

1. Identify the following that best describes the purpose of CFCC's ADN program:
  - a. Graduate only those who are 100% sure to pass state boards.
  - b. Prepare graduates with beginning level abilities to provide safe, effective care.
  - c. Teach responsibility and accountability to all students.
  - d. Implement strategies that provide nursing care to a small group of patients.
  
2. Which of the following teaching strategies best facilitates learning?
  - a. Group discussion
  - b. Hearing a lecture
  - c. Watching a film
  - d. Assigned reading
  
3. After successfully completing the ADN curricula, Mary Beth informs the director of a drug related conviction in Mary Beth's past. Identify the most likely consequences.
  - a. The director will inform her that the Board of Nursing never licenses a felon.
  - b. Misrepresentation of information will always prohibit one from taking the Board exam.
  - c. The Board of Nursing will review the situation on an individual basis before reaching a decision.
  - d. Mary Beth has wasted two long hard years of study because she isn't honest.
  
4. The nurse enters a patient's room and the patient says, "My Dr. says I have to have an operation for my gallbladder. What do you think?" The most appropriate response by the nurse is:
  - a. "I saw your X-rays and I believe he's right."
  - b. "Why don't you get a couple more opinions?"
  - c. "I would never have surgery if there's an easier way out."
  - d. "How are you feeling about the Dr.'s recommendation?"

## Math Test Grading Guidelines

1. Answers with “dangling” decimals will be graded as wrong.  
Example: **.5mg** is incorrect; the correct answer is **0.5mg**.
2. Answers with a zero placed behind a decimal will be graded as wrong.  
Example: **5.0mg** is incorrect; the correct answer is **5 mg**.
3. The correct rounding procedure is as follows:
  - If a number is **less than 1ml**, round to the nearest **hundredth** place.  
Example: **0.666ml** is rounded to **0.67ml**.
  - If a number is **greater than 1ml**, round to the nearest **tenth** place,  
Example: **1.68ml** is rounded to **1.7ml**.
4. The student must **show ALL work** when solving math questions. The question will be counted wrong if the work is not shown.
5. When solving an IV calculation, the gtts/hr must be rounded.
  - Example: **20.83gtts/hr** has to be **rounded to 21gtts/hr**.

## Library Resources:

(Texts and articles older than five years are considered out-of-date and are not to be used as references without instructor permission.)

### **NURSING JOURNALS Available in the CAPE FEAR COMMUNITY COLLEGE LIBRARY**

AAOHN Journal	Journal of Psychosocial Nursing & Mental Health Services
Advance for LPNS	Journal of the American Medical Association (See JAMA)
AJN Career Guide to Nursing Opportunities	Medical Letter on Drugs and Therapeutics
American Journal of Nursing	New England Journal of Medicine
American Nurse	Nurses Drug Alert
AORN Journal (Association of Operating Room Nurses)	Nursing
AORN Connections	Nursing Clinics of North America
AORN Member News	Nursing Homes
AWHONN Lifelines (Association of Women's Health, Obstetrics & Neonatal Nurses)	Nursing Management
Children's Health Care	Nursing Outlook
CIN Plus (Computers in Nursing Plus)	Nursing Research
Computers in Nursing	Nutrition in Clinical Care (Nutrition in Disease Prevention and Clinical Practice)
Computers Informatics Nursing: CIN	Nutrition Reviews
Critical Care Nursing Quarterly	Nutrition Today
Geriatric Nursing	Pain Management Nursing
Heart and Lung	Rehabilitation Nursing
JAMA (Journal of the American Medical Association)	RN: National Magazine for Nursing
Journal of Emergency Nursing	Tar Heel Nurse
Journal of Environmental Health	Topics in Geriatric Rehabilitation
Journal of Obstetrics and Gynecology	Urologic Nursing
Journal of Practical Nursing	

## NURSING COMPUTER PROGRAMS AVAILABLE IN THE CFCC LEARNING LAB

### Clinical Simulations →

- ♦ Maternity Nursing I
- ♦ Maternity Nursing II
- ♦ Pediatric Nursing II

### Delmar's Nursing Skills →

- ♦ Basic Care Nursing Skills
- ♦ Critical-Surgical Care Nursing Skills
- ♦ Intermediate Care Nursing Skills
- ♦ Special Procedure Nursing Skills

### NCLEX – RN Success→

- ♦ NCLEX-RN Success Help
- ♦ NCLEX-RN Success →
  - Cultural Sensitivity & Alternative Medicine
  - Disaster Planning
  - Gerontology 1
  - Gerontology 2
  - Management Concepts
  - Medical Surgical Exam 1
  - Medical Surgical Exam 2
  - Pediatric
  - Pharmacology Exam 1
  - Pharmacology Exam 2
  - Psychiatric
  - Women's Health
  - Final Exam 1
  - Final Exam 2
  - Final Exam 3
  - Final Exam 4
  - Final Exam 5
  - Final Exam 6 (w/Graphics)

### Physical Findings→

- ♦ 01A Integument System #'s 1-92
- ♦ 01B Integument System #'s 93-185
- ♦ 01C Integument System #'s 186-208
- ♦ 02A Head and Neck #'s 1-76
- ♦ 02B Head and Neck #'s 77-129
- ♦ 03 Ears
- ♦ 04A Eyes #'s 1-67
- ♦ 04B Eyes #'s 68-113
- ♦ 05 Cardiovascular
- ♦ 06 Respiratory
- ♦ 07A Musculoskeletal #'s 1-84
- ♦ 07B Musculoskeletal #'s 84-120
- ♦ 08 Neurological
- ♦ 09 Abdomen
- ♦ 10 Breasts
- ♦ 11 Female Genitalia
- ♦ 12 Male Genitalia
- ♦ Slide List
- ♦ Tutorial

### Psychomotor Skills Series→

- ♦ Care of Chest Tubes
- ♦ Oral & Nasotracheal Suctioning
- ♦ Physical Assessment of a Child

### **Accu.Calc**

### **Arterial Blood Gases**

### **CM Nursing Process**

### **Fluids & Electrolytes**

### **Making Sense of PH**

### **Physical Assessment – Heart and Lungs**

### **Physical Assessment Findings**

### **PN CAT**

### **RN CAT PLUS – 9.1.2.**

### **Vital Signs**

**Updated: August 2006**

### Written Assignments:

All papers to be handed in to the instructor are to be legibly written in black ink. First time writing of written material must be complete. Partially complete written assignments will not be accepted and are subject to late penalties.

Written work that is required but not assigned a letter or numerical grade must be turned in when specified by faculty. Late written work indicates the student is not completing program objectives. The first occurrence of late written work will result in a verbal reprimand. A second occurrence will result in academic probation and further occurrences may result in dismissal.

Drug sheets or appropriate cards are to be completed using the identified format on each drug addressed in theory classes and each drug administered in the clinical setting.

## **Textbooks:**

### **Required:**

- Adams, Michael Patrick. Josephson, Dianne L., & Holland, Leland Norman. (2005). *Pharmacology for Nurses: A Pathophysiologic Approach*. New Jersey:Prentice Hall.
- Carpenito-Moyet, Lynda J. (2006). *Nursing Diagnosis: Application to Clinical Practice*. (11<sup>th</sup> ed). PA: Lippencott.
- Cherry, Barbara & Jacob, Susan R. (2002). *Contemporary Nursing Issues, Trends, and Management*. MO: Elsevier.
- Deglin, Judith & Vallerand, April. (2005). *Davis's Drug Guide for Nurses*.(9<sup>th</sup> ed). PA: F.A. Davis
- Ignatavicius, Donna D. & Workman, M. Linda. (2006). *Medical-Surgical Nursing: Critical Thinking for Collaborative Care*. (5<sup>th</sup> ed). MO: Elsevier.
- Lacharity, Linda, Kumangai, & Bartz, Barbara. (2006). *Prioritization, Delegation, and Assignment: Practice Exercises for Medical-Surgical Nursing*. MO: Mosby
- Kozier, Barbara, Erb, Glenora, Berman, Audrey J. & Snyder, Shirlee.(2004). *Fundamentals of Nursing* (7<sup>th</sup> ed). NJ: Prentice Hall.
- Martinez de Castillo, Sandra & Werner-McCollough, Maryanne. (2002). *Calculating Drug Dosages*. (1<sup>st</sup> ed). PA: F.A. Davis
- Pagana, Kathleen & Pagana, Timothy.(2006).*Mosby's Manual of Diagnostic and Laboratory Tests*, (3<sup>rd</sup> ed). MO: Mosby.
- Tabers Cyclopedic Medical Dictionary* (20th ed.).(2005). PA: F. A. Davis & Co.
- Williams, Sue Rodwell.(2006). *Essentials of Nutrition and Diet Therapy*. (12<sup>th</sup> ed). MO: Elsevier.

### **Recommended:**

- Barnes, S.(2004). *Study Guide: Fundamentals of Nursing*.(7<sup>th</sup> ed). NJ: Prentice Hall
- Ignatavicius, Donna D. & Workman, M. Linda. (2006). *Critical Thinking Study Guide to Accompany Medical-Surgical Nursing*. (5<sup>th</sup> ed).MO:Elsevier.
- Myers, Ehren.(2006).*RNotes Nurse's Clinical Pocket Guide*. (2<sup>nd</sup> ed). PA: F. A. Davis & Co

**Cape Fear Community College**  
**Associate Degree Nursing**  
**NUR-110 Course Outcomes:**

Nursing 110 course outcomes relate to the nursing management of one to three patients experiencing alterations in mental health status, neurological and burns. At the completion of the course the student is expected to satisfactorily:

1. Understand gathering objective and subjective data from appropriate sources for patients with a common health stressor.
2. Determine common nursing diagnosis based on identification of actual or potential health needs and individual patient response to health stressors.
3. Develop patient-centered goals, planned interventions, and expected outcomes based on input from the patient, significant others, and the health team.
4. Describe methods to provide humanistic and caring applications of scientific principles to safely initiate and complete actions necessary to accomplish the defined goals.
5. Describe the effectiveness of nursing intervention on the patient's status
6. Participate in accountable management of nursing care.
7. Demonstrate critical thinking as it relates to fundamental patient care.
8. Determine behaviors that are reflective of professional growth, continuous learning and self-development.
9. Develop beginning competencies to utilize informatics to communicate, manage knowledge, mitigate error and support decision-making.
10. Identify quality improvement processes to measure client outcomes, identify hazards and errors, and develop changes in processes of client care.

## **ASSOCIATE DEGREE NURSING**

### **NUR-110 NURSING I**

#### **TOPICAL OUTLINE**

#### **UNIT I      INTRODUCTION TO NURSING**

- A. Basic Concepts Of Nursing Practice

#### **UNIT II      THE NURSING PROCESS**

- A. Basic Concepts Of The Nursing Process

#### **UNIT III      BASIC KNOWLEDGE**

- A. Wellness-Illness
- B. Growth And Development
- C. Homeostasis
- D. Communication
- E. Teaching Learning

#### **UNIT IV      HEALTH ASSESSMENT: PHYSIOLOGICAL**

- A. Physical Mobility And Immobility
- B. Assessment Of Vital Signs
- C. Safe Environment & Asepsis
- D. Personal Hygiene
- E. Rest And Sleep

#### **UNIT V      PHYSICAL ASSESSMENT**

- A. Comprehensive Nursing Assessment: Adult Patient
- B. Physical Assessment Process

#### **UNIT VI      BASIC PRINCIPLES OF REPORTING AND RECORDING**

- A. Reporting & Recording: Pertinent Information
- B. Admission And Discharge

UNIT VII      NURSING MANAGEMENT OF MEDICATION ADMINISTRATION

- A. Principles Of Pharmacology In Safe Administration Of Medications

UNIT VIII      NURSING MANAGEMENT OF THE PATIENT EXPERIENCING PERIOPERATIVE CARE NEEDS

- A. Nursing Process: Management Of The Perioperative Patient  
B. Pre-operative Care  
C. Postoperative Care

UNIT IX      NURSING MANAGEMENT OF THE PATIENT EXPERIENCING ALTERATION IN COMFORT

- A. Nursing Management: Alteration In Comfort

UNIT X      URINARY ELIMINATION

- A. Urinary Elimination

UNIT XI      NUTRITION

- A. Nutrition

UNIT XII      HEALTH ASSESSMENT PSYCHOSOCIAL

- A. Self-Concept  
B. Sex & Sexuality  
C. Ethnicity and Culture  
D. Spirituality  
E. Loss And Grieving  
F. The Family

**Evaluation of each unit consists of:**

- **Paper and Pencil Tests**
- **Classroom Participation**
- **Clinical Performance**

CAPE FEAR COMMUNITY COLLEGE ADN  
NUR 110 NURSING I

Florence Nightengale - efforts made nursing respectable vocation again. Education of nurses one of her major goals. Started Nightengale School of Nurses 1860 in London - first planned educational program for nurses.

Clara Barton - formed the American Red Cross. Although she offered nursing type care to wounded during civil war, she was not a trained nurse.

Linda Richards - first trained nurse in America. Graduated 1873 New England Hospital for Women and Children (Boston). Developed system of nurses notes.

Isabel Hampton Robb - one of founders of AJN. Worked for 8-hour rather than 12-hour days for nurses.

Mary Eliza Mahoney - first black professional nurse in America. Graduated New England Hospital for Women and Children in 1879. Devoted life to private-duty patients and acceptance for blacks into nursing profession.

Luther Christmon - work centers around improvement of nursing practice. Has been administrator, educator, researcher.

Mildred Montag - responsible for ADN programs in community colleges. Her 1951 doctoral dissertation led to these events. She said we could educate RN's in two years.

Virginia Henderson - one of first theorist in nursing. Identified 14 basic needs of individuals as they strive for independence.

Overall Objective	Content/ Objective	Learning Environment and Activities
<p style="text-align: center;"><b>UNIT 1</b></p> <p style="text-align: center;">Introduction to Nursing</p> <p>Discuss The Role Of The Associate Degree Nurse</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I. Introduction To Nursing</p> <p>II. Describe basic components of ADN program at CFCC</p> <ol style="list-style-type: none"> <li>1. Philosophy</li> <li>2. Organizing framework</li> <li>3. Purpose</li> <li>4. Program outcomes</li> <li>5. Educational outcomes</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Handouts: ADN Policy Manual (distributed during ADN orientation) and course syllabus</p> <p style="text-align: center;"><b><u>During Class</u></b></p> <p style="text-align: center;">Discussion</p>
	<p>B. Identify campus resources for students</p> <ol style="list-style-type: none"> <li>1. Physical layout</li> <li>2. Library</li> <li>3. Computer lab</li> <li>4. Student services</li> </ol>	
	<p>C. State ADN program requirements</p> <ol style="list-style-type: none"> <li>1. Course requirements</li> <li>2. Program policies</li> </ol>	
	<p>D. Describe skills for academic success</p> <ol style="list-style-type: none"> <li>1. Use of course syllabus</li> <li>2. Correlation of objectives and testing</li> <li>3. Time management</li> <li>4. Note taking</li> <li>5. Test format</li> </ol>	<p style="text-align: center;"><b><u>During Class</u></b></p> <p>Discussion: course syllabus</p> <p style="text-align: center;"><b><u>Prior to Test</u></b></p> <p>CAI: Test-taking skills</p>
	<p>E. Identify three (3) types of nursing education leading to RN</p> <ol style="list-style-type: none"> <li>1. ADN</li> <li>2. Diploma</li> <li>3. BSN</li> </ol>	
	<p>F. Identify three (3) types of nursing education leading to RN</p> <ol style="list-style-type: none"> <li>1. ADN</li> <li>2. Diploma</li> <li>3. BSN</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>G. Discuss the roles and competencies of the ADN graduate as identified by NLN and the NC Board of Nursing</p> <ol style="list-style-type: none"> <li>1. Role as provider of care               <ol style="list-style-type: none"> <li>a. Competencies at graduation</li> <li>b. Anticipated competencies following 6 months of practice</li> </ol> </li> <li>2. Role as manager of care               <ol style="list-style-type: none"> <li>a. Competencies at graduation</li> <li>b. Anticipated competencies following 6 months of practice</li> </ol> </li> <li>3. Role as member within the profession of nursing               <ol style="list-style-type: none"> <li>a. Competencies at graduation</li> <li>b. Anticipated competencies following 6 months of practice</li> </ol> </li> <li>4. CFCC entry level activities</li> </ol> <p>H. Explore the Institute of Medicine's competencies for health professionals</p> <ol style="list-style-type: none"> <li>1. Patient-centered care</li> <li>2. Interdisciplinary Teams</li> <li>3. Evidence-based practice</li> <li>4. Quality Improvement</li> <li>5. Informatics</li> </ol> <p>I. State a definition of nursing</p>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 1</p> <p><b><u>During Class</u></b></p> <p>Handouts: NLN Core Competencies</p> <p>IOM Competencies</p> <p>NC Board of Nursing: Delegation of Nursing Activities by RN/LPN, NAI, NAII</p> <p><b><u>During Class and Assignment:</u></b></p> <p>Informatics: <a href="http://www.ncbon.org">www.ncbon.org</a> <a href="http://www.ana.org">www.ana.org</a></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>J. Identify the contribution of specified individuals to nursing</p> <ol style="list-style-type: none"> <li>1. Florence Nightingale</li> <li>2. Clara Barton</li> <li>3. Linda Richards</li> <li>4. Isabel Robb</li> <li>5. Mary Mahoney</li> <li>6. Luther Christmon</li> <li>7. Dr. Faye Abdellah</li> <li>8. Dr. Mildred Montag</li> <li>9. Virginia Henderson</li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapters 1, 2, and 3</p>
	<p>K. Describe setting in which nurses' practice</p> <ol style="list-style-type: none"> <li>1. Hospital</li> <li>2. Community agencies</li> <li>3. Physicians offices</li> <li>4. Industry</li> <li>5. Schools</li> <li>6. Pharmaceutical Research</li> <li>7. Oversight of clinical trials</li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Page: 53 Culturally Competent Care</p>
	<p>L. Identify functions of health care team members</p> <ol style="list-style-type: none"> <li>1. Physicians</li> <li>2. Nurse Practitioners</li> <li>3. Clinical Nurse Specialists</li> <li>4. Physicians Assistants</li> <li>5. Nurses</li> <li>6. Therapists (physical, occupational, respiratory, speech etc.)</li> <li>7. Pharmacists</li> <li>8. Social workers</li> <li>9. Chaplain</li> <li>10. Dietitian</li> </ol>	<p>Discussion: Interdisciplinary Collaboration</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>M. Discuss values, rights, and ethics and their influence on nursing practice</p> <ol style="list-style-type: none"> <li>1. Values               <ol style="list-style-type: none"> <li>a. Definition</li> <li>b. Personal and professional</li> <li>c. Clarification</li> <li>d. Client identification</li> </ol> </li> <li>2. Rights               <ol style="list-style-type: none"> <li>a. Client / Patient Bill of Rights</li> <li>b. Nurses rights</li> <li>c. Students rights</li> </ol> </li> <li>3. Ethics               <ol style="list-style-type: none"> <li>a. Code of ethics</li> <li>b. Bioethical</li> <li>c. Peers</li> <li>d. Nurse</li> </ol> </li> <li>4. Resolution</li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 5</p> <p><b><u>During Class</u></b></p> <p>AV: “Nurse, Ethics &amp; The Law: Professional Ethics” ANA Code of Ethics</p>
	<p>N. Discuss legal aspects of nursing practice</p> <ol style="list-style-type: none"> <li>1. Sources of law               <ol style="list-style-type: none"> <li>a. NC Nurse Practice Act</li> </ol> </li> <li>2. Dimensions               <ol style="list-style-type: none"> <li>a. Credentialing</li> <li>b. Standards of practice</li> </ol> </li> </ol>	<p><b><u>During Class</u></b></p> <p>Discussion - ANA Standards</p>
	<p>O. Discuss the difference between crimes and torts</p> <ol style="list-style-type: none"> <li>1. Crime</li> <li>2. Tort               <ol style="list-style-type: none"> <li>a. Intentional</li> <li>b. Unintentional</li> </ol> </li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 4</p>
	<p>P. Describe potential malpractice situations in nursing</p>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	Q. Discuss selected legal concerns of nursing practice <ol style="list-style-type: none"> <li>1. Informed consent</li> <li>2. Record keeping</li> <li>3. Controlled substance</li> <li>4. Incident reports</li> <li>5. Wills</li> <li>6. Living will</li> <li>7. No-Code</li> <li>8. Abortions</li> <li>9. Death</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> AV: "Ethics & The Law: Legal Responsibilities"
	R. Identify legal protection for nurses <ol style="list-style-type: none"> <li>1. Good Samaritan acts</li> <li>2. Liability insurance</li> </ol> S. Discuss legal responsibilities of nursing <ol style="list-style-type: none"> <li>1. Physicians orders</li> <li>2. Legal precautions for nurse</li> <li>3. Legal responsibilities of students</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> Informatics: <a href="http://www.ncbon.org">www.ncbon.org</a> <a href="http://www.nursingworld.org">www.nursingworld.org</a>

Overall Objective	Content/ Objective	Learning Environment and Activities
<p style="text-align: center;"><b>UNIT 2</b></p> <p><b>THE NURSING PROCESS</b></p> <p>Discuss The Components Of The Nursing Process As A Method Of Providing Safe Effective Nursing Care</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>III. The Nursing Process</p> <p>A. Discuss the five (5) steps in the nursing process</p> <ol style="list-style-type: none"> <li>1. Assessment</li> <li>2. Diagnosing</li> <li>3. Planning</li> <li>4. Implementing</li> <li>5. Evaluating</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapters 16 and 17</p>
	<p>B. Identify advantages of utilizing the nursing process</p> <ol style="list-style-type: none"> <li>1. Nurse</li> <li>2. Patient</li> </ol>	
	<p>C. Contrast theories that guide the implementation of the nursing process</p> <ol style="list-style-type: none"> <li>1. Critical thinking</li> <li>2. Problem solving process</li> <li>3. Decision making process</li> <li>4. Holism</li> <li>5. Maslow's hierarchy of needs</li> </ol>	
	<p>D. Identify descriptions of data collected for assessment</p> <ol style="list-style-type: none"> <li>1. Objective</li> <li>2. Subjective</li> <li>3. Variable</li> <li>4. Constant</li> </ol>	<p style="text-align: center;"><b><u>During Class</u></b></p> <p>Handout: Assessment activity Evidence Based Practice: Case study: 38 year old female was diagnosed with rheumatoid arthritis at age 20</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	E. Describe sources of data <ol style="list-style-type: none"> <li>1. Client</li> <li>2. Significant others</li> <li>3. Health personnel</li> <li>4. Medical records</li> <li>5. Other records and reports</li> <li>6. Literature</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> Informatics: <a href="http://Nursing.about.com/od/Nursesgeneralinfo/a/Nursingprocess.htm">http://Nursing.about.com/od/Nursesgeneralinfo/a/Nursingprocess.htm</a>
	F. Discuss four (4) methods of collecting data for analysis <ol style="list-style-type: none"> <li>1. Observing</li> <li>2. Interviewing</li> <li>3. Consulting</li> <li>4. Examining</li> </ol>	PRIOR TO CLASS  Read Kozier & Erb: Chapter 16
	G. Discuss the characteristics of nursing diagnoses <ol style="list-style-type: none"> <li>1. Analysis</li> <li>2. Synthesis</li> </ol>	
	H. Differentiate between nursing diagnoses and medical diagnoses <ol style="list-style-type: none"> <li>1. Medical</li> <li>2. Nursing</li> </ol>	
	I. Discuss three (3) phases of nursing diagnoses <ol style="list-style-type: none"> <li>1. Data processing</li> <li>2. Determination of problems and strengths</li> <li>3. Formulation of nursing diagnoses</li> </ol>	<p style="text-align: center;"><b><u>During Class</u></b></p> Evidence Based Practice: case study: client admitted to undergo surgery from fractured hip
	J. Identify the process of writing a diagnoses <ol style="list-style-type: none"> <li>1. Characteristics</li> <li>2. Guidelines</li> <li>3. Taxonomy of N/D</li> </ol>	PRIOR TO CLASS  Read Kozier & Erb: Chapter 18

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>K. Discuss the five (5) components of the planning phase of the nursing process</p> <ol style="list-style-type: none"> <li>1. Setting priorities</li> <li>2. Goals and outcome criteria               <ol style="list-style-type: none"> <li>a. Providing a safe and effective environment</li> <li>b. Promotion of physiological and psychosocial integrity</li> <li>c. Health promotion / maintenance</li> </ol> </li> <li>3. Planning nursing strategies</li> <li>4. Writing the care plan</li> <li>5. Discharge planning</li> </ol>	<p>PRIOR TO CLASS</p> <p>Read Kozier &amp; Erb: Chapter 19</p> <p style="text-align: center;"><b><u>During Class - Lab</u></b></p> <p>Writing Nursing Care Plans</p> <p>Evidence Based Practice: Client has experienced intermittent nausea for approx. six months due to a possible gastric ulcer.</p>
	<p>L. Identify three (3) types of nursing actions in the implementation of the nursing process</p> <ol style="list-style-type: none"> <li>1. Independent</li> <li>2. Dependent</li> <li>3. Collaborative               <ol style="list-style-type: none"> <li>a. Interdisciplinary Team Members</li> </ol> </li> </ol>	<p>PRIOR TO CLASS</p> <p>Read Kozier &amp; Erb: Chapter 20</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>M. Discuss the process of implementation of the nursing care plan</p> <ol style="list-style-type: none"> <li>1. Process               <ol style="list-style-type: none"> <li>a. Reassessment</li> <li>b. Validation</li> <li>c. Need for assistance</li> <li>d. Implementation strategies</li> <li>e. Communication actions</li> </ol> </li> <li>2. Implementation skills               <ol style="list-style-type: none"> <li>a. Cognitive</li> <li>b. Interpersonal</li> <li>c. Technical</li> </ol> </li> <li>3. Implementation activities               <ol style="list-style-type: none"> <li>a. Communication</li> <li>b. Caring</li> <li>c. Teaching</li> <li>d. Counseling</li> <li>e. Managing</li> <li>f. Authority and accountability</li> </ol> </li> </ol>	<p>PRIOR TO CLASS</p> <p>Read Kozier &amp; Erb: Chapter 20</p> <p style="text-align: center;"><b><u>During Class</u></b></p> <p>Case Study: writing a care plan</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Informatics: <a href="http://www.rncentral.com/">http://www.rncentral.com/</a></p>
	<p>N. Discuss the process of evaluation in the nursing process</p> <ol style="list-style-type: none"> <li>1. Outcome criteria</li> <li>2. Assessment of outcome</li> <li>3. Care plan modification</li> <li>4. Evaluation of quality nursing care</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
<p style="text-align: center;"><b>Unit 3</b></p> <p style="text-align: center;">Basic Knowledge 1</p> <p><i>Discuss The Concept Of Wellness-Illness</i></p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>IV. Wellness-Illness</p> <p>A. Discuss factors which influence the individual's definition of health</p> <ol style="list-style-type: none"> <li>1. Developmental</li> <li>2. Social / Cultural</li> <li>3. Prior experience</li> <li>4. Self-expectations</li> <li>5. Self-perceptions</li> </ol>	<p>PRIOR TO CLASS</p> <p>Read Kozier &amp; Erb: Chapters 8 and 11</p>
	<p>B. Discuss concepts of wellness-illness</p>	
	<p>C. Describe the wellness-illness continuum</p> <ol style="list-style-type: none"> <li>1. Health and illness</li> <li>2. Illness and disease</li> </ol>	
	<p>D. Discuss variables which impact on health</p> <ol style="list-style-type: none"> <li>1. Variables affecting health status <ol style="list-style-type: none"> <li>a. Beliefs and behaviors</li> <li>b. Internal factors</li> <li>c. External factors</li> </ol> </li> </ol> <p>E. Variables affecting health behavior</p> <ol style="list-style-type: none"> <li>a. Perceptions</li> <li>b. Compliance</li> <li>c. Nursing intervention</li> </ol>	
	<p>F. Describe stages of illness</p> <ol style="list-style-type: none"> <li>1. Symptoms</li> <li>2. Sick role</li> <li>3. Medical contact</li> <li>4. Dependent role</li> <li>5. Recovery</li> </ol>	
	<p>G. Discuss the ramifications of illness</p> <ol style="list-style-type: none"> <li>1. Sick role behavior</li> <li>2. Effects of hospitalization</li> <li>3. Impact of family</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
Describe Essential Concepts Of Growth And Development And The Significance To Nursing	<p>V. Growth and Development</p> <p>A. Identify stages of growth and development and related factors</p> <ol style="list-style-type: none"> <li>1. Principles of growth and development</li> <li>2. Factors which influence growth and development               <ol style="list-style-type: none"> <li>a. Heredity</li> <li>b. Environment</li> </ol> </li> <li>1. Growth and development               <ol style="list-style-type: none"> <li>a. Erickson's' eight (8) stages of development</li> <li>b. Theories of growth and development</li> </ol> </li> </ol>	<p>PRIOR TO CLASS</p> <p>Read Kozier &amp; Erb: Chapter 21</p>
	<p>B. Discuss essential factors of growth and development from young adulthood through late adulthood. (Infancy-Adolescence will be addressed in NUR-130)</p> <p>C. Young adults</p> <ol style="list-style-type: none"> <li>a. Physical development</li> <li>b. Psychosocial development</li> <li>c. Cognitive development</li> <li>d. Moral and spiritual development</li> <li>e. Potential health problems</li> </ol> <p>D. Middle-aged adults</p> <ol style="list-style-type: none"> <li>1. Physical changes</li> <li>2. Psychosocial development</li> <li>3. Cognitive development</li> <li>4. Moral and spiritual development</li> <li>5. Potential health problems</li> </ol> <p>E. Late adulthood</p> <ol style="list-style-type: none"> <li>1. Physical development</li> <li>2. Psychosocial development</li> <li>3. Cognitive development</li> <li>4. Moral and spiritual development</li> <li>5. Potential health problems</li> </ol> <p>F. Effects of illness and hospitalization on the elderly</p>	<p>PRIOR TO CLASS</p> <p>Read Kozier &amp; Erb: Chapter 23</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>AV: "Gerontology: Natural Process of Aging"</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
Discuss The Concepts Of Psychologic And Physiologic Homeostasis And The Impact Of Stress And Adaptation On Health Status	VI. Physiologic / Psychologic A. Define homeostasis and discuss essential factors <ol style="list-style-type: none"> <li>1. Definition</li> <li>2. Physiologic homeostasis</li> <li>3. Psychologic homeostasis</li> </ol>	PRIOR TO CLASS  Read Kozier & Erb: Chapter 40
	B. Discuss the concept of stress and its implications for health care <ol style="list-style-type: none"> <li>1. Stress as a stimulus</li> <li>2. Stress as a response</li> <li>3. General adaptation syndrome</li> <li>4. Physiologic manifestation</li> <li>5. Psychologic manifestation</li> <li>6. Cognitive response</li> <li>7. Verbal / motor response</li> <li>8. Ego defense mechanisms (unconscious)</li> </ol>	
	C. Identify factors which influence stress responses <ol style="list-style-type: none"> <li>1. Nature of stressor</li> <li>2. Perception of stressor</li> <li>3. Number of stressors</li> <li>4. Duration</li> <li>5. Past experience</li> <li>6. Support</li> <li>7. Age</li> <li>8. Personality type</li> </ol>	
	D. Describe modes of stress adaptation <ol style="list-style-type: none"> <li>1. Physiologic</li> <li>2. Psychologic</li> <li>3. Socio-cultural</li> <li>4. Characteristics of adaptive responses</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>E. Discuss the nursing process related to stress and adaptation</p> <ol style="list-style-type: none"> <li>1. Assessment of stress               <ol style="list-style-type: none"> <li>a. Stressors according to developmental stage</li> <li>b. Determination of coping abilities</li> <li>c. Gerontological considerations</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Response guidelines</li> <li>b. Mediating anger</li> <li>c. Exercise</li> <li>d. Nutrition</li> <li>e. Rest and sleep</li> <li>f. Time management</li> <li>g. Problem solving</li> <li>h. Relaxation techniques</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	
<p>Describe Principles Of Communication As A Basis For The Nurse-Patient Relationship</p>	<p>VII. Communication Lab</p> <p>A. Explain two (2) kinds of communication</p> <ol style="list-style-type: none"> <li>1. Verbal: characteristics of effective verbal communication</li> <li>2. Non-verbal assessment</li> </ol>	<p>PRIOR TO CLASS</p>
	<p>B. Discuss four (4) main components to the communication process</p> <ol style="list-style-type: none"> <li>1. Sender</li> <li>2. Message</li> <li>3. Receiver</li> <li>4. Response</li> </ol>	<p>Read Kozier &amp; Erb: Chapter 24</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	C. Describe factors influencing the communication process <ol style="list-style-type: none"> <li>1. Ability to communicate</li> <li>2. Perceptions</li> <li>3. Personal space</li> <li>4. Territoriality</li> <li>5. Roles</li> <li>6. Time</li> <li>7. Attitudes</li> <li>8. Age</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>D. Discuss the nursing process as it relates to effective communication</p> <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Language development</li> <li>b. Nonverbal</li> <li>c. Style</li> <li>d. Gerontological considerations</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Listening and responding               <ol style="list-style-type: none"> <li>a. Attentive listening</li> <li>b. Responding</li> <li>c. Paraphrasing</li> <li>d. Clarifying</li> <li>e. Open-ended statements</li> <li>f. Focusing                   <ul style="list-style-type: none"> <li>• Touch</li> <li>• Specific, tentative, informative</li> </ul> </li> <li>g. Silence</li> <li>h. Summarizing</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol> <p>E. Describe non-therapeutic responses in the communication process</p> <ol style="list-style-type: none"> <li>1. Failing to listen</li> <li>2. Reassurance</li> <li>3. Judgmental responses</li> <li>4. Defensive responses</li> <li>5. Agreement / disagreement</li> <li>6. Probing</li> </ol>	<p>PRIOR TO CLASS</p> <p>Read Kozier &amp; Erb: Chapter 24</p> <p style="text-align: center;"><b><u>During Class</u></b></p> <p>Role Play: Communication Techniques</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	F. Discuss development of the therapeutic nurse / patient relationship 1. Active listening 2. Identification of feelings 3. Empathy 4. Honesty 5. Genuineness 6. Summarizing	
	G. Discuss four (4) phases of the therapeutic relationship 1. Pre-interaction 2. Introductory 3. Working 4. Termination	
	H. Teaching/Learning	
	I. Review three domains of learning 1. Cognitive 2. Affective 3. Psychomotor	PRIOR TO CLASS  Read Kozier & Erb: Chapter 24
	J. Describe factors that influence teaching / learning	
	K. Discuss five principles of teaching	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>L. Discuss the nursing process as it relates to the teaching / learning process</p> <ol style="list-style-type: none"> <li>1. Assessment learning needs               <ol style="list-style-type: none"> <li>a. Readiness</li> <li>b. Motivation</li> <li>c. Personal characteristics</li> <li>d. Gerontological considerations</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Guidelines</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	
	<p>M. Discuss specific teaching strategies according to developmental stage</p> <ol style="list-style-type: none"> <li>1. Client contract</li> <li>2. Group</li> <li>3. Behavior modification               <ol style="list-style-type: none"> <li>a. Infants / toddlers</li> <li>b. Pre-school</li> <li>c. School-age</li> <li>d. Adolescent</li> <li>e. Young-middle age</li> <li>f. Elderly</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>During Class</u></b></p> <p>Case Study: Diagnosing Communication Problems</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
<p align="center"><b>UNIT 4</b></p> <p align="center">HEALTH ASSESSMENT -- PHYSIOLOGICAL</p> <p>Examine Physiological Concepts Of Health Assessment</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I. Activity and Exercise</p> <p>A. Discuss aspects of mobility</p> <ol style="list-style-type: none"> <li>1. Joint mobility <ol style="list-style-type: none"> <li>a. Synovial joints</li> </ol> </li> <li>2. Factors affecting mobility</li> </ol>	<p>PRIOR TO CLASS</p> <p>Read Kozier &amp; Erb: Chapter 42</p>
	<p>B. Describe complications resulting from immobility</p> <ol style="list-style-type: none"> <li>1. Degrees</li> <li>2. Decubitus ulcer</li> <li>3. Physiologic response <ol style="list-style-type: none"> <li>a. Musculoskeletal</li> <li>b. Cardiovascular</li> <li>c. Respiratory</li> <li>d. Metabolic and nutritional</li> <li>e. Urinary and endocrine</li> <li>f. Bowel elimination</li> <li>g. Integumentary</li> <li>h. Neurosensory</li> </ol> </li> <li>4. Psychosocial response</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>C. Discuss the nursing process as it relates to the patient experiencing mobility problems</p> <ol style="list-style-type: none"> <li>1. Assessment immobility               <ol style="list-style-type: none"> <li>a. Baseline data</li> <li>b. Abnormal findings</li> <li>c. ADL</li> <li>d. Pressure areas</li> <li>e. Gerontological considerations</li> </ol> </li> <li>2. Common nursing diagnoses               <ol style="list-style-type: none"> <li>a. Activity intolerance</li> <li>b. Impaired physical mobility</li> </ol> </li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> <li>d. Interdisciplinary teams</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Pressure source</li> <li>b. Musculoskeletal</li> <li>c. Range of motion</li> <li>d. Cardiovascular</li> <li>e. Respiratory</li> <li>f. Metabolism and nutrition</li> <li>g. Elimination</li> <li>h. Evaluation of expected outcomes</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>During Class</u></b></p> <p>Guest Speaker: Chiropractor</p> <p>Case Study</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	D. Describe principles of body mechanics <ol style="list-style-type: none"> <li>1. Body mechanics               <ol style="list-style-type: none"> <li>a. Base of support</li> <li>b. Balance</li> <li>c. Line of gravity</li> <li>d. Moving objects or clients</li> </ol> </li> <li>2. Structural abnormalities</li> <li>3. Developmental variations in body alignment</li> <li>4. Mechanics of lifting</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> CAI: "Body Mechanics"
	E. Describe Factors which affect mechanics, alignment and ambulation <ol style="list-style-type: none"> <li>1. Nutrition</li> <li>2. Emotional State</li> <li>3. Life style</li> <li>4. Values</li> <li>5. Disease or injury</li> </ol>	
	F. Identify problems associated with poor mechanics <ol style="list-style-type: none"> <li>1. Falls</li> <li>2. Back stress</li> <li>3. Risk groups</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>G. Discuss the nursing process as it related to body mechanics and alignment</p> <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Data Review</li> <li>b. Body alignment</li> <li>c. Limitations</li> </ol> </li> <li>2. Common nursing diagnoses               <ol style="list-style-type: none"> <li>a. Risk for injury</li> <li>b. Acute pain</li> </ol> </li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Patient positions                   <ul style="list-style-type: none"> <li>• Fowlers</li> <li>• Dorsal recumbent</li> <li>• Supine</li> <li>• Prone</li> <li>• Sims</li> <li>• Bed positions</li> </ul> </li> <li>b. Transferring patients                   <ul style="list-style-type: none"> <li>• Stretcher</li> <li>• Wheelchair</li> </ul> </li> <li>c. Ambulation                   <ul style="list-style-type: none"> <li>• Mechanical aids: canes, walkers, crutches</li> </ul> </li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol> <p>H. Demonstrate implementation of body mechanics</p>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Procedures: Read Kozier &amp; Erb Chapter 42</p> <p style="text-align: center;"><b><u>During Class – Lab Mobility Lab Practice:</u></b></p> <ul style="list-style-type: none"> <li>-Make occupied bed</li> <li>-transfer client</li> <li>-Positioning, ROM</li> <li>-Move up in bed</li> <li>-Log roll</li> <li>-Sit to edge of bed</li> </ul>

Overall Objective	Content/ Objective	Learning Environment and Activities
	II. Assessment of Vital Signs - Lab A. Define Vital Signs	<p style="text-align: center;"><b><u>PRIOR TO LAB</u></b></p> <p>Read Kozier &amp; Erb: Chapter 27</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Informatics:  <a href="http://www.nhlbi.nih.gov/guidelines/hypertension">www.nhlbi.nih.gov/guidelines/hypertension</a>  <a href="http://www.epa.gov.epaoswer/hazwaste/mercury/faq/spills.htm">www.epa.gov.epaoswer/hazwaste/mercury/faq/spills.htm</a>  <a href="http://www.med.ucla.edu/wilkes/lungintro.htm">www.med.ucla.edu/wilkes/lungintro.htm</a></p>
	B. Discuss factors affecting and regulating body temperature <ol style="list-style-type: none"> <li>1. Heat production</li> <li>2. Heat loss</li> <li>3. Regulation</li> <li>4. Factors affecting body temperature</li> </ol>	
	C. Describe three most commonly used methods of measuring body temperature <ol style="list-style-type: none"> <li>1. Oral</li> <li>2. Rectal</li> <li>3. Axillary</li> <li>4. Advantages / disadvantages of each method</li> </ol>	
	D. Describe types of thermometers	
	E. Identify alterations in body temperature	
	F. Describe components of pulse <ol style="list-style-type: none"> <li>1. Stroke volume</li> <li>2. Compliance</li> <li>3. Cardiac output</li> </ol>	
	G. Discuss factors affecting pulse rate	
	H. Identify pulse sites <ol style="list-style-type: none"> <li>1. Reasons for use of specific site</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	I. Define respiration <ol style="list-style-type: none"> <li>1. Terminology</li> <li>2. Mechanics of breathing</li> <li>3. Control of respirations</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 27 – Utilize techniques outlined in this chapter</p> <p style="text-align: center;"><b><u>LAB:</u></b></p> <p><b>Demonstration, Practice &amp; Return:</b> VS: Temperature, Pulse, Respiration, Blood Pressure: Aneroid &amp; Mercury <i>Utilize Techniques Outlined In Kozier &amp; Erb Cha. 27</i></p>
	J. Describe arterial blood pressure <ol style="list-style-type: none"> <li>1. Systolic</li> <li>2. Diastolic</li> <li>3. Pulse pressure</li> <li>4. Hypertension</li> <li>5. Hypotension</li> </ol>	
	K. Discuss the physiology of blood pressure <ol style="list-style-type: none"> <li>1. Physiology</li> <li>2. Factors affecting blood pressure</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>III. A Safe Environment</p> <p>A. Discuss the nursing process related to prevention of injury</p> <ol style="list-style-type: none"> <li>1. Assess potential for injury <ol style="list-style-type: none"> <li>a. Age</li> <li>b. Life style</li> <li>c. Sensory</li> <li>d. Awareness</li> <li>e. Mobility</li> <li>f. Emotional state</li> <li>g. Communication</li> </ol> </li> <li>2. Common nursing diagnoses <ol style="list-style-type: none"> <li>a. Risk for injury</li> </ol> </li> <li>3. Planning <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> <li>d. Interdisciplinary teams <ul style="list-style-type: none"> <li>• NAI, Clerks, LPN, RN</li> <li>• Environmental Services</li> <li>• Maintenance</li> </ul> </li> </ol> </li> <li>4. Implementation <ol style="list-style-type: none"> <li>a. Strategies <ul style="list-style-type: none"> <li>• General</li> <li>• Fire</li> <li>• Falls</li> <li>• Restraints</li> </ul> </li> <li>b. Guidelines for use</li> </ol> </li> <li>5. Evaluation of expected outcomes <ol style="list-style-type: none"> <li>a. Quality improvement <ul style="list-style-type: none"> <li>• Restraint documentation and assessment</li> </ul> </li> </ol> </li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 30 – Utilize techniques outlined in this chapter</p> <p><b><u>During Class</u></b></p> <p>Handouts: Restraint Policy , Practice Documentation: Restraint Flow Sheet</p> <p><b><u>During Class LAB</u></b></p> <p><b>LAB: Demo, Practice &amp; Return</b> Demonstration, Practice &amp; Return: Application &amp; Care Of Patient In Restraints a. Jacket Restraint b. Wrist Restraint <i>Utilize Techniques Found In Kozier &amp; Erb Cha. 30</i></p> <p><b><u>Additional/Optional</u></b></p> <p>Informatics: <a href="http://www.cdc.gov/niosh/topics/safety.html">www.cdc.gov/niosh/topics/safety.html</a></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	B. Asepsis: Describe the importance of preventing the transfer of microorganisms to the biologic safety of the patient. <ol style="list-style-type: none"> <li>1. Infection</li> <li>2. Microorganisms</li> <li>3. Etiology</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p><b><u>Asepsis Videos:</u></b>            AV: Medical Asepsis #10; 14 min            Bed Bath #3; 20 min</p>
	C. Discuss normal body defenses that protect from infection <ol style="list-style-type: none"> <li>1. Nonspecific</li> <li>2. Inflammation</li> <li>3. Specific defenses</li> </ol>	
	D. Discuss the six links in the chain of infection and how the chain may be broken <ol style="list-style-type: none"> <li>1. Links in chain of infection               <ol style="list-style-type: none"> <li>a. Agent</li> <li>b. Reservoir</li> <li>c. Portal of exit</li> <li>d. Mode of transmission</li> <li>e. Portal of entry</li> <li>f. Host</li> </ol> </li> <li>2. Breaking the chain</li> <li>3. Cellular immunity</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Informatics &amp; EBP  <a href="http://www.cdc.gov/niosh/topics">www.cdc.gov/niosh/topics</a>  <a href="http://www.osha.gov">www.osha.gov</a></p>
	E. Describe factors which increase risk of infection <ol style="list-style-type: none"> <li>1. Factors               <ol style="list-style-type: none"> <li>a. Age</li> <li>b. Heredity</li> <li>c. Stress</li> <li>d. Nutritional status</li> <li>e. Immunization</li> <li>f. Medical therapy</li> <li>g. Existing disease</li> </ol> </li> <li>2. Nosocomial Infection</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>AV: Infection Control</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>F. Discuss the nursing process as it relates to the infections process</p> <ol style="list-style-type: none"> <li>1. Assessment</li> <li>2. Common nursing diagnoses               <ol style="list-style-type: none"> <li>a. Risk for infection</li> </ol> </li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> <li>d. Gerontological considerations</li> </ol> </li> <li>4. Implementation</li> <li>5. Evaluation of expected outcomes</li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 29 – Utilize techniques outlined in this chapter</p> <p><b><u>During Class - LAB</u></b></p> <p>Demonstration, Practice &amp; Return: Hand washing Asepsis LAB: Demonstration, Practice &amp; Return: Use of Face Masks, Isolation technique, Gowns, Sterile field, Gloves, Bagging <i>Utilize Techniques Found In Kozier &amp; Erb Cha.29</i></p> <p><b><u>Additional/Optional</u></b></p> <p>AV: Medical Asepsis #10; 14 min</p>
	<p>G. Demonstrate correct technique for hand washing</p>	
	<p>H. Discuss components for protective asepsis or isolation</p> <ol style="list-style-type: none"> <li>1. Guidelines</li> <li>2. Psychologic problems</li> </ol>	
	<p>I. Demonstrate protective asepsis technique</p>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>J. Discuss the appropriate utilization of surgical asepsis and demonstrate sterile technique.</p> <ol style="list-style-type: none"> <li>1. Appropriate use</li> <li>2. Equipment and supplies               <ol style="list-style-type: none"> <li>a. Sterile forceps</li> <li>b. Sterile field</li> </ol> </li> <li>3. Principles and practices of surgical asepsis</li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 29 – Utilize techniques outlined in this chapter</p> <p><b><u>During Class - LAB</u></b></p> <p><b><u>Asepsis LAB:</u></b> <b><u>Demonstration, Practice &amp; Return:</u></b></p> <p>Establishing a Sterile Field, Opening Sterile Packages, Donning Sterile Gloves <i>Review Techniques</i> <i>Outlined In Kozier &amp; Erb</i> <i>Cha. 29</i></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	IV. Personal Hygiene A. Discuss guidelines for care of the skin <ol style="list-style-type: none"> <li>1. Functions of skin</li> <li>2. Purpose of hygiene</li> <li>3. Risk factors</li> <li>4. Functions of bathing (categories of baths)               <ol style="list-style-type: none"> <li>a. Hair care</li> <li>b. Eye care</li> <li>c. Ear care</li> <li>d. Nose care</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 31</p>
	B. Discuss the aspects of making a hospital bed <ol style="list-style-type: none"> <li>1. Equipment               <ol style="list-style-type: none"> <li>a. Mechanics</li> <li>b. Mattresses</li> <li>c. Footboard</li> <li>d. Bed cradle</li> <li>e. IV poles</li> </ol> </li> <li>2. Bed making               <ol style="list-style-type: none"> <li>a. Guidelines</li> <li>b. Mitering a corner</li> <li>c. Unoccupied bed</li> <li>d. Occupied bed</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>During Class LAB</u></b></p> <p><u>Lab Practice:</u> Bed Making: Occupied &amp; Unoccupied</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>AV: "Making A Bed"</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	V. Rest and Sleep A. Describe the importance of rest and sleep to health <ol style="list-style-type: none"> <li>1. Purpose of rest and sleep</li> <li>2. Functions of sleep               <ol style="list-style-type: none"> <li>a. Two kinds of sleep</li> <li>b. Four stages of sleep</li> </ol> </li> <li>3. Requirements of sleep related to developmental stage</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> Read Kozier & Erb: Chapter 31
	B. Discuss factors which affect sleep <ol style="list-style-type: none"> <li>1. Illness</li> <li>2. Environment</li> <li>3. Exercise</li> <li>4. Emotions</li> <li>5. Medications</li> <li>6. Nutrition</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> Informatics: <a href="http://www.cdc.gov/nasd/docs">www.cdc.gov/nasd/docs</a> <a href="http://www.cdc.gov/niosh">www.cdc.gov/niosh</a>
	C. Discuss common sleep disorders <ol style="list-style-type: none"> <li>1. Insomnia</li> <li>2. Hypersomnia</li> <li>3. Parasomnia</li> <li>4. Narcolepsy</li> <li>5. Sleep apnea</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>D. Discuss the nursing process as it is applicable to rest and sleep</p> <ol style="list-style-type: none"> <li>1. Assessment</li> <li>2. Common nursing diagnoses               <ol style="list-style-type: none"> <li>a. Fatigue</li> <li>b. Altered comfort</li> </ol> </li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> <li>d. Gerontological considerations</li> <li>e. Interdisciplinary team</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Environment</li> <li>b. Activity</li> <li>c. Developmental</li> <li>d. Comfort and safety</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
<p style="text-align: center;"><b>UNIT 5</b></p> <p><b>PHYSICAL ASSESSMENT</b></p> <p>Discuss A Comprehensive Nursing Assessment Of The Adult Patient. Demonstrate Basic Nursing Skills In The Nursing Lab.</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I. Physical Assessment</p> <p>A. Discuss principles of obtaining a health history</p> <ol style="list-style-type: none"> <li>1. Ethical consideration</li> <li>2. Guidelines for the nurse</li> <li>3. Content of the interview               <ol style="list-style-type: none"> <li>a. Biographical data</li> <li>b. The informant</li> <li>c. Chief complaint</li> <li>d. History present illness</li> <li>e. Past health history</li> <li>f. Family history</li> <li>g. Review of systems</li> <li>h. Patient profile</li> </ol> </li> <li>4. Interdisciplinary Team</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 28</p> <p>Read Iggy: Chapters 1, 27, 33, 39, 41, 46, 50, 53, 62, 66, 69, and 73</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>AV: Video Performing /Head-to-Toe Assessment" #179A</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>B. Describe the process of physical assessment</p> <ol style="list-style-type: none"> <li>1. Fundamental process               <ol style="list-style-type: none"> <li>a. Inspection</li> <li>b. Palpation</li> <li>c. Percussion</li> <li>d. Auscultation</li> </ol> </li> <li>2. Nutritional assessment               <ol style="list-style-type: none"> <li>a. Clinical exam</li> <li>b. Lab results</li> </ol> </li> <li>3. Sequence of head to toe physical assessment</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 28</p>
	<p>C. Discuss the assessment process when examining</p> <ol style="list-style-type: none"> <li>1. Color the skin</li> <li>2. Lesions</li> <li>3. Vascularity</li> <li>4. Temperature</li> <li>5. Edema</li> <li>6. Gerontological considerations</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Evidence Based Practice: Describing skin lesions. Informatics: <a href="http://www.pediatrics.wisc.edu/education/derm/text.html">www.pediatrics.wisc.edu/education/derm/text.html</a></p>
	<p>D. Describe physical assessment of the head and neck</p> <ol style="list-style-type: none"> <li>1. Size</li> <li>2. Hair and scalp</li> <li>3. Facial symmetry</li> <li>4. Nose / sinus</li> <li>5. Pharynx</li> <li>6. Larynx</li> <li>7. Tonsils / Adenoids</li> <li>8. Lymph nodes</li> <li>9. Trachea</li> <li>10. Thyroid</li> <li>11. Oral cavity</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	E. Discuss findings that may be found during examination of the eye <ol style="list-style-type: none"> <li>1. Visual acuity</li> <li>2. External evaluation</li> <li>3. Field of vision</li> <li>4. Gerontological considerations</li> <li>5. Nystagmus</li> <li>6. Red reflex</li> <li>7. Optic disc</li> <li>8. Retina</li> </ol>	
	F. Discuss the following as noted in the assessment of the ear <ol style="list-style-type: none"> <li>1. Eardrum</li> <li>2. Level of hearing</li> <li>3. Weber test</li> <li>4. Rinne test</li> <li>5. Gerontological considerations</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>G. Discuss physical assessment of the thorax and lungs</p> <ol style="list-style-type: none"> <li>1. Definitions               <ol style="list-style-type: none"> <li>a. Midsternal line</li> <li>b. Midclavicular line</li> <li>c. Anterior axillary line</li> <li>d. Midaxillary line</li> <li>e. Posterior axillary line</li> <li>f. Scapular line</li> <li>g. Vertebrae line</li> </ol> </li> <li>2. Inspection of the thorax               <ol style="list-style-type: none"> <li>a. Breathing pattern assessment</li> <li>b. Respiratory excursion</li> </ol> </li> <li>3. Palpation               <ol style="list-style-type: none"> <li>a. Anterior tactile fremitus</li> <li>b. Posterior tactile fremitus</li> </ol> </li> <li>4. Percussion of the thorax               <ol style="list-style-type: none"> <li>a. Size of heart</li> <li>b. Diaphragmatic excursion</li> </ol> </li> <li>5. Auscultation of the thorax               <ol style="list-style-type: none"> <li>a. Breath sounds</li> <li>b. Adventitious sounds</li> <li>c. Vocal resonance</li> <li>d. Bronchophony</li> <li>e. Egophony</li> </ol> </li> <li>6. Gerontological considerations</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Informatics:  <a href="http://www.med.ucla.edu/wilkes/inex.htm">www.med.ucla.edu/wilkes/inex.htm</a>   <a href="http://solutions.3m.com/wps/portal/3m/en_us/littmann/stethoscope/education/heart-lung-sounds/">http://solutions.3m.com/wps/portal/3m/en_us/littmann/stethoscope/education/heart-lung-sounds/</a></p>
	<p>H. Define normal and abnormal findings in physical assessment of the breast</p> <ol style="list-style-type: none"> <li>1. Inspection</li> <li>2. Palpation</li> <li>3. Self-examination</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>I. Discuss physical assessment of the cardiovascular system</p> <ol style="list-style-type: none"> <li>1. Blood pressure</li> <li>2. Pulse</li> <li>3. Inspect               <ol style="list-style-type: none"> <li>a. Edema</li> <li>b. JVD</li> <li>c. Extremity color</li> </ol> </li> <li>4. Auscultation               <ol style="list-style-type: none"> <li>a. First heart sound</li> <li>b. Second heart sound</li> <li>c. Third heart sound</li> <li>d. Fourth heart sound</li> <li>e. Interpretation of cardiac sounds</li> </ol> </li> <li>5. Gerontological considerations</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Informatics:  <a href="http://www.med.ucla.edu/wilkes/inex.htm">www.med.ucla.edu/wilkes/inex.htm</a></p>
	<p>J. Discuss physical assessment of the abdomen</p> <ol style="list-style-type: none"> <li>1. Abdomen           <ol style="list-style-type: none"> <li>a. Skin</li> <li>b. Hernias</li> <li>c. Ascites</li> <li>d. Pain</li> </ol> </li> <li>2. Auscultate           <ol style="list-style-type: none"> <li>a. Bowel sounds</li> <li>b. Renal artery</li> </ol> </li> <li>3. Percussion</li> <li>4. Palpation           <ol style="list-style-type: none"> <li>c. Rebound tenderness</li> <li>d. Referred rebound tenderness</li> </ol> </li> </ol>	
	<p>K. Describe findings in physical assessment of the rectum</p> <ol style="list-style-type: none"> <li>1. Anal canal</li> <li>2. Prostate</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	L. Discuss physical assessment of the male and female genitalia <ol style="list-style-type: none"> <li>1. Female genitalia               <ol style="list-style-type: none"> <li>a. Speculum exam</li> <li>b. Visual exam</li> <li>c. Bimanual exam</li> <li>d. Self exam</li> </ol> </li> <li>2. Male genitalia</li> <li>3. Gerontological considerations</li> </ol>	
	M. Discuss physical examination of the nervous system <ol style="list-style-type: none"> <li>1. Mental status               <ol style="list-style-type: none"> <li>a. Language</li> <li>b. Orientation</li> <li>c. Memory</li> <li>d. Attention span</li> </ol> </li> <li>2. Cranial nerves and function</li> <li>3. Motor function</li> <li>4. Reflexes</li> <li>5. Sensory function</li> <li>6. Gerontological considerations</li> </ol>	<p style="text-align: center;"><b><u>During Class</u></b></p> Evidence Based Practice: Case Study – outpatient clinic assessments
	N. Describe physical assessment of the musculoskeletal system <ol style="list-style-type: none"> <li>1. Normal and abnormal findings</li> <li>2. Gerontological considerations</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
<p>Evaluation: Observation Of Return Demonstration</p>	<p>II. Physical Assessment Practice / Lab            A. Practice techniques of physical assessment in the nursing lab            B. Demonstrate techniques of physical assessment in the nursing lab</p>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 28 – Utilize techniques outlined in this chapter</p> <p><b><u>During Class - LAB</u></b></p> <p>LAB: Demonstration, Practice &amp; Return  <i>Utilize Techniques Found In Kozier &amp; Erb Cha. 28</i></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
<p style="text-align: center;"><b>UNIT 6</b></p> <p style="text-align: center;"><b>BASIC PRINCIPLES OF REPORTING AND RECORDING</b></p> <p>Discuss Basic Principles Of Reporting And Recording Pertinent Information Related To Provision Of Care. Demonstrate Basic Skills In The Nursing Lab.</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I. Reporting And Recording</p> <p style="padding-left: 20px;">A. Define terms related to reporting and recording</p> <ol style="list-style-type: none"> <li>1. Medical record (chart)</li> <li>2. Recording (charting)</li> <li>3. Legal document</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 28 – Utilize techniques outlined in this chapter</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>B. Identify types of records found in the patient's chart</p> <ol style="list-style-type: none"> <li>1. Admission sheet</li> <li>2. Physician's order sheet               <ol style="list-style-type: none"> <li>a. History sheet</li> <li>b. Nurses notes</li> <li>c. Lab reports</li> <li>d. X-ray reports</li> <li>e. Care plan</li> </ol> </li> </ol>	
	<p>C. Discuss information found in nurses notes</p> <ol style="list-style-type: none"> <li>1. Assessment</li> <li>2. Independent nursing</li> <li>3. Dependent nursing functions</li> <li>4. Evaluation</li> <li>5. Measures carried out by physician</li> <li>6. Visits by health team members</li> </ol>	
	<p>D. Discuss types of progress notes</p> <ol style="list-style-type: none"> <li>1. Narrative and soap</li> <li>2. Flow sheet</li> <li>3. Discharge notes</li> </ol>	<p style="text-align: center;"><b><u>During Class</u></b></p> <p>Handouts</p>
	<p>E. Discuss guidelines for recording</p> <ol style="list-style-type: none"> <li>1. Confidentially</li> <li>2. Type; ink</li> <li>3. Legibility</li> <li>4. Signature and date</li> <li>5. Errors</li> <li>6. Accuracy</li> <li>7. Appropriateness</li> <li>8. Completeness</li> <li>9. Abbreviations and symbols</li> </ol>	<p style="text-align: center;"><b><u>During Class - LAB</u></b></p> <p>Demonstration, Practice &amp; Return Flow Sheets, Plan Of Care, Reporting Client Status</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>AV: Documenting Nursing Practice</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	F. Discuss guidelines for reporting 1. Change of shift 2. Pertinent information	
	G. Demonstrate reporting and recording techniques in the nursing lab	

Overall Objective	Content/ Objective	Learning Environment and Activities
<p align="center"><b>UNIT 7</b></p> <p>Nursing Management Of Medication Administration</p> <p>Discuss The Basic Principles Of Pharmacology In The Safe Administration Of Medications. Demonstrate Basic Nursing Skills In The Nursing Laboratory.</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I. Pharmacology</p> <p>A. Describe names and types of medication</p> <ol style="list-style-type: none"> <li>1. Generic vs. brand names</li> <li>2. Types of drug preparation</li> </ol>	<p align="center"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 33  Read Adams: Chapters 1 through 9 and Chapters 11 and 12</p>
	<p>B. Discuss legal aspects of drug administration</p> <ol style="list-style-type: none"> <li>1. Food, Drug, and Cosmetic Act</li> <li>2. Comprehensive Drug Abuse Prevention &amp; Control Act</li> <li>3. Nursing implications in administering controlled drugs</li> </ol>	<p align="center"><b><u>PRIOR TO CLASS</u></b></p> <ul style="list-style-type: none"> <li>• Complete Practice Exercises in Calculation Book/Disk. (pages 1 through 77)</li> </ul> <p align="center"><b><u>During Class</u></b></p> <p>Discuss Five (5) Rights</p>
	<p>C. Describe the actions of the drugs on the body</p> <ol style="list-style-type: none"> <li>1. Time frames</li> <li>2. Variables influencing drug action</li> <li>3. Pharmacokinetics</li> </ol>	
	<p>D. Discuss routes of drug administration</p> <ol style="list-style-type: none"> <li>1. Oral</li> <li>2. Sublingual</li> <li>3. Buccal</li> <li>4. Parenteral</li> <li>5. Topical</li> </ol>	
	<p>E. Discuss types of medication orders</p> <ol style="list-style-type: none"> <li>1. State</li> <li>2. Single</li> <li>3. Standing</li> <li>4. PRN</li> <li>5. Common abbreviations</li> <li>6. Legal aspects</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>F. Identify avenues to prevent medication errors</p> <ol style="list-style-type: none"> <li>1. Prescribed procedure</li> <li>2. Concentration</li> <li>3. Effective communication</li> <li>4. Identify similar names</li> <li>5. Correct identification of patient</li> <li>6. Immediate charting</li> <li>7. Knowledge of patient condition</li> <li>8. Interdisciplinary team:               <ol style="list-style-type: none"> <li>a. Pharmacy</li> <li>b. Physicians</li> <li>c. Physician Assistants</li> <li>d. Nurse Practitioners</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Informatics:  <a href="http://www.fda.gov/cder/drug/mederrors/default.htm">www.fda.gov/cder/drug/mederrors/default.htm</a></p>
	<p>G. Determine the calculation of dosages for drug administration</p> <ol style="list-style-type: none"> <li>1. The metric system</li> <li>2. Apothecary system</li> <li>3. Conversion between metric and apothecary systems</li> <li>4. Review fractions</li> <li>5. Ratio and proportion</li> <li>6. Formula</li> <li>7. Decimals</li> <li>8. Percentage</li> <li>9. Dosages               <ol style="list-style-type: none"> <li>a. Calculate oral dosages</li> <li>b. Calculate liquid dosages</li> <li>c. Calculate parenteral dosages</li> </ol> </li> </ol>	<p>The student must pass a test on math calculations, achieving a score of 90%. Three opportunities will be provided for the student to demonstrate competency in math computation. Students who fail to achieve 90% after three attempts will not be allowed to continue in clinical. This will result in student receiving WF.</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	H. Identify developmental considerations in medication administration <ol style="list-style-type: none"> <li>1. Pregnancy and lactation</li> <li>2. Pediatrics</li> <li>3. Young and middle adults</li> <li>4. Older adults</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> Read Adams: Chapter 8
	I. Discuss procedures for the administration of medication <ol style="list-style-type: none"> <li>1. Oral medication</li> <li>2. Parenteral medication               <ol style="list-style-type: none"> <li>a. Syringes</li> <li>b. Ampules and vials</li> <li>c. Mixing medication</li> <li>d. Intradermal</li> <li>e. Subcutaneous</li> <li>f. IM medications</li> <li>g. Topical medications</li> <li>h. Irrigations and instillations                   <ul style="list-style-type: none"> <li>• Ophthalmic</li> <li>• Otic</li> <li>• Nasal</li> </ul> </li> <li>i. Vaginal irrigations</li> <li>j. Rectal suppositories</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> Read Kozier & Erb: Chapter 33 <p style="text-align: center;"><b><u>During Class - LAB</u></b></p> Basic Clinical Skills AV: “Administering PO Medications and IM, Intradermal & SQ injections.” <p>Evidence based practice:            Case Study: Administering PO Digoxin</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>J. Discuss problems related to drug-nutrient interaction</p> <ol style="list-style-type: none"> <li>1. Cause and effect</li> <li>2. Drug effects on food intake               <ol style="list-style-type: none"> <li>a. Increased appetite</li> <li>b. Increased nutrient absorption</li> <li>c. Decreased nutrient absorption</li> <li>d. Mineral depletion</li> <li>e. Vitamin depletion</li> <li>f. Adverse reactions</li> </ol> </li> <li>3. Food absorption and drugs               <ol style="list-style-type: none"> <li>a. Increased absorption</li> <li>b. Decreased absorption</li> <li>c. Food effects on drug distribution and metabolism</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p><b>Informatics / Evidence based practice:</b></p> <p><a href="http://www.healthsystem.virginia.edu/uvahealth/adult-nontrauma/fooddrug.cfm">http://www.healthsystem.virginia.edu/uvahealth/adult-nontrauma/fooddrug.cfm</a></p> <p><a href="http://ohioline.osu.edu/ss-fact/0129.html">http://ohioline.osu.edu/ss-fact/0129.html</a></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>II. Demonstrate techniques of medication administration in the nursing lab</p> <p>A. Practice techniques of medication administration in nursing lab</p> <ol style="list-style-type: none"> <li>1. Oral medications</li> <li>2. Topical medication</li> <li>3. Ophthalmic medications</li> <li>4. Otic medications</li> <li>5. Nasal medications</li> <li>6. Parenteral medications</li> <li>7. Suppositories: <ol style="list-style-type: none"> <li>a. Rectal / vaginal</li> </ol> </li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 33 – Utilize techniques outlined in this chapter</p> <p>During Class -LAB</p> <p>Lab: Demonstration, Practice &amp; Return Utilize Techniques Of Medication Administration Found In Kozier &amp; Erb: Cha. 33</p> <p>The student must pass a test on math calculations, achieving a score of 90%. Three opportunities will be provided for the student to demonstrate competency in math computation. Students who fail to achieve 90% after three attempts will not be allowed to continue in clinical. This will result in student receiving WF.</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
<p align="center"><b>UNIT 8</b></p> <p align="center"><b>NURSING MANAGEMENT OF THE PATIENT EXPERIENCING PERIOPERATIVE CARE NEEDS.</b></p> <p>Discuss The Nursing Process As It Relates To Accountable Management Of The Peri-operative Patient. Demonstrate Basic Nursing Skills In The Nursing Laboratory.</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I. Wounds and Wound Health</p> <p>A. Describe types of wounds</p> <ol style="list-style-type: none"> <li>1. Intentional</li> <li>2. Unintentional</li> </ol>	<p align="center"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 34</p> <p>Williams: Chapter 22</p> <p align="center"><b><u>Additional/Optional</u></b></p> <p>AV: "Closed Suction, Wound Drainage, Wound Irrigation, &amp; Specimen Collection"</p>
	<p>B. Discuss types of wound drainage</p> <ol style="list-style-type: none"> <li>1. Serous</li> <li>2. Purulent</li> <li>3. Sanguineous</li> </ol>	
	<p>C. Describe factors which affect wound healing</p> <ol style="list-style-type: none"> <li>1. Local</li> <li>2. Systemic</li> </ol>	
	<p>D. Identify complications of wound healing</p> <ol style="list-style-type: none"> <li>1. Hemorrhage</li> <li>2. Infection</li> <li>3. Dehiscence and evisceration</li> <li>4. Keloid</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>E. Discuss the nursing process as it relates to wounds and wound healing.</p> <ol style="list-style-type: none"> <li>1. Assessment           <ol style="list-style-type: none"> <li>a. Physical               <ul style="list-style-type: none"> <li>• History</li> <li>• Physical assessment</li> <li>• Psychological assessment</li> <li>• Lab findings</li> <li>• Gerontological considerations</li> </ul> </li> <li>b. Psychosocial</li> </ol> </li> <li>2. Common nursing diagnoses           <ol style="list-style-type: none"> <li>a. Risk for Impaired skin integrity</li> <li>b. Impaired tissue integrity</li> </ol> </li> <li>3. Planning           <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation           <ol style="list-style-type: none"> <li>a. Purpose effective dressings</li> <li>b. Open method</li> <li>c. Closed method</li> <li>d. Methods of lowering incidence of infection</li> <li>e. Supporting and immobilizing wounds</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 34 – Utilize techniques outlined in this chapter</p> <p style="text-align: center;"><b><u>During Class - LAB</u></b></p> <p>Evidence based practice:        PUSH Tool        LAB: Demonstration, Practice &amp; Return</p> <ol style="list-style-type: none"> <li>1. Applying binders/bandages</li> <li>2. Sterile dressing change</li> <li>3. Wet to dry dressing</li> <li>4. Hot and cold applications</li> <li>5. Removal of sutures / staples / clips</li> </ol> <p><i>Utilize Techniques Found In Kozier &amp; Erb Cha. 34</i></p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <ul style="list-style-type: none"> <li>• AV: Providing Wound Care</li> <li>• Informatics:  <a href="http://www.npuap.org">www.npuap.org</a>  <a href="http://www.aad.org">www.aad.org</a></li> </ul>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>II. Peri-operative Care</p> <p>A. Discuss the nursing process as it relates to the Pre-operative patient</p> <ol style="list-style-type: none"> <li>1. Assessment <ol style="list-style-type: none"> <li>a. Psychosocial</li> <li>b. Nutritional status</li> <li>c. Medications</li> <li>d. Fluid and electrolyte status</li> <li>e. General physical assessment</li> <li>f. Screening tests</li> </ol> </li> <li>2. Common nursing diagnoses <ol style="list-style-type: none"> <li>a. Deficient knowledge</li> <li>b. Fear</li> </ol> </li> <li>3. Planning <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation <ol style="list-style-type: none"> <li>a. Pre-op patient teaching</li> <li>b. Informed consent</li> <li>c. Pre-anesthetic medications</li> <li>d. Pre-op checklist</li> <li>e. Helping the family cope</li> <li>f. Nutrition and fluids</li> <li>g. Per-operative skin prep</li> <li>h. Prosthesis and valuables</li> <li>i. Vital signs</li> <li>j. Intestinal preparation</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 35</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>AV: Basic Clinical Skills: Pre-op &amp; Post-op Care</p> <p>Informatics:  <a href="http://www.aana.com">www.aana.com</a>  <a href="http://www.aorn.org">www.aorn.org</a></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>B. Discuss the nursing process as it relates to the postoperative patient.</p> <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Physical</li> </ol> </li> <li>2. Common nursing diagnoses               <ol style="list-style-type: none"> <li>a. Acute Pain</li> <li>b. Risk for Infection</li> </ol> </li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Optimum lung expansion</li> <li>b. Relief of pain</li> <li>c. Relief of restlessness</li> <li>d. Relief of nausea and vomiting</li> <li>e. Relief of abdominal distention</li> <li>f. Maintenance of adequate tissue perfusion</li> <li>g. Maintenance of adequate nutrition</li> <li>h. Return of normal urinary function</li> <li>i. Return of usual bowel elimination</li> <li>j. Avoidance of infection</li> <li>k. Restoration of mobility</li> <li>l. Psychosocial well-being</li> </ol> </li> <li>5. Evaluation of expected outcomes               <ol style="list-style-type: none"> <li>a. Effectiveness of interventions</li> <li>b. Goal achievement</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 35 Read Iggy: Chapter 22</p> <p style="text-align: center;"><b><u>During Class</u></b></p> <p>Evidence based practice: Case study – post-op patient</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>C. Describe post-operative complications</p> <ol style="list-style-type: none"> <li>1. Hemorrhage               <ol style="list-style-type: none"> <li>a. Physiology</li> <li>b. Classification</li> <li>c. Signs and symptoms</li> <li>d. Diagnostic assessment</li> <li>e. Nursing management</li> </ol> </li> <li>2. Hypovolemic shock               <ol style="list-style-type: none"> <li>a. Classification</li> <li>b. Signs and symptoms</li> <li>c. Nursing management</li> </ol> </li> <li>3. Deep venous thrombosis               <ol style="list-style-type: none"> <li>a. Pathophysiology</li> <li>b. Signs and symptoms</li> <li>c. Management</li> </ol> </li> <li>4. Respiratory complication               <ol style="list-style-type: none"> <li>a. Risk factors</li> <li>b. Types</li> <li>c. Management</li> </ol> </li> <li>5. GI complication               <ol style="list-style-type: none"> <li>a. Intestinal obstruction.</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 35            Read Iggy: Chapter 22</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
<p style="text-align: center;"><b>UNIT 9</b></p> <p style="text-align: center;"><b>NURSING MANAGEMENT OF THE PATIENT EXPERIENCING ALTERATION IN COMFORT</b></p> <p>Discuss The Nursing Process As It Relates To The Accountable Management Of The Patient / Client Experiencing Alteration In Comfort</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I. Pain</p> <p>A. Discuss factors related to pain</p> <ol style="list-style-type: none"> <li>1. Types of pain</li> <li>2. Perceptions of pain</li> <li>3. Responses to pain               <ol style="list-style-type: none"> <li>a. Past experience</li> <li>b. Values</li> <li>c. Family expectation</li> <li>d. Environment</li> <li>e. Cultural</li> <li>f. Gerontological considerations</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 44 Read Iggy: Chapter 7</p> <p style="text-align: center;"><b><u>During Class</u></b></p> <p>Handout: Pain flow sheet and protocol</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>AV: "Managing Pain &amp; Discomfort"</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>B. Describe the nursing process as it relates to the patient experiencing alteration in comfort</p> <ol style="list-style-type: none"> <li>1. Assessment of pain               <ol style="list-style-type: none"> <li>a. Physical                   <ul style="list-style-type: none"> <li>• Pathophysiology</li> <li>• Guidelines for assessment</li> <li>• Clinical signs and symptoms</li> <li>• Endorphins and enkephalins</li> </ul> </li> <li>b. Psychosocial</li> </ol> </li> <li>2. Common nursing diagnoses               <ol style="list-style-type: none"> <li>a. Pain</li> <li>b. Anxiety</li> </ol> </li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Noninvasive management                   <ul style="list-style-type: none"> <li>• Distraction</li> <li>• Relaxation</li> <li>• Cutaneous stimulation</li> </ul> </li> <li>b. Administering pharmacologic agents                   <ul style="list-style-type: none"> <li>• Narcotic</li> <li>• Non-narcotic</li> <li>• Placebo</li> </ul> </li> </ol> </li> <li>5. Evaluation of response to pain intervention</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Review Relaxation Techniques Covered In NUR-110, Unit 1</p> <p style="text-align: center;"><b><u>During Class</u></b></p> <p>Evidence based practice: case study- patient with abdominal pain</p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Informatics:  <a href="http://www.stvincent.org/ourservices/hospice/caregiving/pain/management.htm">www.stvincent.org/ourservices/hospice/caregiving/pain/management.htm</a>   <a href="http://www.enh.org/healthandwellness.encyclopedia/ency/article/002123.aspx">www.enh.org/healthandwellness.encyclopedia/ency/article/002123.aspx</a></p> <p>AV: "PCA: Patient Controlled Analgesia Of The Management of Pain"          AV: "Epidural Analgesia"</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
<p align="center"><b>UNIT 10</b></p> <p align="center"><b>Urinary Elimination</b></p> <p>Describe The Process Of Urinary Elimination As It Relates To Nursing Practice</p>	<p>I. Urinary Elimination</p> <p>A. Define terminology related to urinary elimination</p> <ol style="list-style-type: none"> <li>1. Glomerular filtrate</li> <li>2. Reflex</li> <li>3. Micturition</li> </ol>	<p align="center"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 47</p> <p>Read Iggy: Chapters 69, 70, 71, and 72</p>
<p>Evaluation Of Each Unit Consists Of:</p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>B. Describe the anatomy and physiology of the urinary elimination process</p> <ol style="list-style-type: none"> <li>1. Process</li> <li>2. Micturition               <ol style="list-style-type: none"> <li>a. Incontinence</li> <li>b. Automatic bladder</li> <li>c. Retention</li> </ol> </li> </ol>	<p align="center"><b><u>During Class</u></b></p> <p>Evidence based practice: case study – client with severe urinary retention</p>
	<p>C. Identify variables in urinary elimination related to developmental stage</p>	
	<p>D. Discuss problems in urinary elimination</p> <ol style="list-style-type: none"> <li>1. Polyurea</li> <li>2. Oliguria /anurea</li> <li>3. Frequency</li> <li>4. Urgency</li> <li>5. Dysuria</li> <li>6. Enuresis</li> <li>7. Incontinence</li> </ol>	<p align="center"><b><u>Additional/Optional</u></b></p> <p>Informatics: <a href="http://www.mayoclinic.com/health/urinary-incontinence/ds00404">www.mayoclinic.com/health/urinary-incontinence/ds00404</a></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>E. Discuss the nursing process as it relates to urinary elimination</p> <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Clinical signs</li> <li>b. Usual patterns of urination</li> <li>c. Physical assessment</li> <li>d. Characteristics of normal and abnormal urine</li> <li>e. Intake and output</li> <li>f. Diagnostic tests</li> </ol> </li> <li>2. Common nursing diagnoses               <ol style="list-style-type: none"> <li>a. Incontinence</li> <li>b. Knowledge Deficit</li> </ol> </li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> <li>d. Gerontological considerations</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Positioning</li> <li>b. Relaxation</li> <li>c. Timing</li> <li>d. Bedpan</li> <li>e. Bladder training</li> <li>f. Condom catheter</li> <li>g. Urinary catheterization</li> <li>h. Bladder irrigations</li> <li>i. Suprapubic catheter care</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 47 – Utilize techniques outlined in this chapter</p> <p style="text-align: center;"><b><u>During Class - LAB</u></b></p> <p>LAB: Demonstration, Practice &amp; Return          Clean-Catch Specimen          Urinary Catheterization          Female          Male          Bedpan / Urinal  <i>Utilize Techniques Found In Kozier &amp; Erb Cha. 47</i></p> <p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>AV: “Urinary Care”          “Urethral Catheterization”</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
<p style="text-align: center;"><b>UNIT 11</b></p> <p style="text-align: center;"><b>NUTRITION</b></p> <p><i>Examine The Concept Of Nutrition As It Relates To Nursing Practice</i></p> <p>Evaluation Of Each Unit Consists Of:</p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I.Nutrition</p> <p>A. Define terms associated with nutritional needs</p> <ol style="list-style-type: none"> <li>1. Nutrient</li> <li>2. Calorie</li> <li>3. Metabolism</li> <li>4. Basal metabolic rate</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 45</p> <p>Williams: Chapter 1</p>
	<p>B. Discuss factors related to energy</p> <ol style="list-style-type: none"> <li>1. Potential energy is free energy</li> <li>2. Controlled energy reaction rates</li> <li>3. Anabolism /catabolism</li> <li>4. Sources stored energy</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Williams: Chapter 6</p>
	<p>C. Discuss factors which influence BMR</p> <ol style="list-style-type: none"> <li>1. Lean body mass</li> <li>2. Growth</li> <li>3. Fever and disease</li> <li>4. Temperature</li> <li>5. Food intake</li> <li>6. Activity</li> <li>7. Total energy requirements</li> </ol>	<p style="text-align: center;"><b><u>Additional/Optional</u></b></p> <p>Informatics:  <a href="http://www.nutrition.gov">www.nutrition.gov</a>  <a href="http://www.healthypeople.gov">www.healthypeople.gov</a>  <a href="http://www.mypyramid.gov">www.mypyramid.gov</a>  <a href="http://www.eatright.org">www.eatright.org</a></p>
	<p>D. Describe basic principles of digestion</p> <ol style="list-style-type: none"> <li>1. GI mobility</li> <li>2. GI secretions</li> <li>3. Mechanical digestions</li> <li>4. Chemical digestion</li> <li>5. Absorption</li> <li>6. Metabolism</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	E. Discuss the role of carbohydrates in the human diet <ol style="list-style-type: none"> <li>1. Basic fuel</li> <li>2. Photosynthesis</li> <li>3. Classification</li> <li>4. Functions</li> <li>5. Digestion</li> <li>6. Absorption</li> <li>7. Metabolism</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> Williams: Chapter 2
	F. Discuss the role of fats in human nutrition <ol style="list-style-type: none"> <li>1. Sources</li> <li>2. Health need</li> <li>3. Fatty acids</li> <li>4. Triglycerides</li> <li>5. Cholesterol</li> <li>6. Lipoproteins</li> <li>7. Fat digestion</li> <li>8. Absorption</li> <li>9. Metabolism</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> Williams: Chapter 3
	G. Discuss the role of protein in human nutrition <ol style="list-style-type: none"> <li>1. Amino acids</li> <li>2. Nature of proteins</li> <li>3. Function</li> <li>4. Digestion</li> <li>5. Absorption</li> <li>6. Metabolism</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> Williams: Chapter 4

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>H. Discuss vitamins as an essential component of human nutrition</p> <ol style="list-style-type: none"> <li>1. Fat soluble A, D, E, K</li> <li>2. Water soluble B complex and C</li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Williams: Chapter 7</p> <p><b><u>During Class</u></b></p> <p>Evidence based practice: Nutrient presentations</p>
	<p>I. Describe the importance of minerals in human nutrition</p> <ol style="list-style-type: none"> <li>1. Metabolic role</li> <li>2. Classification</li> <li>3. Intake, absorption, output, balance</li> <li>4. Functions</li> <li>5. Clinical problems</li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Williams: Chapter 8</p>
	<p>J. Discuss factors influencing dietary patterns</p> <ol style="list-style-type: none"> <li>1. Culture</li> <li>2. Religion</li> <li>3. Economics</li> <li>4. Peer groups</li> <li>5. Personal preference</li> <li>6. Life-style</li> <li>7. Beliefs</li> <li>8. Health status</li> <li>9. Alcohol and drugs</li> <li>10. Age (older adults)</li> </ol>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 45</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>K. Discuss the application of the nursing process to nutrition</p> <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Risk factors</li> <li>b. Biochemical data</li> <li>c. Clinical signs</li> <li>d. Dietary history</li> <li>e. Gerontological considerations</li> </ol> </li> <li>2. Common nursing diagnoses               <ol style="list-style-type: none"> <li>a. Imbalanced nutrition: More than body requirements</li> <li>b. Imbalanced nutrition: Less than body requirements</li> </ol> </li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation</li> <li>5. Evaluation of expected outcomes</li> </ol>	<p style="text-align: center;"><b><u>During Class</u></b></p> <p>Case study: Client with percutaneous endoscopic Gastrostomy</p> <p style="text-align: center;"><b><u>Prior to Test:</u></b></p> <p>Evidence based practice: Padula, C. Enteral feedings: what the evidence says. AJN 2004; 104(7) 62-69</p>
	<p>L. Describe techniques to assist patients with nutritional needs</p> <ol style="list-style-type: none"> <li>1. Procedure</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p>
	<p>M. Demonstrate monitoring of intake and output</p> <ol style="list-style-type: none"> <li>1. Purpose</li> <li>2. Procedure</li> </ol>	<p>Read Kozier &amp; Erb: Chapter 45 – Utilize techniques outlined in this chapter</p> <p style="text-align: center;"><b><u>During Class – LAB</u></b></p> <p>LAB: Demonstration &amp; Practice: Intake &amp; Output <i>Utilize Techniques Found In Kozier &amp; Erb Cha. 45</i></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>N. Demonstrate procedures for insertion and removal of NG tube</p>	<p><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 45 – Utilize techniques outlined in this chapter</p> <p><b><u>During Class - LAB</u></b></p> <p>LAB: Demonstration, Practice &amp; Return:  NG Tube Insertion &amp; Removal  AV: NG Intubation</p>
	<p>O. Demonstrate procedures for alternative feeding methods</p> <ol style="list-style-type: none"> <li>1. Tube feedings</li> <li>2. Gastrostomy or critical elements</li> </ol>	<p>LAB: Demonstration OF NG Tube Feedings  <i>Utilize Techniques Found In Kozier &amp; Erb Cha. 45</i></p>

Overall Objective	Content/ Objective	Learning Environment and Activities
<p style="text-align: center;"><b>UNIT 12</b></p> <p style="text-align: center;"><b>HEALTH ASSESSMENT PSYCHOSOCIAL</b></p> <p>Discuss Psychosocial Concepts Of Health Assessment</p> <p><b>Evaluation Of Each Unit Consists Of:</b></p> <ul style="list-style-type: none"> <li>• Paper And Pencil Tests</li> <li>• Classroom Participation</li> <li>• Clinical Performance</li> </ul>	<p>I. Health Assessment - Psychosocial</p> <p>A. Describe the development of self-concept</p> <ol style="list-style-type: none"> <li>1. Erickson's developmental stages - positive and negative self-concept</li> <li>2. Components of self-concept               <ol style="list-style-type: none"> <li>a. Role</li> <li>b. Role performance</li> <li>c. Self-identity</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 37</p>

Overall Objective	Content/ Objective	Learning Environment and Activities
	B. Discuss the nursing process as it relates to self-concept <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Self perception</li> <li>b. Roles / relationships</li> <li>c. Stressors / coping</li> <li>d. Gerontological considerations</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Identifying strength</li> <li>b. Changing behavior</li> <li>c. Encouraging positive self-esteem</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	
	II. Sexuality <ol style="list-style-type: none"> <li>A. Define sex and sexuality               <ol style="list-style-type: none"> <li>1. Sex</li> <li>2. Sexuality</li> <li>3. Gender identity</li> <li>4. Gender role</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 38</p>
	B. Describe influences which impact on individual views of sexuality <ol style="list-style-type: none"> <li>1. Ethnocultural</li> <li>2. Religious - ethical</li> <li>3. Current</li> <li>4. Gerontological considerations</li> </ol>	
	C. Discuss sexuality as it relates to developmental changes	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>D. Discuss the nursing process as it relates to sexuality</p> <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Characteristics of sexual health</li> <li>b. Alterations in sexual functioning</li> <li>c. Physiologic conditions</li> <li>d. Factors influencing decreased sexual motivation</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation</li> <li>5. Evaluation of expected outcomes</li> </ol>	
	<p>III. Ethnicity And Culture</p> <p>A. Define terms related to ethnicity and culture</p> <ol style="list-style-type: none"> <li>1. Ethnic group</li> <li>2. Race</li> <li>3. Culture</li> <li>4. Dominant group</li> <li>5. Minority group</li> <li>6. Ethnocentric</li> <li>7. Stereotyping</li> <li>8. Ethnoscience</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 13</p>
	<p>B. State characteristics of culture</p>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>C. Identify factors which assist nurses to meet cultural needs</p> <ol style="list-style-type: none"> <li>1. Male-female roles</li> <li>2. Communication</li> <li>3. Personal space</li> <li>4. Time</li> <li>5. Work</li> <li>6. Family</li> <li>7. Nutritional consideration               <ol style="list-style-type: none"> <li>a. Class structure</li> <li>b. Income groups</li> <li>c. Value systems</li> <li>d. Social factors</li> <li>e. Food fads</li> <li>f. Psychosocial factors</li> <li>g. Ethnic group and food</li> </ol> </li> <li>8. Beliefs impacting on health care</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Williams: Chapter 9</p>
	<p>D. Discuss the nursing process as it relates to cultural and ethnic needs</p> <ol style="list-style-type: none"> <li>1. Assessment           <ol style="list-style-type: none"> <li>a. Cultural data</li> <li>b. Ethnic and cultural</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning           <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation</li> <li>5. Evaluation of expected outcomes</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	IV. Spirituality A. Define terms related to spirituality <ol style="list-style-type: none"> <li>1. Spirituality</li> <li>2. Religion</li> <li>3. Faith</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> Read Kozier & Erb: Chapter 39
	B. Discuss how religion and health care are related <ol style="list-style-type: none"> <li>1. Religion and illness</li> <li>2. Beliefs and health</li> </ol>	
	C. Discuss the nursing process as it relates to spiritual needs <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Spiritual need</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation</li> <li>5. Evaluation of expected outcomes</li> </ol>	
	V. Loss And Grieving A. Discuss factors related to loss and grief <ol style="list-style-type: none"> <li>1. Types of loss</li> <li>2. Developmental stage and perceptions of death</li> <li>3. Grief               <ol style="list-style-type: none"> <li>a. Stages of grief according to Kubler-Ross</li> </ol> </li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> Read Kozier & Erb: Chapter 41

Overall Objective	Content/ Objective	Learning Environment and Activities
	<p>B. Discuss the nursing process as it relates to patients experiencing loss or grief</p> <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Awareness</li> <li>b. Grief reaction</li> <li>c. Factors influencing a loss reaction</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation</li> <li>5. Evaluation of expected outcomes</li> </ol>	
	<p>C. Discuss the nursing process in relation to care of the dying patient</p> <ol style="list-style-type: none"> <li>1. Assessment               <ol style="list-style-type: none"> <li>a. Clinical signs of impending death</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation               <ol style="list-style-type: none"> <li>a. Physiologic needs</li> <li>b. Psychosocial needs</li> <li>c. Spiritual needs</li> </ol> </li> <li>5. Evaluation of expected outcomes</li> </ol>	
	<p>D. Relate nursing care of the body after death</p> <ol style="list-style-type: none"> <li>1. Hospital policies</li> <li>2. Death related beliefs of religious groups</li> </ol>	

Overall Objective	Content/ Objective	Learning Environment and Activities
	VI. Individual, Family, and Community Health A. Identify types of families found in today's society <ol style="list-style-type: none"> <li>1. Traditional</li> <li>2. Two-career</li> <li>3. Single-parent</li> <li>4. Blended</li> <li>5. Adolescent parent</li> <li>6. Cohabiting</li> <li>7. Gay and lesbian</li> <li>8. Different cultural</li> <li>9. Single adults</li> </ol>	<p style="text-align: center;"><b><u>PRIOR TO CLASS</u></b></p> <p>Read Kozier &amp; Erb: Chapter 12</p>
	B. Describe how the nursing process may be utilized to meet family needs during illness <ol style="list-style-type: none"> <li>1. Assessment of families               <ol style="list-style-type: none"> <li>a. Health appraisal</li> <li>b. Beliefs</li> <li>c. Communication</li> <li>d. Coping</li> <li>e. Families at risk</li> <li>f. Developmental factors</li> <li>g. Heredity factors</li> <li>h. Life style</li> <li>i. Sociologic</li> <li>j. Crisis</li> </ol> </li> <li>2. Common nursing diagnoses</li> <li>3. Planning               <ol style="list-style-type: none"> <li>a. Safe environment</li> <li>b. Physiological and psychosocial integrity</li> <li>c. Health promotion and maintenance</li> </ol> </li> <li>4. Implementation</li> <li>5. Evaluation of expected outcomes</li> </ol>	

## NURSE AIDE I TASKS\*

### I. PERSONAL CARE (ADL)

- Bathing (assist, bed bath, tub bath, shower, sitz)
- Side rails/ call rails
- Mouth care
- Skin care
- Hair care
- Nail care
- Bedmaking (modified)
- Dressing and undressing

### II. BODY MECHANICS

- Turn and position
- Transfer – chair and stretcher
- Use of lifts
- Assist with ambulation
- Range of motion exercises

### III. NUTRITION

- Prepare patients for meal time
- Feed patients
- Intake and output
- Force and restrict fluids

### IV. ELIMINATION

- Bedpan/urinal
- Bowel/bladder retraining
- Collect/test specimens
- Perineal/catheter care
- Apply condom caths
- + Douches
- Enemas
- + Insert rectal tubes/flatus bags
- Empty drainage devices from body cavities/wounds
- + Maintain gastric suction

### V. SAFETY

- Side rails/call rails
- Mitts and restraints
- CPR/Heimlich Maneuver
- Infection control
  - Hand washing
  - Isolation technique
  - Universal precautions

### VI. SPECIAL PROCEDURES

- Vital signs
  - Temp (oral, rectal, axillary)
  - Pulse (radial, apical)
  - Respirations
  - BP
- Height and weight (stand-up scales/bed scales)
- Application of heat/cold
- Prevent and care for decubitus ulcers
- + Surgical skin preps and scrubs
- Clean dressing changes
- Apply ace bandages, TEDs and binders
- + Apply and remove EKG monitor leads
- Postmortem care
- Cough/deep breathing

\*The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care. Decisions regarding delegation of any of the above activities are made by the licensed nurse on a client-by-client basis. The following criteria must be met before delegation of any task may occur:

- task is performed frequently in the daily care of a client or group of clients
- task is performed according to an established sequence of steps
- task may be performed with a predictable outcome
- task does not involve on-going assessment, interpretation or decision-making that cannot be logically separated from the task itself.

As part of accountability, the licensed nurse must validate the competencies of the NA I prior to delegating tasks, as well as monitor the client's status and response to care provided on an on-going basis.

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\* Tasks which the North Carolina Board of Nursing has determined are within the Scope of Practice for an NA I

+ Tasks which are within the scope of practice for an NA I, but are not required to be taught in the DFS approved 75 hour course.

## NURSE AIDE II TASKS\*

<b>OXYGEN THERAPY</b> <ul style="list-style-type: none"> <li>• Room Set-up</li> <li>• Monitoring flow-rate</li> </ul>	<b>SUCTIONING</b> <ul style="list-style-type: none"> <li>• Oropharyngeal</li> <li>• Nasopharyngeal</li> </ul>
<b>BREAK-UP AND REMOVAL OF FECAL IMPACTION</b>	<b>TRACHEOSTOMY CARE</b>
<b>STERILE DRESSING CHANGE</b> (Wound over 48 hours old)	<b>WOUND IRRIGATION</b>
<b>I.V. FLUID – ASSISTIVE ACTIVITIES</b> <ul style="list-style-type: none"> <li>• Assemble/flush tubing during set-up</li> <li>• Monitoring flow-rate</li> <li>• Site care/dressing change</li> <li>• Discontinuing peripheral intravenous infusions</li> </ul>	<b>ELIMINATION PROCEDURES</b> <ul style="list-style-type: none"> <li>• Ostomy Care</li> <li>• Irrigation</li> </ul>
<b>NUTRITION ACTIVITIES</b> <ul style="list-style-type: none"> <li>• Oral/nasogastric infusions (after placement verification by licensed nurse)</li> <li>• Gastrostomy feedings</li> <li>• Clamping tubes</li> <li>• Removing oral/nasogastric feeding tubes</li> </ul>	<b>URINARY CATHETERS</b> <ul style="list-style-type: none"> <li>• Catheterizations</li> <li>• irrigation of tubing</li> </ul>

### ROLE OF NURSING II ON HEALTH CARE TEAM\*

\* The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care. Decisions regarding delegation of any of the above activities are made by the licensed nurse on a client-by-client basis. The following criteria must be met before delegation of any task may occur:

- Task is performed frequently in the daily care of a client or group of clients
- Task is performed according to an established sequence of steps
- Task may be performed with a predictable outcome
- Task does not involve on-going assessment, interpretation or decision-making that cannot be logically separated from the task itself

As part of accountability, the licensed nurse must monitor the client's status and response to care provided on an on-going basis.

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\* Tasks which the North Carolina Board of Nursing has determined are within the Scope of Practice for an NA II

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## Evaluation of Clinical Simulation

Mastery of clinical objectives must be demonstrated by a "S" Satisfactory. Students who do not achieve a "S" on clinical objectives will receive an "F" for the course. A student whose clinical performance reflects behavior which conflicts with safety essential to nursing practice may be asked to exit the ADN program at any point during the quarter and receive a "WF."

Alternative methods for clinical makeup will be allowed only in the event of absence and in accordance with departmental attendance policies.

Clinical performance will be discussed with the students on an ongoing basis. Final clinical evaluation conferences will be held with each student.

Each student is expected to come to the clinical area prepared to give nursing care to the assigned patients.

## **Barriers to Active Listening**

### **Internal:**

1. The person's views are different from the nurse's perceptions.
2. The person's dialect or accent is different.
3. The person's appearance is different or distracting.
4. The person is in pain or anxious.
5. The person is telling the nurse something he/she does not want to hear.
6. The nurse feels a dislike toward the person.
7. The nurse is thinking of something else.
8. The nurse is planning the next statement.
9. The nurse is anxious or apprehensive.

### **External:**

1. Noise from equipment, speakers, television, radio, etc.
2. Lack of privacy
3. Physical hindrances such as desks, equipment, space, etc.
4. Verbal remarks such as clichés, trite comments, or interruptions.

CFCC ASSOCIATE DEGREE NURSING  
NUR-110 NURSING 1  
**Clinical Objectives**

The clinical evaluation tools in each course in the ADN curriculum are based on course outcomes. Each week the student will be expected to perform with increasing proficiency as they develop skills in implementing nursing procedures and problem solving. The following focus objectives will assist the student in achieving satisfactory performance in the clinical area. The student must become familiar with behaviors identified in the Evaluation Tool.

- Week 1
1. Assist assigned patient in meeting physical and psychosocial needs.
  2. Demonstrate basic skills of physical assessment
  3. Utilize Basic communications skills with patients, significant others, and members of the health care team to:
    - Collect data on assigned patient.
    - Demonstrate techniques in reporting and recording.
  4. Maintain safety of the patient's environment
- Week 2
1. Describe the pathophysiology and symptomatology of the assigned patient primary diagnosis.
  2. Using data collected, identify primary problems/needs of assigned patient and develop a statement of nursing diagnosis.
  3. Safely and accurately administer medications to assigned patient
  4. Identify the top three priority problems or needs of the assigned patient.
- Week 3
1. Describe the pathophysiology and symptomatology of the assigned patient primary diagnosis.
  2. Using data collected, identify primary problems/needs of assigned patient and develop a statement of nursing diagnosis.
  3. Safely and accurately administer medications to assigned patient
  4. Identify the top three priority problems or needs of the assigned patient.
  5. Develop a short-term and a long-term goal for each identified nursing diagnosis on assigned patient.
- Week 4
1. Incorporate nursing interventions to meet goals and establish a rationale for each intervention.
  2. Evaluate the outcome criteria for one identified problem/need and make adjustments to the problem, goal or interventions as necessary.
  3. Apply teaching-learning concepts
  4. Continue to refine skills in assessment, aseptic technique, medication administration, safety, etc.

- Week 5
1. Develop a complete nursing care plan for one identified problem for assigned patient.
  2. Continue to refine skills in use of the nursing process to assist patient in the promotion/maintenance/restoration of optimum health.
  3. Continue to refine skills in medication administration, sterile procedures, etc.
- Week 6
1. Develop a complete nursing care plan for one identified problem for assigned patient.
  2. Continue to refine skills in use of the nursing process to assist patient in the promotion/maintenance/restoration of optimum health.
  3. Continue to refine skills in medication administration, sterile procedures, etc.
- Week 7
1. Develop a complete nursing care plan for one identified problem for assigned patient.
  2. Continue to refine skills in use of the nursing process to assist patient in the promotion/maintenance/restoration of optimum health.
  3. Continue to refine skills in medication administration, sterile procedures, etc.
- Week 8
1. Develop a complete nursing care plan for one identified problem for assigned patient.
  2. Continue to refine skills in use of the nursing process to assist patient in the promotion/maintenance/restoration of optimum health.
  3. Continue to refine skills in medication administration, sterile procedures, etc.

## **NUR 110 – Clinical Assignments**

### **Week 1**

1. Anecdotal
2. CAS
3. Medication Sheet

### **Week 2**

1. Anecdotal
2. CAS
3. Medication Sheet
4. ADN Assessment (This week only, if satisfactory)

### **Week 3**

1. Anecdotal
2. CAS
3. Medication Sheet
4. LABS
5. Data Collection Sheet (This week only if satisfactory)

### **Week 4**

1. Anecdotal
2. CAS
3. Medication Sheet
4. LABS
5. NCP (one problem)

### **Week 5**

1. Anecdotal
2. CAS
3. Medication Sheet
4. LABS
5. NCP (one problem)

### **Week 6**

1. Anecdotal
2. CAS
3. Medication Sheet
4. LABS
5. NCP (one problem)

### **Week 7 - Turn in your Clinical Evaluations – List 3 strengths and 3 weaknesses on the back.**

1. Anecdotal
2. CAS
3. Medication Sheet
4. LABS
5. NCP (one problem)

### **Week 8**

1. Anecdotal
2. CAS
3. Medication Sheet

4. Each instructor will determine whether NCPs are required based on previous performance.

## **Clinical Make-up Research Paper Guidelines**

- Topic per instructor (nursing related)
- 10 pages – 5 for ½ week
- Double spaced
- Margins: 1” all around
- Typed: Times New Roman, 12 pt
- APA (American Psychological Association) format
  - May check out at Library
- 10 references: last 4 years
  - 5 must be journal articles (include copies)
  - 2 can be web sources from accredited sites
- If not done correctly, paper will be handed back with suggestions and must be redone or it may become an unsatisfactory week.
- Due: same date clinical paperwork is due.

## The In's and Out's of Unapproved Abbreviations at NHHN

Unapproved Abbreviations or Symbols	Why This Is Not To Be Used	What Is Acceptable Practice
<b>U or u</b>	Mistaken for number zero or number four	<b>Write out the word “units”</b>
<b>cc</b>	Mistaken for units (with the cc looking like a “u”)	<b>Use “ml” or write out “cubic centimeters”</b>
<b>&gt; and &lt;</b>	Misinterpreted to mean the opposite	<b>Write out the terms: “greater than” or “less than”</b>
<b>µg</b>	The “µ” can be mistaken for “m” and microgram then becomes milligram	<b>Use the abbreviation “mcg” or write out “microgram”</b>
<b>q.d. or Q.O.D.</b>	Mistaken for q.i.d.	<b>Use “daily” or “every day” or “qd” without the periods. Use “every other day”</b>
<b>Sub q</b>	“q” mistaken for the term “every”	<b>Write out the word “subcutaneous”</b>
<b>SC</b>	SC mistaken for sublingual	<b>Write out the word “subcutaneous”</b>
<b>AU</b>	Mistaken for OU	<b>Write out “each ear”</b>
<b>OD</b>	Mistaken for right eye or once daily	<b>Write out “right eye” or write out “daily”</b>
<b>IU</b>	Mistaken for intravenous	<b>Write out the word “units”</b>
<b>X 3d</b>	Mistaken for three doses	<b>Write out “for three days” or “x 3 days”</b>
<b>Trailing zero or lack of leading zero</b>	Decimal point is missed Ex: 3.0 or .7	<b>Never write a zero after a decimal point (eg 5.0). Always lead with a zero before a decimal point (eg: .35)</b>
<b>MS MSO<sub>4</sub> MGSO<sub>4</sub></b>	Confused for one another – can mean morphine sulfate or magnesium sulfate	<b>Write “morphine sulfate” or “magnesium sulfate”</b>

## Medication List Guidelines

- List all medications patient is taking routinely and PRN. This should be completed and brought to each clinical. Student is responsible for letting the instructor know of any medications they were unable to find.
  
- Drug: list class, generic and trade name
  
- Dosage/route/frequency: list ordered. Also indicate if the recommended dose is different.
  
- Rationale: Why your patient is receiving the medication.
  - If the medication is an antibiotic, where is the infection?
  - If medication is a pain medication, where is the location of the pain?
  
- Nursing Implications:
  - List any nursing assessment or vital sign that needs to be done before, during or after medication is given.
  - List any major side effects to look for.
  - List any labs that need to be monitored.
  - List any teaching that needs to be done.
  - Insulin: onset, peak, and duration.
  
- Students may use their drug disc to cut and paste their patient's information on this sheet.
  
- Students are still held accountable for reading this information before clinical and having this information available prior to drug administration.  
Below is an example:

Drug (Generic, Trade and Class)	Dosage/Route/Frequency	Rationale	Nursing Implications
Digoxin (lanoxin, Lanoxicaps) Antiarrhythmic, inotropic	0.25mg PO QD	Atrial Fibrillation	Monitor apical pulse for 1 full minute before administering. Withhold dose and notify physician if pulse rate is less than 60 bpm in an adult or any significant changes in rate, rhythm or quality of pulse.



### Lab Results

<b>PT. INITIALS</b>						
<b>TEST</b>	<b>NORMAL</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>INTERPRET EACH ABNORMAL VALUE</b>
<b>HEMATOLOGY</b>						
WBC	4.8-10.8 THOUS					
RBC	4.2 - 5.4 MIL					
HGB	12-16 L / GM					
HCT	37- 47 %					
PLATELETS	145 - 400 THOUS					
NEUTROPHILS	40 - 74 %					
BANDS	0 - 9 %					
LYMPHS	15 - 47 %					
MONO	0 - 11 %					
BASOPHILS	0 - 3 %					
EOSINOPHILS	0 - 6 %					
SED RATE	0 -20 mm/H					
PT	9.9 - 13.8 SEC					
INR	2.0 – 3.0 (therapeutic)					
PTT	21.6 - 39.1 SEC					
CULTURES						

TEST	NORMAL	DATE	DATE	DATE	DATE	INTERPRET EACH ABNORMAL VALUE
<b>URINALYSIS</b>						
COLOR	STRAW / AMBER					
CLARITY	CLEAR / HAZY					
PROTEIN	< 30					
LEUK/ESTERAS	NEGATIVE					
NITRITES	NEGATIVE					
BLOOD	NEGATIVE					
GLUCOSE	NEGATIVE					
KETONES	NEGATIVE					
PH	4.5 - 8.0					
SP GRAVITY	1.001 - 1.035					
BILIRUBIN	NEGATIVE					
UROBILINOGEN	< 1 EU / DL					
WBC / HPF	0 - 3					
RBC / HPF	0 - 3					
MUCOUS	OCCASIONAL					
CASTS	OCCASIONAL LPF					
BACTERIA	OCCASIONAL					
CRYSTALS	NONE					
YEAST	NEGATIVE					
CULTURES						

TEST	NORMAL	DATE	DATE	DATE	DATE	INTERPRET EACH ABNORMAL VALUE
<b>CHEMISTRY</b>						
SODIUM	137 - 145 MMOL / L					
POTASSIUM	3.6 -5 MMOL / L					
CHLORIDE	98 - 107 MMOL / L					
CO2	22 - 29 MMOL / L					
ANION GAP	+ / - 12 MEQ / L					
GLUCOSE	60 - 115 MG / DL					
HBA1C	< 7 %					
BUN	9 – 20 MG / DL					
CREATININE	0.5 – 1.2 MG/DL					
CALCIUM	8.8 - 10.5 MG / DL					
PHOSPHORUS	2.5 - 4.4 MG / DL					
CHOLESTEROL	120 - 200 MG / DL					
HDL	>45 mg/dL					
LDL	<100 mg/dL					
TRI'S	<200 mg/dL					
URIC ACID	2.7 - 8.0 MG / DL					
TOT PROTEIN	6.3 - 8.2 G / DL					
ALBUMIN	3.9 - 5.0 G / DL					
AST	M: 14 - 50 F: 8.0 - 39					
ALT	M: 21 - 72 F: 9 - 52					
LDH	313 - 618 U / L					
ALK PHOS	30-120 U / L					
CONJ BILIRUB	0.0 - 0.3 MG / DL					
CREATINE	0.8 - 1.5 MG / DL					
TOT BILIRUBIN	0.2 - 1.3 MG / DL					
MAGNESIUM	1.8 - 2.4 MG / DL					

<b>TEST</b>	<b>NORMAL</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>INTERPRET EACH ABNORMAL VALUE</b>
<b>ABG</b>						
PH	7.35 –7.45					
PCO2	35 – 45 mm/Hg					
PO2	75 – 85 mm/Hg					
HC03	22 – 26 meq/L					
TC02	22 – 29 meq/L					
BASE EXCESS	0+ / - 2 meq/L					
O2 SAT	96 –97 %					
<b>OTHER LABS</b>						
DIGOXIN	0.8 – 2.0 NG/ML					
CK / CPK	55 - 170 U / L					
TROPONIN	<0.2 NG/ML					
CKMB	0%					
BNP	< 100 PG/ML					
TSH	2 –10 MU/ML					
FT4	0.8 – 2.8 MG/DL					
<b>CULTURES</b>						
MRSA	NEGATIVE					
VRE	NEGATIVE					
OTHER						

## Guidelines for Clinical Assessment Sheet

### NUR-110 Nursing 1

1. Developmental Stage: Identify the developmental stage of the assigned patient and describe the characteristics assessed in your patient. (Use Erikson's Developmental Stages)
2. V.S.: Indicate frequency/schedule for taking Vital Signs
3. TPR-B/P: Indicate patient's VS readings for each assigned clinical days
4. Activity: Level of activity prescribed/appropriate for assigned patient.
5. Elimination: Indicate if Intake & Output is being done. Is there an order to strain urine? Does the patient use/need a condom catheter? Is the patient incontinent or continent?
6. Diet: Type diet prescribed (includes tube feedings/TPN/etc.). Indicate amount of assistance the patient needs with meals.
7. Hygiene: Indicate the amount of care the patient requires. C=Complete, P=Partial, S=Self Care.
8. Diagnostics: Identify the various diagnostic studies/tests/procedures ordered for the patient. Indicate the test results and what they mean.
9. Treatments: (Organize by time) List prescribed treatments/procedures the nurse is responsible for, i.e. incentive spirometer q1h, etc.
10. IV's: Indicate type of IV line(s) and location. If patient has a central line, indicate the number of lumens/ports.
11. Solution: Name of fluids prescribed (includes any additives). Rate of flow
12. Current medical problem(s) and any additional health problems the patient may have. Ex: PVD, COPD, DM, Hypertension.
13. Explain the admitting diagnosis:
  - Define the primary diagnosis
  - Describe:
    - a. the etiology/pathophysiology
    - b. onset/clinical course
    - c. S&S (textbook and actual)
    - d. prognosis
    - e. medical management (textbook and actual)
  - Describe any additional health problems and prescribed treatments.

**CFCC ASSOCIATE DEGREE NURSING –  
Example CLINICAL ASSESSMENT SHEET**

<b>Dates of Clinical:</b>		<b>Gender (circle one)</b> M F		<b>Marital Status (circle one)</b> S M D W		<b>Medical Diagnoses:</b>	
<b>Student:</b>		<b>Allergies:</b>		<b>Medical History:</b>			
<b>Pt Init.:</b>		<b>Rm:</b>	<b>Age:</b>	<b>Ht:</b>	<b>Wt:</b>		
<b>Developmental Stage:</b>						<b>Consults &amp; Purpose:</b>	
						<b>Operations / Procedures (Past &amp; Future) &amp; Dates:</b>	
<b>V.S. Q:</b>		<b>T - P - R - B/P</b>		<b>Activity:</b>			
Dly wt:		Day 1:					
Telem:				Fall Precautions:			
O2 Sat:		Day 2:					
Call Md if:							
Pain:							
<b>Elimination:</b>		<b>Nutrition:</b>		<b>Hygiene:</b>			
<i>Continent/Incontinent</i>		C, P, or S		C, P, or S			
Cath:		Tube Feeding:		Shower or Bed bath:			
I & O:		Precautions: Supplements:		Last bath & linen change:			
<b>Diagnosics/Cultures</b>							
<u>Date:</u>		<u>Procedure:</u>			<u>Results:</u>		
<b>Diagnosics/Cultures</b>							
<u>Frequency</u>		<u>Procedure</u>			<u>Purpose</u>		
<b>IV's:</b>		<b>IVFs &amp; Rate:</b>			<b>Respiratory</b>		
Type#1:					Nebs:		
Site:					O2:		
Type:#2					I/S:		
Site:					Keep Sats:		
						<b>Example CAS</b> <b>Write Up:</b> <ul style="list-style-type: none"> <li>▪ Diagnosis and Definition</li> <li>▪ Pathophysiology</li> <li>▪ Etiology</li> <li>▪ Onset/Clinical course</li> <li>▪ S/Sx (text and actual)</li> <li>▪ Complications (text and actual)</li> <li>▪ Prognosis (text and actual)</li> <li>▪ Medical Management and Nursing Management</li> <li>▪ Additional Health problems: definition and how client is being treated</li> </ul>	

**CFCC ASSOCIATE DEGREE NURSING –  
CLINICAL ASSESSMENT SHEET**

<b>Dates of Clinical:</b>		<b>Gender (circle one)</b> M F		<b>Marital Status (circle one)</b> S M D W		<b>Medical Diagnoses:</b>	
<b>Student:</b>		<b>Allergies:</b>				<b>Medical History:</b>	
<b>Pt Init.:</b>		<b>Rm:</b>	<b>Age:</b>	<b>Ht:</b>	<b>Wt:</b>		
<b>Developmental Stage:</b>							
						<b>Consults &amp; Purpose:</b>	
						<b>Operations / Procedures (Past &amp; Future) &amp; Dates:</b>	
<b>V.S. Q:</b>		<b>T - P - R - B/P</b>		<b>Activity:</b>		<b>CAS Write Up:</b> <ul style="list-style-type: none"> <li>▪ Diagnosis and Definition</li> <li>▪ Pathophysiology</li> <li>▪ Etiology</li> <li>▪ Onset/Clinical course</li> <li>▪ S/Sx (text and actual)</li> <li>▪ Complications (text and actual)</li> <li>▪ Prognosis (text and actual)</li> <li>▪ Medical Management and Nursing Management</li> <li>▪ Additional Health problems: definition and how client is being treated</li> </ul>	
Dly wt:		Day 1:					
Telem:				Fall Precautions:			
O2 Sat:		Day 2:					
Call Md if:							
Pain:							
<b>Elimination:</b>		<b>Nutrition:</b>		<b>Hygiene:</b>			
<i>Continent/Incontinent</i>		C, P, or S		C, P, or S			
Cath:		Tube Feeding:		Shower or Bed bath:			
I & O:		Precautions: Supplements:		Last bath & linen change:			
<b>Diagnostics/Cultures</b>							
<u>Date:</u>		<u>Procedure:</u>			<u>Results:</u>		
<b>Treatments/Special Equipment</b>							
<u>Frequency</u>		<u>Procedure</u>			<u>Purpose</u>		
<b>IV's:</b>		<b>IVFs &amp; Rate:</b>			<b>Respiratory</b>		
Type#1:					Nebs:		
Site:					O2:		
Type:#2					I/S:		
Site					Keep Sats:		

**CAPE FEAR COMMUNITY COLLEGE  
GUIDELINES - ADN ASSESSMENT SHEET  
NUR-110 NURSING I**

**PREVIOUS HISTORY:**

Describe how your health has been most of your life.

Have you ever been sick before? (If yes . . . ) What was wrong or what kind of illnesses have you had?

Have you ever had any surgery or operations? (If yes . . . ) What kind and why did you have it? When did you have it?

Have you ever had any serious injuries? (If yes . . . ) What kind and how did it happen?

Have you ever been in the hospital before? (If yes . . . ) What hospital, when, why were you in the hospital? Were experiences with past hospitalizations good or bad (positive or negative) and why?

How often do you go to the doctor?

Are you allergic to any medicine? Food? Anything else?

Do you smoke, chew tobacco, or dip snuff? How much or how often?

What kind of exercise do you get during the day? (Example: sedentary lifestyle, does lots of yard work, or works in field)

Do you ever drink alcoholic beverages? How much? How often?

Do you take any medicine at home? What medicines do you take and when do you take them?

Were you on any special diet before you came to the hospital?

What kind of diet?

**ENVIRONMENTAL HEALTH:**

Describe your home.

Do you have any stairs to climb? What kind of heat do you use?

Do you have screens over your windows and doors? Do you have indoor plumbing, if not, where do you get your water and use the toilet? Do you have electricity? Do you have any problems with bugs or mice? Is there enough space for everyone who lives there?

What kind of work do you do?

On your job, are you exposed to chemicals, excess noise, heavy lifting, or machinery?

In your neighborhood, are there problems with noise, water, air pollution, inadequate police protection, heavy traffic, overcrowding or isolation from neighbors?

How far do you live from a grocery store? Drugstore? Laundry?

Physician? Hospital? Do you have transportation when you need to go to these places?

## **CURRENT HISTORY:**

Why did you come to the hospital (or doctor, if saw doctor first)?

When did these symptoms start? Describe the symptoms. What were you doing when these symptoms started?

Medical dx. available on chart.

What has the doctor told you is wrong? Do you understand the doctor when he is talking with you? What questions do you have?

## **NUTRITION:**

Type of diet - put diet before hospitalization and current diet (which is available on chart).

What are your favorite foods?

What do you eat for snacks? How many snacks do you eat each day?

What foods do you not eat because of spiritual beliefs?

What foods have your doctor told you not to eat?

What foods disagree with you?

What foods do you not eat because you dislike them?

Do you take any vitamins or minerals? Which ones and when?

Who cooks for you?

Where do you eat your meals?

What time of day are you the hungriest?

Do you ever skip meals? When? Why?

Have your eating habits changed in the past 12 months? If so, in what way?

How tall are you?

How much do you weigh?

Have you gained or lost any weight recently? How much? How recently?

Twenty-four recall (start with most recent meal or snack and work back twenty-four (24) hours).

What do you usually eat for breakfast?

What do you usually eat for lunch (or dinner)?

What do you usually eat for dinner (or supper)?

What time do you usually eat breakfast?

What time do you usually eat lunch (or dinner)?

What time do you usually eat dinner (or supper)?

What do you season your food with?

**CAPE FEAR COMMUNITY COLLEGE  
ADN ASSESSMENT SHEET**

Student: \_\_\_\_\_ Date: \_\_\_\_\_

**DEMOGRAPHIC DATA:**

Client's Initials: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Physician: \_\_\_\_\_

City of Residence: \_\_\_\_\_

Type of Payment: Medicare: \_\_\_\_\_ Medicaid: \_\_\_\_\_ Insurance: \_\_\_\_\_ Payment Pay: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

**PREVIOUS HEALTH:**

General Health: \_\_\_\_\_

Illnesses: \_\_\_\_\_

Operations: \_\_\_\_\_

Injuries: \_\_\_\_\_

Frequency of physician visits: \_\_\_\_\_

Hospitalizations (approximate date, chief complaint on admission, were experiences positive or negative) \_\_\_\_\_

\_\_\_\_\_

Allergies: Drug \_\_\_\_\_

Food \_\_\_\_\_

Other \_\_\_\_\_

Habits and frequency (tobacco, exercise, ETOH): \_\_\_\_\_

\_\_\_\_\_

Current Medication (prescription and non-prescription) and dose schedule: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CAPE FEAR COMMUNITY COLLEGE  
ADN ASSESSMENT SHEET  
Page -2-**

Diet (prior to hospitalization): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ENVIRONMENTAL HEALTH:**

Briefly describe client's home environment as it relates to safety and comfort: \_\_\_\_\_

Hazards in the home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employment: \_\_\_\_\_

Hazards related to employment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hazards in the neighborhood: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Community hazards: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT HISTORY:**

Reason for entry into health care system (chief complaint): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Onset (date and precipitating events): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CAPE FEAR COMMUNITY COLLEGE  
ADN ASSESSMENT SHEET  
Page -3-**

Medical diagnosis this admission: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of past and current symptoms related to problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Knowledge/understanding of current condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NUTRITION:**

Type of diet: \_\_\_\_\_

What are your favorite foods? \_\_\_\_\_

What foods do you like for snacks? \_\_\_\_\_

How many snacks do you eat each day? \_\_\_\_\_

Name any foods you do not eat because of spiritual beliefs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name any foods you do not eat because your doctor told you not to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What foods disagree with you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name any foods you do not eat because you dislike them: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take vitamins and minerals? Which areas and when? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CAPE FEAR COMMUNITY COLLEGE  
ADN ASSESSMENT SHEET  
Page -4-

Who does the cooking for you? \_\_\_\_\_  
Where do you eat your meals? \_\_\_\_\_  
What time of the day are you most hungry? \_\_\_\_\_  
Do you ever skip meals? In what situations? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have your eating habits changed in the past twelve (12) months? In what way? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Any recent weight loss or weight gain? How much? \_\_\_\_\_

Twenty-four (24) hour recall: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Typical breakfast: \_\_\_\_\_  
Typical lunch: \_\_\_\_\_  
Typical dinner: \_\_\_\_\_  
What time do you usually eat breakfast? \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_  
With what is patient's food usually seasoned? \_\_\_\_\_

**Cape Fear Community College**  
**Guidelines for Utilization of the NCP**  
**NUR-110 Nursing I**

**Identifies:**

- Problem with appropriate need
- Date of patient care
- Patient identification by initials only
- Primary diagnosis

**Nursing Diagnosis (Problem):**

- States specific nsg dx/problem and etiology
- Uses NANDA standards to formulate appropriate nsg dx
- Prioritize key diagnoses and develop with goals, interventions and rationales.

**Goals: (Expected Actions)**

- States goals in client-centered terms.
- States at least one STG and one LTG for each identified nsg dx.
- Specifies a specific time frame to assess goals.
- Identifies specific outcome criteria of all STG's
- Goals appropriate for nursing diagnosis.

**Interventions (Nursing Orders)**

- Begins each intervention with an action verb.
- Begins initial intervention with patient assessment.
- Specifies intervention criteria; time, amounts, etc.
- Stars dependent interventions.
- Individualizes interventions.
- Prioritizes interventions.
- Separately numbers each intervention.
- Interventions appropriate to goal.

**Rationales**

- Accurately states reasons for each separate intervention.
- Numbers each rationale to correspond to the appropriate intervention.

**CFCC ADN PROGRAM-  
SAMPLE NCP**

**STUDENT NAME:** \_\_\_\_\_  
**DATES OF CARE** \_\_\_\_\_

**PT INITIALS:** \_\_\_\_\_ **MEDICAL DIAGNOSIS:** \_\_\_\_\_

**NURSING DIAGNOSIS:**

PRIORITY BASED ON (S) AND (O) DATA COLLECTED. DX R/T ETIOLOGY OF DX AEB S/SX

**STG: BEGIN WITH PT OR CLIENT WILL...**

ONLY ONE GOAL. EASY TO REACH (SUCCESS OF MEETING GOALS MOTIVATES PTS)

SPECIFIC/MEASUREABLE – INCLUDE DEADLINES

**LTG: BEGIN WITH PT OR CLIENT WILL...**

ULTIMATE SUCCESS RELATED TO NURSING DX - BIGGER PICTURE BUT STILL SPECIFIC / MEASUREABLE \_ INCLUDE DEADLINES \_\_\_\_\_

<b>SUBJECTIVE AND OBJECTIVE DATA</b>	<b>INTERVENTIONS</b>	<b>RATIONALES</b>	<b>EVALUATION OF GOALS / ADJUSTMENT TO PLAN</b>
<p>SELECTED DATA RELATED TO NSG DX TO PROVE TO SELF, PT AND INSTRUCTOR THAT IT IS PRIORITY</p> <p>(S) + (O) INCLUDE ALL DATA RELEVANT (VS, ASSESS, LABS, ETC)</p>	<p>PLEASE NUMBER. #1 ALWAYS ASSESSMENT OF THE PROBLEM. INCLUDE EVERYTHING TO MEET STG AND LTG AND RESOLVE PROBLEM, NOT JUST WHAT WAS DONE, BUT WHAT YOU PLAN TO DO.</p>	<p>PLEASE NUMBER. ALIGN WITH INTERVENTION. SPECIFICALLY WHY THE INTERVENTION WILL HELP RESOLVE THE NURSING DX.</p>	<p>STG: MET, NOT MET OR PARTIALLY MET PLUS WHY AND WHAT YOU PLAN TO DO – CONTINUE PLAN, MODIFY AND HOW OR RESOLVE THE PROBLEM.</p> <p>ALSO EVALUATE LTG THE SAME WAY.</p>

**Sample Nursing Care Plan**

**STUDENT NAME:** \_\_\_\_\_  
**DATES OF CARE:** \_\_\_\_\_ **MEDICAL DIAGNOSIS:** \_\_\_\_\_  
**PT INITIALS:** \_\_\_\_\_

**NURSING DIAGNOSIS:** \_\_\_\_\_  
\_\_\_\_\_

**STG:** \_\_\_\_\_  
**LTG:** \_\_\_\_\_

<b>DATA: SUBJECTIVE (S) &amp; OBJECTIVE (O)</b>	<b>NURSING INTERVENTIONS</b>	<b>RATIONALES</b>	<b>EVALUATION/ ADJUSTMENTS</b>

<b>DATA: SUBJECTIVE (S) &amp; OBJECTIVE (O)</b>	<b>NURSING INTERVENTIONS</b>	<b>RATIONALES</b>	<b>EVALUATION/ ADJUSTMENTS</b>

**Nursing Care Plan**

**STUDENT NAME:** \_\_\_\_\_

**DATES OF CARE:** \_\_\_\_\_

**PT INITIALS:** \_\_\_\_\_ **MEDICAL DIAGNOSES:** \_\_\_\_\_

**NURSING DIAGNOSIS:** \_\_\_\_\_

**STG:** \_\_\_\_\_

**LTG:** \_\_\_\_\_

<b>SUBJECTIVE AND OBJECTIVE DATA</b>	<b>INTERVENTIONS</b>	<b>RATIONALES</b>	<b>EVALUATION OF GOALS / ADJUSTMENT TO PLAN</b>

<b>SUBJECTIVE AND OBJECTIVE DATA</b>	<b>INTERVENTIONS</b>	<b>RATIONALES</b>	<b>EVALUATION OF GOALS / ADJUSTMENT TO PLAN</b>

Cape Fear Community College  
**ADN Data Collection Guidelines**  
 NUR-110 NURSING I

INTEGUMENTARY	SUBJECTIVE	OBJECTIVE
<b>Skin</b>	What problems have you had with your skin in the past or now? (rashes, grafts, itching, etc.) What is your normal routine for taking a bath or shower?	Turgor, temperature to touch, color, diaphoresis, edema, lesions, rashes, reddened areas, bruises, texture, dry or oily, growths, tumors, masses.
<b>Hair</b>	Have you had any changes in the amount of texture of your hair recently? Do you use dye on your hair? How do you care for your hair?	Distribution of hair over head and body, condition of scalp, oily or dry
<b>Nails</b>	How do you care for your nails?	Color and condition of nails.
<b>Head/Neck</b>	Do you ever have headaches? How often? Where does it usually hurt? How long do they last? What makes it go away? Have you ever had any problems with dizziness or fainting?	Shape, size of head, condition of lymph nodes in neck. Any swelling masses, tenderness, limitation of movement, stiffness.
<b>Eye/Ear/Nose/ Mouth</b>		
<b>Eye</b>	Do you have any history of eye infections? How often? How was it treated? Do you have any itching in eyes? Do you have any pain? Do you have cataracts or glaucoma? Do you have double vision? Blurred vision? Difficulty reading or seeing? Unusual sensation or twitching? Do you ever see things?	Discharge (characteristics, color, amount, etc.) lacrimation, excessive tearing, swelling, corrective or prosthetic devices, sensitivity to light, how pupils react to light, eye movement.
<b>Ear</b>	Any history of ear infections (if so, how treated), pain, ringing, recent changes in hearing? Any dizziness (vertigo)?	Hearing, prosthetic devices, condition of ear canal or ear drum, presence of cerumen (wax).
<b>Nose</b>	Any discharge, pain over sinuses, hx sinusitis (how treated)	Status of sense of smell, size, shape, symmetry of nose, appearance of nasal drainage, sneezing
<b>Mouth</b>	Any sore throat, voice changes, dentures or bridges, problems chewing or swallowing? How often do you brush your teeth?	Lesions of tongue or mouth, bleeding gums, hoarseness, prosthetic devices, ability to swallow, condition of mouth, teeth, gums, tongue. Status of sense of taste. Condition of tonsils.
<b>Breast</b>	Any pain, tenderness, hx CA or other breast disease? Do you do self-breast exams? How often? Describe how often you do them.	Swelling, size, shape, symmetry, nipple discharge, lumps, dimples, unusual characteristics, condition of lymph nodes in axillae.

	<b>SUBJECTIVE</b>	<b>OBJECTIVE</b>
<b>Cardiovascular</b>	Any hx of chest pain (amount, frequency, duration, how relieved). Heart attack, heart problems? Any palpitations (heart beating fast) SOB? Any hx of HTN?	Pulse, heart sounds, (S3, S4), varicose veins, orthopnea, pacemaker, capillary refill, peripheral pulses, coldness, numbness, or discoloration of extremities, intermittent claudication, peripheral edema, BP, pulse rhythm, pulse volume.
<b>RESPIRATION</b>	Any hx asthma, breathing problems, SOB, night sweats? What causes breathing problems? (precipitating factors) Do you use O2 at home? How often? How much?	Rate of respirations (regular or irregular), breath sounds, depth of respirations, shape, symmetry, and expansion of chest, effort of breathing, body posture, SOB, cyanosis (where), sputum (describe), hemoptysis, chronic cough (characteristics) amount and type of O2 on, nasal flaring, retractions, orthopnea, dyspnea.
<b>Gastrointestinal</b>	Any abdominal pain, difficulty swallowing, indigestion, gas, n/v? What antacids do you use? How often? What is your normal pattern for having bowel movements? Any hx of an ulcer or any other stomach problems? Do you use laxatives? How often? Do they work?	Bowel sounds, size, shape of ABD., presence of scars and where, ability to swallow, distention, tenderness, guarding, rigidity, vomiting, hematemesis, jaundice, ascities, stool characteristics, presence of peristaltic waves, diarrhea, fecal colostomy, bowel incontinence, epigastric distress, hemorrhoids.
<b>URINARY</b>	Any hx renal stones, UTI, dribbling, urinary incontinence? How often do you get up at night to go to the bathroom? (nocturia) How often do you urinate during the day? Do you have any pain or burning on urination? Hx of hematuria (No.1 symptom of bladder CA is painless hematuria)? When you feel the need to urinate, do you have time to get to the bathroom? Have you ever had a catheter? Any flank or subrapubic pain?	Urine color, consistency, odor, distention, retention, palpate bladder, ostomy, hematuria, urinary incontinence, catheter (foley, subrapubic, size, connected to straight drain, leg bag, irritation), oliguria, polyuria, anuria, pyuria, urine output, urinalysis results, frequency of urination, character of stream (if able to observe).
<b>GENITAL</b>		
<b>General</b>	Any pain, burning, itching, hx venereal dz? What birth control methods do you practice?	Lesions, discharge (describe) odors, swelling, condition of inguinal lymph nodes, bleeding.
<b>Male</b>	Any hx of prostate problems, impotence? Do you do self-exams of penis and scrotum? How often? Describe how you do this.	Condition of the scrotum, circumcised or not.
<b>Female</b>	Menstrual hx (LMP, age of onset, duration, amount of flow problems). Any pain with intercourse, vaginal itching, # of pregnancies? Do you take estrogens?	Amenorrhea, menorrhagia, dysmenorrhea, metrorrhagia.

<b>SUBJECTIVE</b>		<b>OBJECTIVE</b>
<b>Neurological</b>	Any hx of CNS disease, fainting, seizures, paralysis, tingling sensations?	LOC, alert, oriented, drowsiness, stuporous, coma, attention span, memory, (short and long term), coordination, equilibrium, syncope, headache, grasps, movement (all extremities), pupillary reaction, tremors, vertigo, gait, speech pattern, seizures, hallucinations, ataxia, paralysis, intention tremors, tic, spasm.
<b>MUSCULOSKELETAL</b>	Any hx of fractures, pain, arthritis, etc.? How does this affect your activities of daily living? Hx of back injury?	Eye Muscle twitching, cramping, weakness deformity of extremities, gait, coordination, assistive devices used for ambulation, joint swelling/redness/stiffness, limitations of movement, edema of ext., skin discolorations, any problems positioning pt., prosthesis, bed or chair bound.
<b>PSYCHOSOCIAL</b>	How would you describe yourself? What do you like or dislike about yourself? (i.e., physical self- how client views self in terms of appearance).	Eye contact, appearance, appropriateness of dress and appearance, vital signs, anxiety, anger, depression, quiet, level of self- esteem, biting nails, chewing gum, smoking, smell of alcohol, crying, mood swings?
<b>Interpersonal relationships</b>  1. most significant relationship  2. community activities and religious affiliation  3. work or school relationships  4. family cohesiveness	Satisfaction or dissatisfaction with relationships? Who would you call if you needed help or were in trouble? Who lives with you? What is your position in the home? Religious affiliation and how often attends? Do you have family members that live nearby? Do you feel comfortable calling on these family members? Day-to-day relationships with family members. Who assumes your responsibilities while you are gone?	Visitors, interactions with visitors, presence of flowers, gifts, cards, etc. Phone calls, pictures. Who does client talk about?

<b>SUBJECTIVE</b>		<b>OBJECTIVE</b>
<p>Activities of daily living</p> <ol style="list-style-type: none"> <li>1. distribution of day</li> <li>2. hobbies</li> <li>3. methods of relaxing</li> <li>4. family demands</li> <li>5. community involvement</li> <li>6. ability to cope with ADLs</li> </ol>	<p>How do you spend your day? (work, leisure, rest) Do you accomplish all that you desire in a day or week? What do you do in a day or week? What do you do in your spare time? What do you do to relax? What are your responsibilities for children, household, elderly parents, financial? Types of organizations you belong to, volunteer work, etc?</p>	<p>Hobbies client is engaging in (TV, radio, talking, needlework, reading, etc.) How does client spend day in hospital?</p>
<p>Communication Style</p> <p>Verbal Nonverbal Interactions Occupational Hx (1) jobs held in past (2) current employment (3) educational preparation (4) satisfaction with present and past employment (5) time spent at work vs. time spent at play</p>	<p>What jobs have you held in the past? How long did you hold each one? How did you like each job? Why did you leave each job? What do you see yourself doing one year and five years from now? How many hours a day do you work? How does your hospitalization and illness affect your job? How far did you get in school?</p>	<p>Observe nonverbal (eyes, facial expressions, gestures, touch, posture) Is it congruent with verbal? Is client able to express self and emotions verbally? Note interactions with support persons and emotions expressed.</p>
<p>Major stressors in lifestyle experienced in past year and perception of these</p>	<p>e.g. new baby, job change, move, divorce, family illness, financial stressors, How did this change your life?</p>	
<p>Coping mechanisms (patterns)</p>	<p>What do you do to cope with serious problems or high levels of anxiety? Does this work?</p>	<p>Wring hands, chewing gum, biting nails, smoking, crying, etc. Does client use coping/defense mechanisms such as denial, projection, etc.? (refer to Kozier and Erb)</p>
<p>Response to illness</p>	<p>How do you feel about your illness? How does this illness affect your life and your family or friend?</p>	<p>Client's reaction when you discuss his/her illness (verbal or nonverbal)</p>
<p>History of psychiatric care or counseling</p>	<p>Have you ever been to human services, mental health, or hospitalized for psychiatric illness? Is there a family history of psychiatric illness?</p>	<p>List medications currently taking. Any mention of history in chart.</p>

<b>SUBJECTIVE</b>		<b>OBJECTIVE</b>
Feelings of anxiety, nervousness, or depression	What situations make you feel anxious or nervous? How do you cope with this? Have you ever considered killing yourself? Do you have insomnia? Unexplained crying? Fear? Change in sleep habits, bowel habits, appetite, energy level. Sexual functioning? How frequently do these changes occur? Any change in personality? Mood? Behavior? Do you ever take any medicine or treatments for anxiety, nervous, depression, or stress?	Nonverbal evidence of anxiety, nervousness, depression (irritability, anger, etc.)
Habits	Kind consumed, frequency per week, pattern past five years and past year, drive companions? Does drinking increase with anxiety or stress?	Smell of alcohol, physical manifestations of alcohol abuse or withdrawal.
1. alcohol		
2. smoking	Kind of tobacco used (cigarette, pipe, chewing, snuff, etc.). Amount used per day or week, pattern in past five years and past year. Does smoking increase with anxiety or stress? Desire to quit and methods attempted.	Amount of tobacco used in your presence.
3. coffee and tea	Amount consumed per day. Pattern over past year. Does consumption increase with anxiety or stress? Physiological effects?	Amount you observe client consume.
4. prescription, OTC, and street drug use	Do you take any prescription medicines? Which ones? How often? Do you take any OTC medicines regularly? Which ones? Do you use any street drugs? Which ones? How often?	List medications currently taking. Any symptoms of drug addiction, abuse, or withdrawal noted? Condition of nose and antecubital spaces.
5. Other		
<ul style="list-style-type: none"> <li>▪ overeating or sporadic eating</li> <li>▪ nailbitting</li> <li>▪ nervous noneating</li> <li>▪ cookie jar syndrome</li> <li>▪ soft drink abuse</li> </ul>		
Developmental Stage		Review data already collected i.e., activities of daily living, communication patterns, feeling about self-Make a determination as to where patient is progressing toward completion of developmental tasks.

STUDENT NAME: \_\_\_\_\_

CAPE FEAR COMMUNITY COLLEGE ADN PROGRAM:

**DATA COLLECTION SHEET**

DATE: \_\_\_\_\_

PAGE 1 of 4

INITIALS: \_\_\_\_\_

DX(S): \_\_\_\_\_

SURGERY: \_\_\_\_\_

	<b>INTEGUMENTARY</b>	<b>EYE / EAR / NOSE / THROAT</b>	<b>FUNCTIONAL ABILITY</b>
<b>DATA: SUBJECTIVE(S) &amp; OBJECTIVE(O)</b>			
<b>NSG DX / PROBLEM</b>			
<b>STG GOALS</b>			
<b>LTG</b>			

**DATA COLLECTION SHEET**  
**PAGE 2 of 4**

	<b>CARDIOVASCULAR</b>	<b>RESPIRATORY</b>	<b>GASTROINTESTINAL</b>
<b>DATA: SUBJECTIVE(S) &amp; OBJECTIVE(O)</b>			
<b>NSG DX / PROBLEM</b>			
<b>STG GOALS</b>			
<b>LTG</b>			

**DATA COLLECTION SHEET**  
**PAGE 3 of 4**

	<b>URINARY / GENITAL</b>	<b>IMMUNOLOGICAL</b>	<b>NEUROLOGICAL</b>
<b>DATA: SUBJECTIVE(S) &amp; OBJECTIVE(O)</b>			
<b>NSG DX / PROBLEM</b>			
<b>STG GOALS</b>			
<b>LTG</b>			

**DATA COLLECTION SHEET**  
**PAGE 4 of 4**

	<b>MUSCULOSKELETAL</b>	<b>ENDOCRINE</b>	<b>PSYCHOSOCIAL / SEXUALITY</b>
<b>DATA: SUBJECTIVE(S) &amp; OBJECTIVE(O)</b>			
<b>NSG DX / PROBLEM</b>			
<b>STG GOALS</b>			
<b>LTG</b>			

Final Evaluation: \_\_\_\_\_ Date: \_\_\_\_\_

Student: \_\_\_\_\_

Instructor: \_\_\_\_\_

Instructor: \_\_\_\_\_

**S = Satisfactory:** The student is performing at a level which expresses the application of knowledge and skills reflected in the course content and integrated knowledge and skills from previous courses.

**Satisfactory Behaviors:**

**AFTER INITIAL CLINICAL ORIENTATION, THE STUDENT:**

1. With guidance, meets clinical outcomes as specified.
2. Initiates care appropriately.
3. With appropriate supervision, safely performs psychomotor skills.
4. Observes professional ethics at all times.
5. With guidance, is sensitive to patients= needs.
6. Needs limited direction in developing effective communication skills.
7. Within a reasonable length of time, plans, organizes, and implements care for one adult with clearly identified medical-surgical health care problems.

**U = CRITERIA FOR UNSATISFACTORY CLINICAL EVALUATION FOR THE SEMESTER**

An unsatisfactory clinical evaluation for the semester results in a grade of F for the semester regardless of the classroom average on didactic units and may result from any of the following:

1. A documented pattern of below average performance for two weeks which does not improve to at least average in the third week after evaluation conferences have resulted in weaknesses and deficiencies being specifically identified on the Anecdotal Record and assistance or guidance provided to enable the student to overcome the deficiencies.

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2. **A documented accumulation of three weeks of below average performance wherein evaluation conferences resulted in weaknesses and deficiencies being specifically identified on the Anecdotal Record and assistance or guidance provided without sustained performance at the level of average.**
3. **A documented serious incident of failure to perform satisfactorily a competency that is potentially threatening to a patient's safety or well-being and where extenuating or mitigating factors do not justify the failure to perform.**

**Unsatisfactory Behaviors:**

**AFTER INITIAL CLINICAL ORIENTATION, THE STUDENT:**

1. **Does not meet the clinical outcomes.**
2. **Does not take initiative and/or takes initiative inappropriately, approaching or actually endangering patient safety.**
3. **Exhibits inability to perform designated psychomotor skills safely.**
4. **Violates professional ethics such as, but not limited to:**
  - a. **Carelessness with patient confidentiality,**
  - b. **violates agency policies.**
  - c. **inability or unwillingness to recognize implications of behavior on nursing practice.**
5. **Insensitive to the needs of patients and/or significant others.**
6. **Does not utilize appropriate communication skills and forming therapeutic relationships with patients and/or significant others.**
7. **Requires an unreasonable length of time to plan, organize, and implement nursing care for assigned patients.**

**Clinical evaluations will be conducted with students on an ongoing basis. A formal clinical evaluation will be conducted with the student at the end of the semester. At the end of the semester the student must have achieved a "Satisfactory" in all areas of clinical evaluation in order to pass the course.**

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In NUR-110 the student will be assigned one patient each clinical day. Assignments will reflect course theory related to nursing management of adult patients experiencing alterations in health and associated activities of daily living.

ROLE AS PROVIDER OF CARE	S	U	COMMENTS
<b>I. Assessment:</b> Understand gathering objective and subjective data from appropriate sources for patients with a common health stressor.			
<b>A. Gathers objective and subjective data relative to the patient experiencing common stressors identified in NUR 110</b>			
<b>1. gathers verbal and nonverbal information from the patient, significant others, health team members, records, and other pertinent resources.</b>			
<b>2. reviews standard data sources for information (textbook, chart, patient/family, resource persons)</b>			
<b>3. states symptoms and significant findings</b>			
<b>4. identifies patient's ability to assume care of daily health needs</b>			
<b>5. discusses environment of patient relative to care</b>			
<b>6. identifies own reactions to patient, significant others, and/or environment</b>			
<b>7. initiates effective communications skills</b>			
<b>B. Verifies data:</b>			
<b>1. discusses observation or perception with faculty</b>			
<b>C. Communicates information gained in assessment</b>			

NUR-110 Nursing I

	S	U	COMMENTS
<b>II. Analysis:</b> Determine common nursing diagnosis based on identification of actual or potential health needs and individual patient response to health stressors.			
<b>A. Explains data:</b>			
1. verifies data			
2. organizes related data			
<b>B. Gathers additional data as indicated:</b>			
<b>C. States a common nursing diagnosis:</b>			
<b>III. Planning:</b> Develop patient-centered goals, planned interventions, and expected outcomes based on input from the patient, significant others, and the health team.			
<b>A. States goals of care:</b>			
1. involves patient, significant others and/or health team members in identifying goals			
2. identifies needs/problems based on established priorities			
<b>B. Develops plan of care:</b>			
1. involves patient, significant others, and/or health team member in plan of care			
2. includes all information needed for organizing patient's care, such as age, sex, culture, ethnicity, religion, and developmental stage			
3. plans for patient's comfort and maintenance of optimal functioning			
4. selects learned nursing measures appropriate for accountable delivery of patient care			
<b>C. Plans with other health team members for delivery of patient care:</b>			
<b>D. States expected outcomes of nursing interventions:</b>			

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	S	U	COMMENTS
<b>IV. Implementation:</b> Describe methods to provide humanistic and caring applications of scientific principles to safely initiate and complete actions necessary to accomplish the defined goals.			
<b>A. Performs or assists patient in performing activities of daily living:</b>			
1. institutes measures for patient comfort			
2. assists patient to maintain optimal functioning			
<b>B. Reinforces teaching plan developed by others:</b>			
1. recognizes patient=s relationships with significant others and health team members			
2. reinforces correct principles, procedures, and techniques for health maintenance			
<b>C. Provides care to achieve established patient goals:</b>			
1. used correct and safe techniques in administering patient care			
2. uses precautionary and preventive measures in providing care to patients			
3. administer and monitor prescribed medical regimen			
4. recognize patients adverse responses			
5. initiates necessary life-saving measures for emergency situations			
<b>D. Provides care to optimize achievement of patients health care goals:</b>			
1. provides an environment conducive to attainment of patient health care goals			

NUR-110 Nursing I

	S	U	COMMENTS
2. adjusts care in accordance with patient's expressed or implied needs/problems			
3. motivates patient to achieve self-care and independence			
4. encourages patient to follow treatment regimen			
5. offers caring support to the patient and significant others			
<b>E. Records and exchanges information (all charting must be reviewed by faculty prior to writing on patient's chart):</b>			
1. provides complete, accurate reports on assigned patient to other health team members			
2. records actual patient responses, nursing actions, and other information relevant to implementation of care			
<b>V. Evaluation:</b> Describes the effectiveness of nursing intervention on the patient's status			
<b>A. Express actual and expected outcomes:</b>			
1. describes responses (expected and unexpected) in order to determine degree of success of nursing interventions			
<b>B. Determines compliance with prescribed and/or proscribed therapy:</b>			
1. identifies impact of actions on patient, significant others, and/or health team members			
2. describes patient's, significant others, and/or health team members understanding of information given			
<b>C. Records patient's response to therapy and/or care:</b>			

NUR-110 Nursing I

ROLE AS MANAGER OF CARE	S	U	COMMENTS
<b>I Management:</b> Participates in accountable management of nursing care.			
<b>A. Identifies priorities for meeting nursing care needs:</b>			
<b>B. States roles and responsibilities of members of the health care team:</b>			
<b>C. Completes nursing care within a reasonable time frame:</b>			
<b>D. Recognize the need for assistance from faculty or health team members when the situation is beyond student knowledge and experience:</b>			
<b>II Critical Thinking:</b> Demonstrate critical thinking as it relates to fundamental patient care.			
<b>ROLE AS A MEMBER WITHIN THE DISCIPLINE OF NURSING</b>			
<b>I. Determines behaviors which are reflective of professional growth, continuous learning and self-development</b>			
<b>A. Identifies resources for continuous learning and self-development:</b>			
<b>1. identifies own learning needs and communicates to faculty</b>			
<b>2. seeks feedback for self-improvement</b>			
<b>3. utilizes feedback for professional growth</b>			
<b>B. Practices within legal and ethical framework of nursing:</b>			
<b>1. maintains confidentiality of information regarding patients</b>			
<b>2. communicates truthfully in verbal and written form the patient's behaviors and responses to interventions</b>			
<b>3. assists peers in delivery of patient care</b>			

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	S	U	COMMENTS
<b>C. Utilizes current literature in researching patient care concerns:</b>			
<b>D. Is knowledgeable regarding therapeutic use of self during patient care:</b>			
<b>II: Evaluation:</b> Develop beginning competencies to utilize informatics to communicate, manage knowledge, mitigate error and support decision-making.			
<b>A. Demonstrate computer documentation</b>			
<b>B. Identifies informatics to research best practice recommendations for planning of patient care.</b>			
<b>III: Evaluation:</b> Identifies quality improvement processes to measure client outcomes, identify hazards and errors, and develop changes in processes of client care.			
<b>A. Identify quality improvement efforts in the clinical area.</b>			
<b>B. Recognize quality improvement initiatives identified by the clinical area.</b>			

Final Evaluation

Date: \_\_\_\_\_

Student

Signature: \_\_\_\_\_

Faculty

Signature: \_\_\_\_\_

**References:**

National League for Nursing (1990). **Educational Outcomes of Associate Degree Nursing Programs: Roles and Competencies.**

National Council of State Boards of Nursing, Inc. (1998). **Test Plan for the National Council Licensure Examination for Registered Nurses.** Chicago: National Council of State Boards of Nursing.