

INTERNATIONAL INSTITUTE OF HEALTH SCIENCES



CURRICULUM FOR DIPLOMA IN GENERAL NURSING

DIPLOMA IN GENERAL NURSING CURRICULUM

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MISSION

The mission of the Diploma in General Nursing program is to prepare students to provide competent nursing care for all patients of all ages, in any country, by utilizing the nursing process while functioning in the role of the associate degree nurse in the context of caring human service. This mission fulfilled by provision of the following students:

1. Opportunities to develop a life philosophy that conveys tolerance of others and concern for them.
2. A curriculum based on scientific principles, current concept of nursing, community health needs, and trends in nursing education.
3. A curriculum that provides students the knowledge and competencies to meet successfully the established standards required in the nursing profession.
4. A foundation for upward mobility in nursing education.
5. Experiences that stimulate students toward optimal personal and professional growth through- life long learning.
6. An environment that fosters critical thinking and instills a desire for ongoing inquiry.

OBJECTIVES

I. Collaborate with clients and families to restore, promote or maintain health throughout the life span.

1. Employ theory –based judgment while developing, providing and evaluating nursing care.
2. Manifest within the role of provider and manager of care, the following behaviors.
 - Provide safe, effective nursing care for individuals and/or groups of clients
 - Implement principals of teaching learning in nursing practice to improve client outcome.
 - Collaborate with and support members of the health care team and other professionals to promote continuity of care.
3. In restoring, promoting and maintaining health, emphasis is on the following.
 - Health perception- Health management
 - Nutritional- Metabolic
 - Activity- Exercise
 - Sleep- Rest
 - Cognitive- Perceptual
 - Self-Perception and Self – Concept
 - Coping- Stress Tolerance
 - Value-Belief

II. Participate in caring relationships which motivate and empower clients.

1. Exemplify a caring spirit, with effective, cognitive and psychomotor components in the roles of provider and manager of care and member within the profession.
2. Consistently assess and appropriately advocate for client within their value belief patterns.
3. In reflecting a spirit of caring for humanity, emphasis is on the following functional patterns.
 - Self- Perception and self –concept
 - Role –Relationship
 - Sexuality- Reproductive
 - Coping- Stress Tolerance
 - Value-Belief

III. Demonstrate critical thinking, which enhances the concept of nursing, humanity, health and environment in a dynamic world.

1. Exhibit excellence in clinical judgment in the role of provider of care and manager of care, integrating and building upon theoretical concept from the related disciplines.
2. Generate and maintain client-focused therapeutic communications, enhancing and demonstrating critical thinking, emphasis is on the following functional Patterns: Health Perception – Health Management
 - Nutritional – Metabolic
 - Elimination
 - Activity- Exercise
 - Sleep- Rest
 - Cognitive – Perceptual
 - Role- Relationship
 - Value- Belief

IV. Demonstrate commitment to lifelong learning and professional excellence in the roles of the associate degree nurse.

1. Create opportunities for enhancing professional and personal growth within the roles of provider care, manager of care (including health care team) and member within the profession.
2. Appraise, verify and use available resources to improve levels of practice based on self and peer review
 - Seek current knowledge of factors which affect nursing practice.
 - Adhere to policies and standards of care within the workplace
 - Appreciate the importance of participating in professional organizations and community activities.
 - Seek knowledge of current laws and levels of health care practice.
3. In the development of professional and personal excellence, emphasis is on the following functional patterns:
 - Health Perception- Health Management
 - Cognitive – Perceptual
 - Role- Relationship
 - Coping – Stress Tolerance
 - Value- Belief

CONCEPTUAL FRAMEWORK



CONCEPTUAL FRAMEWORK

INTRODUCTION

The philosophy of ACHS guides the conceptual framework which is congruent its mission, purpose and goals. The concepts identified as basic to the role and functions of the professional nurse are:

1. HUMANITY
2. HEALTH
3. NURSING
4. ENVIRONMENT

The integration of concept and sub-concepts progresses from foundational principles of health to complex alterations in health as the student advances through each level of study in the Nursing program. Concepts, principles, and theories from support courses provide the foundation for the Nursing curriculum and for nursing practice.

HUMANITY

Humanity is a holistic creation. Individuals are viewed as an integrated whole. Aspects of the whole person include spiritual, physiological, psychological, sociological and intellectual components. Individuals have needs associated with each component of wholeness. If specific needs are not met, the result may be a compromise in health. Individuals are dynamic and unique, vary in their abilities and are capable of thinking, adapting and making choices.

Humanity has sub concepts. Individuals become members of families, groups and communities. These sub concepts are viewed as open systems that continually adapt to their environment. The students begin delivery of care to Humanity on the individual level, then proceeds to families, groups and communities.

HEALTH

ACHS views health as a dynamics process. It encompasses spiritual, physiological, psychological, sociological and intellectual dimensions. Any definition of health must be broad enough to accommodate personal beliefs and values, as health means different things to different people. This principle is essential for nurses to be able to communicate effectively with clients in planning and providing nursing care. Health is client- defined in terms of one or any combination of the following; human response to health and illness, functioning in one's roles, adapting to changing situations, living to one's maximum potential. When nurses do not recognize individual definitions of health, clients may not value nursing measures designed to enhance their health.

NURSING

The components of the discipline of nursing include caring, critical thinking, lifelong learning and professional excellence.

Caring

Nursing is an intellectual activity encompassing the art and science of caring, which provides an essential service to humanity. Caring, inherent through nursing, involves the whole client- spirit, mind and body. Benner (1984) sees the “healing power of caring” as a relationship in which the nurse motivates clients, finds interrelationships for situations and functions as an advocate assisting clients to use all resources available to them. As nursing functions within the practice areas of health promotion, health maintenance, health restoration and care of dying, nurses assist individuals to attain optimal well-being or to die with dignity.

Critical thinking

The skill of reasoning is predominant in critical thinking, allied to logic, scientific knowledge and philosophical thinking (Bandman & Bandman, 1995). Competence in reasoning enhances analytical and critical skills and reflective examination of multiple factors as nurses’ work through increasingly complex problems. The curriculum emphasizes the process and application of critical thinking skills which helps students explore situations and weigh the logic and accuracy of evidence to arrive at valid conclusions.

The nursing process is a systemic, problem solving approach to assessment, diagnosis, planning, implementation and evaluation. The clients needs, associated with each component of wholeness, are identified, appropriate nursing diagnoses established, outcomes described and interventions initiated. The effectiveness of care is evaluated as indicated and changes made in the plan as required.

The spirit of inquiry is basic to critical thinking, and is a frame of mind which emphasizes the examination of ideas, beliefs, arguments and issues for the purpose of expanding understanding. The numerous methods of inquiry pertinent to nursing include the utilization of current research from a variety of disciplines.

Lifelong learning

Learning is a lifelong process of integrating past experiences with current needs and goals. Life situations facilitate learning. Learning is both an inner process of self discovery and a corporative activity. It is enhanced by the process of immediate feedback, hands on laboratory experiences and ability to research and discover solutions to complex problems through collaboration and group process.

Professional excellence

Professional excellence includes responsibility, accountability, and the knowledge of current practice standards, ability to think critically and awareness of health care policy. It means having expertise to carry out safe, efficient competent nursing care in increasingly complex situations and settings. Faculty serves as role models of professional excellence and challenge students to attain excellence in all areas of practice.

Changing health care needs of society demand an increase in nursing knowledge and competencies. The curriculum follows an articulated plan that facilitates and amplifies professional excellence as well as higher education and upward career mobility.

The Associate of sciences graduate is prepared to use the nursing process as a provider and manager of direct patient care. The nurse who completes the Associate Degree will have the educational preparation to fulfill the three basic roles of the Associate Degree Nurse.

The roles are:

Provider of care

Manager of care

Member within the Discipline of Nursing

In each of these nursing roles, decisions and practice are determined on the basis of critical thinking, knowledge and competencies, the nursing process and human response to health and illness, current laws, established protocols of the settings and an awareness of available personal and community resources.

ENVIRONMENT

Environment is all that is internal and external to an individual. It encompasses family, culture, society and health care. Environment is dynamic force and directly impacts holistic development and learning.

The health care system is a sub concept of environment which includes the three levels of prevention: primary, secondary and tertiary with appropriate intervention in structured and unstructured care settings.

An additional sub-concept is Culture. Society has many different cultural groups, each sharing similar beliefs, attitudes, values and practices. These entities are influenced to a great degree by economic, political and technological forces. The cultural beliefs of individuals have great importance on the practice of nursing

CONCLUSION

The conceptual framework of ACHS is based on the belief that the individual is a holistic being, having dignity and worth. The curriculum emphasizes nursing, care of individuals and communities and application of critical thinking skills. The goals of the college is to promote a vision of nursing education that fosters personal and professional attainment of goals and the preparation of competent and caring nurses while exemplifying professional excellence and lifelong learning.

FUNDAMENTALS OF NURSING

NURSING I

NURS 121

COURSE DESCRIPTION

Diploma Nurse; Provider of Care, Manager of Care, and Member within the Discipline of Nursing. The focus is on using dependent nursing measures to care for individuals in a state of health and wellness within the of functional health patterns.

Integrated into the use of the nursing process are the concepts of health, humanity, and environment as they relate to the components of wholeness. Basic concepts of normal adult assessment, alterations in patterns of health, comfort and pain, rest and sleep, asepsis, infection control and the use of Universal Precautions, safety, pharmacology, mental health and therapeutic communication are introduced.

Concepts related to dealing with self and different spiritual, cultural, and ethnic backgrounds are presented. Overdoing concepts include caring, critical thinking, professional excellence, and lifelong learning.

COURSE OBJECTIVES

Upon completion of this course, the student will be able to:

1. Demonstrate an understanding of the concept of man as an integrated whole and the relationships which exist between the components of wholeness:
 - Intellectual
 - Physiological
 - Psychological
 - Sociological
 - Spiritual
2. Provide care for the adult client at a beginning level of competence in the roles of the nurse.
 - Provider of Care
 - Manager of Care
 - Member within the Discipline of Nursing
3. Relate theoretical knowledge to given simulated and actual clinical situations.
4. Apply concepts of nursing, humanity, health, and environment to case studies with adult clients in a state of health and wellness within the functional health patterns.
5. Formulate and initiate nursing care plans integrating basic concepts related to:
 - a. Asepsis
 - b. Communication
 - c. Culture
 - d. Mental Health
 - e. Activity, rest
 - f. Basic Pharmacology
 - g. Comfort and Safety
 - h. Fluids and nutrition
 - i. Basic personal needs
 - j. Spirituality
 - k. Legal issues
 - l. Medication administration
 - m. Advocacy
 - n. Client education
 - o. Life span
6. Calculate basic nursing math correctly in the safe administration of oral medications
7. Develop critical thinking ability.

NURSING I NURS 121

THEORY SYLLABUS

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HEALTH PERCEPTION

THE PATIENT WITH POTENTIAL FOR ALTERED HEALTH MAINTENANCE

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Identify at least three important concepts brought out in the philosophy the PUC department of nursing.
2. Discuss the meaning of each component of the Conceptual Model of the PUC department of nursing.

HEALTH

- 1 Discuss the meaning of the wholeness of man.
- 2 Describe hierarchy of needs.
- 3 Discuss the concepts of health and wellness.

HUMANITY

- 1 Analyze your personal and professional goals and describe the best way to reach them.

ENVIRONMENT

- 1 Identify factors affecting health status, beliefs, and practices.
- 2 Describe factors affecting health

PREPARATIONS GUIDELINES

1. 1. Potter, P.A., Perry, A.G.Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott
4. Harkreader.H, Fundamentals of nursing: Caring and Clinical Judgment. Saunders.

ACTIVITY-EXERCISE PATTERN

THE PATIENT WITH POTENTIAL FOR IMPAIRED PHYSICAL MOBILITY (IMMOBILITY)

OBJECTIVES

Upon the completion of this class the student will be able to:

NURSING

1. From the list of accepted nursing diagnoses, select one that you believe would be valid if a patient is immobile.
2. Discuss what the nurse can do to prevent problems due to immobility.
3. Define vocabulary and abbreviations in this assignment:

Muscular atrophy	Catabolism
Contracture	Anabolism
Decubitus	Thrombosis
Ischemic	Embolism
Necrotic	AMB-ambulatory, walking
Stasis	BR-bed rest
Urinary calculi	pt-patient
Incontinence	ct-client
Osteoporosis	
Hypostatic pneumonia	
Postural hypotension	

HEALTH

1. Identify intellectual, physiological, psychological, sociological, and spiritual disruptions of functions due to immobility and appropriate
2. Discuss the physiology involved or reasons for the above disruptions.
3. Discuss the relationship of nutrition, age and mobility with skin integrity.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott

EFFECTS OF IMMOBILITY

Physiological Dimension

Metabolic

- Fluid and electrolyte changes
- Bone demineralization
- Altered exchange of nutrients and gases
- Altered gastrointestinal functioning

Respiratory

- Decreased lung expansion
- Pooling of secretions

Cardiovascular

- Orthostatic hypotension
- Increased cardiac workload
- Thrombus formation

Musculoskeletal

- Decreased endurance
- Decreased muscle mass
- Atrophy
- Decreased stability
- Contracture formation
- Osteoporosis

Skin

- Decubitus ulcer formation

Elimination

- Renal calculi
- Stasis urine
- Kidney infection
- Fecal constipation
- Fecal impaction

Developmental Dimension

Young

- Retardation of developmental states

Elderly

- Increased rate of dependence
- Increased rate of loss of system

Psychosocial Dimension

Depression

Behavioral changes

Change in sleep-wake cycles

Decreased coping abilities

Decreased problem-solving abilities

Decreased interest in surroundings

Increased isolation

**SELF-PERCEPTION -SELF-CONCEPT PATTERN
THE PATIENT WITH POTENTIAL FOR SELF-ESTEEM DISTURBANCE**

(SELF AWARENESS)

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

- 1 Identify a three part nursing diagnosis for a patient with self-esteem disturbance.
- 2 Discuss ways the nurse may assist clients in developing their self-esteem.

HUMANITY

- 1 Differentiate between self-awareness, self-concept, self-esteem, and self-disclosure.
- 2 Discuss the development of self-esteem through the life span.
- 3 Discuss self-disclosure in communication with individuals and groups.
- 4 Discuss the components of self-concept.
- 5 Discuss the effects self-esteem has on communication and interpersonal relationships.
- 6 Explain "Perception" and "Reality".
- 7 Discuss from a Christian perspective, how difficult experiences in our lives can help in becoming aware of our weaknesses and how they can be strengthened.
- 8 Discuss the concept of assertiveness.

PREPARATION GUIDELINES

- 1.Potter, P.A., Perry, A.G.Fundamentals of Nursing, 6th edi, Elsevier.
- 2.Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
- 3.C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott

CONCEPTS BASIC TO NURSING PRACTICE

ETHICS, VALUES ADVOCACY

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Discuss types of ethical problems in nursing.
2. Recognize nursing roles and responsibilities with regard to ethics.
3. Identify the uses and limitations of professional codes of ethics.
4. Describe the nurse's role in dealing with patients with different values.
5. Discuss how personal or group values can conflict with professional responsibilities.
6. Identify the nurse's role as an advocate for the patient.

HUMANITY

1. Demonstrate an awareness of personal values.
2. Identify ethical dilemmas that may occur at various stages in the life span

ENVIRONMENT

Define the terms: ethics, bioethics, values, and morality

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C. Taylor, C. Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott

HEALTH PERCEPTION -HEALTH MAINTENANCE PATTERN

THE PATIENT WITH POTENTIAL FOR ALTERATION IN HEALTH MAINTENANCE (VITAL SIGNS and BLOOD PRESSURE)

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Interpret commonly used abbreviations in charting Vital Signs:

Abbreviations

- a. A.P
- b. B.P
- c. C
- d. F
- e. P
- f. R or resp
- g. T or temp
- h. TPR
- i. V.S
- j. wt
- k. ht

Vocabulary

Temperature

Crisis
Diaphoresis
Fever
Heat cramps
Heat stroke
Heat exhaustion
Hyperpyrexia
Hypothermia
Intermittent fever and remittent fever
Lysis
Pyrexia
Relapsing fever
Febrile and Afebrile
Hyperthermia

Respiration

Apnea
Bradypnea
Cheyne-Stokes
Dyspnea
Eupnea
Hyperventilation
Hypoventilation
Ortopnea
Rales
Stridor
Tachypnea
Wheezing

Pulse

Arrhythmia
Bradycardia
Full or bounding pulse
Pulse deficit
Tachycardia
Weak, feeble or thready pulse

Blood Pressure

Diastolic
Pulse Pressure
Sphygmomanometer
Systolic

2. Discuss temperature in relation to:

- a. Process of heat production and heat loss.
- b. Factors that affect body temperature.
- c. Clinical signs of fever.
- d. Types of fever.
- e. Determining the appropriate type of temperature assessment for the condition and the normal ranges for each.
- f. Identifying appropriate nursing interventions for chilling and flush phases of
- h. Causes for inaccurate temperature

3. Discuss pulse in relation to:

- a. Reasons for taking a pulse and factors affecting pulse rate.
- b. Three specific factors assessed when palpating a pulse. Pulse sites with purpose and proper procedure for each.
- c. Explain pulse deficit
- e. Causes of errors in taking a pulse.

4. Discuss respiration in relation to:

- a. Types of breathing.
- b. Factors that affect respiration.
- c. Four factors to assess while taking respirations.
- d. Causes of errors in assessing respirations.

5. Discuss blood pressure in relation to:

- a. Explain what blood actually measures.
- b. Discuss factors that pressure.
- c. Explain pulse pressure.
- d. Discuss methods for measuring blood pressure.
- e. Evaluate causes of error in blood pressure assessment.

HEALTH

Explain the anatomy, physiology, normal ranges and effects of aging related to vital signs, and why vital signs are important.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott

DATE:		VITAL SIGNS					Today's Weight: lbs. = _____ Kg = _____ 1 Kg = 2.2 lbs			
Nurse:							Scale Type: <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Chair			
Room #:							Diet type: _____ B/W Score _____			
Room # (if different):							Breakfast	<input type="checkbox"/> NPO		
Diet #:							Lunch	<input type="checkbox"/> NPO		
Diet # (if different):							Dinner	<input type="checkbox"/> NPO		
Date to be changed / Change (Nurse # / 72 hr):							AMI / IM Score	T-AP	B-AP	I-P/A
Initial # attempts per IV start or Restart:							Bedside			
RH LH = Hand RW LW = Wrist RP LP = Radial RA' LA' = Anterior RU' LU' = Upper Arm RL' LL' = Distal Arm RA' LA' = Axilla							Bedside			
IV Site Port or GAT GE & length:							Bedside			
	IV	IV	IV	IV	IV	Functional Independence Measures (FIM) Key: 7 = Total independent 6 = Modified independent 5 = Supervision 4 = Minimal assist for 25% 3 = Max assist for 25% 1 = Total assist for 100%				
Time							Patient Activities <input type="checkbox"/> Activities of Daily Living <input type="checkbox"/> Dressing <input type="checkbox"/> Eating <input type="checkbox"/> Grooming <input type="checkbox"/> Mobility <input type="checkbox"/> Transfer			
AM TOTAL							Last PM: _____ BM today: [] Bowel / _____ [] Stool / _____ [] Urine / _____ [] Urine / _____ <input type="checkbox"/> Urine / _____ [] Stool / _____			
PM TOTAL							Guided Stools: [] _____ [] _____ [] _____ [] _____			
OC TOTAL							INTAKE: Oral _____ P/NG _____ BRG/ _____ IV _____ IV Ph _____ Basal Nutrition _____ 8 hr _____			
							OUTPUT: VOIDED _____ CAT# _____ NG _____ EMESIS _____ RESIDUAL _____ Drains _____ 8 hr TOTAL _____			
AM SIGNED _____ AM SIGNED _____										
PM SIGNED _____ PM SIGNED _____										
NOC SIGNED _____ NOC SIGNED _____										
SIGNED _____ SIGNED _____										
								24 hr Intake/Output		
								1 or - Balance		

HEALTH PERCEPTION -HEALTH MANAGEMENT PATTERN THE PATIENT WITH A HIGH RISK FOR INFECTION I

(ASEPSIS I)

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

- 1 Give examples of nursing Diagnoses related to infection.
- 2 Discuss nursing interventions that prevent infections.
- 3 Discuss nursing interventions that break the chain of infection.
- 4 Discuss how to evaluate the process of tissue healing as to regeneration or replacement with fibrous tissue.
5. Define the following terms:
 - a. infection
 - b. disease
 - c. virulence
 - d. communicable disease
 - e. trauma
 - f. pathogenicity
 - g. opportunistic pathogen
 - h. etiology
 - i. parasite
 - j. carriers
 - k. nosocomial infection
 - l. inflammation
 - m. iatrogenic infection

HEALTH

1. Identify procedures and situations that increase the probability of infection and be able to explain why they do.
2. Identify the 6 links in the chain of infection.
3. Describe environmental conditions favorable to the growth of microorganisms.
4. Identify ways microorganisms exit the body.
5. Describe various modes of transmission of microorganisms.
6. Describe four stages of an infectious process.
7. Describe the nonspecific and specific defenses of the body.
8. Discuss the contributing factors to nosocomial infections.
9. Identify factors affecting the risk of infection.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott

HEALTH PERCEPTION -HEALTH MANAGEMENT PATTERN THE PATIENT WITH HIGH RISK FOR INFECTION

(ASEPSIS II)

OBJECTIVES

Upon the completion of this class, the student will be able to:

1. Define the following terms:

Asepsis (medical and surgical)	f. bactericidal
Sterilization	g. fomites
Disinfection	h. clean
Antiseptic	i. contaminated
bacteriostatic	
2. Discuss control of spread of pathogens by cleaning, disinfection, sterilization and how these measures destroy or minimize the number of organisms present.
3. Plan nursing actions to prevent the spread of infection in the hospital.
4. Select and discuss nursing measures to strengthen the body's barriers against infection.
5. Discuss Universal Precautions.
6. Differentiate between aseptic techniques -medical and surgical.
7. State how nurses can evaluate the effectiveness of aseptic techniques.
8. Discuss primary nursing considerations relative to the administration of antimicrobials.
9. Describe the role of the nurse in obtaining or having specimens obtained prior to beginning antimicrobial treatment.
10. Describe follow-up nursing assessment related to untoward and allergic reaction to antibiotics.

HEALTH

1. Explain the main actions and spectra of activity of antimicrobials as a group.
2. Explain bacterial resistance, bacteriostatic, and bactericidal effects.
3. List the main actions, major side effects, and nursing implications of the following antibiotic categories:

a. Penicillins	d. Aminoglycosides
b. Cephalosporins	e. Sulfonamides
c. Tetracyclines	

PREPARATION GUIDELINES

4. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
5. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
6. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott

**SELF-PERCEPTION -SELF-CONCEPT PATTERN
THE PATIENT WITH POTENTIAL FOR ANXIETY AND/OR
INEFFECTIVE COPING MECHANISMS
(FEELINGS AND EMOTIONS)**

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

- 1 Describe ways a nurse can assist a hospitalized client cope with his feelings and emotions, to minimize anxiety.
- 2 Discuss ways nurses can help an anxious person lower his anxiety level.
- 3 Discuss constructive nursing actions for dealing with anger.
- 4 Identify nursing behaviors which are effective in assisting the depressed client.
- 5 Discuss how to evaluate if the nursing implementation has been effective.
- 6 Recognize the nurse's role as advocate for the anxious patient.

HEALTH

Discuss emotions which help promote health.

HUMANITY

Describe anxiety, anger, depression and stress in relation to causes and ways of expression

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G.Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott
4. Harkreader.H, Fundamentals of nursing: Caring and Clinical Judgment. Saunders.
5. Basavanathappa, B.T.,Fundamentals of Nursing, Jaypee2004

SELF-PERCEPTION - SELF-CONCEPT PATTERN
THE PATIENT WITH POTENTIAL FOR INEFFECTIVE COPING MECHANISMS
(STRESS, COPING, AND ADAPTATION)

OBJECTIVES

Upon the completion of this class the students will be able to:

NURSING

1. Describe stress management therapies and the nurse's role in their implementation.
2. Discuss the nurse's as advocate for the patient experiencing stress.
3. Describe strategies (interventions) which reduce the effects of stress.
4. Describe the nurse's role in the administration of antianxiety medications.
5. Describe the role of the nurse in referring patients who are at risk or experiencing stress to community resources.
6. Identify outcome criteria which can be used in evaluating the care of a person experiencing stress.
7. Construct nursing diagnostic statements related to the person experiencing stress.

HEALTH

1. Discuss the concepts and theories of adaptation, stress, over adaptation, stress and burnout.
2. Identify factors influencing stress responses.
3. Describe physiologic and behavioral responses to stress.
4. Describe calorie and protein requirements in response to stress.
5. Recommend diets for persons in stress.
6. Describe types of effective and ineffective coping strategies.
7. Explain the relationship between defense mechanisms and coping.

HUMANITY

1. Identify stressors associated with various stages of development through the lifespan.
2. Explain the relationship of stress to optimal function and growth.

ENVIRONMENT

1. Differentiate between stress and stressor.
2. Explain how stress and stressors affect the work environment.
3. Explain the importance of recognizing stress, stressors and coping mechanisms among colleagues in interdisciplinary teams.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott
4. Harkreader.H, Fundamentals of nursing: Caring and Clinical Judgment. Saunders.
5. Basavanathappa, B.T., Fundamentals of Nursing, Jaypee 2004

ROLE-RELATIONSHIP PATTERN
THE PATIENT WITH A POTENTIAL FOR IMPAIRED VERBAL COMMUNICATION
COMMUNICATION

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Assess methods "Our Example" used as He communicated and worked with others.
2. Identify and explain the different kinds of interview questions.
3. Identify a three-part nursing diagnosis for a client with impaired verbal or non-verbal Communication
4. Plan a interaction using all the techniques discussed.
5. Demonstrate and discuss how to implement verbal and nonverbal bridges and barriers to communication
6. Discuss how you will introduce yourself to your client.
7. Discuss the three major stages of an interview.
8. Identify your patterns of communication.
9. Analyze your nurse-client communication

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

ROLE-RELATIONSHIP PATTERN
THE PATIENT WITH POTENTIAL FOR IMPAIRED VERBAL COMMUNICATION
COMMUNICATION I

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Discuss the therapeutic-professional nurse-patient relationship.
2. Describe the nurse's role in a helping relationship.
3. Differentiate between therapeutic and non-therapeutic communication.
4. Identify therapeutic verbal techniques to aid communication.
5. Identify non therapeutic verbal responses.
6. Objectively evaluate your communication with patients in clinical labs.
7. Identify a 3-part nursing diagnosis for a patient with impaired verbal communication.
8. Identify the nurse's role in improving health-care team communication.

HUMANITY

1. Define communication.
2. Discuss two channels by which we communicate:
 - a) Verbal
 - b) Non-verbal
3. Discuss causes of communication breakdown.
4. Discuss how to give clear verbal messages and instructions

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G.Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott
4. Harkreader.H, Fundamentals of nursing: Caring and Clinical Judgment. Saunders.
5. Basavanathappa, B.T.,Fundamentals of Nursing, Jaypee2004

ROLE-RELATIONSHIP PATTERN PATIENT WITH POTENTIAL FOR IMPAIRED NON-VERBAL COMMUNICATION

COMMUNICATION II-NON-VERBAL

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Describe essential attitudes for the nurse which facilitate communication with patients
2. Differentiate between "acceptance" and "approval."
3. Discuss effective non verbal communication techniques.
4. Discuss the appropriate use of touch in nurse/patient communication.
5. Identify a three-part nursing diagnosis for a patient with impaired non-verbal communication.

HUMANITY

1. Discuss the importance of non-verbal communication
2. Identify body language and symbolic communication and give examples
3. Identify non verbal barriers to communication
4. Differentiate between intrapersonal and interpersonal communication

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott
4. Harkreader.H, Fundamentals of nursing: Caring and Clinical Judgment. Saunders.
5. Basavanathappa, B.T., Fundamentals of Nursing, Jaypee 2004

**CONCEPTS BASIC TO NURSING PRACTICE
WRITTEN COMMUNICATION
DOCUMENTATION**

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Discuss the purpose of the patient record
2. Differentiate and discuss the problem-oriented medical record and traditional Patient record
3. Discuss the importance of charting as a communication tool
4. Discuss how and where the nursing process and diagnosis are recorded
5. Describe how the patients' charts are used to communicate patients needs and information
6. Describe the types of information recorded on the following pages of the traditional client record:
 - a. Admission sheet
 - b. Admission nursing assessment
 - c. Doctor's orders
 - d. Doctor's progress notes
 - e. History and physical report
 - f. Nurse's notes : Patient care activity/treatment record
 - g. Medication Administration Records
 - h. Laboratory and x-ray reports
7. Discuss the types of data that should be included in the nurse's notes

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G.Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. C.Taylor, C.Lillis, C. Lemone, Fundamentals of Nursing, the Art of nursing 5th edi, Lippincott
4. Harkreader.H, Fundamentals of nursing: Caring and Clinical Judgment. Saunders.
5. Basavanathappa, B.T.,Fundamentals of Nursing, Jaypee2004

CONCEPTS BASIC TO NURSING PRACTICE NURSING PROCESS I

OVERVIEW AND ASSESSMENT

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Define "Nursing Process."
2. Differentiate between the nursing and medical processes.
3. Identify the steps/parts of the nursing process and what is included in each step.
4. Relate the steps of the nursing process to problem solving.
5. Discuss the purpose of the assessment step of the nursing process.
6. Recognize the purpose of a nursing diagnosis.
7. List the components of planning.
8. Identify the essential implementing activities.
9. Describe the components of the evaluation process.
10. Discuss the nursing care plan as an important means of communication between members of care team.
11. Identify the advantages of using the nursing process for the client and the nurse
12. Describe how the nurse uses critical thinking, problem solving, and decision making in the nursing process

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange

HEALTH PERCEPTION -HEALTH MANAGEMENT PATTERN

THE PATIENT WITH POTENTIAL FOR ALTERED HEALTH MAINTENANCE

BASIC ASSESSMENT

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Define terms associated with health assessment.
2. Identify essential components of a nursing health history.
3. Recognize purposes of physical health examination.
4. Explain the four methods of examining.
5. Recognize the significance of selected mental and physical findings and how they should be reported.
6. Identify expected outcomes of health assessment.
7. Describe the various steps in selected assessment procedures.
8. State suggested sequencing for conducting a health assessment.
9. Explain how all the components of wholeness are assessed.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. Susan.G.D., Nutrition Hand Book for Nursing Practice, 2nd ed, Lippincott, 1993
4. Peggy.S.S., Hui.Y.H., Nutrition and Diet Therapy, 4th ed, Jones and Bartlett, 2003

**CONCEPTS BASIC TO NURSING PRACTICE
NURSING PROCESS**

DIAGNOSING

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Compare and contrast nursing diagnoses, medical diagnoses and collaborative problems.
2. Discuss the parts of nursing diagnostic statements.
3. Identify the guidelines for writing nursing diagnostic statements.
4. Write a three part nursing diagnosis for given patient case studies.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange

**CONCEPTS BASIC TO NURSING PRACTICE
NURSING PROCESS III
PLANNING**

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Describe the planning phase of the nursing process.
2. State the purposes of establishing patient goals/expected outcomes.
3. Describe the relationship of patient goals to the nursing diagnosis.
4. Identify factors that the nurse must consider when setting priorities.
5. Describe the relationship between patient goals and nursing strategies.
6. List components of a nursing order.
7. Identify major purposes of a written care plan.
8. Identify essential guidelines for writing patient outcomes.
9. Write appropriate patient goals for given patient situations.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange

**CONCEPTS BASIC TO NURSING PRACTICE
NURSING PROCESS IV**

IMPLEMENTING AND EVALUATING

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

- 1 Identify four activities of the implementing phase.
- 2 Describe three categories of skills used to implement nursing strategies.
- 3 Identify essential guidelines for implementing nursing strategies.
- 4 Explain how evaluating relates to other phases of the nursing process.
- 5 Describe the steps involved in re-examining and modifying the client's care plan.
- 6 Write nursing interventions and evaluative statements on a NCP for given patient situations.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange

CONCEPTS BASIC TO NURSING PRACTICE

CRITICAL THINKING, PROBLEM SOLVING, AND DECISION MAKING

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Differentiate critical thinking, problem solving, decision making, and creative thinking.
2. Describe the importance of critical thinking for nurses.
3. Discuss characteristics, skills, and attitudes of critical thinking.
4. Describe the decision making process.
5. Identify the relationship between the nursing process, critical thinking, and the problem solving and decision making processes.
6. Apply the concepts of critical thinking, problem solving and decision making to given situations.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange

**NUTRITIONAL -METABOLIC PATTERN
THE PATIENT WITH POTENTIAL FOR ALTERED NUTRITION**

INTRODUCTION TO THERAPEUTIC DIETS

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Discuss the assessment of a patient's nutritional status.
2. Identify nursing diagnoses associated with a patient's nutritional status.
3. Describe nursing interventions to assist patients with various needs with meals, and stimulate their appetites.
4. Describe ways of evaluating the effectiveness of nursing interventions used to promote or improve nutritional status.

HEALTH

1. Describe nutrition, metabolism and energy requirements.
2. Discuss factors which affect caloric needs and appetite.
3. Identify essential nutrients.
4. Discuss the essentials of progressive hospital diets.
5. Differentiate between the following diets stating when each may be used and the foods on each.
 - a. Clear liquid
 - b. Full liquid
 - c. Soft
 - d. Regular
 - e. Bland
 - f. Diabetic
 - g. Low-sodium

HUMANITY

Discuss how nutritional needs change throughout the life span

ENVIRONMENT

Discuss the impact culture has on diet.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th ed, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange
3. Susan.G.D., Nutrition Hand Book for Nursing Practice, 2nd ed, Lippincott, 1993
4. Peggy.S.S., Hui.Y.H., Nutrition and Diet Therapy, 4th ed, Jones and Bartlett, 2003

THERAPEUTIC DIETS

1. Clear liquid diet:

- a. Primary purpose to relieve thirst and keep and maintain water balance
- b. Often used for 24-48 hours following acute vomiting, diarrhea or surgery
- c. Consists of: tea, coffee or coffee substitutes, strained fat free broth, jell, ginger ale, 7-up some clear fruit juices, (eg:apple)

2. Full liquid diet

- a. Nutritionally adequate consisting of liquids and foods that liquefy at body temperature.
- b. May be ordered as first progression from clear liquid diet
- c. Consists of: any fluid on clear liquid diet plus milk, cream soups, cereals, custards, fruit juices, ice cream

3. Soft diet

A nutritionally adequate diet that differs from regular in reduced fiber content, soft in consistency and bland in flavor.

- a. Tender, minced or ground meat.
- b. Elimination of sharp cheeses, raw fruits or vegetables, fibrous foods, hot spices seasonings, most fried foods, rich pastries, pies and desserts.

4. Regular diet

- a. Most frequently used hospital diet.
- b. Provides daily dietary requirements.
- c. Provides opportunity for nutrition education.
- d. No restrictions in food choice.
 - 1) strong flavored vegetables (onions, cabbage)
 - 2) foods
 - 3) cakes
 - 4) pies
 - 5) spicy foods
 - 6) relishes

5. Bland diet

- a. Similar to soft diet but excludes:
 - 1) meat extractive and meat soups
 - 2) coffee tea omitted or limited
 - 3) highly spiced foods
- b. When used for treatment of peptic ulcer the diet should:
 - 1) provide nutritive adequacy
 - 2) dilute, neutralize or reduce the secretion of acid by the stomach
 - 3) avoid mechanical, chemical and thermal irritation

6. Diabetic diet

A carefully calculated diet with the amount of carbohydrate, protein and fat prescribed measured

7. Low sodium diet

- a. Restriction of sodium may be mild to severe
- b. Used for cardiac patients, those with cirrhosis of the liver, nephritis or nephrosis, hypertension
- c. Levels of sodium restriction
 - 1) very low sodium diet -250 mg daily
 - 2) strict low sodium diet -500 mg daily
 - 3) moderate sodium restricted diet -1,000 mg daily
 - 4) mild sodium restriction -2,400-4,500 mg daily

Note: Normal daily sodium intake on a regular diet is 3-7 (3,000-7,000 mg). 35

NUTRITIONAL-METABOLIC PATTERN

THE PATIENT WITH HIGH RISK FOR FLUID VOLUME DEFICIT OR EXCESS

INTAKE AND OUTPUT

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Discuss the nurse's role in recording I & O.
2. Identify what types of fluids are measured for intake
3. Identify what is measured for Output.

HEALTH

1. Discuss the stages in the lifespan when patients are most vulnerable to alterations in their fluid volume balance.
2. Identify signs and symptoms of Fluid Volume Excess and Fluid Volume Deficit and patients who are most at risk for these problems.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange

CONCEPTS BASIC TO NURSING PRACTICE PHARMACOLOGY I

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Describe the major principles of drug action nurses should know.
2. Discuss the various routes of medication administrations.
3. Describe each of the following dosage forms:
 - a. tablets
 - b. capsules
 - c. troches or lozenges
 - d. pill
 - e. elixir
 - f. suspensions
 - g. syrup
4. Discuss pharmacokinetic factors in drug therapy.
 - a. absorption
 - b. distribution
 - c. biotransformation
 - d. elimination or excretion
5. Outline the measurement of drug action on the body:
 - a. Onset of action
 - b. Peak plasma level
 - c. Drug half-life
 - d. Plateau effect
6. Discuss the nurse's role in the administration of medications.
7. Explain the "Five Rights" of medication administration.
8. Differentiate between therapeutic effects of drugs and side effects and list and define major types of side effects:
 - a. toxic or adverse effects
 - b. cumulative effects
 - c. allergic reactions
 - d. idiosyncratic effects
 - e. drug tolerance
 - f. drug interactions

9. Differentiate drug interactions as to synergistic and antagonistic and relate these to administration of medications.

10. Identify the major drug information resources including:

- a. Published resources
- b. Professional personnel

HUMANITY

Identify factors which affect the actions of drugs in the body:

- a. Lifespan development
- b. Weight
- c. Gender
- d. Genetics
- e. Psychological
- f. Illness
- g. Time
- h. Environment
- i. Ethnicity and culture

ENVIRONMENT

Compare the significance of chemical name, generic name and brand name of drugs

PREPARATION GUIDELINES

1. Linda.S.R.,Mosby's Nursing Drug Reference,Elsevier,2006
- 2.LindaL.L.,Robert S.A., Joseph A.A.,Pharmacology and the Nursing Process, Mosby, 1996.
3. Clayton.B.D., Yvonne N.S.,Basic Pharmacology for Nurses, 12ed,Mosby,2001

CONCEPTS BASIC TO NURSING PRACTICE
PHARMACOLOGY 11
LEGAL, ETHICAL, AND CULTURAL CONSIDERATIONS OF DRUGS

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

Outline the legal and ethical aspects of drug administration.

ENVIRONMENT

1. Briefly outline the advancement of pharmacology in historic times.
2. Identify significant drug legislation at the state and federal levels.
3. Differentiate between the four major categories of drugs:
 - a. Prescriptions or Legend drugs and Controlled substances
 - b. Non-Prescription/OTC drugs
 - c. Investigational drugs
 - d. Illicit or “street” drugs
4. Explain the effect of culture on a patient's response to and compliance with drug therapy.

PREPARATION GUIDELINES

1. Linda.S.R.,Mosby’s Nursing Drug Reference,Elsevier,2006
2. LindaL.L.,Robert S.A., Joseph A.A.,Pharmacology and the Nursing Process,Mosby 1996.
3. Clayton.B.D., Yvonne N.S.,Basic Pharmacology for Nurses, 12ed,Mosby,2001

CONCEPTS BASIC TO NURSING PRACTICE
PHARMACOLOGY III
ADMINISTRATION OF ORAL MEDICATIONS

OBJECTIVES

Upon the completion of this class, the student will be able to:

NURSING

1. Identify where and how medication orders are transcribed on the MAR.
2. Identify where the medication sheet is located on various units.
3. Discuss guidelines related to administration of medications.
4. Identify essential steps to follow when administering oral medications.
5. Identify how to sign out controlled drugs correctly.
6. Identify how to chart the administration of oral medications correctly.
7. Identify the essential parts of a drug order.
8. Identify various types of medication orders.
9. Recognize abbreviations commonly used in medication orders.
10. Identify where medication orders are written on the chart.
11. Outline three of the major systems of drug delivery in use in hospitals today:
 - a. stock supply system
 - b. individual client system
 - c. unit-dose system
12. Discuss what nurses should do if they have a question on a medication order.

HUMANITY

Discuss physiologic changes associated with aging that influence medication administration and effectiveness.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange

MEDICATION ADMINISTRATION RECORD

Diagnosis:						
Allergies:						
Start date/Date expired	Medications Dose/frequency	Route	Time	Date	Date	Signature

CONCEPTS BASIC TO NURSING PRACTICE

LEGAL ISSUES

OBJECTIVES

Upon completion of this class, the student will be able to:

NURSING

1. Explain the concept of licensure and Nursing Practice Acts as they apply to nursing.
2. Identify who may revoke a nursing license and for what reason.
3. Compare negligence and malpractice, and cite examples of each.
4. Describe invasion of privacy, libel, slander, privileged communication, and assault and battery.
5. Discuss the protection provided for nurses under Good Samaritan Acts.
6. Describe the function of professional liability insurance.
7. Explain the nurse's responsibilities in relation to the law.
8. Discuss rights of patients, health care consumers, nurses, and students.

ENVIRONMENT

1. Discuss the different types of laws and actions.
2. Discuss lawsuits and the steps involved.
3. Discuss contracts and wills.
4. Discuss crimes, torts, and fraud.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating for Optimal Health. Appleton and Lange

SEXUALITY-REPRODUCTIVE PATTERN
THE PATIENT WITH POTENTIAL FOR ALTERED SEXUALITY PATTERNS

SEXUALITY

OBJECTIVES

Upon completion of this class, the student will be able to:

NURSING

1. Describe the nurse's role in relationship to patient's sexual health and related teaching
2. Discuss ways in which patients may be sexually inappropriate with nurses and effective nursing strategies for dealing with it.
3. Identify questions the nurse can use to conduct a sexual health history

HEALTH

1. Discuss characteristics of sexual health.
2. Describe the relationship between illness and sexuality.
3. Identify common STD's (Sexually Transmitted Diseases), their signs and symptoms symptoms, and effective preventive measures
4. Describe the effects on sexual function by selected types of drugs and alcohol.
5. Discuss the procedures for breast and testicular self-examination.

HUMANITY

1. List factors that affect sexual attitudes and behaviors, and how these change over the lifespan.
2. Recognize sexuality considerations for the elderly patient

ENVIRONMENT

1. Differentiate between common sexual misconceptions and facts.
2. Discuss the relationship between culture and sexuality.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

**COGNITIVE-PERCEPTUAL PATTERN
THE PATIENT WITH POTENTIAL FOR KNOWLEDGE DEFICIT**

PATIENT EDUCATION

OBJECTIVES

Upon completion of this class, the student will be able to:

NURSING

1. Describe types of patients who are most at risk for a potential knowledge deficit.
2. Identify factors that interfere with learning and strategies nurses can use to adapt teaching accordingly.
3. List the essential aspects of a teaching plan.
4. Discuss guidelines for effective teaching
5. Explain ways learning can be evaluated
6. Demonstrate patient education for given situations

HUMANIT

Recognize how learning needs change throughout the life span

ENVIRONMENT

Describe cultural barriers to learning and teaching methods to reduce or eliminate them.

HEALTH

Identify major areas in which patients frequently require health teaching.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

VALUE-BELIEF PATTERN
THE PATIENT WITH POTENTIAL SPIRITUAL DISTRESS RELATED TO
ILLNESS AND HOSPITALIZATION
SPIRITUAL CARE

OBJECTIVES

Upon completion of this class, the student will be able to:

NURSING

1. Discuss ways to identify spiritual needs.
2. Explain the role of the nurse in meeting spiritual needs.

HEALTH

1. Describe how spiritual beliefs can affect health.
2. Discuss the use of prayer for the healing of the sick.

HUMANITY

1. Identify ways to show respect for other people's religious beliefs.
2. Discuss manifestations of spiritual distress.

ENVIRONMENT

1. Discuss the purpose that religion serves in the human life.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

**SLEEP-REST PATTERN
THE PATIENT A POTENTIAL FOR SLEEP-PATTERN
DISTURBANCE RELATED TO HOSPITALIZATION**

OBJECTIVES

Upon completion of this class, the student will be able to:

NURSING

1. Describe how to perform a clinical assessment of sleep problems.
2. Write a three part nursing diagnosis for a patient with a sleep pattern disturbance.
3. Describe nursing interventions that restore appropriate sleep and rest patterns for selected disorders
4. Discuss methods of dealing with sleep disturbance in the hospitalized client
5. Recognize usual classifications and nursing implications for drugs used in promotion of sleep

HEALTH

1. Describe characteristics of NREM and REM sleep
2. List clinical signs and symptoms indicative of insufficient rest and sleep
3. Identify factors influencing rest and sleep
4. Identify conditions necessary to promote rest
5. Define the following selected terms
 - a. biorhythm
 - b. brain waves
 - c. circadian rhythm
 - d. electroencephalogram
 - e. insomnia
 - f. sleep apnea

PREPARATION GUIDELINES

- 1.Potter, P.A., Perry, A.G.Fundamentals of Nursing, 6th edi, Elsevier.
- 2.Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

COGNITIVE-PERCEPTUAL PATTERN
THE PATIENT WITH POTENTIAL FOR PAIN
COMFORT AND PAIN

OBJECTIVES

Upon completion of this class, the student will be able to:

NURSING

1. Identify subjective and objective data to be collected and analyzed when assessing pain.
2. Identify examples of nursing diagnoses for clients with pain.
3. Discuss non-pharmacologic nursing interventions for pain.
4. Differentiate three types of analgesics: narcotics, non-steroidal anti-inflammatory drugs and adjuvant drugs, and state the nursing implications for each type.
5. State outcome criteria by which to evaluate a client's response to interventions for pain.
6. Recognize commonly used pain descriptors.

HEALTH

1. Differentiate various of pain according to origin, cause, and acuteness or chronicity.
2. Describe the body's natural analgesic system.

ENVIRONMENT

Recognize common misconceptions about pain

HUMANITY

1. Describe age variations in the pain experience.
2. Recognize some culturally oriented responses to pain

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

ROLE-RELATIONSHIP PATTERN THE PATIENT WITH POTENTIAL FOR IMPAIRED SOCIAL INTERACTIONS

CULTURES

OBJECTIVES

Upon of this class, the student will be able to:

NURSING

1. Identify nursing diagnoses related to ethnicity and culture.
2. Discuss accommodations nurses can make when providing nursing care to patients according to their cultural or ethnic needs

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange
3. David.M.N., Sociology-Exploring the Architecture of Everyday Life, 4thed, Pine Forge, 2002
4. Roger.E., The ways of Religion-An introduction to the Major Traditions, Oxford, 1999

HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN THE PATIENT WITH POTENTIAL FOR ALTERED HEALTH MAINTENANCE

AIDS, LOSS, GRIEVING DEATH

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Discuss the use of Universal Precautions.
2. Identify nursing measures that facilitate the grieving process.
3. Discuss the nurse's role in helping patients die with dignity.

Health

1. Identify risk factors for AIDS.
2. Discuss approaches to prevention of the spread of AIDS in the community and in the Hospital setting
3. State projections for the AIDS epidemic from Centers for Disease Control
4. Identify clinical symptoms of grief.
5. Recognize various losses a hospitalized patient may experience
6. Discuss factors affecting a loss reaction
7. Describe common fears associated with dying
8. Discuss how developmental stage affects the impact of loss.

PREPARATION GUIDELINES

1. David.M.N.,Sociology-Exploring the Architecture of Everyday Life, 4thed, Pine Forge, 2002
2. Roger.E., The ways of Religion-An introduction to the Major Traditions, Oxford, 1999

NURSING I

CLINICAL SYLLABUS

ACTIVITY-EXERCISE PATTERN THE PATIENT WITH POTENTIAL FOR IMPAIRED PHYSICAL MOBILITY

MOVING AND POSITIONING, HANDWASHING AND

BODY MECHANICS, RESTRAINTS

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Discuss the importance of hand washing and discuss and demonstrate the correct hand washing procedure.
2. Discuss body alignment:
 - a. Purpose
 - b. Criteria essential for assessing
3. List guidelines for positioning.
4. Discuss aspects of safety for nurse and patient when moving and positioning.
5. Describe shearing force, its cause and how it can be prevented.
6. Write a three- part nursing diagnosis for a patient with potential for skin breakdown because of immobility.
7. Demonstrate assisting a person to:
 - a. Move up in bed
 - I. Patient can assist
 - II. With help of another nurse
 - III. With a lift sheet
 - b. Move to side of bed
 - c. Turn from back to lateral
 - d. Log rolling patient
 - e. Sit on side of bed (dangle)
 - f. Move from bed to chair and back
 - g. Ambulate
 - h. Assume the following bed positions and use pressure reducing and positioning

aids:

- I. Fowler's
- II. Dorsal recumbent/supine
- III. Prone
- IV. Lateral(side lying)
- V. Sim's

HUMANITY

Recognize developmental variations in body alignment as related to age.

HEALTH

1. Describe the etiology and pathogenesis of pressure sores.
2. Discuss principles of good body mechanics.
3. Describe the basic movements used in good body mechanics.
4. Discuss factors that influence body mechanics.
5. Discuss the consequences of poor body mechanics and poor ambulation.
6. Identify ways to prevent back injury
7. Give examples of how good body mechanics can be used while doing nursing procedures.
8. Recognize body areas subject to most pressure for each of the positions listed below.

ENVIRONMENT

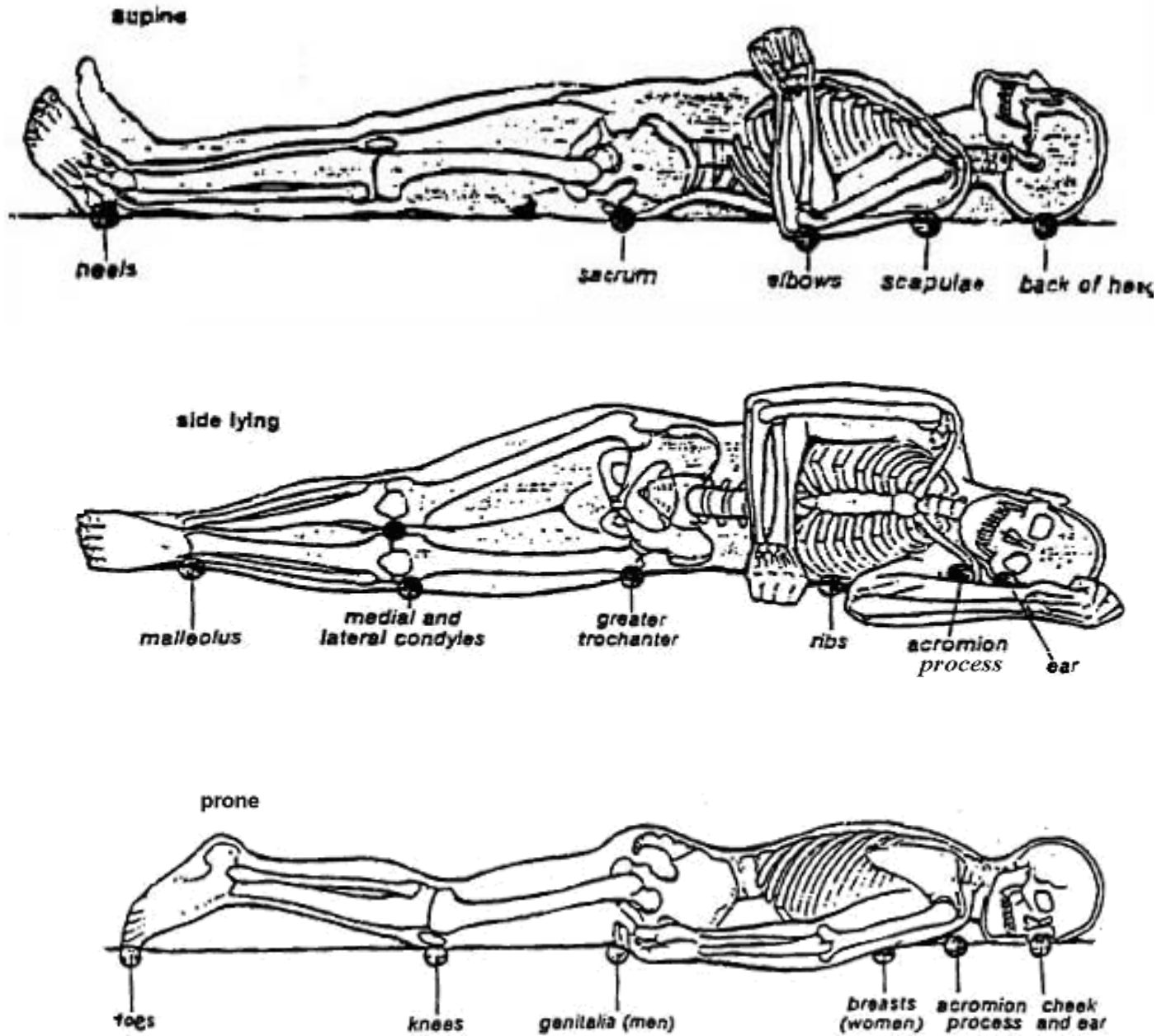
Discuss the use of restraints to partially immobilize a patient and state principles of safety and legality.

- a. Limb restraint
- b. Belt restraint (waist)
- c. Body or jacket restraint (vest)
- e. Mitt restraint (hand)

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PRESSURE POINTS IN VARIOUS POSITIONS



DEPARTMENT: GENERAL NURSING MANUAL
SECTION: IV. PATIENT RELATED
TITLE: RESTRAINTS, SOFT

POLICY

Patients and their families can expect that the appropriate steps will be taken to safe guard the safety and well being of the patient. At the same time every effort will be made to preserve the dignity and privacy of the patient and family member.

KEY POINTS:

1. Soft restraints should be applied snugly, but not be restrictive of circulation.
2. Restraints should be referred to in terms of safety devices, when discussing with patient or family.
3. Restraints should be secured to the bed frame (not to the side rails) on both sides of the bed.
4. Hand mitts are used to protect patients from pulling at catheters, I.V., etc.
5. If the restraints allow less than 50% range of motion of the restrained limbs, the patient must be checked at least every hour for proper placement of restraints, adequate circulation, and proper body alignment.
6. If the restraints allow 50% or more range of motion of the restrained limbs, the patient must be checked at least every two hours for proper placement of restraint, adequate circulation, and proper 'body alignment.
7. All patients in soft restraints must have their positions changed at least every two hours. If in bed, the patient must be turned. If sitting, position in chair must be altered.
8. Remove restraints at least every two hours, and provide range of motion activities to the restrained extremities.
9. Whenever clinically appropriate, the patient should be ambulated at least every four hours.
10. Adequate hydration, nourishment, and bathroom privileges must be maintained.

DEPARTMENT: GENERAL NURSING MANUAL
SECTION: IV. PATIENT RELATED
TITLE: RESTRAINTS, SOFT

PROCEDURE

1. An explanation of what the restraints are, how they will be used, and the reason for them, must be given to the patient, and clearly documented.
2. A skin care flow sheet will be initiated for all patients who are placed in soft restraints.

DOCUMENTATION

Nursing documentation will include:

1. Clear, concise description of the reasons the restraints have been applied.
2. Date and time restraints are applied, and the type of soft restraints used.
3. Assessments and interventions, including frequency check.
5. Time of removal of restraints.

**HEALTH PERCEPTION-HEALTH MANAGEMENT AND
ACTIVITY-EXERCISE PATTERNS
THE PATIENT WITH POTENTIAL FOR INJURY, IMPAIRED
PHYSICAL MOBILITY AND HIGH RISK FOR JOINT CONTRACTURES
RANGE OF MOTION AND HOT COLD APPLICATIONS**

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Discuss when ROM would be appropriate or inappropriate.
2. Demonstrate the range of motion for each joint.
3. Explain the procedure nurses should follow should a fire occur within the hospital.
4. Formulate a prioritized plan for the protection of patients should a fire occur in the hospital while you are there.
5. Discuss several methods of patient evacuation and be able to select the best carry for each patient.
 - a. Knee drop
 - b. Cradle drop
 - c. Two-man extremity carry
6. Discuss conditions for which heat or cold treatments might be applicable.
7. Identify common methods of applying heat and cold to the body.
8. Discuss nursing responsibilities and precautions in the application of heat and cold.
9. Explain how the nurse can evaluate the effects of heat or cold treatments.

HEALTH

1. Describe the types of movements possible for moveable joints.
2. Discuss the effects of exercise.
3. Discuss the effects of heat and cold on the body.

ENVIRONMENT

1. Name common causes and types of fires.
2. Identify common fire hazards within a hospital environment.
3. Describe the process of determining if a fire has been effectively extinguished

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

DEPARTMENT: GENERAL NURSING MANUAL
SECTION: IV. PATIENT RELATED
TITLE: HYDROCOLLATOR PACKS

POLICY

Hydrocollator packs are given on physician order only

KEY POINTS:

- Heat begins to take effect after 3-5 minutes
- Skin sensitivity may increase in the following situations:
 - Age (very old and very young are more sensitive)
 - Diabetes
 - Paralysis
 - Peripheral vascular disease
 - Scar tissue
 - Hemorrhagic disorder or suspected malignancy (contraindicated)
 - Visible signs of infection (contraindicated)
 - After local anesthetic (contraindicated)

NT:

1. Hydrocollator pack or hot pack
2. Hydrocollator covers or hot pack blanket wrappers
3. Hydrocollator heating unit
4. Three to four towels

PROCEDURE

- Carefully remove Hydrocollator pack from heating unit with metal tongs or by grasping loops on the pack.
- Wrap in cover, fastening blanket wrapper together around both sides of the pack with Velcro fastener.
- Explain purpose and procedure of the treatment to patient. **INSTRUCT PATIENT TO CALL IMMEDIATELY IF AREA UNDER THE PACK FEELS TOO HOT.**
- Place a doubled terry towel over the treatment area to protect sensitive prominences from excessive heat.
- Hydrocollator /hot pack over the towels
- Check skin for redness every few minutes for the first ten minutes. Add more layers of towel if the if the patient complains the pack feels excessively hot
- .Leave pack in place for 15-20 minutes. Instruct patient to leave the towels and Hydrocollator cover in place throughout entire procedure

ack, sponge area with a cold compress or apply alcohol and dry thoroughly

- Replace Hydrocollator pack in the heating tank and the cover on the lower shelf beside the tank

**HEALTH PERCEPTION-HEALTH MAINTENANCE PATTERN
THE PATIENT WITH POTENTIAL FOR ALTERATION IN
HEALTH MAINTENANCE**

VITAL SIGNS

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

Temperature

1. Describe technique for measuring temperature, orally, rectally, axillary, and tympanically, and the procedures for using and cleaning the equipment.
2. Obtain an oral temperature reading with both "Glass Mercury Thermometer"

Pulse

1. Obtain a radial and apical pulse reading and chart them to within 5 beats per minute of accuracy,
Reporting the rhythm and strength
2. Locate the pedal pulse by both palpation and use of Doppler
3. Obtain an pulse reading and state the pulse deficit

Respirations

1. Obtain a respiration reading and chart it to within 2 respirations per minute of accuracy,
reporting the rhythm, depth, and character.

Blood Pressure

1. Discuss methods and location of measuring B/P
2. Obtain a blood pressure reading and chart it to within 6 points of accuracy.
Calculate the
pulse pressure.

Miscellaneous

1. Demonstrate the ability to accurately weigh and measure a patient and chart appropriately.
2. Identify the parts of a stethoscope and use correctly.

NAME

Name:.....

DATE.....

VITAL SIGNS PRACTICE RECORD

Initials	T	P	R	BP	Pain	Pulse	
						Apical/Radial	Deficit
1.							
2.							
3.							
4.							
5.							
6.						PEDAL PULSES	
7.						Post Tibial	Dorsalis Pedis
8.							
9.							-
10.							

**SKILLS EVALUATION FOR
VITAL SIGNS**

NAME-----

DATE -----

___EXCELLENT

___SATISFACTORY

___REPEAT

OVERRIDING AREAS OF CONCERN

ASEPSIS

* __Wash Hands

* __Wash hands

* _

___ Care of Equipment

PHYSICAL SAFETY

* __Identify pt.

* __Bed low

* __ Side rails adjust.

* __ Call bell avail

EMOTIONAL SAFETY

___Greet, Explain

___ Comfortable, neat

___ Provide Privacy

* __Chart

CRITICAL ELEMENTS

* __ Correct placement of

* __ Correct counting time

* __Check respiration in connection with pulse

* __Read temp± 0.2 degrees F

* __Radial pulse+ 5beats/min

* __Apical + 5beats/min

* __Respiration+ 2/min

* __B.P. ± 6mmHg

* __Ht

* __Wt. Kgs

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d within twenty minutes

Tester's Signature

THE ENTIRE PROCEDURE WILL BE REPEATED IF:
Any one of the starred *items is unsatisfactory
Any two of the non-starred *items are unsatisfactory

WAND MONTH	DATE	NAME	AGE	REL. NO.	Temperature		
					Fahrenheit	Centigrade	
						107.0	
						106.0	
						105.0	
						104.0	
						103.0	
						102.0	
						101.0	
						100.0	
						99.0	
						98.0	

Property of

HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN THE PATIENT WITH POTENTIAL FOR HEALTH MANAGEMENT DEFICIT

BEDMAKING, BATHING, BACKRUBS, BEDPANS, PERSONAL CARES

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Discuss considerations included in planning assistance with personal hygiene
2. Choose a nursing diagnostic category of a skin problem requiring nursing interventions
3. Write a three-part nursing diagnosis for a patient who needs help with her bath because of weakness.
4. Discuss the use of special bed equipment--bed board, side rails, foot boards, bed cradles, and specialized beds.
5. List equipment necessary to assemble before giving a bed bath.
6. Discuss potential hazards which are specific to the patient in bed and nursing interventions to minimize these hazards
7. State how nurses plan for and show respect for the patient's right to privacy during these procedures
8. Discuss the various types of baths and their effects.
9. Discuss perineal and genital care as part of the bath.
10. Discuss how the nurse should relate to the seductive patient.
11. Discuss the procedures for a shower bath, basin bath, partial bath, and tub bath.
12. Discuss interventions for skin care.
13. Demonstrate how to make an occupied and unoccupied good body mechanics and medical asepsis and economy of time, energy and materials.
14. Demonstrate the ability to put on or remove a hospital gown if a patient has an I.V
15. Give a bed bath
16. Give backrub
17. Review information on basic hygiene which nurses should include in patient teaching.
18. Give examples of observations that could be charted after bathing.
19. Discuss the use of the bath time for assessment and communication
20. Demonstrate how to prepare, offer, remove, and clean a bedpan for a patient who can help or a helpless patient using both the standard and fracture pans.
21. Discuss the use of the male urinal and the bedside commode.
22. State nursing responsibilities associated with the above procedures.

HEALTH

1. Describe characteristics of normal skin
2. Explain the developmental changes which occur due to aging in the skin and implications these have for nursing care
3. Elaborate on the purposes and functions of bathing

ENVIRONMENT

1. Identify factors influencing personal hygiene practices

Early A.M. Cares, P.M., H.S Cares

- Define and describe early A.M. Cares, P.M. Cares and H.S. Cares, stating what is included in each.
- Assist a person to do early A.M. Care.

Oral Care:

- Discuss and demonstrate oral care for the patient who can assist, cannot assist, and who is unconscious.
- Role play oral care for the person with dentures, including safety measures when caring for dentures.
-

Hair. Shampoo, Shave:

- Brush, comb, and shampoo a patient's hair without causing discomfort or injury to the patient. List the articles necessary.
- Describe how to shave a patient and list the items necessary.

Catheter Care

- Verbalize the equipment necessary and explain how catheter care is given at bath time.

Feet and Nail Care

- Describe planning and intervention for feet and nail care and the changing characteristics in aging nails

Eye Care

- Discuss care for eyes, eye glasses, and contact lenses

BATH TIME --WHAT TO INCLUDE

1. Oral hygiene PRN
2. Bath --include face PRN and as patient desire
3. ROM
4. Backrub
5. Linen change
6. Comb hair
7. Shave PRN
8. Nails
9. Shampoo PRN
10. Cleanliness and neatness of tables (inside and out)
11. Change trash bag (as necessary)
12. The “Backward Look”
 - a. Call light attached within reach
 - b. Drinking water --fresh and within reach
 - c. Urinal for men -empty and within reach
 - d. Position of patient --look comfortable
 - e. Safety --bed low; rails up PRN and posey belt PRN
 - f. Ventilation and lighting
 - g. Neatness of unit in general

TYPES OF BATHS

CLEANSING

A. Bed Bath - given to patients unable to have other types.

Basin Bath

1. May be done by nurse or patient (self-bath).
2. If patient gives bath, the nurse washes areas patient cannot reach, such as legs and back.
3. May be complete or partial. If partial, should include face, hands, armpits, genital area, and back.

B. Tub Bath

C. Shower Bath

MEDICATED/THERAPEUTIC

A. Soothing

1. Soothes, sedates, and provides relief of skin disorders.
2. May be given as a tub bath or basin bath.
3. Water temperature 100-105 degrees Fahrenheit.
4. Patting motion used to dry skin.
5. Add to water
 - Oatmeal
 - Sodium bicarbonate
 - Starch

B. Stimulating

1. Saline
2. Mustard

C. Whirlpool

1. Soothing effect.
2. Tension and discomfort relieved by movement of water that gives a gentle massage

D. Sitz

1. The patient sits in water in a special tub or device to bring moist heat to perineal or rectal area for the promotion of healing a wound and to relieve discomfort

SUGGESTED ORDER FOR PATIENT CARE

(For patient receiving complete bed bath)

1. Assess patient's care and needs from Kardex. Read History and Physical by M.D.
2. Get report from R.N.
3. Introduce self to patient and state you will be with them until 9.30 am. Assess patient's needs.
4. Remove breakfast tray--noting amount eaten and I&O info.
5. Prioritize patient's needs and complete plan of care.
6. Wash hands.
7. Provide privacy.
8. Collect supplies -linen, basic, soap, etc.
9. Offer bed pan (remember to measure if on I & O)
10. Oral care.
11. Remove top linen /patient covered with bath blanket
12. ROM
13. Get water and bathe face, upper body, chest, abdomen, legs, and (patient assisting, if possible) .
14. Change water.
15. Bath back and perineal area.
16. Cath care (if Foley catheter present).
17. Back rub.
18. Shampoo (if needed) .
19. Put on clean gown.
20. Comb hair.
- 21 Nail care and shave PRN.
22. Move to chair if allowable.
23. Make bed.
24. Room care.
25. The "Backward"Look!"
 - a. Bell cord attached within reach.
 - b. Drinking water -fresh and within reach.
 - c. Urinal for men (empty and within reach).
 - d. Position of patient -look comfortable?
 - e. Safety -bed low; rails and restraints
 - f. Ventilation and lighting.
 - g. Neatness of unit in general
26. Ambulate patient.
27. Wash hands.
28. Charting -flow sheet

**NO
S**

NOTES IN PREPARATION FOR PATIENT CARE

When you go to the hospital to do patient care your instructor will choose a patient for you. You are expected to prepare the Pathophysiology and Medication sections of your worksheet prior to Clinical.

You will not be expected to do anything for a patient that you have not been taught to do. However, it is possible that your patient may have a tube or some appliance that you are not familiar with. Here are a few basics. If your patient has a:

1. Dressing

- a. Be sure it is in place -report if it is loose.
- b. Report if it has wet drainage on it.

2. Urinary Catheter (This is a sterile tube that goes into the bladder and connects to a drainage bag for urine.)

- a. Be sure it is not kinked and the patient is not lying on it
- b. Be gentle -pull on it.
- c. You may move your patient to a chair or ambulate if the drainage bag is moved, too. Always keep the drainage bag below bladder level.

3. I.V. (A tube that supplies fluid to the patient through a vein.)

- a. Know that the patient can move around but it may be necessary to move the bag of fluid if the tube reaches. Don't change the height of the bag except momentarily if necessary to remove patient's gown.
- b. Use gown with snaps on shoulder for easy removal.
- c. Wash body part, but not area around needle insertion.
- d. Watch to make sure I.V. is dripping; insertion area is not swollen or leaking.
- e. If patient is wearing a regular gown, put I.V. bag through the sleeve (from outside to inside) to remove gown.

4. Telemetry

Your patient may be wearing a little device that monitors his heart rate. This is like a portable electrocardiogram and the monitoring is actually done in ICU. So you have nothing to be concerned about. It is easier for your patient if he wears a gown with a pocket so the monitor can slip into the pocket. These are solid blue gowns and may be obtained from ICU if there are none in the linen room.

5. Fractured Hip

If your patient has a fractured hip or a total hip replacement, the patient will turn best to his uninjured side, but it is imperative that the injured leg be supported well while the patient is being turned and while on the side.

If the patient is allowed out of bed with no weight bearing the patient must not put weight on the Injured side, but may put weight on the uninjured side and pivot from the bed to a chair close to the bed. You should have help with both procedures of turning and transferring this type of patient the first time you do it or any time you do not feel secure about your patient's abilities.

MOVEMENTS OF MASSAGE TO THE BACK

TYPES OF BACK MASSAGE

1. LUBRICATING--Begin at the base of the spine and bring hands straight up spine to base of skull, then well out over shoulders and deltoids, then down back with rotary movement covering entire back including gluteus. This should be with a light stroking movement to ensure even coverage of entire area with lubricant.
2. ROTARY EFFLEURAGE (STROKING) ---Entire back is now lubricated so move upward from gluteus area using rotary movements with firmer pressure.
3. EFFLEURAGE TO NECK AND SHOULDERS--Starting at base of skull bring hands down sides of neck, over shoulders, and well out over deltoids, then bring hands together at spine up to base of skull and repeat movement 3-5 times. Use firm pressure with this movement molding hands to contours of patient's body.
4. TRANSVERSE EFFLEURAGE TO BACK --Beginning at shoulders, place one hand on near side and one hand on far side and move hands toward each other across back until position of hands is reversed. Continue moving with firm strokes down back to base of spine.
5. GLUTEAL EFFLEURAGE-- From base of spine bring hands down over gluteals with light stroke, then upward with firm pressure, low on sides, coming back to spine at iliac crest, repeat 2-3 times then give several firm upward strokes over top portion of gluteals gliding back down as before. Keep movements smooth and continuous.

6. CIRCULAR DIGITAL FRICTION TO SACRO-ILIAC AND SPINE --Reinforcing fingers of one hand with the other to exert firm pressure, give rotary friction to area across back at iliac crest and sacro-iliac junction, then continue up back with 4-5 inch circles to base of skull on one side, glide down and repeat on other side.

7. PETRISSAGE (KNEADING TO ENTIRE BACK)--Beginning at base of skull using alternate kneading movement with hands work down far side of neck, across shoulder and well out over deltoid, then come back up higher on same side with movement following up spine to neck area at base of skull. Bring hands to near side of patient's neck without interrupting movement and repeat movement down side and up back on near side of patient. Be sure to include deltoid and gluteal areas.

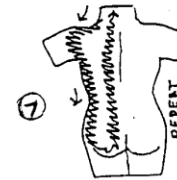
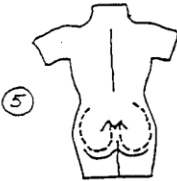
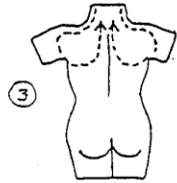
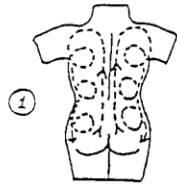
8. ROTARY PALMER KNEADING-- With palm of one hand reinforcing of other hand give heavy effleurage to neck and shoulders working well out over deltoids then down under scapula to spine, then proceed to base of spine. Glide up. Repeat on other side. Keep fingers relaxed.

9. ROTARY EFFLEURAGE UP BACK - Beginning at base of spine move up back with large alternating circular strokes keeping thumbs extended to cover as wide an area as possible

nating give soothing strokes down spine, beginning with firm strokes at medium speed and becoming slower and somewhat lighter to complete massage.

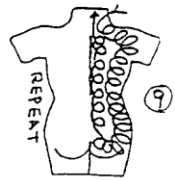
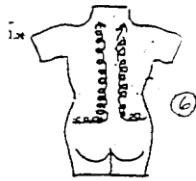
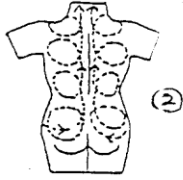
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DIAGRAMS OF
BACK MASSAGE



1. LUBRICATION Hands move simultaneously in smooth stroking motion
2. ROTARY EFFLEURAGE (Stroking) Simultaneously, 1x
3. EFFLEURAGE to neck and shoulders. Simultaneously, 3x
4. TRANSVERSE EFFLEURAGE begins at shoulders one hand pulls while the other pushes, bedline to bedline, moving simultaneously, 1x
5. GLUTEAL EFFLEURAGE Firmly work from sacrum down to thighs, 1x
6. CIRCULAR DIGITAL FRICTION One side at a time, one hand reinforces the other. 1x
7. PETRISSAGE (Squeeze, pick up tissue, pass from hand to hand. Dont PINCH!)
8. Repeat #'s 3,4,5
9. ROTARY PALMAR KNEADING Heavy pressure with palm; one hand over other
10. ROTARY EFFLEURAGE up spine, simultaneously 1x see #2
11. SOOTHING EFFLEURAGE down spine and back, hands alternate, pressure decreases. 3x each hand.

DIAGRAMS OF BACK MASSAGE



PROCEDURE FOR ASSISTING WITH A SHOWER

Equipment needed:

- Shower chair Bath
- Bath towel
- Wash cloth
- Soap
- Shampoo PRN
- Shower cap PRN
- Exam gloves (if assisting with peri-care)
- Bath blanket or clean sheet to drape patient in hallway PRN
- Clean gown or clothes to be worn after shower

Procedure:

- Check patient ID
- Introduce self, greet, and explain procedure
- Encourage patient to use toilet or bedpan prior to shower
- Assist patient to shower PRN, draping for privacy PRN
- Assist in removing soiled gown, etc.
- Ask if patient wants hair shampooed or not (use shower cap PRN)
- Adjust and test water temperature prior to patient entering shower
- Always have shower chairs ready in case of need
- Starting with face, use same order for shower as for bath, using washcloth
- Using towel, dry patient, starting with face
- If hair was washed, towel dry and use hair dryer PRN to avoid chill
- Assist patient in putting on clean gown or clothes, slippers or shoes
- Assist patient to room or common area, as appropriate
- Return to shower and clean area PRN for next patient

Key principles:

- Patient safety! (and nurse safety)
- Patient privacy and comfort
- Hygiene
- Universal precautions

CARES

EARLY A.M. CARES

DEFINITION AND PURPOSE:

The procedure used before breakfast to refresh and cleanse the patient and make him comfortable.

KEY POINTS:

1. If a patient is bedfast, he should be given a warm, wet wash cloth.
2. Wash your hands after handling bedpan.
3. Allow patient to wash hands after using urinal or bedpan.

EQUIPMENT:

1. Thermometer (rectal or oral), stethoscope, and sphygmomanometer.
2. Toothbrush and dentifrice, glass of water, emesis basin, comb or brush, wash basin (optional), soap, towel, and wash cloth.
3. Bedpan and/or urinal PRN.

PROCEDURE:

1. Take temperature of patient and note.
2. Take pulse, respiration, and blood pressure and make note of them.
3. Offer bedpan (empty urinal for men), washing your hands afterward.
4. Set up wash and oral hygiene equipment.
5. Assist patient with washing, grooming, and oral hygiene as necessary.
6. Straighten bedding, fluff pillow, and turn. Be sure bed is not wet from perspiration or urine -- if it is, replace it with dry linen.
7. Position patient and tray table for breakfast.
8. Replace liner of pitcher with clean liner and fill with fresh water.

P.M. and H.S. Cares are much the same as A.M. Cares. Following are the most common variations

P.M. CARES

Time -Afternoon to refresh for evening meal. Equipment and Procedure: May not care to brush teeth until after meal. May wash only hands.

H.S. CARES

Time -"Hour of Sleep" -At least after evening meal.

ASSISTING WITH A BEDPAN

24. R

The student will demonstrate the ability to perform the total procedure for a patient who can help, and for a patient who is totally helpless, using the standard size pan and a fracture pan.

1. Wash your hands.
2. Explain what you are going to do.
3. Provide privacy.
4. Raise bed as necessary with far side rail up.
5. Obtain bedpan and toilet tissue.
6. Put on gloves.
7. With as much assistance from patient as possible, position bedpan.
8. Patient who can help may bend knees and lift hips. Helpless patients may be turned to side. Further elevate head of bed as patient desires.
9. Make sure toilet tissue and call bell are in patient's reach.
10. Leave patient if possible.
11. Return to patient.
12. If necessary, clean genital area with toilet tissue, wiping from front to back. Patient may turn on side to have back wiped. Be sure to wear gloves.
13. Remove pan, reversing method used to position it. Hold pan securely if roll technique is used.
14. Carry to bathroom and observe contents.
15. Collect specimen of urine or feces if ordered.
16. Measure urine if necessary.
17. Empty contents into toilet.
18. Thoroughly clean pan and return to storage unit.
19. Give patient hand washing materials if patient has helped himself.
20. Wash genital area if necessary (see Perineal Care).
21. Adjust bed to low position and make patient comfortable.
22. Proper care of equipment.

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ises every two hours while awake:

1. Instruct patient to draw imaginary circles with the big toe 5 times.
2. Alternate dorsiflexion and plantarflexion. Press the backs of the knees into the bed during dorsiflexion. Repeat 5 times.
3. Instruct patient to alternate flexing and extending knees one leg at a time. Repeat 5 times.
4. Raise and lower the legs alternately from the surface of the bed. Keep leg straight that is being raised. Repeat 5 times.

DEEP BREATHING EXERCISES

1. Assist patient to a Fowlers position, if possible.
2. Assist patient in placing palms of hands over the lower portion of the rib cage with third fingers touching.
3. Have patient inhale slowly and evenly through the nose (feel fingers separate) until the greatest chest expansion is achieved.
4. Instruct patient to hold breath 2-3 seconds.
5. Exhale slowly through mouth as if blowing out a candle.
6. Have patient repeat above exercise, hold breath for 2-3 seconds, then cough once or twice.
7. Ensure that patient is coughing deeply and not just clearing the throat.
8. Demonstrate how patient can splint the abdomen if coughing is painful.
 - a. Place the palms on either side of the incision or place one palm on top of the other directly on the incision. .
 - b. Clasp hands around a firmly rolled pillow held against the patient's abdomen.
9. Breathing exercises are valuable for all bedridden patients but especially surgical patients. Those patients having abdominal or chest surgery should do deep breathing and coughing exercises a minimum of every two hours while awake, taking a minimum of 5 breaths at each session.

**HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN
THE PATIENT WITH POTENTIAL FOR
INFECTION RELATED TO
ASEPSIS, DRESSING CHANGES, WOUND CARE,
AND PRECAUTIONS**

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Identify and discuss assessment of a wound.
2. Differentiate between articles or areas.
3. Differentiate between medical and surgical asepsis.
4. Identify clinical applications of asepsis in nursing practice.
5. State the nine basic principles of surgical asepsis and discuss the practices that relate to each principle.
6. Relate principles of safety and asepsis to wound care.
7. Perform the following skills correctly, while stating the purposes, general principles, and precautions for:
 - a. putting on sterile gloves
 - b. cleansing a wound dressing a wound
 - c. removing and disposing of a soiled dressing
8. Recognize types of sterile packages and how to open them correctly without contamination.
9. Describe what the nurse would observe for when evaluating the effectiveness of aseptic technique.
10. Discuss the procedure for placing a patient on precautions.
11. Discuss precaution techniques for the following:
 - a. Universal precautions
 - b. Respiratory/AFB precautions
 - c. Blood/Body fluid precautions
 - d. Strict precautions

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

DRY DRESSING CHANGE

1. Collect equipment:
 - Sterile gloves
 - Exam gloves
 - Plastic bag
 - swabs, 2 pkgs
 - Sterile gauze
 - pkgs
 - Sterile split dressing, 1 pkg
 - Surgipad
 - Tape, PRN
2. Provide privacy.
3. Adjust bed height.
4. Wash hands. Identify client.
5. Greet, explain procedure.
6. Undo Montgomery straps or removes tape toward wound).
7. Set up plastic bag to use as place to discard dressing, etc. Turn top of bag to outside to make a cuff.
8. Remove Surgipad with exam gloves or hand covered with plastic bag. (Do not dislodge drain.)
9. Remove rest of dressing and in plastic bag.
10. Remove and discard exam gloves.
11. Assess area.
12. Open swabs and set up so you can remove them from package without contaminating sterile gloves.

14. Put on sterile gloves.

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for each stroke

- b. Clean from top to bottom
- c. Clean the incision line first
- d. Cleanse outward from incision line (far side, then near side).

16 Cleanse drain and area around it:

- a. Hold drain with fingers of non-dominant hand
- b. Use a separate swab for each wipe
- c. Start at drain site
- d. Swab in a full circle around the drain. With a second swab, wipe a wider circle, etc., until the area is clean.
- e. Use one side of a swab to clean from site to end of drain, use other side of same swab to clean other side of drain.

17. Continue holding drain with non-dominant hand while applying sterile gauze to incision area with dominant hand.

18. Holding drain with non-dominant hand, place split dressing around drain with dominant hand.

19. Place sterile gauze 4x4s on top of drain using dominant hand.

20. Apply Surgipad.
21. Remove gloves.
22. Secure dressing with tape or Montgomery straps.
23. Bed low.
24. Side rails in correct position.
25. Call bell available.
26. Client comfortable and area neat.
27. Open curtains.
28. Care for equipment.
29. Wash hands.
30. Chart.

SKILLS EVALUATION FOR DRY DRESSING CHANGE

NAME-----

DATE -----

___EXCELLENT

___SATISFACTORY

___REPEAT

OVERRIDING AREAS OF CONCERN

PREPARATION

AFTER CARE

ASEPSIS

*___Wash Hands

*___Wash hands

___ Care of Equipment

PHYSICAL SAFETY

*___Identify patient

*___Bed low

*___Side rails adjust

*___Call bell avail

EMOTIONAL SAFETY

___Greet, Explain

___Nest, comfortable

___ Provide privacy

___Open curtain

___Chart

1. Time/procedure

2. Location

3. Assessment

CRITICAL ELEMENTS

___Undo Montgomery straps or remove tape pulling toward wound

*_Remove surgipad with exam gloves or plastic bag

*_Open awabs/dressing aseptically

*_Remove inside dressing

*_Done sterile gloves correctly

*_Cleanse wound appropriately (Clean to dirty)

*_Assess area

*_Cleanse drain area and drain

*_Apply sterile dressings to wound,then drain

*_Apply Surgipad

___Apply tape or Montgomery straps

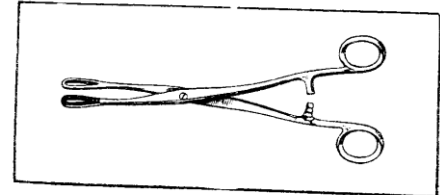
*_Test completed within twenty minute

Tester's Signature

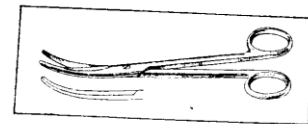
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2. Any two of the non-starred *items are unsatisfactory

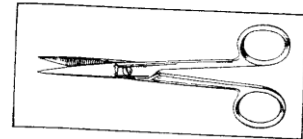
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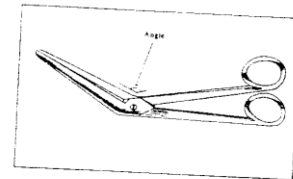
RAMPLEY'S SPONGE HOLDING FORCEPS.



MAYO'S CURVED-ON-FLAT SCISSORS.



MAYO'S STRAIGHT SHARP POINTED SCISSORS.



ANGLED-ON-EDGE SCISSORS.

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RESSING CHANGE

1. Wash hands.
2. Collect equipment:
 - a. Sterile gloves
 - b. Exam gloves
 - c. Plastic bag
 - d. Fluff roll, 1 roll
 - e. Non-adhering dressing, 1 pkg
 - f. Tape
3. Identify client.
4. Greet, explain procedure.
5. Provide privacy.
6. Adjust bed height.
7. Position client by placing pillow under leg until heel is well off the bed.
8. Remove tape.
9. Set up plastic bag to discard dressing.
10. Remove dressing, wearing exam gloves.
11. Cleanse wound, as ordered.
12. Assess area.
13. Open sterile dressing packages on table.
14. Put on sterile gloves.
15. Using sterile technique, place non-adhering dressing over wound with non-dominant hand.
16. Continue holding dressing in place while using your other hand to remove dressing from package.
17. Slightly unroll fluff dressing and apply over wound, continuing to unroll around ankle and heel using a figure-8 pattern.

18. Make sure the dressing is not too tight by assessing client's sensation and capillary refill.
19. Remove gloves.
20. Secure dressing with tape.
21. Bed low.
22. Side rails in correct position.
23. Call bell available.
24. Client comfortable and area neat.
25. Open curtains.
26. Wash hands.
27. Chart.

SKILLS EVALUATION FOR DRY DRESSING CHANGE

NAME-----

DATE -----

___EXCELLENT

___SATISFACTORY

___REPEAT

OVERRIDING AREAS OF CONCERN

PREPARATION

AFTER CARE

ASEPSIS

* __ Wash Hands

* __ Wash hands

__ Care of Equipment

PHYSICAL SAFETY

* __ Identify patient

* __ Bed low

* __ Side rails adjust

* __ Call bell avail

EMOTIONAL SAFETY

__ Greet, Explain

__ Nest, comfortable

__ Provide privacy

__ Open curtain

__ Chart

1. Time/procedure

2. Location

3. Assessment

CRITICAL ELEMENTS

__ Undo Montgomery straps or remove tape pulling toward wound

* __ Remove surgipad with exam gloves or plastic bag

* __ Open awabs/dressing aseptically

* __ Remove inside dressing

* __ Done sterile gloves correctly

* __ Cleanse wound appropriately (Clean to dirty)

* __ Assess area

* __ Cleanse drain area and drain

* __ Apply sterile dressings to wound, then drain

* __ Apply Surgipad

__ Apply tape or Montgomery straps

* __ Test completed within twenty minute

 Tester's Signature

THE ENTIRE PROCEDURE WILL BE REPEATED IF:

2. Any two of the non-starred *items are unsatisfactory

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Collect equipment:

- Solution
- Exam glove
- Sterile gloves
- Sterile 4x4s (1 pkg and 1 box)
- Surgipad
- Plastic bag
- Tape,

2. Provide for privacy.
3. Wash hands.
4. Identify client.
5. Greet and explain procedure.
6. Client comfortable and warm.
7. Adjust bed height

ROCEDURE

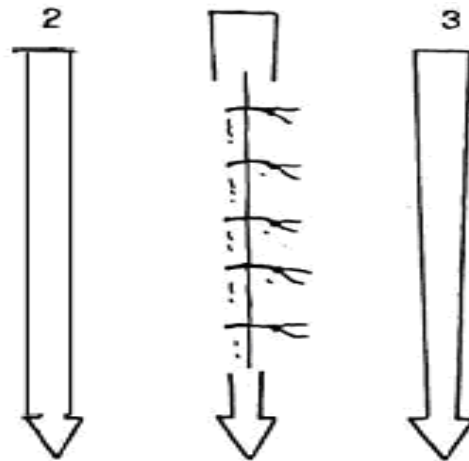
1. Loosen tape or Montgomery straps.
2. Don exam gloves.
3. Remove soiled dressing and place in plastic bag (don't moisten).
4. Assess area.
5. Remove and discard gloves.
6. Wash hands, as needed.
7. Open sterile gauze packages.
8. Open solution and pour into box of sterile 4x4s
9. Don sterile gloves.
10. Cleanse and assess wound:
 - a. Cleanse from top to bottom
 - b. Cleanse wound outward
 - c. Use new gauze for each stroke
11. Squeeze excess solution from gauze and apply to wound.
12. Apply dry 4x4s over wet dressing.
13. Apply surgipad.
14. Remove and discard gloves.
15. Secure dressing with tape or Montgomery straps.

AFTERCARE

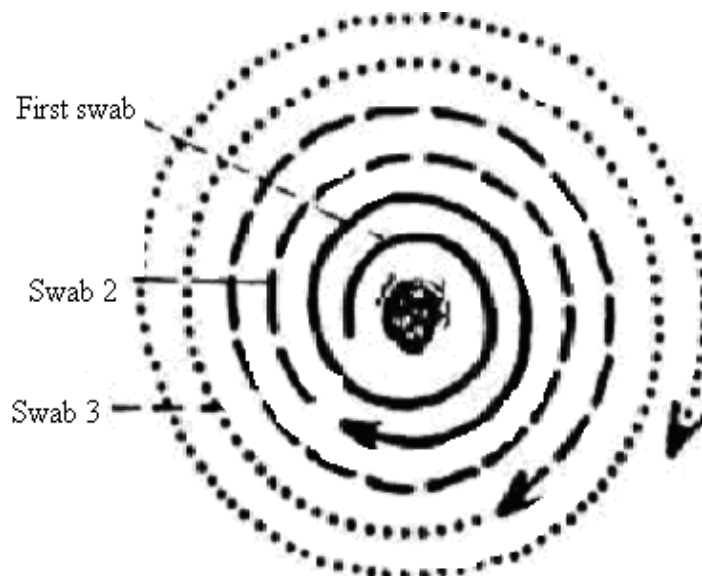
1. Lower the bed
2. Side rails in correct position.
3. Call bell available.
4. Client is comfortable and warm
5. Open curtains.
6. Care for equipment
7. Wash hands
8. Chart

A. Cleansing a linear wound

Stroke First Stroke Stroke



B. Cleansing a circular wound



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SKILLS EVALUATION FOR WET-TO-DRY DRESSING CHANGE

NAME-----

DATE -----

____EXCELLENT

____SATISFACTORY

____REPEAT

OVERRIDING AREAS OF CONCERN

PREPARATION

AFTER CARE

ASEPSIS

*__Wash Hands

*__Wash hands

__ Care of Equipment

PHYSICAL SAFETY

*__Identify patient

*__Bed low

*__Side rails adjust

*__Call bell avail

EMOTIONAL SAFETY

__Greet, Explain

__Nest, comfortable

__Provide privacy

__Open curtain

__Collect equip

__Chart

CRITICAL ELEMENTS

_Undo Montgomery straps or remove tape (pull toward wound) Done exam gloves

*_Place soiled dressings in plastic bag (Don't moisten dressing)

*_Remove gloves

*_Open dressings aseptically

*_Pour solution in box of 4 x 4's

*_Done sterile gloves correctly

*_Cleanse wound appropriately (Clean to dirty)

*_Assess area

*_Pack wound appropriately

*_Apply dry 4 x 4

*_Apply Surgipad

Tester's Signature

THE ENTIRE PROCEDURE WILL BE REPEATED IF:

3. Any one of the starred *items is unsatisfactory.
4. Any two of the non-starred *items are unsatisfactory

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THE PATIENT WITH POTENTIAL FOR
HEALTH MANAGEMENT DEFICIT

OXYGEN ADMINISTRATION, TED HOSE, INCENTIVE SPIROMETERS,
AND ENEMAS

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

T.E.D. Hose

1. Describe what indicates a need for a patient to have T.E.D. hose applied.
2. Apply T.E.D. hose correctly

Oxygen administration:

1. Describe oxygen delivery systems through nasal cannula and mask, identifying the Advantages /disadvantages of each
2. List safety precautions to take when oxygen is administered.
3. Administer oxygen via nasal cannula and face mask.
4. Describe the use of a pulse oximeter

Incentive Spirometers. (REX -Respiratory Exercises) Breathing, Coughing

1. Explain the use of incentive spirometers.
2. Demonstrate deep breathing and coughing.

Enemas

1. Identify normal and abnormal characteristics of feces.
2. Identify factors which influence fecal elimination. Relate these factors to the elderly patient.
3. Describe the method for performing and demonstrate the following procedures:
 - a. retention enema
 - b. carminative enema
 - c. cleansing enema -high enema (including "enemas until clear") -low enema
 - d. return flow enema (Harris flush)
4. Identify criteria for evaluating the care given to a patient with an alteration

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

OXYGEN DELIVERY SYSTEMS

NASAL CANNULA

- Liter Flow/100% O₂ : 1- 6
- Inspired O₂ : 24-44
- Estimating Inspired O₂ : For each L above 1, add approximately 4%
- Nursing Precautions : Make sure the nares are patent. May use even with amouth-breather, since orophryngeal air flow creates Bernoulli effect, pulling oxygen through nasophryn. Do not increase L above 6 because it will not increase FI O₂ ; switch to a mask.

OXYGEN MASK

- Liter Flow/100% O₂ : 5 - 8
- Inspired O₂ : 40-60
- Estimating Inspired O₂ : For each L above 5, add 10%
- Nursing Precautions : Do not run below 5L, as exhaled CO₂ will not be washed out. To increase FI O₂ above 0.60, do not increase liter flow; switch to a bag with reservoir

**NUTRITIONAL-METABOLIC PATTERN
THE PATIENT WITH HIGH RISK FOR
FLUID VOLUME DEFICIT OR EXCESS**

INTAKE & OUTPUT

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Identify fluids to be measured for Intake & Output.
2. Differentiate between "foods" and "fluids" and how each are recorded.
3. Given lab situations, accurately record Intake and Output.

PREPARATION GUIDELINES

- 1.Potter, P.A., Perry, A.G.Fundamentals of Nursing, 6th edi, Elsevier.
- 2.Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

How to Measure:

Intake

1. Some health care agencies record the intake of water by the individual glassful. Other agencies fill the patient's water pitchers at the beginning of the shift and measure the amount remaining in them at the end of the shift to calculate the intake. Be aware of the procedure in the agency you are in and follow it.
2. Remember to record all types of fluid intake.

Output

1. For bedpans and urinals, use a “graduated” pitcher which has measurements marked on it. Pour the urine into the pitcher and record the amount measured. Pour urine into toilet, flush, and clean the pitcher.
2. For patients with bathroom privileges (B.R.P.), be sure there is a measured container under the toilet seat which will collect the urine. Check and record the amount of urine measured. Empty, clean, and replace receptacle in toilet.
3. Remember to record all types of fluid output.

How to Record:

An 8-hour I record will be found in the patient's room. This is where you will record the I & O. (See sample form in this section.) This slip does not go into the chart, only the 8-hour totals are transferred into the chart. Entries may be made on this sheet.

SINGLE SHIFT INTAKE AND OUTPUT
I & O Record Sheet

DIET	ALL	PART	NONE
BREAKFAST	_____	_____	_____
LUNCH	_____	_____	_____
DINNER	_____	_____	_____

INTAKE (ORAL)					
Time	Amount	Item (Water ,Juices)	Signature		

OUTPUT					
Time	Gastric Drainage	Other drainage	Emesis	Urine	Signature

CONCEPTS BASIC TO NURSING PRACTICE WRITTEN COMMUNICATION DOCUMENTATION

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Identify where to chart appropriate patient information.
2. Chart pertinent patient information correctly.
3. Recognize different types of forms from patient's charts.
4. Demonstrate how to correct a charting error.
5. Use the appropriate signature for a nursing student writing in a patient's chart.
6. Demonstrate correct charting for a simulated patient situation.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

CONCEPTS BASIC TO THE PRACTICE OF NURSING NURSING PROCESS

OBJECTIVES

Upon the of this lab, the student will be able to:

NURSING

1. Apply each step of the Nursing Process appropriately to given client situations.
2. Write Nursing Care Plans for given client situations.
3. Discuss the use of the Nursing Care Plan as a means of communication between nurses.
4. Discuss each step of the Nursing Process. Explain how the use of the Nursing Process benefits both the client and the nurse.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

**HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN
THE PATIENT WITH POTENTIAL FOR ALTERED HEALTH MAINTENANCE**

BASIC ASSESSMENT

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Use terms associated with health assessment appropriately.
2. Perform a comprehensive nursing health history.
3. Demonstrate the four methods of examining.
4. Differentiate between normal and abnormal findings.
5. Recognize the significance of selected mental and physical findings, and report appropriately.
6. Use an organized sequence while conducting a health assessment.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

CONCEPTS BASIC TO THE PRACTICE OF NURSING

ADMINISTRATION OF MEDICATIONS

OBJECTIVES

Upon the completion of this lab, the student will be able to

NURSING

1. Locate where PRN medication orders are transcribed in the chart.
2. Locate where the medication sheet is located on various units.
3. Discuss guidelines related to administration of medications.
4. Identify essential steps to follow when administering oral, rectal, ophthalmic, ear, nose, inhalers, and transdermal medications.
5. Calculate and measure oral medication doses correctly.
6. Sign out controlled drugs correctly.
7. Demonstrate the correct procedure for administering medications by the oral route.
8. Chart the administration of oral medications correctly.
9. Recite the "five rights" of drug administration.
10. State the purpose, normal dosage range, and special nursing considerations for all drugs given.
11. Locate where medication orders are written on the chart.
12. Differentiate between three of the major systems of drug delivery in use in hospitals today:
 - a. Stock supply system
 - b. Individual client system
 - c. Unit-dose system
13. Calculate dosages correctly for given medication orders.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange
3. Susan.C.D., Rambo's Nursing Skills for Clinical Practice, 4th edi, Saunders

MEDICATION CARD INFORMATION

Generic Name _____

Student _____

Trade Name _____

Classification _____

Recommended Dosage Range _____

Method of Administration _____

Action -how it works, what the drug does in the body

Side and/or toxic effects

Contraindications

Special precautions and nursing implications in administration

References

CONCEPTS BASIC TO THE PRACTICE OF NURSING ADMINISTRATION OF MEDICATIONS

OBJECTIVES

Upon the completion of this lab, the student will be able to:

NURSING

1. Apply principles of medication administration to simulated patient situations.
2. Discuss the actions, side effects, and contraindications for the assigned medications.
3. Demonstrate the "three checks" of medication administration.
4. List the "five rights" of medication administration.
5. Sign out controlled drugs correctly.
6. Calculate dosages correctly for given medication orders.
7. Demonstrate accurate charting for medications, including prns .

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange
3. Susan.C.D., Rambo's Nursing Skills for Clinical Practice, 4th edi, Saunde

MEDICATION LIST

This will cover a variety of oral medications by presenting "scenarios" of patients, each with medical diagnoses. Listed below are the medications that will be covered in this lab. Know generic names, action, side effects, contraindications, etc. You will also want to review the 5 rights checks in prep for your oral med skills test.

Drug List

1. Amoxicillin
2. Darvon
3. Bisacodyl
4. Acetaminophen
5. Vitamin (ascorbic acid)
6. Cardizem
7. Nitro-Dur (topical)
8. Benadryl
9. Dicloxacillin
10. Metamucil
11. Ferrous sulfate

SKILLS EVALUATION -ORAL MEDICATIONS

NAME _____

DATE _____

____EXCELLENT

____SATISFACTORY

____REPEAT

CONCERN OVERRIDING AREAS OF

CARE

ASEPSIS

equipment

PHYSICAL SAFETY

____Bed low.

____Side rails

EMOTIONAL SAFETY

____Neat, comfortable

PREPARATION

____Wash Hands

____identify pt.

____Greet, Explain

____Collect equip

AFTER

____Wash hands

____ Care of

____Call bell available

____Chart

CRITICAL ELEMENTS

* ____ Check medication, dosage and time with MAR 3X

* ____ Chart signature and time on MAR

____ Put unopened meds. in med. cup

* ____ Demonstrate correct medication

Dose, client, route, time

____ At bedside. Open meds

____ Verbalizes appropriate knowledge of specific medications (e.g. action, SE, Nsg)
Digoxin -take apical pulse for full minute, withhold if 60 and notify physician.

ASA -watch for of GI upset and bleeding.

____ Give meds to client with water.

____ Test completed within twenty minutes

Tester's Signature

**SELF PERCEPTION -SELFCONCEPT PATTERN
THE PATIENT WITH POTENTIAL FOR
ANXIETY AND /OR INEFFECTIVE COPING MECHANISMS
SITUATIONS**

OBJECTIVES

Upon completion of this lab, the student will be able to:

HUMANITY

1. Recognize ways patients cope with feelings, emotions and stressful situations.
2. Identify how individuals may perceive stressors differently.

HEALTH

1. Discuss the impact stress can have on physical and emotional health
2. Describe the health benefits of humor as a coping mechanism

ENVIRONMENT

1. Identify stresses and losses hospitalized patients frequently experience.

NURSING

1. Discuss the nurse's role in helping patients cope with issues and stress.
2. Explain the benefits of therapeutic communication techniques when working with the patient experiencing stress.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G.Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

HEALTH PERCEPTION -HEALTH MANAGEMENT PATTERN THE PATIENT WITH POTENTIAL FOR ALTERED HEALTH MAINTENANCE

GROUP PROJECTS

OBJECTIVES

Upon completion of this lab, the student will be able to:

NURSING

1. Apply the nursing process to given patient situations.
2. Participate in a team approach to resolving patient issues.
3. Synthesize content learned this quarter to solve patient problems.
4. Communicate effective nursing approaches to patient problems.
5. Discuss and evaluate alternative approaches with the entire class.

PREPARATION GUIDELINES

1. Potter, P.A., Perry, A.G. Fundamentals of Nursing, 6th edi, Elsevier.
2. Berger, K.J., Williams, M.B., and Fundamentals of Nursing: Collaborating For Optimal Health. Appleton and Lange

**NURSING I
NURS 121**

CLINICAL EXPERIENCE

Date _____ Instructor _____ Student Name _____

NURSING CLINICAL LAB WORKSHEET

Lab # _____
ASSESSMENT

5 _____

I. Patient Initials _____ Room # _____ Facility _____
Date of Admission _____ Code Status: Full Code DNR
Age ____ Sex ____ Ht. ____ Wt. ____
Admission Vital Signs T _____ P _____ R _____ BP _____
Current Vital Signs T _____ P _____ R _____ BP _____
Appearance (observations you make of pt. regarding physical, emotional state)

Allergies _____

Diet _____

Activity Level: Bed/BRP _____ Chair/WC _____ Amb with Asst _____ Ambulate _____
Restraints: Yes _____ No _____ Type _____

Intake/Output: Yes _____ No _____ Fluids: Restrict _____ Push _____

Last BM _____ Foley: Yes _____ No _____

IV: Yes _____ No _____ Ostomy bag: Yes _____ No _____

Feeding tube: NG _____ PEG _____

Dressings: Yes _____ No _____ Location _____

Oxygenation: O₂ _____ L/min _____ N/C _____ Mask _____
_____ Continuous _____ PRN _____ Spirometer _____

II. **Medical Diagnosis(es):** _____

III. **History of events** leading to the present illness(es): _____

Past Illnesses and Surgeries: _____

IV. **Family History** (brief social and cultural history of the family including work, education, significant persons in patient's life, number/age of siblings): _____

<p>Pathophysiology of the Disease (What happens to the body)</p>	<p>Textbook S/S of disease</p>	<p>Pt's S/S of the disease that you Observed (If your patient had surgery and S/S of pathophysiology no longer exist, then write the S/S noted by the doctor leading up to the surgery)</p>
		<p>S/S prior to admission S/S observed today</p>

Medications: / 10 pts Trade/Generic Name	Classification of Drug	Nursing Implications—Side Effects
		NI SE
		NI SE
		NI SE
		NI SE
		NI SE
		NI SE
		NI SE
		NI SE
		NI SE
		NI SE
		NI SE

NURSING CARE PLAN

Assessment (Pt's S/S)	Nursing Diagnosis	Expected Patient Outcomes (Goals/Objectives)	Nursing Interventions	Rationale for Interventions	Evaluation of Expected Outcomes

Additional Abbreviations

AAA	Aortic Abdominal Aneurysm repair
AMB	Ambulate
ASA	Aspirin
ASHD	Arteriosclerotic Heart Disease
AVR	Atrial Valve Replacement
BPH	Benign Prostatic Hypertrophy
CABG	Coronary Artery Bypass Graft
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CPM	Continuous Passive Motion machine
CVA	Cerebrovascular Accident
DM	Diabetes Mellitus
DNR	Do Not Resuscitate (No Code)
DSS	Docusate Sodium
DVT	Deep Vein Thrombosis
Dx	Diagnosis
ETOH	Alcohol
Fem-Pop	Femoral-Popliteal Bypass graft
FESO ₄	Ferrous Sulfate
Fx	Fracture
GU	Genito Urinary
HTN	Hypertension
I & O	Intake Output
MI	Myocardial Infarction
MS	Morphine Sulfate Multiple Sclerosis
NAS	No Added Salt
NC	Nasal Canula
NKA	No Known Allergies
NTG	Nitroglycerin
O ₂	Oxygen
OU	Both eyes
PCN	Penicillin
PRN	As Necessary
PVD	Peripheral Vascular Disease
RX	Medication
SOB	Shortness of Breath
T IA	Transient Ischemic Attacks
TURP	Transurethral Repair of the Prostate
Tx	Treatment
UR I	Upper Respiratory Infection
UTI	Urinary Tract Infection

NURSING II
NURS 124

COURSE DESCRIPTION

Nursing II utilizes dependent and interdependent nursing functions and applies the nursing process through the roles of the Associate Degree nurse. Emphasis is on caring for patients with variations in functional health patterns associated with aging. There is particular focus on Health Perception/ Health Management, Nutrition/Metabolic, Activity/ exercise, and Cognitive/Perceptual. Beginning knowledge and skill is gained in physical assessment of aging clients with alterations in health patterns in both the acute care setting and the community. The concept of wholeness and variations related to the aging process are integrated throughout the course in order to facilitate the restoration of humanity, health and the environment to God's original plan. The concepts of caring, critical thinking, professional excellence, and learning are included.

COURSE OBJECTIVES

Upon successful completion of this course, the student will be able to:

1. Provide care of the elderly client in the dependent and interdependent roles of the nurse.
2. Recognize and apply the concept of man as an integrated whole and an understanding of the which exist between the components of wholeness when utilizing the nursing process.
3. Select appropriate concepts and principles related to the assessment, nursing care and evaluation of aging clients with variations in health patterns. These include problems related to:
 - a. Assessment changes related to aging
 - b. Elderly Health Education
 - c. Health and illness
 - d. Gerontological Considerations
 - e. Adult Development
 - f. Pain
 - g. Loss Death and dying
 - h. Diabetes
 - i. Integumentary problems
 - j. Immune system alterations
 - k. Immobility (arthritis and other CT disorders)
 - l. Visual/auditory impairment
4. Contrast appropriate nursing care plans integrating concepts from:
 - a. Physical, biological and social sciences
 - b. Health promotion
 - c. Nutrition
 - d. Client education
 - e. Nursing ethics
 - f. Pain management
 - g. Pharmacology
 - h. Communication
 - i. Advocacy
5. Apply theoretical knowledge and skills, within the format of the nursing process, to given clinical situations involving caring for aging, the chronically ill, and the dying client.
6. Calculate oral and parenteral medication dosages correctly.

THEORY SYLLABUS

TABLE OF CONTENT

1. CLASSIFICATION OF NANDA NURSING DIAGNOSIS BY GORDON'S FUNCTIONAL HEALTH PATTERNS.
2. VARIATIONS IN PATTERNS OF HEALTH
 - HEALTH HISTORY: FUNCTIONAL HEALTH PATTERN APPROACH
 - ELDERLY HEALTH EDUCATION
3. HEALTH PROMOTION AND ILLNESS CONCEPTS
 - CONCEPTS OF HEALTH PROMOTION, HEALTH AND ILLNESS
 - TEACHING PLAN FOR EDEMA CARE
4. HEALTH PROMOTION AND ILLNESS CONCEPTS
 - CONCEPTS OF HEALTH PROMOTION, HEALTH AND ILLNESS
 - GERONTOLOGICAL CONSIDERATIONS
 - ADULT DEVELOPMENT
5. BIOPSYCHOSOCIAL CONCEPTS RELATED TO HEALTH CARE
 - PAIN
 - LOSS, DEATH, AND DYING WITH DIGNITY
 - DIABETES MELLITUS
6. ALTERATIONS IN PATTERNS OF HEALTH
7. NUTRITIONAL METABOLIC PATTERN
 - INTEGUMENTARY PROBLEMS AND INTERVENTIONS
 - ACTIVITY EXERCISE PATTERN
 - COGNITIVE PERCEPTUAL PATTERN
 - ALTERED SENSORY INPUT
8. ELDERLY PROJECT

CLASSIFICATION OF NANDA NURSING DIAGNOSIS BY GORDON'S FUNCTIONAL HEALTH PATTERNS

Based on Gordon, M: Nursing Diagnosis: Process and Applications. Hill, New York, 1986, with permission.

HEALTH PERCEPTION HEALTH MANAGEMENT PATTERN

- Altered health maintenance
- Ineffective management of therapeutic regimen
- Total health management deficit (specify)
- Noncompliance (specify)
- High risk for noncompliance
- Health seeking behaviors (specify)
- High risk for High risk for injury (trauma)
- High risk for poisoning
- High risk for suffocation
- Altered protection

NUTRITIONAL-METABOLIC PATTERN

- Altered nutrition: potential for more than body requirements or high risk for obesity.
- Altered nutrition: more than body requirements or exogenous obesity.
- Altered nutrition: less than body requirements or nutritional deficit (specify)
- Ineffective breastfeeding
- Effective breastfeeding
- Ineffective infant feeding pattern
- High risk for aspiration
- Impaired swallowing or uncompensated swallowing impairment
- Altered oral mucous membrane
- High risk for volume deficit
- Fluid volume deficit (1)
- Fluid volume deficit (2)
- Fluid volume excess
- High risk for impaired skin integrity or high risk for skin breakdown
- Impaired skin integrity
- Pressure ulcer (specify stage)
- Impaired tissue integrity
- High risk for altered body temperature
- Ineffective thermoregulation
- Hyperthermia
- Hypothermia

ELIMINATION PATTERN

- Constipation or intermittent constipation pattern
- Colonic constipation
- Perceived constipation
- Diarrhea
- Bowel incontinence
- Altered urinary elimination pattern
- Functional incontinence
- Reflex incontinence
- Stress incontinence
- Urge incontinence
- Total incontinence
- Urinary retention

ACTIVITY-EXERCISE PATTERN

- High risk for activity intolerance
- Activity intolerance (specify level)
- Fatigue
- Impaired physical mobility (specify level)
- High risk for disuse syndrome
- High risk for joint contractures
- Total self-care deficit (specify level)
- Self-bathing-hygiene deficit (specify level)
- Self dressing grooming deficit (specify level)
- Self-feeding deficit (specify level)
- Self-toileting deficit (specify level)
- Altered growth and development: self-care skills (specify)
- Diversional deficit Impaired maintenance management (specify level)
- Dysfunctional ventilatory weaning response(DVWR)
- Inability to spontaneous ventilation
- Ineffective airway clearance
- Ineffective breathing pattern
- Impaired gas exchange
- Decreased cardiac output
- Altered tissue perfusion (specify)
- Dysreflexia

- High risk for peripheral neurovascular dysfunction
- Altered growth and development

SLEEP-REST PATTERN

- Sleep-pattern disturbance

COGNITIVE-PERCEPTUAL PATTERN

- Pain
- Chronic pain
- Pain self-management deficit (acute, chronic)
- Uncompensated sensory deficit (specify)
- Sensory-perceptual alterations: input deficit or sensory deprivation
- Sensory-perceptual alterations: input excess or sensory overload
- Unilateral neglect
- Knowledge deficit (specify)
- Impaired processes Uncompensated short-term memory deficit
- High risk for cognitive impairment
- Developmental conflict (specify)

SELF-PERCEPTIONSELF-CONCEPT PATTERN

- Fear (specify)
- Anxiety
- Mild anxiety
- Moderate anxiety
- Severe anxiety (panic)
- Reactive depression (situational)
- Hopelessness
- Powerlessness (severe, low, moderate)
- Self-esteem disturbance
- Chronic low self-esteem
- Situational low self-esteem
- Body image disturbance
- High risk for self-mutilation
- Personal identity confusion

ROLE-RELATIONSHIP PATTERN

- Anticipating grieving
- Dysfunctional grieving
- Disturbance In role performance

- Unresolved independence-dependence conflict
- Isolation or rejection Social isolation
- Impaired social interaction
- Altered growth and development: social skills (specify)
- Relocation stress syndrome
- Altered family process
- High risk for altered parenting
- Parental role conflict
- Parent-Infant separation
- Weak mother-infant or parent-infant attachment
- Caregiver role strain
- High risk for caregiver role strain
- Impaired verbal communication
- Altered growth and development: communication skills (specify)
- Potential for violence

SEXUALITY-REPRODUCTIVE PATTERN

- Sexual dysfunction (specify type)
- Altered sexuality patterns
- Rape trauma syndrome
- Rape trauma syndrome: compound reaction
- Rape trauma syndrome: silent reaction

COPING-STRESS TOLERANCE PATTERN

- Coping, ineffective (Individual)
- Avoidance coping
- Defensive coping
- Ineffective denial or denial
- Impaired adjustment
- Post-trauma response
- Family coping: potential for growth
- Ineffective family coping: compromised
- Ineffective family coping: disabling

VALUE-BELIEF PATTERN

- Spiritual distress (distress of the human spirit)

VARIATIONS IN PATTERNS OF HEALTH

Upon of this unit the student will be able to:

- 1) Identify; and discuss the physiological and psychological changes that occur with the aging process.
- 2) Summarize and demonstrate the essential components of the health history and physical assessment, as related to variations in the older adult.
- 3) Assess the normal changes and alterations in functioning that occur with aging, in all areas of wholeness.
- 4) Formulate a nursing care plan that plans, prioritizes, implements, and evaluates the client with variations in health patterns.
- 5) Prepare a personalized teaching plan for an elderly client taking into consideration deficit, cognitive ability, and willingness to learn.

VARIATION IN PATTERNS OF HEALTH

HEALTH HISTORY: FUNCTIONAL HEALTH PATTERN APPROACH

OBJECTIVES

Following completion of this class, the student will be able to:

NURSING

1. Explain the purpose, components and techniques of a health history.
2. Differentiate between a Medical History, Nursing Assessment, Nursing or Health General Survey, and Physical Exam.
3. Demonstrate the use of the Functional Health Pattern Approach to the Nursing Data Base as it relates to the elderly.
4. Conduct a screening health history on a senior citizen as demonstrated in Class.

This class is only on assessment and diagnosis.

VARIATIONS IN PATTERNS OF HEALTH
PHYSICAL ASSESSMENT: CHANGES RELATED TO AGING

OBJECTIVES

Following completion of this class, the student will be able to:

NURSING

1. Describe the structure and function of all systems.
2. Distinguish between normal and abnormal findings during a physical assessment.
3. Differentiate the various methods of physical exam
4. Identify the normal assessment changes related to the aging process.
5. Describe the physical and psychosocial implications of age-related assessment changes.
6. Complete a physical assessment of an elderly client demonstrating proper procedure.
7. Formulate nursing diagnoses from various functional health patterns based on assessment findings.
8. Design appropriate nursing interventions relevant to a client with variations in health patterns.

VARIATIONS IN PATTERNS OF HEALTH

ELDERLY HEALTH EDUCATION

OBJECTIVES:

Following of this class the student will be able to:

NURSING

- 1) Identify factors that facilitate learning throughout the life span.
- 2) Identify client data nurses need to make a Knowledge deficit diagnosis and to plan appropriate teaching.
- 3) List appropriate patient teaching measures for nurses to include in the nursing care of older adults.
- 4) Prepare and present a personalized teaching plan for an elderly client taking into consideration knowledge deficit, cognitive ability, and willingness to learn.
- 5) Evaluate the effectiveness of teaching plan presented.

HUMANITY

- 6) Discuss how age affects the teaching-learning process.

Teaching Plan for Edema Care

Assessment of the Learner

A 92 year old male Hispanic suffers from edema of his left lower leg. The client has been including large amounts of salt in his diet since his sense of taste started to diminish. The client's physical mobility is reduced and he cane for support while walking. Client states that exercise makes him feel better. Client lives with his son and daughter-in-law. Client has a history of drinking alcohol in large amounts. He used to smoke up to 12 packs of cigarettes a week. Client suffers from hearing impairment and is not able to speak or read English.

Nursing Diagnosis: Knowledge deficit related to edema care.

Short Term Goal: Client will discuss with accuracy edema and its causes.

Long Term Goal: Client will have a 50% reduction in edema.

Behavioral Objectives Upon completion of the teaching session, the client will:	Content Outline	Teaching Methods
1. Describe Edema 2. List causes of edema 3. Describe actions to manage edema 4. Identify interventions to help reduce edema	1 Edema is the presence of excess interstitial fluid in the body (Kozier, Erb, Berman, Burke, 2000) 1 I. Causes include * Increased permeability of capillary walls * Increased capillary pressure * Excessive intake of sodium * Electrolyte disturbances (Stuart 1996) 1 I I. Actions include * Restrict salt intake * Restrict fluid intake * Diuretic therapy (Lewis, Heitkemper & Dirksen, 2000). 1 V. Interventions include: * Elevate legs * TED Hose * No sitting for long periods	1. Describe what edema is by showing several examples. 1 I. Describe causes by explaining them. 1 I I. Describe actions to Client 1 V. Demonstrate interventions

- Evaluation: The clients will
1. Respond to questions regarding edema
 2. Respond to questions regarding causes of edema
 3. Respond to questions regarding management of edema
 4. Return demonstrate interventions

HEALTH PROMOTION AND ILLNESS CONCEPTS

Upon completion of this unit the student will be able to:

1. Identify, discuss and differentiate between the various concepts of health, wellness, illness, health and prevention as they relate to the elderly.
2. Assess middle and older adults in terms of major family developmental tasks.
3. Compare and contrast major theories of adult development and theories of aging.
4. Discuss major health issues affecting the elderly.
5. Identify discuss the role and responsibility of the nurse:
 - a. In promoting client safety
 - b. As an advocate for the clients and families experiencing problems, concerns and/or complications.
 - c. In client and family education, utilizing supportive data from literature and research.
 - d. In utilizing community resources to meet client and family needs

HEALTH PROMOTION AND ILLNESS CONCEPTS

CONCEPTS OF HEALTH PROMOTION, HEALTH AND ILLNESS

OBJECTIVES:

Following completion of this class the student will be able to:

HEALTH

1. Differentiate between the several of health, wellness, illness, health promotion, health status, health beliefs, health behaviors and also taking into consideration how they relate to the elderly.
2. Differentiate between acute and chronic illness, and the incidence of each. Identify the natural remedies or laws of health and describe how each one contributes.
3. Identify the natural remedies or laws of health and describe how each one contributes toward health promotion
4. Explain Dunn's High-Level Wellness Grid and the Health-Illness Continuum of measuring Health/illness

NURSING

5. Summarize and describe the 3 levels of prevention and give examples of each. nursing care plans related to Health Perception-Health Management.
6. Formulate nursing care plans related to Health Perception-Health Management
7. Describe the content included in patient education as related to health promotion.
8. Explain the importance of the nurse as a role model for health promotion as well as an for patients in need of health promotion.

HUMANITY

9. Relate the variables that influence health and illness in the elderly including culture, religion and ethnicity.
10. Analyze and describe your personal beliefs about disease/illness vs health/wellness

ENVIRONMENT

11. Discuss the effects of illness on patient, family, community and society.
12. Define health-promoting behaviors.
13. Identify factors which affect health-promoting behaviors in the older adult.

HEALTH PROMOTION AND ILLNESS CONCEPTS GERONTOLOGICAL CONSIDERATIONS

OBJECTIVES

Following completion of this class the student will be able to:

HEALTH

1. Identify the subgroups of the adult population and their distribution in society and in the health care system.
2. Discuss rehabilitation including goals, definition and assessment and management of clients.
3. Discuss the health issues/risk factors affecting the elderly including how the aging process impacts the absorption, distribution, metabolism and excretion of medication.
4. Differentiate between the mental health changes associated age dementia, and delirium.

NURSING

5. Identify major chronic conditions of the elderly and discuss the implications of each.
6. Describe the nursing interventions and needs of special populations of older adults cultural and ethnic considerations.

HUMANITY

7. Define Gerontology.
8. Describe and define the various forms of elder abuse and the legal requirements for reporting elder abuse.
9. Identify the impact of illness on older adults related to their developmental status.
10. Identify stressors (declining function, reduced income, decreased social activity and effects on the elderly).

HEALTH PROMOTION AND ILLNESS CONCEPTS

ADULT DEVELOPMENT

OBJECTIVES

Following completion of this class the student will be able to:

HEALTH

1. Identify the important health maintenance concerns for older adults related to the aging.
2. Compare and contrast major of aging.
3. Compare and contrast major theories of adult development, including developmental and tasks.

NURSING

4. Assess the major psychodynamic concerns of young, middle and older adults in terms of self-concept, concept of death, intellectual processes and sexuality.
5. Discuss teaching content to be included in health education for common problems of the older adult, taking into consideration the patient's comprehension level, emotional, psychological, physical, religious, cultural differences and resistance to change.
6. Educate the client or family members regarding applicable care to be given based upon a selected theory of aging.

HUMANITY

7. Discuss the social and physiologic processes of the older adult.

BIOPSYCHOSOCIAL CONCEPTS RELATED TO HEALTH CARE

Upon completion of this unit the student will be able to:

1. Assess changes and alterations in functioning that occur with clients experiencing pain, chronic illness, disabling conditions, or death, in all areas of wholeness.
2. Formulate a nursing care plan that assess/identifies, plans, implements, and evaluates Outcomes as related to the assessed variations/problems for patients/problems for patients/clients and family.
 - a. Supportive data from literature or research
 - b. Community resources and interdisciplinary team members for continuity of care.
3. Discuss the role and responsibility of the nurse:
 - a. In promoting safety
 - b. As an advocate for the client and family experiencing pain, chronic illness, disabling conditions, or death.
 - c. In client and family education.

BIOPSYCHOSOCIAL CONCEPTS RELATED TO HEALTH CARE

Pain

HEALTH

1. Describe the anatomical and physiological basis of pain, including reception, transmission, perception and reaction.
2. Identify types and categories of pain to location, etiology, and duration.
3. Differentiate pain threshold pain tolerance.

NURSING

4. Describe the gate control theory and its application to nursing care.
5. Identify subjective and objective data to collect and analyze when assessing pain.
6. Formulate appropriate diagnoses for individuals experiencing pain. Interventions for the client with pain, including pharmacological and management.
7. Discuss interventions for the client with pain, Including pharmacological and nonpharmacological management.
8. Discuss the mechanism of action, therapeutic effects, adverse effects, and nursing implications of the following drugs:
 - a.Acetaminophen (Tylenol)
 - b. Aspirin (Percocet)
 - c. Codeine
 - d. Ibuprofen
 - e. Morphine (Ms Contin,Roxanol)
 - f.Meperidine(Demerol)
 - g.Oxycodone Hydrochloride
 - h.Ketorolac(toradol)

HUMANITY

9. Describe the normal physiologic changes affecting pain perception in the elderly.
10. Describe the psychosocial implications of chronic pain.
11. Identify one's own beliefs and attitudes regarding pain management.
12. Describe ways in which barriers, misconceptions and various physical, psychosocial, religious, cultural, and intellectual factors, including aging, can effect the outcome of pain management.

ENVIRONMENT

13. Plan specific nursing interventions that facilitate relaxation, rest, comfort, and performance of ADLs in the individual experiencing pain

BIOPSYCHOSOCIAL CONCEPTS RELATED TO HEALTH CARE

LOSS, DEATH, AND DYING WITH DIGNITY

OBJECTIVES

Following completion of this class the student will be able to:

HEALTH

1. Relate clinical signs of death.
2. Summarize moribund signs of death.
3. Describe changes that occur in the body after death including timing.
4. Compare and contrast the various types of euthanasia.
5. Discuss the grieving process including goals, steps, and signs.

NURSING

6. Identify physiological and medication needs of dying patients.
7. Summarize the advantages, disadvantages, goals and roles of hospice both in the community and in institutions in dealing with families and clients with terminal illness.

HUMANITY

8. Identify the types of losses an individual may experience, including the elderly.
9. Identify coping mechanisms used by family and clients in response to terminal including the grieving process.
10. Assess functional abilities of families with a member in the terminal stage of illness.
11. Differentiate grief, bereavement and mourning.

ENVIRONMENT

12. Identify support available for both client and family in relation to: spiritual, emotional physical, and community resources
13. Demonstrate cultural sensitivity in planning for appropriate religious and ethnic ritual associated with death and dying..

BIOPSYCHOSOCIAL CONCEPTS RELATED TO HEALTH CARE: DIABETES MELLITUS

OBJECTIVES

Following completion of this class the student will be able to:

HEALTH

1. Discuss the types of diabetes mellitus including incidence, Pathophysiology, etiology, manifestations and complications

NURSING

2. Compare and contrast the various blood glucose tests including normal values, criteria for diagnosing diabetes, and patient teaching.
3. Differentiate between the s/s of hypoglycemia and hyperglycemia taking into consideration, the elderly client.
4. Discuss the mechanism of action therapeutic effects, adverse effects, and nursing implications of the following drugs:

a. Insulin: Regular, NPH, Ultralente

b. Diabinase

c. Tolbutamide (Orinase)

d. Metformin

HUMANITY

5. Describe the management of a client with diabetes.

ALTERATIONS IN PATTERNS OF HEALTH

OBJECTIVES

Upon completion of this unit the student will be able to:

1. Identify factors contributing to altered functional health patterns including age related factors.
2. Define terminology related to integumentary problems, connective tissue disorders, and altered input.
3. Describe the etiology, incidence, and clinical manifestations of disorders, connective tissue disorders, and disorders taking into consideration age related and ethnic factors.
4. Construct appropriate nursing diagnoses for clients with altered functional health patterns Focusing on:
 - a.Nutritional/Metabolic
 - b.Activity/Exercise
 - c.Cognitive/Perceptual
5. Select appropriate interventions for diagnoses constructed and give the Rationale for selection.
6. Evaluate interventions in terms of meeting outcome criteria.

NUTRITIONAL/METABOLIC PATTERN

INTEGUMENTARY PROBLEMS AND INTERVENTIONS

OBJECTIVES:

Following completion of this class the student will be able to:

HEALTH

- 1 Describe the structure and function of the skin.
- 2 Explain the pathophysiology, manifestations, etiology, and incidence of various skin disorders taking into consideration ethnic factors.

NURSING

- 1 Assess a client with a possible skin disorder, including diagnostic assessment.
- 2 Discuss collaborative management of skin disorders including pharmacological agents.
- 3 Utilize the system for staging ulcers.
- 4 Explain the indications and nursing management related to plastic surgery and skin grafts.
5. Discuss the mechanism of action, therapeutic effects, adverse effects, and nursing implications of the following drugs:
 - a. Bacitracin
 - b. Benzoyl Peroxide
 - c. Erythromycin
 - d. Tretinoin
 - e. Clotrimazole
 - f. Miconazole

HUMANITY

1. Differentiate normal from abnormal findings in assessing the integumentary system including age related changes.
2. Recognize the characteristics of various primary and secondary skin lesions

ENVIRONMENT

1. Discuss factors predisposing clients to skin problems including diet and environmental exposures.
2. Describe health promotion practices related to the skin.

ACTIVITY/EXERCISE PATTERN
CONNECTIVE TISSUE DISORDERS

OBJECTIVES:

Following completion of this class the student will be able to:

HEALTH

1. Describe the pathophysiology, manifestations, etiology, incidence and management of , connective tissue disorders taking into consideration ethnic differences.
2. Describe the etiologic factors, clinical manifestations, and treatment modalities of autoimmune diseases.

NURSING

3. Assess a client with connective tissue disorders, including diagnostic assessment.
4. Discuss interventions for the client with alterations in pattern, including pharmacological management
5. Discuss the mechanism of action, therapeutic effects, adverse effects, and nursing implications of the following drugs:
 - a. Aspirin
 - b. Indomethacin
 - d. Allopurinol (Zyloprim)
 - e. Cytotec (Alendronate)
 - f. Hydrocortisone
 - g. ACTH
 - h. Colchicine
 - i. Prednisone
 - j.Fosamax (Alendronate)
 - k. Evista(Raloxifene)
6. Describe the management of a client having connective tissue disorders including the preoperative and teaching and collaborative care of clients having reconstructive surgery.

HUMANITY

7. Recognize changes related to aging that affect the connective tissue.

ENVIRONMENT

8. Identify risk factors associated with connective tissue disorders.

COGNITIVE/PERCEPTUAL PATTERN

ALTERED SENSORY INPUT

OBJECTIVES:

Following completion of this class the student will be able to:

HEALTH

1. Describe the physiological processes involved in normal vision and hearing.
2. Describe major eye and ear problems, including pathophysiology, manifestations, and nursing interventions: inflammations, cataracts, glaucoma, retinal detachment, age related macular degeneration, otosclerosis, labyrinthitis, external otitis, otitis media, and Meniere's Syndrome.
3. Compare the causes, management, and rehabilitative potential of conductive and sensorineural hearing loss.

NURSING

4. Identify the significant objective and subjective data related to visual and auditory assessment that should be obtained from the client.
5. Demonstrate basic physical assessment techniques for the eye and ear, differentiate normal common abnormal findings.
6. Explain the general preoperative and postoperative care of the patient undergoing surgery of the eye or ear.
7. Recognize common diagnostic tests used to detect hearing and visual problems.
8. Discuss the major types of medications used in treatment of eye and ear disorders and the nursing responsibilities in the administration.
9. Discuss the mechanism of action, therapeutic effects, adverse effects, and nursing implications of the following drugs:
 - a. Pilocarpine
 - b. Diamox (Acetazolamide)
 - c. Physostigmine
 - d. Gentamycin
 - e. Ciprofloxacin
 - f. Atropine Sulfate
 - g. Artificial Tears Ketorolac
 - h. Timoptic (Timolol)

HUMANITY

10. Describe the structures and functions of the visual and auditory systems.
11. Identify changes in the eye and ear associated with aging.
12. Discuss psychosocial implications of hearing and visual loss.

ENVIRONMENT

13. Explain the use, care, and patient education related to assistive devices for eye and ear problems.
14. Discuss environmental risk factors for clients with visual hearing impairment.

ELDER PROJECT

Adopt a Senior Citizen

This project is designed to acquaint the student with the "life and times" of the well elderly living in the community. Students select an Elder of their choice make arrangements for up to six visits' during clinicals. The paper should reflect the inclusion of such necessary information as:

- a. Health history and physical assessment (with client clothed; no invasive assessment)
- b. Biopsychosocial comparison -Compare and contrast the physical, psychological, and social characteristics of young adults (self) and a well elderly person ("adopted" senior).
- c. Adaptation strategies -Discuss the strategies the senior has used to adapt to the physical, biological, economical and social changes associated with the aging process. Have the strategies been useful and healthy or dysfunctional?
- d. Learning critique -Explain what you personally have learned this adopted contact.

Findings can be presented in any way which meets the objectives. Presentations which incorporate scrap books have been most successful. Creativity is rewarded. APA format is required, including reference list. Minimum references; 10 including textbooks. Effort equivalent to 10-15 pages.

Elder's Project

Nursing History/physical Assessment

Demographic Data

Name..... D.O.B..... Age..... Sex..... Telephone.....

Religion..... Ethnicity..... Marital Status..... Background

Primary Significant Other Occupation..... Retired?

Name of primary information source

Medical Diagnoses

Home Profile

Single/multiple dwelling.....Own/rent.....Pets.....Number of levels

Safety : Stairs.....Rugs.....Cords.....Location of bedroom/bathroom

Health Resources

Private MD.....Hospital.....Clinic.....Insurance

Developmental Stage

Determine developmental stage (Not age group). Explain why you believe patient is in this stage of development

Vital Signs

Temperature.....Pulse rate.....Regular.....Irregular

Respiratory rate.....Abdominal.....Diaphragmatic

Blood Pressure: left arm.....Right arm

Weight.....Height:

Functional Health Patterns

Health Perception-Health Management Pattern

General appearance

General state health

Illnesses in past year

Allergies: No..... YesWhat?

(Check reactions to medications, foods, cosmetics, insect bites, etc)

Use of tobacco, alcohol, drugs History of chronic disease

History of chronic disease

Immunization history:

Tetanus.....Pneumonia.....Influenza.....MMR.....Polio...HepB

Enlarged lymph nodes in the neck? No.....Yes.....Location and size:

Health care assistance in the past year

Current work status

Working conditions (Safety, noise, space, heating, cooling, water, ventilation)

Rate living conditions at home

Difficulty securing the following services

Grocery store.....Pharmacy.....Health Care..... Transportation

Medications (OTC and Prescription)

Name	Dosage	Times	Reason for	Taking as ordered
------	--------	-------	------------	-------------------

Compliance with health care routine

Accidents/falls/injuries/surgeries in past year

Problems with cuts healing

Exercise: RegularIrregular.....

Ringing in ears: yes..... No..... Vertigo: Yes..... No.....

Use of seat belts

Suggestions or requests for improving health status

Breast/Testicular self-examination Yes..... No.....

Nutritional-Metabolic Pattern

Skin examination

Warm.....Cool.....Moist.....Dry.....Turgor: Firm.....Supple....Dehydrated...Fragile

Lesions/Rash No..... Yes.....Describe:
Color: Pale.....Pink.....Dusky.....Cyanotic.....Jaundiced.....Mottled.....Other

Mucous membranes Mouth: Moist..... Dry.... Lesions: No ...Yes.... Describe: Color:
Pale Pink.....

Teeth: Normal..... Abnormal.... Describe:

Dentures: No.....Yes....Upper....Lower.....Partial.....

Gums: Normal....Abnormal.....Describe.....

Tongue:Normal...Abnormal...Describe.....

Eyes: Moist.....Dry....Color of conjunctiva:Pale... Pink....Jaundiced

Lesions:No...Yes.....Describe:

Edema: General: No.....Yes....Describe

Jugular vein distention: No...Yes...

Gag reflex: Present.....Absent...

Pt's ability to move self easily (turning, walking) Yes... No... Limitations:

Dressed appropriate for the weather?

Weight gain/loss in last 6 months No... Yes....Amount:

Appetite:Good...Fair.....Poor

Food intolerances No... Yes....Describe:

Dietary restrictions (both voluntary and prescribed:

Describe average day's food intake (Meals and snacks)

Describe an average day's fluid intake

Describe food likes and dislikes:

Would you like to:Gainweight.....Lose weight....Neither

Any problems with:Nausea-.....Vomiting....swallowing....Chewing...Indigestion

Describe usual lifestyle:Active...Sedate

Elimination Pattern

Bowel sounds:Normal...Increased....Decreased....Absent

Abdomen:Tender...Soft....Masses..... Distention

Usual frequency of bowel movements

Straining:No... Yes.... Same time each day: No.....Yes....

Changes in number of bowel movements in past week? No... Yes... Increased...
Decreased

Character of stool: Consistency: Hard...Soft....Liquid

Color: Brown....Black....Yellow.....Clay colored

Bleeding with bowel movement: No....Yes

History of constipation No....Yes....How often?

Use of bowel movement aids (laxatives, suppositories, diet)No...Yes....

History of diarrhea No...Yes...How often?

History of incontinence: No....Yes....Related to (coughing,laughing,sneezing) No...yes..

History of recent travel: No....Yes... Where:

Usual voiding pattern: Frequency (times per day)....Decreased?.....Increased?

Change in urge void: No... Yes...Increased...Decreased?

Change in amount: No...Yes..... Increased...Decreased?

Color:Yellow...Amber....Dark.....

Incontinence: No... Yes... When?..... Retention: No... Yes..... Describe.....
Pain/burning: No... Yes... Describe.....
Sensation of bladder spasms: No..... yes.... when?

Activity-Exercise Pattern

Cardiovascular: Cyanosis: No Yes..... Where...
Pulses: Easily palpable?
Carotid: Yes... No... Jugular: Yes... Radial Yes... No.. Femoral: Yes. No...
Radial: yes... No... Femoral: Yes... No... Politial: Yes... No...
Dorsal Pedis: Yes... No..
Extremities: Temperature: Cold.... Cool.... Warm.... Hot...
Capillary refill: Normal Delayed.... Color: Pink... Pale.... Cyanotic... Other
Homan's Sign: No... Yes...
Nails/Hair Normal... Abnormal... Describe.....
Heart: PMI location
Abnormal rhythm: No.... Yes... Describe.....
Abnormal sounds: No.... Yes... Describe
Respiratory: Rate... Depth: Shallow.... Deep... Abdominal Diaphragmatic...
Have patient cough: Any sputum? No... Yes... Describe.....
Auscultate chest: Any abnormal sounds (crackles, Wheezes)? No..... Yes..... Describe
Have patient walk in place for 3 minutes (if permissible):
Any shortness of breath after activity? No.... Yes
Any dyspnea? No..... yes
BP after activity...../..... Respiratory rate after activity..... Pulse rate after activity
Musculoskeletal
Range of motion: Normal.... Limited.... Describe.....
Gait: Normal..... Abnormal..... Describe.....
Balance: Normal.... Abnormal..... Describe.....
Muscle mass/strength: Normal..... Increased..... Decreased.....
Toe wiggle: Right: Normal... Decreased..... Left: Normal.....
Hand grasp: Right Normal..... Decreased..... Left: Normal..... Decreased
Postural: Normal.... Kyphosis..... Lordosis
Deformities/Missing limbs: No.... Yes... Describe.....
Use of mobility aids (walker, crutches, etc) No..... Yes..... Describe.....
Tremors: No..... Yes..... Describe.....
Traction/casts present: No... Yes... Describe.....
Spinal cord injury: No..... Yes..... Level
Paralysis present: No.... Yes... Where?
Rate each area of self-care using the following scale
0=Completely independent
1=Requires use of equipment or device
2=Requires help from another
3=Requires help from another person and equipment device
4=Dependent, does not participate in activity
Feeding.....; Bathing/hygiene.....; Dressing/Grooming.....; Toileting.....; Ambulation

Care of home...;Shopping...;Meal Preparation...;Laundry...;Transportation...
Oxygen use at home: No... Yes... Describe
Number of pillows used to sleep on
Episodes of fatigue No... Yes... Describe
Number of stairs able to climb without experiencing difficulty
Distance able to walk without experiencing difficulty
Assistance needed at home for self-care and maintenance of home;No... Yes... Who
Occupation(if retired,former occupation)
Describe leisure-time activities/hobbies
Difficulties in maintaining activities of daily living:No... Yes... Who
concentration:No... Yes... Describe

Sleep-Rest pattern

Usual sleep habits;hours per night...;Naps:No...yes...a.m.....p.m.....
Feel Rested:Yes.....No.....Describe
Any problems:Difficulty going to sleep:No... Yes...Awakening during night:No... Yes
Early awakening:No... Yes... Insomnia:No... Yes... Describe
Methods used to promote sleep:MedicationNo... Yes... Name
Warm fluids:No... Methods used to promote sleep:MedicationNo... Yes... Name
Warm fluids:No... Yes... What?... Relaxation techniques:No... Yes... Describe

Cognitive Perceptual Pattern

Mental status:Oriented...Disoriented... Time... Place... Person:
Sensorium;Alert...Drowsy...Lethargic...Stuporous...Comatose
Cooperative...Combative...Delusional
Memory: Recent:Yes...No...;Remote:Yes...No
Vision:visual acuity; both eyes... Right eye...Left eye...
Pupil size:Right:Normal...Abnormal:...left Norma...Abnormal
Description of abnormalities:
Wears glasses:yes...No...;Contact lenses;Yes...No
Hearing:Right ear WNL... Impaired...Deaf
Hearing aid:Yes...No
Taste:Normal...Abnormal...Describe:
Tongue movement:Normal...Abnormal...Describe:
Tongue appearance:Normal...Abnormal...Describe
Touch:BluntNormal...Abnormal...Sharp:Normal...Abnormal...Describe
Light touch sensation:Normal...Abnormal...Describe
Proprioception:Normal...Abnormal...Describe
Heat:Normal...Abnormal...Cold:Normal...Abnormal...Describe
Numbness:No... Yes...Tingling:No... Yes...Describe
Smell:Right Nostril:Normal...Abnormal...Left Nostril:Normal...Abnormal
Romberg,balance,gait,coordinator,etc.Normal...Abnormal...Describe
Reflexes:Normal...Abnormal...Describe
Any overt signs of pain?No... Yes... Describe
Pain:Location...Intensity(on scale of(0-10)
Radiation:No... Yes...To where?
Timing(how often;related to any specific events.....
Duration.....
What is done to relieve?.....

When did pain begin?

Decision making is: easy.....Moderately easy... Moderately difficult....Difficult

Inclined to make decisions: Rapidly.....Slowly.....Delay

Knowledge level: Can define what current problem is: Yes.....No.....

Can restate current therapeutic regimen: Yes.....No

Self-perception and Self-Concept Pattern

Patient appears: Calm....Anxious.....irritable.....Withdrawn.....Restless

During exam do any physiologic parameters change?

Face reddened....Voice volume changed.....Quavering.....Hesitation....Other

Body language observed:

Are health problems going to result in a body structure/function change No...Yes...Unsure

What is patient's major concern at the current time

Are health problems resulting in life-style changes No....Yes.....What

Patient's view of self: Positive....Neutral...somewhat negative

Any problems dealing with current health situation No...Yes...Describe

On a scale of 0-5 rank perception of level

On a scale of 0-5 rank usual assertiveness level

Role-Relationship Pattern

Speech pattern: Is English the patient's native language native language Yes..No

Native language.....Any speech problems noted

Family interaction: Any dysfunctional family interactions noted

Any evidence of physical too psychosocial abuse No....Yes.....Describe

Does patient live alone? Yes.....No.....With whom?

Is patient married? Yes.....No....Children? No....Yes....Ages of children

Parenting skills: Not applicable....No difficulty...Average...Some difficulty...Describe

Losses(Physical,psychologic,Social) in past year: No....Yes.....

How pt.is handling this loss at this time?

Any expected losses in near future?

Has health condition resulted in any role changes? No...Yes...Describe

Rate usual social activities?

Rate comfort level in social situations? Comfortable.....Uncomfortable

Activities or jobs patient likes to do?

Activities or jobs patient does not like to do?

Sexuality-Reproductivity Pattern

Female: Date of LMP....Pregnancies.....Children.....Menopause: No...Yes....year

Use of birth control measures? No....N/A....Yes.....Type:

History of vaginal discharge, bleeding, lesions No.....Yes.....Describe

Pap smear annually: Yes.....No....Date of last Pap smearDate of last mammogram:

Male: History of prostate problems: No....Yes.....Describe

History of penile discharge, bleeding, lesions: No...Yes....Describe

Date of last prostate exam:

Both: History of sexually transmitted disease: No.... Yes..... Describe

Any problems in sexual functioning No.....Yes..... describe

Satisfaction with sexual relationship No...Yes....Describe

Coping-Stress Tolerance Pattern

Observe behavior: Any overt signs of stress(crying, wringing of hands, clenched fists, etc)
Describe have you experienced any stressful or traumatic events in the past year
How would you rate your usual handling of stress: Good.....Average.....Poor
What is the primary way to deal with stress or problems:
Have you /family used any support/counseling groups in past year No....Yes....Helpful?
Are you satisfied with your current health care Yes.....No.....Describe

Value-Belief Pattern

Observe behavior
: Is the patient exhibiting any signs of alterations in mood
(anger,crying,Withdrawal,etc.)?Describe

Satisfied with the way your life has been developing? Yes...No.....Describe
Religion:Protestant.....Catholic.....Jewish....Muslim...Buddhist....None...Other
Does health status interfere with your spiritual or religious practices?No....Yes...Describe
Any religious beliefs helped you to deal with problems in the past?No...Yes....Describe
Have your religious beliefs helped you to deal with problems in the past? No..Yes..Descr;

General

Any information I need to have not covered in my interviews No...Yes...Describe
Any questions you have concerning your health, plan of care, etc.? No.. Yes.. Describe
What is the first problem you would like to have help with?

Biopsychosocial Comparison

Compare and contrast the physical,psychological,and social characteristics of young adults(self)
and a well elderly person.

Adaptation Strategies

Discuss the strategies the senior has used to adapt to the physical,psychological,economical,and
social changes associated with aging process. Have the strategies been useful and healthy or
dysfunctional?

NURSING II
NURS 124

CLINICAL SYLLABUS

CLINICAL SCHEDULE

1. SKILL REVIEW
2. GUIDELINES FOR ORGANIZING YOUR MORNING
3. ORIENTATION; PARENTERAL MEDICATION
 - Z-TRACK IM INJECTION PROCEDURE
 - HEPARIN INJECTION PROCEDURE
 - PROCEDURE FOR INSULIN INJECTION
4. NASO/GASTRIC TUBE
 - COMMON TYPES OF FEEDING TUBES
 - NASOGASTRIC INTUBATION
 - NASOGASTRIC TUBE REMOVAL
5. URINARY CATHETERIZATION
 - INSERTION OF FOLEY CATHETER
6. DAILY S CLINICAL LAB EVALUATION
7. ASSESSMENT

SKILLS REVIEW

NSG-I Skills	Practice date	Tester initial
Bed bath		
Bed making(inc;Occupied)		
02 Admin		
Major dressing		
Incentive Spirometer		
Cough/Deep breathing		
ROM		
TED Hose		
Enemas		
Oral Med Admin		
Basic Health Assessment		

I have done hands on practice to review these skills and feel competent to perform them.

.....
Signature of Student

I have observed the above student practicing these skills and feel they are competent to perform them.

.....
Signature of the Tester

GUIDELINES FOR ORGANIZING YOUR MORNING

1. Introduce yourself to your unit nurse and get report of your patient.
2. Review Kardex for 2. specifics of care such as:
 - Bath type
 - I/O
 - V.S.
 - Elimination (Foley, enema)
 - Date of last BM (Report to instructor if more than 2 days).
 - Activity Level
 - Special treatments/procedures
 - Appointments off unit (X-ray,P.T,Dr.Office)
3. Check medication sheet for times of meds and for changes a Check medication for times of meds and for changes and additions. medication drawer to make sure med is there. Check with instructor or unit nurse regarding calling Pharmacy to get med (PRN).
4. Check for patient's last BM. If none for two days, check with instructor regarding bowel care.
5. Take V.S. and do a quick assessment for immediate problems and or needs.
6. Prepare for breakfast. Give fresh pitcher of water. Feed breakfast PRN. Record (may have to get new I/O sheet to put up)
7. Do Physical Assessment. Write notes down as you assess so you don't forget. Check your assessment guidelines to see if any items were missed.
8. Bathe patient including ROM, leg exercises, deep breathing and coughing exercises.
9. Give meds at appointed times. Be sure to get instructor to check meds before giving. Immediately chart Meds.
10. Double check your charting. Be sure initials and signature are on all treatment, ADL, and medication sheets.
11. Let patient, instructor, and unit nurse know that you are leaving unit, this includes giving a full report. If you were unable to complete some care or significant you found significant information regarding the patient, be sure to communicate this to the instructor early in the shift.

PARENTERAL MEDICATION ADMINISTRATION

OBJECTIVES

Following participation in lab, the student will be able to:

NURSING

1. Identify the parts of a syringe and needle.
2. Identify appropriate sites for giving the following injections:
 - a. intradermal
 - b. subcutaneous
 - c. intramuscular
3. State which parts of a syringe and needle must be kept sterile.
4. Identify appropriate angles for injection of various types of parenteral medications.
5. Select needles and syringes appropriate to the patient, solution, and method of administration.
6. Explain special instructions regarding the preparation and administration of heparin and insulin injections.
7. State purposes, rationale, precautions, and nursing implications for administration of these types of injections:
 - a. intradermal
 - b. subcutaneous (including insulin)
 - c. intramuscular
 - d. Z track
8. Demonstrate sterile handling of equipment and the removal of a from a vial and an ampule.
9. Select an appropriate injection site for administration of parenteral medications.
10. Correctly prepare and administer solutions by IM, SQ, and Z-track
11. Correctly chart injections.
12. Identify patient responses the nurse should observe for when evaluating the effectiveness of medications given by injection.
13. Successfully pass skills test on IM and Z-track injections.

PARENTERAL MEDICATION PROCEDURE

1. Wash hands
2. Check Medication Administration Record (MAR)
3. Find medicine and check with MAR: correct medication and dosage
4. Do calculation as needed
5. Recheck med with for correct med and dosage
6. Get syringe with correct needle (1 -1/2long for IM,5/8' for subQ)
7. Clean top of vial
8. Draw up correct amount of air; inject into vial; draw up correct amount of medication; withdraw
needle.
9. Recap needle as appropriate.
10. Check medication and dosage for the 3rd time
11. Sign initials on MAR on Correct day and time
12. Thing to take to pt's bedside:
 - a. Syringe filled with med
 - b. Alcohol swab
 - c. Exam gloves
13. Greet patient and explain
14. ID patient
15. Provide privacy PRN
16. Gloves on
17. Position patient
18. Locate site
19. Cleanse skin
20. Make skin tight
21. Dart in quickly 90-degree angle for IM Aspirate
22. Aspirate
23. Inject slowly
24. Remove needle quickly
25. Rub site with alcohol swab (unless contraindicated)
- 26 **DO NOT RECAP NEEDLE!** Put uncapped needle and syringe into sharps disposal
box.
27. Discard gloves, needle cap, and alcohol swab
28. Bed in low position
29. Call bell available
30. Side rails adjusted
31. Pt. comfortable and area neat
32. Open curtain if closed
33. Chart initials, signature, NS at bottom of MAR
34. Chart site given near initials
35. Wash hands

Z-TRACK IM INJECTION PROCEDURE

Procedure is the same as for any parenteral medication until the needle has been withdrawn from the vial.

- 1 Draw up 0.1 ml air
- 2 Recap and change needle; discard first needle in sharps disposal container.
- 3 Locate site (Usually R or L Gluteus Medius)
- 4 Cleanse skin
- 5 Displace tissue (Hold until medication is injected)
- 6 Dart in quickly 90-degree angle
- 7 Aspirate
- 8 Inject slowly
- 9 Wait 10 seconds
- 10 Remove needle and release tissue simultaneously
- 11 Apply light pressure with alcohol swab if needed. **DO NOT RUB!**

Continue as with any injection.

HEPARIN INJECTION PROCEDURE

1. Use 25-gauge needle on TB syringe.
2. Rotate injection sites--usually given across abdomen, but not within 2 inches of umbilicus.
3. Sponge area with alcohol sponge--do not rub.
4. Gently accumulate a roll of tissue without pinching.
5. Insert needle directly into skin at right angle into sub Q fatty layer.
6. **DO NOT ASPIRATE.**
7. Inject solution.
8. Withdraw needle at angle inserted after waiting a few seconds. Press with alcohol sponge but **DOES NOT RUB** injection site.

PROCEDURE FOR INSULIN INJECTION

- 1) Use insulin syringe appropriate to the units of insulin to be given (25 gauge 1/2"). 40, 80, 100 must be same as on vial.
- 2) After selecting appropriate insulin or other, check for expiration date and the date opened. It can be stored for 1 month at room temperature.
- 3) Roll vial between palms to mix and not shake (for insulin suspensions).
- 4) If using two types of insulin NPH and regular: a.) Inject required amount of air into NPH vial; b.) Inject required amount of air into Regular insulin vial and withdraw Regular insulin dose; c.) Withdraw NPH insulin dose. NOTE: This prevents contamination of Regular insulin with NPH insulin.
- 5) Prepare skin for sub Q injection (remember to rotate sites) (site free of hardness, site patient doesn't use, each site is used once in 14 days, and allow 1-1 square Inch q site.)
- 6) The skin may be stretched or "pinched up".
- 7) Needle injected into subcutaneous tissue at 90 angle, depending on amount of subcutaneous tissue.
- 8) **DO NOT NEED TO ASPIRATE.** Inject slowly.
- 9) Remove needle, simultaneously applying pressure.

SKILLS EVALUATION - PARENTERAL MEDICATIONS

NAME _____

DATE _____

_____ WELL DONE

_____ PASS

_____ REPEAT

OVERRIDING CONCERN

PREPARATION

AFTER CARE

ASEPSIS

* ___ * ___ * ___ Wash hands
 * ___ * ___ * ___ Wear exam gloves

* ___ * ___ * ___ Wash hands
 ___ ___ ___ Care for equip.

PHYSICAL SAFETY

* ___ * ___ * ___ Identify pt.
 * ___ * ___ * ___ Correct position

* ___ * ___ * ___ Bed low
 * ___ * ___ * ___ Side rails adj.
 * ___ * ___ * ___ Call bell avail.

EMOTIONAL SAFETY

___ ___ ___ Greet, explain
 * ___ * ___ * ___ Provide privacy
 ___ ___ ___ Collect equip.

___ ___ ___ Neat, comfortable
 ___ ___ ___ Open curtain
 * ___ * ___ * ___ Chart Initials, site

CRITICAL ELEMENTS

PARENTERAL MEDICATIONS

Z-TRACK

___ ___ ___ Check Dr.'s order
 * ___ * ___ * ___ Check medication X 3
 ___ ___ ___ Chart initials
 * ___ * ___ * ___ Calculation correct
 * ___ * ___ * ___ Clean top of ampule/vial
 * ___ * ___ * ___ Draw up correct amt of med.
 * ___ * ___ * ___ Find correct site
 * ___ * ___ * ___ Cleanse skin
 * ___ * ___ * ___ Correct angle - 90 Degrees
 * ___ * ___ * ___ Aspirate - IM only
 ___ ___ ___ Inject slowly
 ___ ___ ___ Rub site

___ ___ ___ Check Dr.'s order
 * ___ * ___ * ___ Check medication X 3
 ___ ___ ___ Chart initials
 * ___ * ___ * ___ Correct needle & syringe
 * ___ * ___ * ___ Calculation correct
 * ___ * ___ * ___ Clean top of ampule/vial
 * ___ * ___ * ___ Draw up correct amt of med
 * ___ * ___ * ___ Draw up 0.1 ml air
 * ___ * ___ * ___ Change needle
 * ___ * ___ * ___ Find correct site
 * ___ * ___ * ___ Displace tissue
 * ___ * ___ * ___ Cleanse Skin
 * ___ * ___ * ___ Aspirate
 ___ ___ ___ Inject slowly
 * ___ * ___ * ___ Wait 10 seconds
 ___ ___ ___ Release tissue
 ___ ___ ___ Don't rub

 Student Tester I Signature

 Student Tester II Signature

 Instructor's Signature

THE ENTIRE PROCEDURE WILL BE REPEATED IF:

1. Any one of the starred (*) items is unsatisfactory.
2. Any two of the non-starred (*) items are unsatisfactory.

NASOGASTRIC TUBES

OBJECTIVES

Upon completion of this lab, the student will be able to:

NURSING

1. Discuss reasons for inserting enteral feeding tubes.
2. Compare and contrast the various types of feeding tubes, and precautions for each.
(See following page in syllabus.)
3. Demonstrate the following procedures:
 - a. Nasogastric tube insertion
 - b. Nasogastric tube removal
 - c. Nasogastric tube feeding
 - d. Nasogastric tube irrigation
4. State nursing responsibilities associated with the above procedures.
5. Discuss the complications associated with enteral feeding including etiology.
6. Explain correct methods used to verify placement of nasogastric tubes prior to administering any fluids.
7. Attach NG tube to suction machine, turn on to "Low Intermittent"

COMMON TYPES OF FEEDING TUBES INDICATIONS FOR USE AND PRECAUTIONS

Nasogastric (NG) Tube

- For short-term use
- Aspiration pneumonia is the major complication

Nasoduodenal Tube

- For short-term use
- May be less likely to cause aspiration than the NG tube because the weighted tip descends into the duodenum

Gastrostomy (GT) Tube

- For long-term use
- Percutaneous endoscopic gastrostomy (PEG) tube is common: PEG tube can be inserted at the bedside under local anesthesia and conscious sedation
- The GT can be inserted laparoscopically or surgically
- Allows client greater mobility and enables self-feeding
- Risk of skin breakdown or infection

Jejunostomy (JT) Tube

- For long-term use
- Percutaneous endoscopic jejunostomy (PEJ) tube or surgically inserted tube may be used
- Minimal risk of aspiration
- Often more comfortable for the client than other tubes

NASOGASTRIC TUBES

- 1) Alternative feeding methods
 - a. Enteral -through the gastrointestinal system
 - b. Parenteral -intravenously - TPN

- 2) Reason for insertion
 - a. Prevent nausea and vomiting
 - b. Remove stomach contents -lab analysis
 - c. Lavage stomach -poisoning, overdose
 - d. Feeding

- 3) Assessment of clients receiving tube
 - a. Food allergies
 - b. Bowel sounds
To determine intestinal activity
 - c. Abdominal distention
May indicate intolerance to previous feeding
 - d. Correct placement of tube
To prevent aspiration
 - e. Presence of regurgitation -residual
May indicate delayed gastric emptying
May need to decrease quantity or rate
 - f. Dumping syndrome
Symptoms include diarrhea and cramps
Caused from hypertonic solutions or rate too fast
 - g. Presence of diarrhea, constipation or flatulence
Lack of bulk
Dumping syndrome
Allergies
Intolerance to ingredients
 - h. Urine for sugar and acetone -hyperglycemia
 - i. Hydration status

- 4) Verification of placement
 - a. Aspirate GI contents
 - b. Measure PH of contents
 - c. Inject air and listen to stomach with stethoscope for gurgling
 - d. Ask patient to speak or hum
 - e. Observe patient for coughing or choking
 - f. X-ray (Ideal Method -surest)

- 5) Procedures
 - a. Nasogastric insertion
 - b. Nasogastric feeding -intermittent
 - c. Gastrostomy feeding Removal of nasogastric tube

INSERTION OF NASOGASTRIC TUBE

PREPARATION

1. Collect Equipment:
 - a. Gastric Tube
 - b. Water soluble lubricant
 - c. 20-60 ml syringe that will attach to tube
 - d. Towel
 - e. Emesis Basin
 - f. Tape
 - g. Plug for end of tube or suction equipment
 - h. Safety pin
 - i. Rubber band
 - j. Glass of water with straw (if patient not NPO)
 - k. Tissues
 - l. Stethoscope
 - m. Pen light
 - n. Exam gloves
 - o. Tongue blade
2. Wash hands
3. Provide privacy
4. client
5. Explain procedure
6. Place in high-Fowler's position. Remove pillow.
7. Cover chest with towel.

PROCEDURE

1. Hyperextend head to assess nostrils. Compress 1 nostril, have pt. breathe through through the other one to select the more patent one. Use penlight. Done exam gloves.
2. Using tube, measure from tip of nose to tip of earlobe to tip of Sternum + 1-2". Mark with pen or tape if no mark on tube.
3. Squeeze lubricant on package (wax paper) and spread it on end of tube.
4. Hold tube with natural curve toward patient.
5. Give client tissues to wipe eyes or nose as needed.
6. Give client glass of water and straw to use when needed (if not **NPO**).
7. Insert tube in selected nostril (head still hyperextended) along floor of nostril toward opposite ear until it reaches the (throat) oropharynx. Client can signal this to you or he may gag. You can look in the throat to see tube. Use tongue blade and pen light.
8. Have client tip head forward.
9. Pass the tube 2-4" with each swallow of water (if allowed) until it reaches premeasured mark.
10. Check for proper placement of tube in stomach with 3 methods (Best Method = X-Ray confirmation).
 - a. Draw 10 ml of air into syringe, attach syringe to tube, inject air rapidly into tube while listening with stethoscope over the stomach for rushing bubbling sound.
 - b. Aspirate some gastric contents, check pH, and then replace.
 - c. Take a bowl of water and put the end of the tube in to the water and check for bubbling and if it present remove tube immediately
11. Put plug in tube or attach to suction.

12. Tape tube to the nose.
 - a. 3" piece of tape with 2" split at one end.
 - b. Put unsplit end of bridge of nose and bring split ends under each side of the tube and wrap around tube.
 - c. Put 2" piece of tape across nose over 1st tape.
13. Attach tube to gown. Loop an elastic band around the tubing and attach the elastic band to the gown with a safety pin.
14. If on suction, attach suction tubing to the bed in same way.
15. Chart: size of tube, method(s) of verification of placement, pt. reaction, etc.

REMOVAL OF NASOGASTRIC TUBES PREPARATION

PREPARATION

Collect Equipment

- a. Towel
- b. Exam gloves
- c. Tissues
- d. Oral hygiene supplies
- e. Wash Hands
- f. Identify client
- g. provide privacy
- h. Explain procedure
- I. Place in Fowler's position

PROCEDURE

1. Turn off if suction is present
2. Carefully remove tape from nose
3. Unpin tube from gown
4. Place towel over chest.
5. Don exam gloves
6. Instill 20 ml. of air into tube to clear tube.
7. Kink tube to close off.
8. Have client take a deep breath and hold it or exhale slowly.
9. Steadily and quickly remove the tube in one motion.
10. Provide oral hygiene.
11. Measure gastric drainage and record on I & O sheet if on suction.
12. Remove gloves.

AFTER CARE

1. Care for equipment
2. Make client comfortable
3. Lower bed
4. Adjust side rails
5. Have call bell available
6. Open curtains
7. Wash hands
8. Chart
 - a. Time and removal of N.G. tube
 - b. If on suction, chart description and amount of drainage
 - c. Client's response

NASOGASTRIC TUBE INSERTION SKILLS TEST

Name _____

Date _____

√ For pass 0 For fail

- 1. Wash Hands _____
- 2. Identify patient in two ways _____
- 3. Explain procedure _____
- 4. Provide privacy _____
- 5. Position patient _____
- 6. Don exam gloves _____
- 7. Place towel over chest _____
- 8. Assess nares with penlight _____
- 9. Measure and flag tube _____
- 10. Find natural curve of tube _____
- 11. Lubricate tube _____
- 12. Insert tube gently along nasal passage with patient's head tipped back _____
- 13. Tip head forward _____
- 14. Advance tube 2-4" to pre-measured mark with each swallow
of water (if not **NPO**) _____
- 15. Check placement with at last two checks _____
- 16. Tape correctly _____
- 17. Prevent entrance of air into stomach by kinking tube when plug is out _____
- 18. Attach to suction machine, turn on to "Low Intermittent" _____
- 19. Check: bed height, bed rail, call bell _____
- 20. Wash hands _____
- 21. Chart: state what you
document (time,
procedure, location,
assessment)

Comment:

Tester Signature

SKILLS EVALUATION - NASOGASTRIC INTUBATION

NAME _____

DATE _____

_____ WELL DONE

_____ PASS

_____ REPEAT

OVERRIDING CONCERN

PREPARATION

AFTER CARE

ASEPSIS

- * ___ * ___ * ___ Wash hands
- ___ ___ ___ Towel over chest
- * ___ * ___ * ___ Wear exam gloves

- * ___ * ___ * ___ Wash hands
- ___ ___ ___ Care for equip.

PHYSICAL SAFETY

- * ___ * ___ * ___ Identify pt.
- * ___ * ___ * ___ Correct position

- * ___ * ___ * ___ Bed low
- * ___ * ___ * ___ Side rails adj.
- * ___ * ___ * ___ Call bell avail.

EMOTIONAL SAFETY

- ___ ___ ___ Greet, explain
- * ___ * ___ * ___ Provide privacy
- ___ ___ ___ Collect equip.

- ___ ___ ___ Neat, comfortable
- ___ ___ ___ Open curtain
- * ___ * ___ * ___ Chart
- Time, procedure, type of tube, patient's reaction.

CRITICAL ELEMENTS

- ___ ___ ___ Assess nares with penlight
- * ___ * ___ * ___ Measure and flag tube
- ___ ___ ___ Find natural curve of tube
- * ___ * ___ * ___ Lubricate tube
- * ___ * ___ * ___ Insert tube gently along nasal passage with pt's head tipped back
- * ___ * ___ * ___ Tip head forward
- * ___ * ___ * ___ Advance tube 2-4" to pre-measured mark with each swallow of water (if not NPO)
- * ___ * ___ * ___ Check placement with at least 2 checks
- * ___ * ___ * ___ Tape correctly
- ___ ___ ___ Plug tube or connect to suction
- ___ ___ ___ Prevent entrance of air into stomach by kinking tube when plug is out

Student Tester I Signature

Student Tester II Signature

Instructor's Signature

THE ENTIRE PROCEDURE WILL BE REPEATED IF:

1. Any one of the starred (*) items is unsatisfactory. !
2. Any two of the non-starred (*) items are unsatisfactory. !

SKILLS EVALUATION - NASOGASTRIC TUBE REMOVAL

NAME _____

DATE _____

_____ WELL DONE

_____ PASS

_____ REPEAT

OVERRIDING CONCERN

PREPARATION

AFTER CARE

ASEPSIS

* ___ * ___ * ___ Wash hands
 ___ ___ ___ Towel over chest
 * ___ * ___ * ___ Wear exam gloves

* ___ * ___ * ___ Wash hands
 ___ ___ ___ Care for equip.

PHYSICAL SAFETY

* ___ * ___ * ___ Identify pt.
 * ___ * ___ * ___ Correct position

* ___ * ___ * ___ Bed low
 * ___ * ___ * ___ Side rails adj.
 * ___ * ___ * ___ Call bell avail.

EMOTIONAL SAFETY

___ ___ ___ Greet, explain
 * ___ * ___ ___ Provide privacy
 ___ ___ ___ Collect equip.

___ ___ ___ Neat, comfortable
 ___ ___ ___ Open curtain
 * ___ * ___ * ___ Chart
 Time, procedure,
 drainage description,
 patient's reaction.

CRITICAL ELEMENTS

___ ___ ___ Turn off suction if present
 ___ ___ ___ Remove tape, unpin tube
 * ___ * ___ * ___ Clear tubing with 15cc air
 * ___ * ___ * ___ Clamp tube (preferably with mechanical clamp)
 * ___ * ___ * ___ Have patient take a deep breath and hold it or exhale slowly
 * ___ * ___ * ___ Remove tube in one steady quick motion
 ___ ___ ___ Wrap in towel and discard
 ___ ___ ___ Give oral hygiene
 ___ ___ ___ If on suction, measure drainage and record on I&O record

 Student Tester I Signature

 Student Tester II Signature

 Instructor's Signature

THE ENTIRE PROCEDURE WILL BE REPEATED IF:

1. Any one of the starred (*) items is unsatisfactory. !
2. Any two of the non-starred (*) items are unsatisfactory. !

URINARY CATHETERIZATION

Following participation in lab, the student will be able to:

NURSING

- 1) Recognize the normal and abnormal characteristics of urine.
- 2) Discuss the purposes of catheterization.
- 3) Describe specific observations when caring for a person with an indwelling catheter.
- 4) Describe and demonstrate the method for performing the following procedures:
 - a. apply an external catheter
- 5)
 - b. catheterization for residual urine
 - c. Foley catheterization
 - d. catheter removal
 - e. specimen collection
- 6) State nursing responsibilities associated with the above procedures
- 7) Describe interventions required for clients with retention catheters.
- 8) Suggest appropriate outcome criteria which can be used in evaluating the care of a person with an indwelling catheter.
- 9) Identify complications associated with catheterization.
- 10) Compare and contrast the following common alterations in urinary elimination including their causes and manifestations:
 - a. nocturia
 - b. urgency
 - c. frequency
 - d. dysuria
 - e. retention
 - f. incontinence
 - g. residual urine

SKILLS EVALUATION - INSERTION OF FOLEY CATHETER

NAME _____

DATE _____

_____ WELL DONE

_____ PASS

_____ REPEAT

OVERRIDING CONCERN

PREPARATION

AFTER CARE

ASEPSIS

* ___ * ___ * ___ Wash hands
 ___ ___ ___ Wash peri area
 * ___ * ___ * ___ Wear exam gloves

* ___ * ___ * ___ Wash hands
 ___ ___ ___ Care for equip.

PHYSICAL SAFETY

* ___ * ___ * ___ Identify pt.
 * ___ * ___ * ___ Correct position
 ___ ___ ___ Warm

* ___ * ___ * ___ Bed low
 * ___ * ___ * ___ Side rails adj.
 * ___ * ___ * ___ Call bell avail.

EMOTIONAL SAFETY

___ ___ ___ Greet, explain
 * ___ * ___ * ___ Provide privacy
 ___ ___ ___ Collect equip.

___ ___ ___ Neat, comfortable
 ___ ___ ___ Open curtain
 * ___ * ___ * ___ Chart
 Time, procedure,
 drainage description,
 patient's reaction.

CRITICAL ELEMENTS

- * ___ * ___ * ___ Use sterile technique
- * ___ * ___ * ___ Set up equipment appropriately
- * ___ * ___ * ___ Put on sterile gloves
- ___ ___ ___ Check balloon
- * ___ * ___ * ___ Expose meatus and cleanse appropriately
- ___ ___ ___ Lubricate catheter well
- * ___ * ___ * ___ Insert catheter aseptically
- ___ ___ ___ Hold catheter in place while inflating the balloon
- ___ ___ ___ Check for balloon inflation (little "tub" on catheter)
- ___ ___ ___ For uncircumcised male patient, replace foreskin
- ___ ___ ___ Remove gloves
- ___ ___ ___ Tape catheter appropriately
- ___ ___ ___ Attach drainage bag to bed frame

 Student Tester I Signature

 Student Tester II Signature

 Instructor's Signature

THE ENTIRE PROCEDURE WILL BE REPEATED IF:

1. Any one of the starred (*) items is unsatisfactory.
2. Any two of the non-starred (*) items are unsatisfactory.

DAILY CLINICAL LAB EVALUATION

Name.....Focus.....

DatePt's Initials..... Room #Dx

The following performances are evaluated on the student's ability to maintain safety, to protect clients from physical and emotional jeopardy and to make sound clinical decisions.

CLINICAL LAB PERFORMANCE WORKSHEET

Humanity		Spirit of injury	
Communication		Spirit of Injury	
Health		Prioritization/Organization	
Assessment		Documentation/Reporting	
Nursing		Preparation	
Nursing process		Environment	
Patient care /Procedures/Medications		Safe Environment	

Comments:.....

Criteria:

- S = Satisfactory: Functions safely with moderate direction and guidance
- N = Weakness noted: Has acquired skills, but needs direction or is inconsistent
- U = Unsatisfactory: Consistently needs direction/Safe

Any U or three or more N's constitutes a failure for clinical lab for that day.

Instructor:Date:

Student:..... Date:

Daily Clinical Lab Work sheet

NAME _____

DATE _____

XII.

A. Skills accomplished: Mark number of times you have done each of these skills

Bed Bath	_____	Enema	_____
Occupied Bed Change	_____	Oral Medications	_____
O2 Administration	_____	Injection	_____
Dressing Change	_____	Health Assessment	_____
Incentive Spirometer	_____	NG Placement	_____
Cough/Deep Breath	_____	NG Feeding/Meds	_____
ROM	_____	Foley Insertion	_____
TED Hose	_____		

B. Describe how you were able to integrate the focus (foci) for this week with your patient(s).

C. What CONCEPTS from 124 theory class were you able to apply to your nursing practice?

Physical Assessment

XI. PHYSICAL ASSESSMENT

Health Perception/Health Management Pattern

Mental Status: Oriented (Yes/No) Person ___ Place ___ Time ___ Situation ___
 Alert ___ Drowsy ___ Lethargic ___ Stuporous ___ Comatose ___
 Cooperative ___ Uncooperative ___ Combative ___

Memory intact: Recent ___ Remote ___

Vision: Right: WNL ___ Impaired ___ Blind ___ Glasses Yes ___ No ___ Contacts Yes ___ No ___
 Left: WNL ___ Impaired ___ Blind ___ Glasses Yes ___ No ___ Contacts Yes ___ No ___
 Pupil size: Equal ___ Unequal ___
 Pupil Response: Brisk ___ Sluggish ___ Absent ___

Hearing: Right: WNL ___ Impaired ___ Deaf ___ Hearing aids Yes ___ No ___
 Left: WNL ___ Impaired ___ Deaf ___ Hearing aids Yes ___ No ___

Nutritional/Metabolic Pattern

Nausea/Vomiting Yes ___ No ___
 Appetite: Good ___ Poor ___
 Intake of food: %Breakfast ___ %Lunch ___ Fluids _____ cc

Skin: Moist ___ Dry ___
 Pink ___ Pale ___ Jaundiced ___
 Turgor: Firm ___ Dehydrated ___ Fragile ___
 Edema: Yes ___ No ___ Pitting ___ Trace ___ +1 ___ +2 ___ +3 ___ +4 ___ Where ___
 Intact ___ Lesions, rashes, bruises ___ Describe ___

Wounds: No ___ Yes ___ Dressing dry and intact ___ Dressing Changed ___
 Condition of wound, size, drainage _____

Mucous Membranes: Moist ___ Dry ___
 Color: Pale ___ Pink ___ Lesions ___ Describe _____

Teeth: Normal ___ Abnormal ___ Describe _____
 Dentures: No ___ Upper ___ Lower ___ Partial ___
 Swallowing problems: Yes ___ No ___

Eyes: Moist ___ Dry ___
 Color of conjunctiva: Pale ___ Pink ___ Jaundiced ___

Elimination

N/G tube: No ___ Yes ___ Patent ___ Placement checked ___ Residual _____
 Character and amount of drainage _____

Abdomen: Soft ___ Hard ___
 Distended ___ Nondistended ___
 Tender ___ Nontender ___
 Bowel sounds: Present ___ Absent ___
 Date of Last BM ___ Color ___ Consistency ___ Continent ___ Incontinent ___
 Voiding: No ___ Yes ___ Foley: No ___ Yes ___ Patent: No ___ Yes ___
 Color/clarity _____ Amount of urine _____
 Bladder distention if not voiding Yes ___ No ___
 Continent ___ Incontinent ___

Activity/Exercise Pattern

Cardiovascular: Cyanosis: No ___ Yes ___ Where _____
 Heart sounds: Strong ___ Weak ___
 Regular ___ Irregular ___ Murmur ___
 Describe any abnormal sounds _____
 Pulses palpable: Radial ___ Pedal ___
 Indicate strength and difference between right and left _____

Extremities: Temperature: Cold ___ Cool ___ Warm ___ Hot ___
Color: Pink ___ Pale ___ Cyanotic ___ Mottled ___
Capillary Refill: Seconds to refill ___
Homan's sign: Positive ___ Negative ___

Respiratory: Rate ___ Depth: Shallow ___ Deep ___ Abdominal ___ Diaphragmatic ___
Breath sounds: Normal ___ Diminished ___ Equal on both sides ___
Lungs clear ___ Crackles ___ Wheezes ___
Any O2: Yes ___ No ___ Via cannula ___ Mask ___ Rate ___
Deep breathing and coughing: Yes ___ No ___ Spirometer ___
Cough: Yes ___ No ___ Sputum: Yes ___ No ___ Amount ___ Color ___

Musculoskeletal: Mobility: Ambulatory ___ Up in Chair ___ Bedrest ___
Any abnormalities in ROM, Gait, Balance _____

Sleep/Rest Pattern

Any difficulties: No ___ Yes ___ Explain _____

Cognitive/Perceptual Pattern

Pain: Overt signs Yes ___ No ___ C/O Pain No ___ Yes ___ Location _____
Intensity: Scale (1-10) _____
Pain Medication _____ Results _____
Knowledge Level: Knows current medical problem and treatment regimen Yes ___ No ___

Self-Perception/Self-Concept Pattern

Patient appears: Calm ___ Anxious ___ Irritable ___ Withdrawn ___ Restless ___
Major stressors _____
Needs: Grief/sadness ___ Frustration/anger ___ Fear/anxiety ___ Hopelessness ___ Loneliness

Role/Relationship Pattern

Language: English ___ Other _____
Speech Problems: Yes ___ No ___ Describe _____
Any dysfunctional family interactions Yes ___ No ___

Sexuality/Reproduction Pattern

Vaginal/Penile discharge, bleeding, lesions: Yes ___ No ___

Coping/Stress Tolerance Pattern

Any signs of stress: Crying, wringing of hands, clenched fists: Yes ___ No ___
Any traumatic events in past year: Yes ___ No ___
Rate your handling of stress: Good ___ Average ___ Poor ___
Family support: Yes ___ No ___

Value/Belief Pattern

Do you observe any implements of religion:
(Rosary, Bible, Religious Books) Yes ___ No ___
How can we help you maintain your spiritual strength: Prayer ___ Call Pastor/Clergy ___
?
!

NURSING III
NURS 125

COURSE DESCRIPTION

Nursing III utilizes dependent, interdependent, and a beginning knowledge in independent nursing functions within the roles of the student Nurse. Applying the nursing process, emphasis is on caring for adult and/or aging patients with acute alteration in functional health patterns, using expanded skills in physical assessment of the client in both acute care. Concentration is on acute problems in Health perception and health Management, Nutritional/metabolic, and Activity/Exercise. The concepts of wholeness, caring, critical thinking, professional excellence, and lifelong learning are integrated through the course.

COURSE OBJECTIVES

Upon completion of this course the student will be able to:

HUMANITY

1. Integrate the components of wholeness in the care of the individual with acute alteration in health patterns. This includes involving the use of the patient's family and community in meeting their needs.

HEALTH

2. Construct and implement nursing care plans integrating concepts of:
 - A. Wholeness
 - B. Pharmacology
 - C. Nutrition
 - D. Lie span
 - E. Communication
 - F. Client education
 - G. Advocacy
 - H. Pain management

NURSING

3. Apply theoretical knowledge and skills, within the format of the nursing process, in providing care for an adult or aging client with acute alteration in health related to:
 - A. Peri-operative care
 - B. Musculoskeletal system
 - C. Cardiac system
 - D. Respiratory system
 - E. Gastrointestinal system
 - F. Endocrine system
 - G. Internal homeostasis
4. Provide nursing care to the adult and aging client at the beginning of independent level within the roles of the Student Nurse.
5. Calculate basic nursing math correctly for the safe administration of medications and intravenous fluids.

ENVIRONMENT

6. Apply and explain the impact of safety and the physical environment on a patient exhibiting alterations in function related to:

- A. Peri-operative care
- B. Musculoskeletal system
- C. Cardiac system
- D. Respiratory system
- E. Gastrointestinal system
- F. Endocrine system
- G. Internal homeostasis

THEORY SYLLABUS

TABLE OF CONTENTS

COURSE DESCRIPTION

UNIT 1 -ALTERATION IN PATTERNS OF HEALTH

PRE-OPERATIVE AND INTRAOPERATIVE CARE

POST-OPERATIVE CARE

FLUID AND ELECTROLYTE IMBALANCE

MAINTAINING ACID BASE BALANCE

UNIT2- ACTIVITY-EXERCISE PATTERN

ALTERED UPPER RESPIRATORY FUNCTION

ALTERED PERIPHERAL VASCULAR FUNCTION

HYPERTENTION

IMPAIRED MOBILITY- TRAUMA

IMPAIRED MOBILITY – MUSCULOSKELITAL DISORDERS

UNIT3 -NUTRITION-METABOLIC PATTERN

ALTERED ORAL, GASTRIC AND BILIARY FUNCTIONS

ALTERED ENDOCRINE FUNCTION

ALTERED ENDOCRINE FUNCTION – DIABETES

ALTERATION IN PATTERNS OF HEALTH PRE-OPERATIVE AND INTRAOPERATIVE CARE

HUMANITY

1. Discuss the process of including families in communicating information regarding the intraoperative period.

HEALTH

2. Explain the nature of informed consent and related nursing responsibilities.
3. Develop a teaching plan for instructing patients regarding pre-admissions requirements, drugs used pre-operative, expected post-op activities such as deep breathing, leg exercises, pain relief, and expect times for post-op stay.

NURSING

4. Discuss pre-operative nursing assessment relative to the proposed surgical procedure.
5. Design a plan to prevent potential complications of surgery because of the aging process.
6. Discuss the role of the nurse in drug administration pre-op.
7. Explain the role of the scrub nurse and circulating room nurse.
8. Describe major aspect of preoperative nursing assessment carried out in the operating room.
9. Describe beginning independent nursing interventions for clients with the

nursing diagnoses of:

Anxiety r/t fear of the unknown secondary to surgery
Knowledge deficit r/t surgery

Pre-operative positioning injury, risk r/t surgery
Impaired Tissue Integrity r/t surgical incision
Altered Protection r/t surgery

ENVIRONMENT

10. Compare cultural considerations of patients during the intra-operative period.

PREOPERATIVE AND INTRAOPERATIVE DRUGS

Atropine, Scopolamine, Hydrobromind, Glycopyrrolate(Robinul)

- Action:** Cholinergic blocking agent at the PSNS leading to the nerve transmission.
- Use:** Reduces respiratory tract secretions restore cardiac rate during anesthesia, controls nausea
- Route:** IM, IV, SC, transdermal
- SE:** Flushing, dry mouth, tachycardia, urinary retention Do not give to patients who have glaucoma

Hydroxyzine (Atarax, Vistaril) and promethazine (phenergan)

- Action:** Acts as a CNS producing sedation and controlling nausea. Anticholinergic effect.
- Use:** Promotes amnesia, sedation, decreases nausea
- Route:** IM, IV
- SE:** Drowsiness, dry mouth, pain injection site, confusion, Extrapyramidal reaction.
Assess mental status, mood, and degree of nausea and frequency

Midazolam Hydrochloride (Versed), Diazepam (Valium)

- Action:** Inhibits neuro-transmission in the CNS leading to amnesia
- Use:** Promote impair memory of events, and decrease anxiety
- Route:** IV, IM
- SE:** Respiratory depression, apnea, laryngospasm, hypotension, cardiac arrest
- Special Concerns:** Cough, Patient is not to drink alcohol 24 hours before administration.
Have Narcan available for use in respiratory depression

Katamine (Ketalar), Methohexital (Brevital)

Action: Affects the nerve cell membranes in the brain to produce loss of the senses of sight, touch, taste, smell and awareness leading to unconsciousness.

Use: Short acting anesthesia

Route: IV

SE: Respiratory circulatory and anaphylaxis

Nitrous Oxide, Halthan (Fluothane), Enflurane (Ethrane), Isoflurane (Forane)

Use: General anesthetics-inhalant: produces unconsciousness and skeletal relaxation.

Route: Inhalant

SE: Affects the heart, peripheral circulation, liver, kidney and respiratory tract
nausea
and vomiting

Nursing: Monitoring status post procedure

Benzocaine (Lanocaine), Cocaine, Lidocaine (Xylocaine), Butamben (Bustesin), Dibucain(Nupecainal), Proparacaine (Alcaine), Tetracaine (Pontocaine)

Action: Renders the body part insensitive to pain by interfering with nerve transmission

Use: Surgical, dental or diagnostic procedures

Route: Topical, Infiltration, Spinal, Epidural

SE: Hypotension, cardiac arrest, allergic reaction, and anaphylaxis

Nursing: Will have numbness in the area for several hours; protect the site from injury

Dantrolene (Dantrium)

Action: Decreases the response of the muscles to stimuli causing relaxation of the striated
Muscles

Use: Prophylaxis and treatment of malignant hyperthermia

Route: IV

SE: Hepatotoxicity, diarrhea, drowsiness, muscle weakness, tachycardia

ALTERATION IN PATTERNS OF HEALTH POST-OPERATIVE CARE

Following completion of the class student will be able to do the following:

NURSING

1. Describe the nursing assessment of the patient in the recovery room and when transferred to hospital room.
2. Enumerate nursing diagnoses common to the post-operative patient:
 - Impaired Gas Exchange r/t depressed respirations.
 - Pain r/t surgical incision
 - Fluid Volume Deficit r/t NPO greater than 12 hours and surgery
 - Ineffective Airway Clearance, Risk r/t positioning post surgery
 - Knowledge Deficit r/t post surgery activities
 - Spiritual Distress r/t questioning surgical outcomes
 - Body Temperature, Imbalanced, Risk for surgery procedure
3. Explain the nursing responsibility for administering post-operative medication and other therapeutic treatments in relationship to control of pain.
4. Describe nursing interventions that help prevent post-operative complications.
5. Outline the normal diet progression following surgery.

ENVIRONMENT

6. Describe safety measures of importance in the early post-op period, including special needs of the elderly.

POST OPERATIVE DRUGS

Fentanyl Citrate, Morphine Sulphate, Meperidine Hydrochloride (Demerol), Hydromorphone HCL (Dilaudid) Tramadol (Ultram)

Action: Binds to the receptor sites in the CNS to decrease pain.

Use: Analgesic

Route: IM, IV, P.O. (Ultram p.o.only)

SE: Circulatory depression, respiratory depression or arrest, sedation, constipation, NN, addiction

Darvon-Darvocet N-100, Oxycodone Hydrochloride (percocet, percodan) Tylenol with Codeine

Action: Binds to the receptor sites in the CNS to decrease pain.

Use: Moderate to severe pain

Route: PO SE: Sedation, respiratory depression, constipation, NN

Ketoralac (Tordol) Ibuprofen (Mortin), Acetomenophen

Action: Inhibits prostaglandin synthesis thus decreasing pain.

Use: Short-term management of pain

Route: IM, PO, IV (Toradol)

SE: Drowsiness, nausea

Implications: Assess type, location, and intensity of pain prior to and 1 hour following PO and IM, and 20 min following administration.
Toradol should not be given more than five day.
Assess for bleeding on NSAIDS.
Give Motrin with food, milk or antacids.
Assess for allergy to Tylenol for darvocet and percocet.

Naxalone Hydrochloride (Narcan), Naltraxone HCL (Trexan)

Use: Narcotic antagonist for complete or partial reversal of narcotic depression associated with respiratory depression.

Route: IV

SE: Increase BP, reversal of analgesia leading to c/o pain

Nursing: Assess respiratory status and response to medication

ALTERATION IN PATTERNS OF HEALTH

Upon completion of this unit the student will be able to:

HUMANITY

1. Discuss the process of including families in the education and care of patients with fluid and electrolyte imbalances, imbalances, and surgery.
2. Determine community resources available to help meet ongoing needs of the patients and their families and/or significant others
3. Integrate the components of wholeness in the care of the individual with acute alterations in health patterns.

HEALTH

4. Develop teaching plans appropriate to fluid and electrolyte imbalances, Acid base imbalances, and the peri-operative period concerning prevention, medication, nutrition and pain for adult patient
5. Understand the pathophysiology of the alterations and how it relates to normal health processes.

NURSING

6. Adapt the nursing process as a framework for developing plan of care for patients with fluid and electrolyte imbalances, acid-base imbalances, and experiencing surgery.
7. Explain the dependent, interdependent, and independent nursing roles in treatments, medication administration, and diagnostic analysis related to patient care.
8. Relate to outcome criteria.
9. Evaluate appropriate times and ways to be a patient's advocate.

ENVIRONMENT

10. Specify the role of the nurse in promoting safety during the peri-operative phase.
11. Explain the impact of the physical environment on patients with fluid and electrolyte and imbalances.

ALTERATION IN PATTERNS OF HEALTH

FLUID AND ELECTROLYTES IMBALANCE

Following completion of the class, the student will be able to:

NURSING

1. Describe nursing assessment of a patient with fluid and electrolyte imbalance.
2. Explain the nurse's role in analyzing the following laboratory tests:

Electrolyte panel
Urine Specific Gravity

3. Discuss the role of the nurse in drug administration of potassium, sodium, calcium, magnesium, phosphorous, furosemide, Bumex, Midamor and spironolactone.
4. Describe the dependent, interdependent, and independent nursing interventions for clients with the nursing diagnoses of:

Fluid Volume Deficit
Fluid Volume Excess
Decreased Cardiac Output
Hyperthermia

5. Discuss the use of diets in control of fluid and electrolyte imbalance.
6. Develop evaluation questions for fluid and electrolyte imbalance.

Fluid and Electrolyte Drugs

Sodium Polystyrene Sulfonate(Kayexalate)

Action: Exchanges sodium ions for potassium ions in the intestine

Use: Hyperkalemia

Route: Oral, Enema

Implications: Retention enema
Monitor serum potassium level

Potassium Chloride

Use: hypokalemia (actual or potential)

Route: Oral,IV

Implications: Give food and 8-02.
IV must be diluted
Do not give IV push
Monitor IV site for necrosis or phlebitis
Must have an IV pump
Do not give with K⁺ sparing diuretic
Monitor output, if <30cc/hour notify doctor.

Teaching: Report tingling of the hands or feet, severe nausea or feeling of weakness

Calcium (Carbonate, Chloride, Gluconate)

Use: Decreased calcium intake, hyperkalemia, hypermagnesemia, cardiac arrest,hyperphosphatemia and GI upset

Route: Oral, IV and IM

Implications: IV: Monitor
IV site
Administer after Meal 1-3 Hrs.
Monitor IM site
Must have an IV pump

Teaching: Common side effects are constipation.
Do not give with tetracycline,floxin, iron, kayexalate, and Dilantin. Wait at least one hour.

Sodium Chloride

Use: Electrolyte (Replacement Solution)

Route: IV, PO

Implications: Assess fluid balance
Monitor lab values
Administer right solutions
Assess for dehydration for oral tablets

Magnesium Salts (Chloride,Citrate,Hydroxide, Oxide)

Use: Hypomagnesemia

Route:IV, IM, and PO

Implications: Monitor vitals, ECG, and neurological Status
Monitor lab values: calcium, potassium and phosphate
Deep IM
Must have an IV pump
Do not give as an antacid to patient in renal failure
Do not give within two hours of other medications
For IV: check for incompatibility of other medication causes diarrhea

Phosphorus

Use: Decreased intake

Route: PO,IV

Implications: Antacids can reduce absorption

S.E.: Diarrhea, N/V, confusion, weakness

Furosemide (Lasix), Bumetanide (Bumex) , and Torsemide (Demadex)

Action: Increase renal excretion of water and sodium at the loop of henle

Use: Diuretic

Route: PO, IV

Implications: Time: Give early if a 2nd dose is ordered
Monitor Potassium, magnesium and calcium, BUN and creatinine levels

S.E.: Urinary frequency, N/V, weakness, dehydration, hypotension, and dry mouth

Teaching: Eating foods high in potassium--raisins, cantaloupe, spinach, banana, orange, strawberry and potato
Assess hearing status.

Mannitol (Resectial,Osmitrol)

Action: Pulls fluid into the blood vessel and nephrons

Use: Promotes excretion of toxic substance: cerebral edema and peripheral edema

S.E.: Convulsion, pulmonary congestion, renal failure and CHF

Route: I.V.

Implications: Monitor Potassium and sodium levels, vital signs, urine output

Amiloride (Midamor), Spirolactone (Aldactone), Triamterene (Dyrenium)

Action: Causes sodium bicarbonate, calcium, and water to be excreted and retain Potassium

Use: Hypertention and fluid volume overload

Route: PO

S.E.: Dizziness, arrhythmias, impotence triamterence- bluish urine

Implications: Do not give with potassium supplements, and do not increase intake of potassium-rich foods.
Monitor potassium levels and blood pressure

Hydrochlorothiazides

Action: Prevents tubular resorption of sodium and chloride ions

Use: Hypertension and fluid volume overload

Route: P.O.

S. E.: Potassium imbalance, dizziness, vertigo, headache, impotence,
decreased libido potassium and calcium levels, vital signs, urine output

Implications: Monitor potassium and calcium levels, vital signs, urine output

ACTIVITY -EXERCISE PATTERN

Upon completion of this class, the student will be able to:

HUMANITY

1. Discuss the process of including families in the education and care of patients with altered respiratory and peripheral vascular functions, and impaired mobility.
2. Determine community resources available to help meet ongoing needs of the patients.
3. Integrate the components of wholeness in the care of the individual . with acute alterations in health patterns.

HEALTH

4. Develop teaching plans appropriate to altered respiratory and peripheral vascular functions and impaired mobility concerning prevention, medication, nutrition, communication and pain for patients over the life span.

NURSING

5. Adapt the nursing process as a for developing plan of care for patients with altered respiratory and peripheral vascular functions and impaired mobility.
6. Explain the dependent, and interdependent nursing roles in treatments, medication administration and diagnostic analysis related to patient care.
7. Relate evaluations to outcome criteria.
8. Evaluate appropriate times and ways to be a client's advocate.

ENVIRONMENT

9. Explain the impact of physical environment (home, transportation, etc.) on the patient who has had altered respiratory and peripheral vascular functions and impaired mobility

ACTIVITY – EXERCISE PATTERN IMPAIRED MOBILITY- TRAUMA

Following completion of the class, the student will be able to :

HEALTH

1. Describe the pathophysiology/ etiology of various types of fractures.

NURSING

2. Explain the independent nursing role in the following nursing diagnoses:
 - Impaired transfer ability
 - Activity intolerance
 - Risk for falls
 - Pain
 - Anxiety
3. Plans ways to provide psychological support for a person who is experiencing acute musculoskeletal alteration, including the use of appropriate communication.
4. Demonstrate neurovascular assessment for a patient in traction or cast.

ACTIVITY - EXERCISE PATTERN ASSESSMENT OF ALTERATION IN MUSCLE SKELETAL FUNCTION

Following completion of the class, the student will be able to:

NURSING

1. Plan questions to obtain personal, family, activity, socioeconomic, and dietary history that will assess factors that might affected impaired mobility.
2. Explain the nurse's role in abnormal diagnostic tests related to impaired mobility: X-ray,arthroscopy, arthrocentesis, and MRI.
3. Describe the nurse's role in prevention of musculoskeletal dysfunction.
4. Explain the nurse's role in caring for a patient with: sprain, dislocations, strain or amputation, low back pain, common foot problems, carpal tunnel, bone cancer, and osteomyelitis.
5. Analyze the nurse's role in administration, supervision and education of the following medications: aspirin, acetaminophen, Ibuprofen (Motrin), Naproxen, Nabumetone (Relafen), Ketorolac (Toradol), Celebrex, Meclofenamic acid (Meclomen), and Rofecoxib (Vioxx).

Seven P's of Orthopedic Assessment

1. Pain
2. Pallor
3. Paresthesia or numbness
4. Paralysis
5. Polar temperature
6. Puffiness
7. Pulselessness

ACTIVITY-EXERCISE PATTERN
Module - Physical
Assessment Impaired
Mobility

I. PURPOSE

This module will provide expanded concepts of alterations of muscle skeletal functions.

II. OBJECTIVES

Upon completion of this module, the student will be able to:

NURSING

1. Describe age-related changes in the muscle skeletal systems and differences in assessment.
2. Discuss the significant subjective and objective data related to alteration of muscle skeletal functions that should be obtained from a client.
3. Describe the appropriate techniques of inspection, palpation and ROM used in the physical assessment.
4. Differentiate normal from common abnormal finds of a physical assessment.
5. Discuss the proper data to be included in documentation.

III. PREREQUISITE KNOWLEDGE

Anatomy of the muscle skeletal system.

**ACTIVITY - EXERCISE PATTERN
ASSESSMENT OF CARDIAC FUNCTION**

Following completion of the class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology for hypertension.

NURSING

2. Plan questions to obtain personal, family, socioeconomic and dietary history that will assess factors that might affected altered cardiac function.
3. Outline steps of physical assessment of altered cardiac function.
4. Explain the nurse's role in abnormal diagnostic tests related to altered cardiac function: Serum Lipid, Prothrombin Time, Partial Thromboplastin Time, angiography, cholesterol, HDL, LDL, INR.
4. Describe the nurse's role in prevention of cardiac dysfunction
5. Analyze the nurse's role in administration, supervision and education of antihypertensive medications.

ACTIVITY - EXERCISE PATTERNS

Module – Physical Assessment Altered Cardiac Function

I. PURPOSE

This module will provide expanded concepts for assessing altered cardiac and vascular functions.

II. OBJECTIVE

At the completion of this module, the student will be able to:

NURSING

1. Locate the anatomical landmark best suited for auscultating heart sounds
2. Summarize the essential components of the cardiac health history and assessment.
3. Relate the physical and anatomical changes that occur in the older adult's cardiac and vascular functions.
4. Discuss the significant subjective and objective data related to the respiratory assessment that should be obtained from the patient.
5. Discuss the appropriate techniques and methods of inspection, palpation and auscultation used in the physical assessment.
6. Differentiate normal from abnormal findings.
7. Discuss the proper data to be included in documentation.

III. PREREQUISITE KNOWLEDGE

Anatomy and physiology of the circulatory system.

ACTIVITY – EXERCISE PATTERN

ALTERED PERIPHERAL VASCULAR FUNCTION

Completion of the class, the student will be able to:

HEALTH

1. Describe the Pathophysiology in the following:

Aneurysm

Phlebitis

Thrombosis

Raynaud's Disease

Peripheral venous disease

NURSING

2. Explain the independent nursing role in the following nursing diagnoses:

Activity Intolerance

Altered Tissue Perfusion (peripheral)

Pain

Impaired Skin Integrity

Ineffective management of treatment plan

Altered health maintenance

Spiritual Distress

3. Analyze the nurse's role in administration, supervision and education of medications.
(See the list in the next page)

4. Explain the nurse's role as an advocate to the geriatric patient facing the possibility of losing a limb as the result of the disease process.

COAGULATION MODIFYING AGENTS

ANTICOAGULANT

Heparin, Enoxaparin (lovenox)

Action: Inhibits the effect of factor Xa and thrombin preventing formation of clots.

Use: Prophylaxis and treatment of various thrombus embolic disorders.

Route: S.C. and I. V. (Heparin only)

SE: Bleeding

Nursing: Do not aspirate or rub after S.C.
Monitor PTT test
Assess for bleeding
Protamine time

Warfarin sodium (Coumadin)

Action: Inhibits the synthesis of the vitamin K dependent clotting factors

Use: Prophylaxis and treatment of various thrombus disorders

Route: P. O.

SE: Bleeding

Nursing: Monitor for bleeding
Assess PT and Drug is regulated based on these tests.
Do not eat food high in vitamin K such as green leafy vegetables.
Vitamin K or Aquamephton as antidote.

ANTIPLATELETS FORMATION

Aspirin, Ticlopidine(ticid), Clopidogrel (plavix), Dipyridamole (persantine), Pentoxifyline (trental)

Action: Effects the functions of platelets by either preventing aggregation, increasing flexibility of RBC or reducing viscosity of whole blood.

Use: Prophylaxis of various thrombus embolic disorders preventing blood clots to heart ,brain or extremities.

Route: P.O.

SE: Bleeding, ringing in the ear (aspirin), nausea or abdomen discomfort

Nursing: Notify doctor if symptoms of increase bruising or bleeding.

Thrombolytic Streptokinase

Action: Breaks down blood, clots

Use: Blood clots obstructing blood flow in heart.

Route: I. V.

Nursing: Monitoring for bleeding during and after treatment

Dextran

Use: Prevent post-op deep vein thrombosis

Route: I. V.

S.E.: Bleeding, and anaphylaxis

Atovastatin (lipitor), Clofibrate (atromid-S), Gemfibrozil (lopilid), Simvastatin (zocor), Garlic

Action: Either breaks down cholesterol or inhibits production of cholesterol in the liver

Use: Lower

cholesterol levels as wells as triglycerides

SE: Nausea, vomiting, abdominal pain, muscle ache

Nursing: Educate regarding low cholesterol diet Increase water, fiber and vegetables and fruits Notify doctor if persistent gas, bloating, bleeding, yellow of skin and muscle aching. Liver function test yearly

ACTIVITY EXERCISE PATTERN

HYPERTENSION

Following completion of the class, the student will be able to:

HEALTH

1. Describe the Pathophysiology /etiology of hypertension.

HUMANITY

2. Identify community resources for clients with hypertension.

NURSING

3. Plan questions to obtain personal, family, socioeconomic and dietary history that will assess factors that might lead to hypertension.
4. Explain the nurse's role in abnormal diagnostic tests for hypertension: Serum Lipid, cholesterol, HDL, LDL.
5. Describe the nurse's role in to prevent hypertension
6. Analyze the nurse's role in administration, supervision and education of antihypertensive medications and herbal such as Hawthorn Nursing role in the following nursing diagnoses:

Decrease cardiac out put r/t Altered stroke volume
Risk for fall r/t rapid decrease in blood pressure
Ineffective management of treatment plan
7. Explain evaluation criteria for establishing whether the patient treatment for hypertension is effective.

ACTIVITY – EXERCISE PATTERN DYSRHYTHMIA

Following completion of the class, the student will be able to:

HEALTH

1. Describe the cardiac electrophysiology

NURSING

2. Practice reading an ECG strip.
 - Sinus Rhythm
 - Sinus Bradycardia and Sinus Tachycardia
 - Sinus Arrhythmia
 - Premature Atrial Contraction
 - AV Blocks (4 total)
 - Atrial Flutter
 - Atrial Fibrillation
 - Ventricular Tachycardia
 - Ventricular Fibrillation
 - Electrical Mechanical Disassociation
 - Asystole
3. Analyze the nurse's role in administration, supervision, and education of antiarrhythmic drugs.
4. Explain the role of the nurse in the treatment of Dysrhythmia.
5. Outline education for a patient with a pacemaker or cardio-defibrillator device

Antiarrhythmic Drugs

Class IA: Quinidine, Procainamide (pronestyl)

Action: Prolongs repolarization by slowing conduction through the AV node to the bundle of His

Use: Atrial Fibrillation, PAC, PVC, Ventricular Tachycardia. .

Route: P.O. I.V

S.E: Diarrhea, asystole, heart block, ventricular arrhythmias, hypotension

Nursing: Do not crush pills. To prevent GI discomfort give with food.

Class IB : Lidocaine, Tocainide (tonocard)

Action: Decreases myocardial excitability in the ventricles

Use: PVC, ventricular tachycardia, ventricular fibrillation.

Route: P. O (tonocard), I.V (lidocaine)

SE: Change in mood, hallucination, tremor, seizures, blurred vision, sinus arrest, bradycardia, hypotension, and difficulty breathing.

Nursing: If the patient develop neurological symptom, the drugs should be stopped immediately.

Assess the IV site for infiltration frequently; patient will not feel the infiltration.

If patient has pulmonary disease do not give tonocard.

Class IC : Propafenone (rythmol)

Action: Decrease fast inward flow of sodium at the and myocardial fibers.

Use: Ventricular arrhythmias

SE: Ventricular arrhythmias, altered taste, hypotension, dizziness

Nursing: If patient misses dose, if remember within 4 hours give; otherwise wait until next dose time.

Take at the same time daily.

Precaution with driving may cause dizziness

Class II: Propranolol (nderal), Nodolol (corgard), Esmolol (Brevibloc), Sotalol (Betapace)

Action: Reduce or block SNS stimulation to the heart and the heart's conduction system

Use: Severe arrhythmias

Route: P. O, I.V

SE: arrhythmias, bradycardia, CHF pulmonary edema, fatigue, weakness, bronchospasm

Nursing: Caution in patients with asthma
Monitor BP and ECG during IV administration
Assess for orthostatic hypotension

Class III: Amidorone

Action: Prolong Repolarization by prolonging the ERP in all cardiac tissues

Use: Ventricular and supraventricular tachycardia, and ventricular fibrillation

Route: P.O.,I.V

SE: Dizziness, corneal microdeposits leading to halos and photophobia, adult respiratory distress syndrome, CHF, bradycardia, hypotension, hypothyroidism, ataxia, paresthesia

Nursing: During IV administration, assess ECG and blood pressure.

Class IV: Diltiazem (Cardizem), Verapamil (calan)

Action: Inhibits the transport of calcium into myocardial and vascular smooth muscle cells,resulting in depressing excitability contractions.

Use: Supraventricular tachycardia and atrial flutter or fibrillation.

Route: P.O., I.V.

S.E: Bradycardia, CHF, arrhythmias,peripheral edema

Nursing: Monitor BP and ECG during IV administration Monitor intake and output

Unclassified: Adenosine (Adenocard)

Action: Interrupts the re-entrant pathways in the AV node

Use: Paroxysmal supraventricular tachycardia

Route: I.V

SE: Shortness of Breath., facial flushing, hypotension

Nursing: Monitor ECG and BP

Diaoxin (lanoxin)

Action: Increases the force of myocardial contraction, prolongs refractory period of the AV node, increases cardiac output and slows the heart.

Use: Atrial flutter and fibrillation

Route: P. O. and I. V.

S.E: Fatigue, bradycardia, arrhythmias

Nursing: Monitor apical pulse; do not give if below 60 Watch for toxic effects

Epinephrine (adrenalin)

Action: Affects beta adrenergic receptors leading to vasoconstriction

Use: Management of cardiac arrest

Route: I.V.

S.E: Nervousness, restlessness, hypertension, tachycardia

Atropine

Action: Inhibits the action of acetylcholine at postganglionic sites located in smooth muscle leading to increase in heart rate.

Use: Bradycardia

Route: I.V.

S.E: tachycardia, drowsiness, blurred vision, dry mouth, urinary hesitancy

ACTIVITY-EXERCISE PATTERN

Module - Physical Assessment the Electrocardiogram (ECG)

PURPOSE

This module will provide basic concepts of appropriate skill necessary for interpreting cardiac rhythms from an E.C.G. tracing.

OBJECTIVE

Upon completion of this module, the student will be able to:

NURSING

1. Discuss the events of the conduction system of the heart in relationship to contraction.
2. Describe patient preparation for application of E.C.G. electrodes.
3. Identify 8 steps to interpreting an E.C.G. strip.

PREREQUISITE KNOWLEDGE

Know the conduction system of the heart.

**ACTIVITY-EXERCISE PATTERN
ALTERED UPPER RESPIRATORY FUNCTION**

Following of the class, the student will be able to:

HEALTH

1. Describe the Pathophysiology / etiology in the following

Rhinitis	Sleep Apnea	Cancer of the larynx
Tonsillitis	Nasal and Jaw fractures	Sleep Sinusitis
Pharyngitis	Laryngitis	Airway obstructins

HUMANITY

2. Identify community resources available for a patient with diagnosis of cancer of Larynx.

NURSING

3. Explain the independent/dependent nursing role in the following nursing diagnoses:

- Ineffective Airway Clearance
- Pain
- Ineffective Breathing Patters
- Body Image Disturbance
- Spiritual Distress
- Sleep Pattem Disturbance

4. Analyze the nurse's role in administration and education of medications listed on the following page.

5. Discuss postoperative care and prevention of complication of a patient who has had upper respiratory surgery.

6. Discuss communication to facilitate communication with the individual who has a partial or total laryngectomy.

7. Discuss discharge teaching of a patient who had surgery of the larynx.

Upper Respiratory Drugs

DECONGESTANTS

Oxymetazoline (Afrin, Allerest, Dristan), Phenylephrine (NeoSynephrine) Nasal Sprays pseudoephedrine

Action: Stimulate alpha-adrenergic receptors in the vascular smooth muscle resulting in local vasoconstriction, decrease swelling and increase drainage.

CORTICOSTEROIDS

Beclomethasone dipropionate (Beconase), budesonide fluticasone (Flonase), triamcinolone (Nasacort)

Action: Acts locally to decrease inflammation

Use: Relief nasal congestion due to colds, allergies, and sinusitis

Caution: Hypertension, diabetes, hyperthyroidism

S.E.: Headache, rebound nasal congestion, nasal burning or stinging.
Oral causes nervousness, insomnia, palpitations, and tremor.

Nursing implication and Education:

Instruct proper use of nasal spray;

Instruct individual not to share the container with other people.

Corticosteroid nasal sprays are given two weeks before allergy season starts. Decongestant sprays should not be taken more than two weeks

ANTIHISTAMINE

Astemizole (Hismanal), Diphenhydramine (Benadryl), Loratadine Fexofenadine (Allegra), Cetrizine (Zyrtec) brompheniramine chlorpheniramine (Chlor-Trimeton) cromolyn (Nasalcrom)

Action: Blocks histamine, which decreases secretion, relaxes smooth muscles, and soothes nerve endings prevention the symptoms of itching

Use: Seasonal Allergies, cold

Routine: P.O. Benadryl -I.M. & IV cromolyn -nasal, ophthalmic, and inhalation.

Caution: Glaucoma, diabetes, hypertension and lower respiratory problems

S.E.: Drowsiness, dizziness, dry mouth, fatigue, conjunctivitis, nausea, anorexia, Intranasal-nasal irritation, unpleasant taste.

Nursing Implication: Caution driving vehicles;
Increase water or use sugarless gum or candy.
Nasal crom start before allergy seasons

ANTITUSSIVE

Codein, Dextrometorphan (Benlyn D.M)

Action: Suppresses the cough reflex in the cough center of medulla

Benzonatate (Tessalon)

Action: Anesthetizes stretch receptor of the vagal nerve afferent fibers in lungs, pleura, and respiratory passages.

Route: P.O. (Syrup)

S.E.: Sedation, nasal congestion, constipation, nausea

Nursing Implication: Do not give fluids immediately after administering. It will dilute the effect.

Assess the and nature of cough and type of sputum
Avoid environment irritants –smoke
Caution when driving
Increase fluid - 1500-2000 ml/day
If cough persist more than a week notify physician

EXPECTORANTS

Guaifenesin (Robitussin or humibid)

Action: Removal of excessive mucus that has accumulated in the respiratory tract by thinning out the secretion

Route: PO

SE: nausea, vomiting, gastric upset

Nursing Implication: Do not give fluids after administer It will dilute the effect

Assess the frequency and nature of cough and type of sputum
Avoid environment irritants -smoke; Increase fluid intake -1,500-2,000 ml/ day
If cough persist than a week notify

ALTERATIONS IN PATTERNS OF HEALTH

MAINTAINING ACID-BASE BALANCE

Following completion of the class, the student will be able to:

HEALTH

1. Discuss the pathophysiology and etiology of the following:

Respiratory Acidosis
Respiratory Alkalosis
Metabolic Acidosis
Metabolic Alkalosis
Compensation
Combined problems

NURSING

2. Discuss assessment criteria for acid-base imbalance.

3. Analyze and correctly interpret an arterial blood gas report.

4. Write nursing diagnoses for an individual experiencing disturbances in acid-base balance:

Impaired Gas Exchange r/t decrease oxygen exchange

Fluid Volume Deficit r /t decrease fluid available

5. Discussion nursing interventions appropriate to acid-base imbalance and disease process exhibited.

ENVIRONMENT

6. Discuss safety measures for patients exhibiting signs of acid-base imbalance.

D-BASE IMBALANCES

I. Respiratory Acidosis - retention of CO₂

- A. Causes: Anything that interferes with CO₂ elimination
 - 1. Pneumonia
 - 2. Emphysema
 - 3. Asthma
 - 4. Bronchiectasis
 - 5. CHF leads to pulmonary edema
 - 6. Respiratory center depression (Hypoventilation)
 - a. narcotics
 - b. increase O₂ to COPD patient
 - 7. Airway obstruction — mucus, edema, tumors, foreign body
 - 8. Respiratory arrest
 - 9. Chest trauma
- B. Signs and symptoms
 - 1. Dyspnea/Cyanosis
 - 2. Increased pulse (chemo receptors increase H.R. due to CO₂ stimulation)
 - 3. Disorientation/anxiety
- C. Compensation
 - 1. Kidneys retain HCO₃⁻, excrete H⁺
- D. Treatment
 - 1. Treat cause
 - a. Ventilate
 - b. Antibiotics for infection, bronchodilator
 - c. Suction

II. Respiratory Alkalosis - blowing off CO₂

- A. Causes
 - 1. Anxiety, hysteria
 - 2. Fever/pain
 - 3. CNS stimulation
 - 4. Mechanical ventilation from increased tidal volume and/or rates
 - 5. Hypoxia > breathing deeper and faster to increase O₂ > decrease CO₂

A

C

I

B. Signs and Symptoms

1. Increased neuromuscular irritability, i.e., twitching
2. Inability to concentrate, irritable
3. Dizzy/lightheaded
4. Paresthesia - "pins and needles"

C. Compensation

1. Kidneys retain H^+ , excrete HCO_3^-

D. Treatment

1. Re-breathe CO_2 - brown bag
2. Sedate if anxiety
3. "Talk" them down
4. If on ventilator, change the following:
 - a. Increase dead space - Re-breathe their CO_2
 - b. Decrease rate
 - c. Decrease tidal volume

C

CHECK ABG FREQUENTLY WHEN MAKING THESE CHANGES!

Metabolic A

acidosis - too much acid or too little bases

A. Causes

1. Diabetic ketoacidosis
2. Prolonged vomiting - causes body proteins & fats to be metabolized for energy, also in starvation
3. Renal failure — acids not excreted
4. Lactic acidosis - in low cardiac output states and in cardiac arrest
5. Diarrhea (bases lost)
6. ASA poisoning
7. Hyperkalemia

B. Signs and Symptoms

1. Headache
2. Apathy
3. Disorientation/confusion
4. Stuporous
5. Deep, rapid breathing - as lungs try to compensate
6. Cardiac arrhythmia

C. Compensation

1. Lungs blow off CO₂
2. Kidneys save HCO₃⁻ — and excrete H⁺ (if renal insufficiency is not the cause of the acidosis)

D. Treatment

1. IV Na Bicarbonate
2. Get rid of excess K⁺ - restrict intake, Kay Exalate
3. If diarrhea, vomiting - replace fluids with normal saline or ringers lactate
4. Insulin for diabetes, improve heart function, dialysis for renal problems

IV. Metabolic Alkalosis " too much bases or too little acid

A. Causes

1. Vomiting/NG suction - acids are removed
2. Excess antacid intake
 3. Diuretics — cause loss of K⁺
 4. Hypokalemia

B. Signs and Symptoms

1. Irritable, nervous, disoriented
2. Seizures
3. Tetany
4. Shallow breathing - as lungs try to compensate
5. Arrhythmias
6. Carpopedal spasms

C. Compensation

1. Lungs retain CO₂ - shallow, slow respirations
2. Kidneys keep H⁺ and excrete HCO⁻ (if kidneys are healthy)

D. Treatment

1. Eliminate cause
 - a. Replace fluids and electrolytes lost in vomiting/NG suction
 - b. Withhold antacids
 - c. Give KCl to deal with decreased K⁺

pH VALUES OF BODY FLUIDS

GASTRIC JUICES	1.0-5.0	ACID
URINE	5.5-6.5	
WATER	7.00	NEUTRAL
BLOOD	7.35-7.45	
BILE	7.5	
PANCREATIC JUICE	8.4-8.9	BASE

Examples of Combinations of Mixed Acid-Base Disorders

Type	Cause	Reasons
Metabolic/ Respiratory Acidosis	Cardiopulmonary arrest	<ul style="list-style-type: none"> > Hypoxemia produces lactic acidosis with decrease in HCC>3 > Respiratory arrest causes CO₂ retention
Metabolic acidosis & respiratory alkalosis	Salicylate intoxication	<ul style="list-style-type: none"> > Salicylate alters peripheral metabolism and causes overproduction of organic acids with resultant decrease of HCO₃ > Vomiting causes loss of H⁺ and Cl and, thus, increase in HCO_a
	Vomiting during pregnancy	<ul style="list-style-type: none"> > Vomiting causes loss of H⁺ and Cl and, thus, increase in HCO_a > Progesterone increase during pregnancy stimulates respirations and causes decrease in CO₂;
Metabolic acidosis & metabolic alkalosis	Renal failure with vomiting	<ul style="list-style-type: none"> > Renal failure causes retention of acid metabolites with decrease in HCO₃ ➤ Vomiting causes loss of H⁺ and Cl and, thus,
Metabolic alkalosis & respiratory acidosis	Vomiting with COPD	<ul style="list-style-type: none"> > Vomiting causes loss of H⁺ and Cl and,thus increase in HCO_a ➤ Chronic obstructive pulmonary disease is associated ➤ with sustained elevation of CO₂;

Arterial Blood Gas Interpretation

"Cheat Sheet"

Review:

Acid: able to donate a Hydrogen ion (H⁺)

Base: able to accept a Hydrogen ion (H⁺)

Potassium is also a positive ion. It will add to the acidity of the blood.

Hydrogen ions interact with other molecules and proteins (with a negative charge) in the body i.e hemoglobin

Blood pH is very important for body regulation and also for the absorption and efficacy of medications

pH values approximately greater than 7.8 or lesser than 6.9 are incompatible with life. Organ failure and structural integrity is compromised. cardiac cells

Sources of acids in the body: Main source of acids in the body is cellular metabolism-the waste products from "foodstuff." Glucose and fatty acids oxidized during aerobic metabolism produce end products of CO₂ which is the greatest source of ions.

CO ₂	CO ₂ +H ₂ O	H ₂ CO ₂	H ⁺ + HCO ₃
Gas	Dissolved	Carbonic acid	bicarbonate ion

----->

Cellular metabolism

<-----

Pulmonary cleaning

Most acids from cellular metabolism are removed from the body through the pulmonary capillaries and diffusing CO₂ through the alveolar-capillary barrier and then into the alveoli, which is "blown away" through alveolar ventilation.

Smaller amounts of acids are cleared through the kidneys through NH₃. (excreting H⁺ into the urine) The urine changes according to the body's needs. Kidneys can also retain bicarbonate (buffer) which can compensate for acidosis.

Arterial Blood Gas Values

pH	7.35 to 7.45
PCO ₂	35 to 45 80
pO ₂	80 mmHg and greater but normal value steadily decreases with age (i.e. decreases 1mmHg for every year over 60 years old)

HCO ₃	22 to 26 mEq/L
BE	-2 to + 2

pH 7.30	PCO ₂ 55	pO ₂ 64	HCO ₃ 26	Respiratory Acidosis
pH 7.32	PCO ₂ 40	pO ₂ 75	HCO ₃ 18	Metabolic Acidosis
pH 7.50	PCO ₂ 28	pO ₂ 52	HCO ₃ 22	Respiratory Alkalosis
pH 7.52	PCO ₂ 35	pO ₂ 87	HCO ₃ 30	Metabolic Alkalosis
pH 7.30	PCO ₂ 58	pO ₂ 54	HCO ₃ 16	Combined Respiratory & Metabolic acidosis

Step 1: Look at the pH and determine acidotic or alkalotic

pH is < 7.35 = acidotic

pH between 7.35 and 7.4 = normal acidic

pH between 7.4 and 7.45 = normal alkalotic

pH 7.45 = alkalotic

Step 2: Decide if the PCO₂ is alkalotic or acidotic

PCO₂ < 35 mmHg = low = alkalotic

PCO₂ > 45 mmHg = high = acidotic

Step 3: Decide if the HCO₃ is acidotic or alkalotic

HCO₃ < 22 = low = acidotic

HCO₃ > 26 = high = alkalotic

Step 4: Decide if the PCO₂ or the HCO₃ corresponds to the pH.

Step 5: Decide if there is compensation going on, if the PCO₂ or the HCO₃ is abnormal (or starting) in the opposite direction of the pH.

Step 6: Look at oxygenation, is it high, normal (expected) or low. Is it appropriate for the amount of oxygen the patient is receiving?

Key points

1. PCO_2 refers to RESPIRATORY Respiratory (or pCO_2) responds quickly

Increase respiratory rate, more CO_2 is blown off, CO_2 decreases thus:

ALKALOTIC

Decrease respiratory rate, less CO_2 is blown off, CO_2 increases thus:

ACIDOTIC

2. HCO_3 refers to METABOLIC Metabolic (kidneys) responds in 18 -36 hours

Kidneys reabsorb HCO_3 which increases HCO_3 , thus

ALKALOTIC

Kidneys secrete HCO_3 which decreases HCO_3 , thus

ACIDOTIC

ABG Practice Examples

Example 1

Example 2

Example 3

Example 4

Example 5

pH	7.32	7.50	7.46	7.25	7.35
PaCO ₂	55	45	32	35	48
HCO ₃	22	30	26	15	28
BE	-1	+5	-2	-4	+3
PaO ₂	55	90	98	92	75
SpO ₂	88%	96%	99%	96%	90%

NUTRITION – METABOLIC PATTERN

Upon completion of this class the student will be able to:

HUMANITY

1. Discuss the process of including families in the education and care of patients with alteration in nutrition.
2. Determine community resources available to help meet ongoing needs of the patients.
3. Integrate the components of wholeness in the care of the individual with acute alterations in health patterns

HEALTH

4. Develop teaching plans appropriate to altered endocrine and gastric functions concerning prevention, medication, nutrition, and pain for patients over the life span.

NURSING

5. Adapt the nursing process as a framework for developing a plan of care for patients with alterations in nutrition
6. Explain the dependent, and interdependent nursing roles in treatments, medication administration and diagnostic analysis related to patient care.
7. Relate evaluations to outcome criteria.
8. Evaluate appropriate times and ways to be a client's advocate.

ENVIRONMENT

9. Explain the impact of the physical environment (home, transportation, etc.) on the patient who has had alterations in nutrition.

ALTERED ENDOCRINE FUNCTION

Following completion of the class, the student will be able to:

HEALTH

1. Describe the in the following endocrine impairments:
 - Hypothyroidism
 - Hyperthyroidism
 - Cancer
 - Hypoparathyroidism

NURSING

2. Compare the nursing role related to diagnostics tests such as thyroid function test, parathyroid function test, thyroid scan, and biopsy
3. Describe the assessment process of alteration in endocrine function.
4. Analyze the nurse's role in administration, supervision, and education of patients using the following medications: thyroid, (Thyrolar), liothyronine (Cytomel) Levothyroxine, methimazole.
5. Explain the independent nursing role for patients with the nursing diagnoses of:
 - Alteration in nutrition
 - Altered body temperature
 - Impaired Tissue Integrity

ENVIRONMENT

6. Specify the nurse's role in maintaining safety post-thyroid/parathyroid surgery.

Deep a
log of
response
to
therapy

Thyroid Drugs

Propylthiouracil (PTU) & Methimazole (Tapazole)

Action: Inhibits incorporation of iodine molecules into the amino acid thus
impeding thyroid hormone formation

Use: Palliative, decrease the surge of thyroid hormone

Route: P.O.

SE: Liver and bone toxicity -rash, decrease in the WBC and their
components, jaundice

Education: Take every 8 hours

Never discontinue medication without the doctors approval

Do not take over-the-counter medications

Avoid food high in iodine

Keep a log of their moods, sleep patterns and weight.

Advise patient to avoid eating foods high in iodine such as soy tofu
turnip seafood and iodized salt

Thyroid (Armour Thyroid), Levothyroxine (Levoxine, Synthroid)

Action: Replace thyroid hormone that is not being sufficiently produces

Use: Hypothyroidism, prevention or treatment of various types of goiters

Route: P.O.

SE: Insomnia, tremors, tachycardia, palpitation, weight loss, heat
intolerance

Education: Never discontinue medication with the physician's approval

Do not switch brands of thyroid medication

Take in the morning on an empty stomach

ake over-the-counter medications

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2. Identify community resources available for a patient with diabetes.

NURSING

3. Explain the independent nursing role in the following nursing diagnoses:
 - Altered Nutrition more than body requirements
 - Knowledge deficit
 - Altered Health maintenance
 - Altered thought Process
 - Fluid Volume Deficit
 - Spiritual Distress

NUTR ITION

- MET ABOL

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DIABE TES

4. Compare the nursing role in analyzing diagnostic tests: Fasting Blood sugar, Oral Glucose Tolerance Test, Glycosylated Hemoglobin.
5. Analyze the nurse's role in, administration and education of Insulin.
6. Distinguish the difference between DKA and HHNC regarding pathophysiology and treatment
7. Discuss the education of patient with diabetes regarding topics such as ADA diet, exercise, sick days, travel and foot care

Followin
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completi
on of the
class, the
student
will be
able to:

HEALT H

1. Describe the in the followin
g:
Diabetes

HUMA N

Y FUNCTIONS

Following completion of the class, the student will be able to:

HEALTH

1. Describe the pathophysiology in the following:

Leukoplakia	Gastritis
Hiatal Hernia	Peptic Ulcer
Diverticula	Cholecystitis
Reflux Esophagitis	Cholelithiasis
2. Explain the dependent and independent nursing role in post-operative care of the altered oral, gastric, and biliary function.
3. Explain the Dependent and independent nursing role in the following nursing diagnoses:
 - Altered Nutrition more than or less than body requirements
 - High Risk for Aspiration
 - Swallowing impaired
 - Impaired Tissue Integrity
 - Nausea
4. Analyze the nurse's role in administration and education of Medication.
5. Discuss ways to teach communication to patients with oral surgery.
6. Explain the nurse's role in diagnostic tests related to altered nutrition and gastric function: Potassium, Barium Swallow, Gastric Analysis, Gall Bladder Series, Endoscopy, cholesterol, and protein.

**NUTRI
TION –
METAB
OLIC
PATTE
RN
ALTER
ED
ORAL,
GAST
RIC
AND
BILIAR**

GI DRUGS

Glycopyrrolate

Action: Inhibits the action of acetylcholine at the postganglionic sites in smooth muscle or secretory glands leading to decrease secretion

Use: Decreases Secretion of GI Tract, Used in Peptic Ulcer Disease (PUD)

SE: Drowsiness, Tachycardia, and Dry Mouth

Route: PO, IM

Education: Change Position Slowly
Drink Water to Decrease Dry Mouth
Caution When Driving

Aluminum(Maalox), Aluminium/Magnesium (Gaviscon), Calcium Carbonate (Tums)

Action: Binds phosphate in the GI tract, Neutralizes gastric acid and inactivates pepsin

Use: Neutralizes Acids

SE: Constipation to diarrhea

Route: PO

Education: Capable of causing several drug interactions (e.g. antibiotic, iron)
Take as prescribed by doctor; patients with renal failure do not give magnesium antacids

Cimetadine (Tagamet) Nizatidine (Axid) Ranitidine(Zantac), Famotidine (Pepcid)

Action: Histamine blockers which decrease HCL and gastrin

Use: Gastric ulcer, reflux disorders, upper GI bleeding

SE: Rare

Route: PO, IV

Education: Take ½ before meals
Take full length of time
Do not take at the 'same time as antacids

Simethicone and activate Charcoal

Omeprazole (Prilosec), Lansoprazole (Prevacid), Pantoprazole (protonix)

Action: Binds to an Prevention HCL to Produced

Use: Reflux disease, Duodenal ulcers

Route: PO

SE: Diamhea, Vomiting, Rash, Abdominal Pain

Education: Routinely assess for pain and occult blood in stools

Administer before meals

Take full of drug

Do not crush or split pill

Take with 8 ounces of water

Misoprostol (Cytotec)

Action: Acts as a prostaglandin analogue, decreasing gastric acid secretion and increasing the production of protective mucus

Use: Prophylaxis during NSAIDS therapy

Route: PO

SE: Abdominal pain, diarrhea

Education: Give with meals and avoid antacid containing magnesium

Sucralfate

Action: Reacts with the gastric acid to form a thick paste and adheres to the ulcer

Use: Duodenal Ulcers

SE: Dizziness, Constipation

Education: Take 1 hour before meals

Increase dietary bulk and fluids

Metoclopramide (Reglan)

Action: Stimulates motility of upper GI tract. Accelerates intestinal transit and gastric emptying.

Use: Relieves Symptoms of Acute, Recurrent Nausea, Vomiting, Persistent Fullness after Meals

SE: Restlessness, drowsiness, Fatigue, Dizziness

Route: PO

Education: Report involuntary eye, facial, or limb movement, (extrapyramidal reaction)
Do not drive when using these drugs

Meclizine (Antivert), Prochlorperzine (Compaxine), Ondasterone (Zofran)

Action: Work with the brain to decrease the stimulus to vomit

Use: Prevention and treatment of nausea, and vomiting

SE: Dizziness, drowsiness, dry mouth, and urinary retention

Route: PO, IM, IV

Education: Change position slowly
Do not drive when using this drug

Dronabinol (Marionol)

Action: Not known, marijuana derivative

Use: In treatment of nausea and vomiting stemming chemotherapy drug

Route: P. O

NURSING III

CLINICAL SYLLABUS

TABLE OF CONTENTS

1. CLINICAL LABORATORY OBJECTIVES
2. FOCUS OF CLINICAL LABS
3. MAINTAINING IV FLUIDS
4. NUTRITION ASSESSMENT
5. RESPIRATORY ASSESSMENT
6. SKILLS:SUCTIONING- NASO- PHARYNGEAL ,TRACHEAL
CARDIAC ASSESSMENT
7. MUSCULOSKELETAL ASSESSMENT
8. REQUIREMENTS FOR GARE PLANS
9. MAJOR CARE PLAN WORKSHEET
10. EXAMPLES OF NURSING DIAGNOSES
11. OTHER CLINICAL EXPERIENCES - RESPIRATORY
CLINICAL EXPERIENCE
12. OPERATING ROOM EXPERIENCE

CLINICAL LABORATORY OBJECTIVES

Upon completion of this course, the student will be able to:

HUMANITY

1. Demonstrate progressive skills in communication in order to:
Communicate effectively with adult and geriatric patients and their families.
Communicate effectively with members of the health team, instructor, and peers, both orally and in writing.

HEALTH

1. Use expanded assessment to recognize patient status, wholeness needs (spiritual, intellectual, physiological, sociological and psychological), and family needs by using acute alteration in functional health patterns in gathering data.

NURSING

1. Demonstrate expanded skills in the nursing process by:
 - Assessing information from patient's records, patient, family and health team.
 - Writing nursing care plans, integrating concepts from pharmacology, nutrition, advocacy, legal and ethical issues, communication, health promotion, patient/family education, and pain management.
 - Implementing nursing care to the adult and patient at dependent, interdependent, and beginning independent level.
 - Demonstrating correct and safe patient care, skills, and medication administration.
 - Providing patient/ family education based upon assessed learning needs.
 - -Evaluating expected outcomes and modify nursing care plan.

2. Report and document assessment, observations, and nursing care accurately and in a timely manner.
3. Set priorities and organize patient care.
4. Use the spirit of inquiry to seek learning experience based on assessment of own learning needs.
5. Demonstrate professional responsibility in areas of preparation, conduct, confidentiality, punctuality, personal appearance; and follows policies, standards, and procedures of clinical agency and nursing department.
6. Relate theoretical knowledge and nursing to a given clinical situation.
7. Calculate basic nursing math correctly for safe administration of medication and intravenous fluids.

ENVIRONMENT

1. Provide a safe physical and emotional environment for patient, family and friends. . .
2. Maintain a safe working environment.

FOCUS OF CLINICAL LABS

FOCUS OF CARE

I. Health Perception and Health Management

Alteration in Fluid and Electrolytes

Peri-operative

Acid Base Imbalance

Dysrhythmia

II. Health Assessment and physical examination

Altered respiratory functions

Altered cardiac functions

III. Nutrition / Metabolic patterns

Altered nutrition

Altered endocrine function

IV. Activity – Exercise pattern

Respiratory disorders

Altered peripheral tissue perfusion

Hypertension

Dysrhythmia

Impaired mobility

Module – Operating Room techniques

I. PURPOSE

To enable the student to perform and maintain aseptic technique within the operating room and in the clinical situation

II. OBJECTIVES

Upon completion of this module, the student will be able to :

NURSING

1. Identify the duties of each member of the operating room team.
2. Identify the activities of a routine operation.
3. Describe the steps necessary before performing the role of sterile team member.
4. Discuss proper methods of draping a patient.

ENVIRONMENT

1. Differentiate between sterile and non-sterile areas in the O.R.
2. Demonstrate how to pass a sterile instrument from a non-sterile team member to a sterile team member.
3. Discuss ways of preventing contamination of self and sterile field.

III. Prerequisite skills: Aseptic Techniques

**ALTERATION IN PATTERN OF HEALTH
MAINTAINING IV FLUIDS**

Following completion of this the student will be able to :

NURSING

1. Describe the nursing assessment of a patient receiving IV fluid therapy or blood transfusion and explain how to prevent complications.
2. Demonstrate methods in administering IV therapy.
3. Calculate IV flow rates.
4. Explain nursing responsibilities when IV is not on schedule.
5. Practice documentation of IV therapy.
6. Explain the nursing responsibility in a patient where IV fluids are being withheld.

EMPHASIS ON FLUID AND ELECTROLYTE BALANCE

Module – Managing I.V. Therapy

I. PURPOSE

This module will provide basic concepts for maintaining I.V. therapy and detecting complications of I.V. administration. Please note that although the student is taught I.V. push medications, they cannot do this procedure in the hospital setting. Their responsibility is to maintain I.V. infusion and give piggybacks with supervision.

II. OBJECTIVES

NURSING

Upon completion of this module, the student will be able to:

1. Describe the steps in preparing intravenous therapy.
2. Document the initiation of intravenous therapy.
3. Compare and contrast the steps for administering I.V. medication.
4. Determine the steps to be taken when signs and symptoms of complications of I.V. administration occur.

III. PREREQUISITE SKILLS

Fluid and Electrolyte module.

Intermittent Infusion through a Saline Lock

1. Wash hands
2. Obtain the correct solution container
 - a. Verify the physicians order
 - b. Read the labels of new container
 - c. Verify that you have the correct solution, correct client, correct dose, correct time, and correct route
3. Set up the I.V. equipment
 - a. Connect infusion tubing to medication bag
 - b. Hang medication bag above level of your head
 - c. Fill the drip chamber half way
 - d. Prime tubing
 - e. Attach new needleless device
 - f. Label tubing
4. Identify the client
5. Explain the procedure to client
6. RN to assess I.V. site and inject saline
7. Alcohol end of saline port
8. Insert needleless device into saline port
9. Open clamp and adjust to the proper drip rate
10. Assess drip rate every fifteen minutes
11. Close clamp when I.V. is finished
12. Notify nurse when I.V. is finished
13. Cleanse the saline hub with alcohol
14. Inject the saline into the lock to clear the line
15. Make patient comfortable

Intermittent Infusion Through I.V. Pump

1. Wash hands
2. Obtain the correct solution container
 - a. Verify the physician's order
 - b. Read the label of the new container
 - c. Verify that you have the correct solution, correct client, correct dose, correct time, and correct route
 - d. Calculate ml. per hour for pump
 - e. Chart time on medication sheet
3. Set up the IV equipment
 - a. Connect infusion tubing to medication bag
 - b. Hang medication bag above level of main bag
 - c. Fill the drip chamber half way
 - d. Prime tubing
 - e. Attach new needleless device
 - f. Label tubing
4. Identify the client
5. Explain the procedure to client
6. Assess I.V. site
7. Alcohol I.V. site
8. Alcohol end of saline port
9. Insert needleless device into top I.V. port
10. Make patient comfortable
11. Clean work area and wash your hand
12. Assess drip rate every fifteen minutes

Student Name

MUSCULOSKELETAL ASSESSMENT

Introduce yourself
Provide privacy

A. SUBJECTIVE ASSESSMENT (Include answers to the questions)

1. Ask one question regarding diet history. (Write below)
2. Ask one question regarding family history. (Write below)
3. Ask two questions regarding socioeconomic status. (Write below)
4. Ask one question regarding past medical history. (Write below)
5. Ask two questions regarding present signs and symptoms. (Write below)

B. OBJECTIVE HISTORY

___ Explain procedure to individual.

General Appearance

INSPECTION: What is the person's general appearance? (Write below)

Posture

Ask the individual to stand up. Look for balance.
Observe the individual from the side.
What is the curvature of the spine?
Inspect the back. What is the position of the scapula?
What is the position of the iliac crest?
Palpate along the spinal
column.

the ground.

What is the curvature of the spine? _____

Gait and Balance

Ask the individual to walk 5 to 10 steps back and forth in front of you. What is the gait? _____

Ask the individual to put their feet together. Notice balance. Have the individual close their eyes. What is the balance? _____

Test results _____

Neck and Head ROM and Strength

INSPECTION: Note symmetry and muscle tone of neck and head.

ROM: Ask the individual to bend neck forward.

ANGLE

Ask the individual to bend the neck backward.

ANGLE

Ask the individual to bend ear toward shoulder.

Ask the individual to rotate the neck from side to side.

ANGLE _____

STRENGTH: Ask the client to push laterally against your hand position against the _____ left side of the face to prevent movement. Repeat the procedure on the _____ other side.

Score _____

Shoulder and Upper Extremities

INSPECTION: Note symmetry and muscle tone of shoulder and clavicle.

Ask the individual to hold hands extended.

note skin color

muscle tone

vasculature

Wrist and hand - Is there any swelling or nodules present? Yes ___ No ___

If there is, palpate wrist, finger and hand.

Palpate both radial pulses simultaneously. Are they equal? Yes ___ No ___

CARDIAC ASSESSMENT

____ Introduce yourself

____ Gather your equipment - stethoscope, sphygmomanometer, and scale.

____ Provide privacy

A. SUBJECTIVE ASSESSMENT (Include answers to the questions)

1. Ask one question regarding diet history. (Write below)

2. Ask one question regarding family history. (Write below)

3. Ask two questions regarding socioeconomic status. (Write below)

4. Ask one question regarding past medical history. (Write below)

5. Ask two questions regarding present signs and symptoms. (Write below)

B. OBJECTIVE HISTORY

__ Explain procedure to individual

Weight _____ Pulse _____ B/P Lying _____ Sitting _____

Standing _____

GENERAL APPEARANCE

INSPECTION:

__ What is the person's general appearance? (Write below)

INTEGUMENTARY SYSTEM

Ask the patient to remove their socks

1. Inspection
 - a. Nail bed: _____
Fingers: Color ____ Angle ____ Capillary filling ____
Toes: Color ____ Capillary filling ____
 - b. Mucous membranes: Color _____
 - c. Conjunctiva/mucosa: Color _____
 - d. Lips: Color _____
 - e. Ankles: Any edema present? _____
 - f. Any jugular vein distention? _____
2. Palpation
 - a. Feel the temperature of the skin by touching different areas: arms, hands, legs, and feet. Describe what you feel.
 - b. If there is any edema, what type and what grade? _____
 - c. Palpate the pulses: What is the quality?
Carotid _____
Radial _____
Popliteal _____
Dorsalis pedis _____
Posterior tibial _____

PRECORDIUM

- A. Position patient lying down. Have the room quiet.
- B. Expose area to view - Anterior Chest
 1. Inspection: Anterior Chest
 - a. Access for visible pulsations: Present: Yes No

2. Auscultation

- ___ a. Tell the individual that you are going to listen to their chest. Warm the diaphragm of the stethoscope with your hands. Ask the individual to breathe quietly.
- ___ b. Starting at the aortic area (second intercostal space just right of the sternum), listen for each cardiac cycle component. Continue with the pulmonic area, mitral area and tricuspid area. Listen for the difference of the S1, and S2 at each of the areas.

What is the rhythm?

Any abnormal sounds?

- ___ c. Have the person lie on their left side. Listen at the mitral area. Is there a difference in sound?
- ___ d. Turn the stethoscope over to the bell. Listen at the mitral area. Listen to both sides of the carotid. What do you hear?

Inform the individual of the results.

Chart your results below.

Individual that was examined _____

ACTIVITY - EXERCISE

PATTERN Module

Oro-Pharyngeal Suction

I. PURPOSE

This module will provide basic concepts of appropriate skills necessary in aspirating mucus, other secretions and/or fluid from the nose, mouth or pharynx in clients whose cough and/or reflex is limited or impaired.

II. OBJECTIVES

Upon completion of this module, the student will be able to:

NURSING

1. Outline the steps involved in airway suctioning.
2. Identify side effects that may occur as a result of respiratory suctioning.
3. Describe clinical signs of hypoxia.
4. Apply knowledge previously learned about respiratory care when suctioning patient.

III. PREREQUISITE SKILLS

1. Anatomy of the respiratory system.
2. General principles of aseptic technique.
3. Completed module on respiratory skills.

ACTIVITY - EXERCISE PATTERN

Module – Tracheal Suction

I. PURPOSE

This module will provide basic concepts of appropriate skills necessary in aspirating secretion from an artificial airway tube.

II. OBJECTIVES

Upon completion of this module the student will be able to:

NURSING

1. Outline the steps in artificial airway suctioning.
2. Identify side effects that may occur as the result of artificial airway suctioning.
3. Compare and contrast the difference between naso-oro pharyngeal suction and artificial airway suction.

III. PREREQUISITE SKILLS

1. General principles of aseptic technique.
2. Have completed naso-oro pharyngeal suction part of module.

NASA-ORO PHARYNGEAL CHECKLIST

1. Listen with stethoscope to check the need for suctioning.
- 2. Gather equipment.**
3. Explain procedure.
- 4. Prepare patient:**
 - Position client
 - Drape towel**
 - Close curtain**
 - Wash hands
 - Don goggles/mask/gown as necessary**
5. Oxygenate patient at 100%
6. Set-up sterile field:
 - Check suctioning equipment
 - Select correct suction setting, 80- 120mm Hg wall; (12-15 mm Hg portable)
 - Open package and prepare field
 - Put sterile gloves on
- 7. Clear airway:**
 - Measure catheter**
 - Flush & lubricate catheter
 - Insert catheter
 - Start suction (Intermittent)
 - Rotate and withdraw (10 sec)**
 - Clear suction catheter with sterile saline
 - Oxygenate patient
 - Assess/repeat as necessary
- 8. Dispose equipment:**
 - Remove gloves and dispose equipment**
 - Shut off suction
 - Put oxygen back to prescribed level
 - Comfort patient, bed low, call light**
 - Wash hands
- 9. Documentation**
10. Time - 15 minutes

finished:

Tester Signature _____

Pass: Fail:

Note: Bolded Items = Critical elements

Time started:

Time

TRACHEAL SUCTION CHECKLIST

1. Listen with stethoscope to check the need for suctioning.
2. Gather equipment.
3. Explain procedure.
4. Prepare patient:
 - Position client**
 - Drape towel
 - Close curtain
 - Wash hands**
5. Oxygenate patient at 100%
6. Set-up sterile field:
 - Don goggle/mask/gown as necessary
 - Check suctioning equipment**
 - Select correct suction setting, 80- 120mm Hg wall; (12-15 mm Hg portable)
 - Open package and prepare field**
 - Put sterile gloves on**
7. Clear airway:
 - Flush catheter with sterile water
 - Insert catheter, start suction**
 - Rotate and withdraw (10 sec, intermittent)**
 - Clear suction catheter with sterile saline**
 - Oxygenate patient**
 - Assess/repeat as necessary**
 - Suction mouth PRN
8. Dispose equipment:
 - Remove gloves and dispose equipment
 - Shut off suction**
 - Put oxygen back to prescribed level**
 - Comfort patient, bed low, call light
 - Wash hands**
9. Documentation
10. Time - 15 minutes

___Pass ___Fail

Time started ___ Time finished

Note: **Bolded Items** = Critical element
Must perform all critical elements to pass.
Any two non-critical items not performed is a failure.

RESPIRATORY ASSESSMENT

Introduce yourself
Gather your equipment - stethoscope and flashlight
Provide privacy

A. SUBJECTIVE ASSESSMENT (Include answers to the questions)

1. Ask one question regarding diet history. (Write below)
2. Ask one question regarding family history. (Write below)
3. Ask one question regarding socioeconomic status. (Write below)
4. Ask one question regarding past medical history. (Write below)
5. Ask two questions regarding present signs and symptoms. (Write below)

B. OBJECTIVE HISTORY

___ Explain procedure to individual

Nose and Sinuses

1. Inspection

- ___ a. Inspect nose. Is there any nasal flaring? Yes _ No ___
- ___ b. With the penlight inspect the inside of the nares.
- ___ c. Darken the room. With the penlight put against the sinuses, what do you see?

2. Palpation

- ___ a. Palpate the nose and the sinuses. What do you feel?

Lungs and Thorax

A. Position patient lying down.

B. Expose areas to view - Anterior Chest

1. Inspection - Anterior Chest

- ___ a. Assess for cyanosis. Look at the lips and nail bed. What is the color?
- ___ b. Inspect the patient breathing patterns: Rate _____
Rhythm _____

___ c. Ask the individual to inhale and exhale.
Is there equal expansion? Yes ___ No ___

___ d. Inspect the chest deformities.
Are there any present? Yes ___ No ___

2. Auscultation

___ a. Tell the individual that you are going to listen to their chest. Warm the diaphragm of the stethoscope with your hands. Ask the individual to breathe in and out through their mouth.

___ b. Starting at the apex above the clavicle, listen in each of the areas for a full respiration as you descend the chest. Describe what you hear.

C. Have the patient sit up

D. Expose the area to view - Posterior Chest

1. Inspection - Posterior Chest

___ a. Assess the skin, describe what you see.

___ b. Assess the breathing patterns. Regular? Yes ___ No ___

___ c. Ask the individual to inhale and exhale.
Is there equal expansion? Yes ___ No ___

___ d. Compare the anteroposterior diameter with the lateral diameter. What is it

3. Auscultation

___ a. Tell the individual that you are going to listen to his/her lungs. Warm the diaphragm of the stethoscope with your hands. Ask the individual to breathe in and out through their mouth.

___ b. Starting at the apex above the scapula, listen in each of the areas for a full respiration as you descend the back. Describe what you hear.

___ Inform the individual of the results

___ Chart your results below

Tester's Signature _____

Student's Signature _____

NUTRITION ASSESSMENT

Introduce yourself
Weigh individual
Measure height

What is your conclusion? _____

- Gather your equipment - stethoscope, tongue blade, flashlight, gloves
- Provide privacy

A. SUBJECTIVE ASSESSMENT (Include answers to the questions)

1. Ask two questions regarding diet history. (Write below)
2. Ask two questions regarding family history. (Write below)
3. Ask two questions regarding present signs and symptoms. (Write below)

B. OBJECTIVE HISTORY

Explain procedure to individual and ask if they have voided.

Oral

1. Inspection
 - a. Inspect lips Normal
 - b. With a tongue blade and pin light ask patient to open mouth. Look at Tongue, teeth and back of throat.

Describe _____

Abdomen

- ___ Ask the individual to lie down, put pillow under knees if more comfortable.
- ___ Provide light.
- ___ Raise the bed up.
- ___ Expose the abdomen only.

1. Inspection

- a. Standing at the side of the bed, look at the contour of the abdomen, skin and look for pulsations.
Any pulsations present? _____

2. Auscultation

- a. Tell the individual that you are going to listen to their abdomen. Warm the diaphragm of the stethoscope with your hands.
- b. Listen to the abdomen in all four quadrants.
Describe what you hear _____

- c. With the bell of the stethoscope, listen for bruits at the epigastric region and iliac artery region. Did you hear anything? _____

3. Palpation

- a. Light palpation - Warm your hands by rubbing them together. With one hand start in the upper right quadrant and palpate lightly across the abdomen. Cover all four quadrants. If the patient was having abdominal pain, how would your palpation change?

Describe _____

Results _____

___ Inform the individual

___ Chart your results below.

Individual that was examined _____

2. Auscultation

- a. Tell the individual that you are going to listen to their abdomen. Warm the diaphragm of the stethoscope with your hands. b. Listen to the abdomen in all four quadrants.

Describe what you hear _____

- c. With the bell of the stethoscope, listen for bruits at the epigastric region and iliac artery region. Did you hear anything? _____

3. Palpation

- a. Light palpation - Warm your hands by rubbing them together. With one hand start in the upper right quadrant and palpate lightly across the abdomen. Cover all four quadrants. If the patient was having abdominal pain, how would your palpation change?

Describe _____

Results _____

Inform the individual

Chart your results below

Individual that was examined _____

NURSING 1V
NURS 221

COURSE DESCRIPTION

Nursing IV emphasizes independent nursing functions, and expands the use of the nursing process within the roles of the Associate Degree nurse. Focus is on caring for patients with variations in functional health patterns associated with acute to chronic health problems. These include Elimination, and Health Management. Knowledge and skill are expanded to implement plans for adaptive health maintenance, empowering patients toward optimal wellness within the concept of wholeness.

COURSE OBJECTIVES

Upon successful completion of Nursing the student will be able to:

1. Analyze patients and their family situations, while integrating concepts of nursing, humanity, health and environment for adaptive health maintenance and empowerment of patients with alterations in patterns of health related to Activity/Exercise, Nutritional /Metabolic, Elimination, and Health Perception/Health Management. These include problems related to:
 - a. Altered cardiac function
 - b. Altered respiratory function
 - c. Altered neurological function
 - d. Burns
 - e. Altered hematological function
 - f. Cancer
 - g. Altered lower gastrointestinal function
 - h. Altered renal and urinary function
2. Construct and implement plans for adaptive health maintenance and empowerment of patients.
3. Prioritize the care of adult patients with chronic alterations in functional health patterns.
4. Function in the roles of an Associate Degree Nurse as a:
 - a. Provider of care of patients with altered level of wellness.
 - b. Manager of care by incorporating families into the nursing process plans.
 - c. Member within the profession by studying and applying appropriate nursing research.
5. Use critical thinking in the application of theory and the development of competencies to evaluate clinical situations and plan revisions in care.
6. Use the concepts of Lifespan, Pharmacology, Nutrition, Patient Advocacy, Patient Education, Communication and Pain Management as they apply to the problems listed.
7. Use enhanced assessment skills of the renal system, the blood and the nervous system in making nursing diagnoses and plans for care.

THEORY SYLLABUS

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- 14.THE PATIENT WITH ALTERED NEUROLOGICAL FUNCTION (SPINAL CORD AND PERIPHERAL NERVES)
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- 16.THE PATIENT WITH CANCER
- 17.THE PATIENT WITH BREAST DISORDERS

ELIMINATION PATTERN THE PATENT WITH ALTERED BOWEL FUNCTION

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the involved in patients with the following altered bowel function:

Noninflammratory disorders:

Irritable bowel syndrome

Herniation

Colorectal cancer

Intestinal obstruction

Polyps and hemorrhoids

Malabsorption syndrome

Inflammatory disorders:

Appendicitis.

Peritonitis

Gastroenteritis

Ulcerative colitis

Crohn's disease

Diverticulitis

Anorectal Abscess and anal fissures and fistulas

2. Develop teaching plans appropriate to adult and elderly patients with altered bowel function concerning prevention, medications, diet, diagnostic procedures, colostomy care, stress management, exercise, nasogastric tubes, and preparation for surgery.

NURSING

3. Determine possible complications of altered bowel function and plan assessments that will prepare for early detection and treatment.
4. Compare the nursing roles related to patients with intestinal problems such as surgery, drug therapy, wound care, diet therapy, stress management, colostomy care, nasogastric tubes, surgery, radiation, chemotherapy, and skin care.

5. Explain the nurse's role in the administration, supervision and education of patients using the following medications:
 - a. Antidiarrheals such as paregoric, diphenoxylate hydrochloride and atropine, bismuth subsalicylate, hyoscyamine, hyoscine, attapulgate, loperamide hydrochloride, and lactobacillus acidophilus
 - b. Bulk-forming laxatives
 - c. Emollient laxatives
 - d. Hyperosmotic laxatives
 - e. Saline laxatives
 - f. Stimulant/irritant laxatives
6. Summarize the independent nursing roles and develop treatment plans for patients with nursing diagnoses of:
 - a. Ineffective individual coping
 - b. Altered (gastrointestinal) tissue perfusion
 - c. Fluid volume deficit
 - d. Diarrhea
 - e. Constipation
7. Discuss the process of making appropriate referrals to home health care, discharge planners, social workers, and other allied health-care specialists for collaboration in care.

HUMANITY

8. Discuss the process of including families in the education and care of patients with altered bowel function.
9. Compare community resources available to patients with altered bowel function.
10. Plan to prevent social isolation and other problems that might result from body image disturbances.

ENVIRONMENT

11. Analyze cultural considerations of patients with altered bowel function.
12. Explain the impact of low income and homelessness on patients with altered bowel function.
13. Discuss the impact of physical environment (home, transportation, bathroom facilities, etc.) on patients with altered bowel function.

HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN NURSING

ASSESSMENT OF FUNCTION

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Review the anatomy and physiology of the renal urinary system.
2. Relate the anatomy and physiology of the renal urinary system to the assessments that need to be made to detect deviations normal.

NURSING

3. Plan questions for obtaining a personal, family, socioeconomic, and dietary history that will assess factors that might affect the renallurinary system.
4. Plan a focused physical assessment for renallurinary function.
5. Determine abnormal in blood urea nitrogen (BUN), serum creatinine, urinalysis, creatinine clearance, and osmolality laboratory examinations and identify their significance to patients
6. Compare the dependent/interdependent nursing roles related to other diagnostic exams, such as 24 hour urine collection, urine cultures, intravenous pyelography(IVP), nephrotomogram, CT scan of the kidneys, cystoscopy, renal arteriogram, ultrasound, cystometrogram, and renal biopsy.

ELIMINATION PATTERN

THE PATIENT WITH ALTERED URINARY AND RENAL FUNCTION

OBJECTIVES

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the involved in the following alterations of urinary function:
 - a. Cystitis
 - b. Pyelonephritis
 - c. Polycystic Kidney Disease
 - d. Acute and Chronic Glomerulonephritis
 - e. Nephrotic Syndrome
 - f. Urinary Tract Calculi
 - g. Incontinence (urinary, stress, urge, overflow and functional)
 - h. Hydronephrosis (Obstructive Uropathy)
2. Develop teaching plans appropriate to those with urinary and renal problems concerning prevention, medications, diet and fluid intake, diagnostic procedures, surgery, and hygiene.

NURSING

3. Determine possible complications of altered urinary and renal function and plan assessments that will prepare for early detection and treatment.
4. Compare the nursing roles related to adult and elderly patients with altered urinary and renal function such as laboratory analysis of renal function, renal angioplasty, tumor staging, renal biopsy, surgery, drug therapy, diagnosis, exercises, device care and urinary diversion care (ureterostomies, conduits, sigmoidostomies, and ileal reservoirs).
5. Describe the independent nursing roles, differentiate between the various nursing diagnoses and develop treatment plans for patients with nursing diagnoses of:
 - a. Altered urinary elimination
(Functional, Reflex, Stress, Urge and Total incontinence)
 - b. Urinary retention
 - c. Pain
 - d. High risk for infection
 - e. High risk for injury
 - f. High risk for fluid volume excess
 - g. High risk for activity intolerance

h. Altered nutrition: less than body requirements

6. Analyze the nurse's role in the administration, supervision and education of patients using the following medications and explain how this information would be communicated:

- a. Cholinergic agents such as bethanechol
- b. Cholinergic-blocking agents such as dicyclomine
- c. Alpha-adrenergic agonist such as phenylpropanolamine
- d. Tricyclic antidepressants such as desipramine
- e. Antibiotics such as sulfisoxazole and sulfamethoxazole
- f. Pyridium
- g. Osmotic diuretics such as mannitol
- h. Potassium-sparing diuretics such as spironolactone and triamterene
- i. Loop diuretics such as furosemide and bumetanide and
- j. Thiazide and Thiazide-like diuretics such as chlorothiazide, hydrochlorothiazide and metolazone

7. Make plans for appropriate referral to discharge planners, home health nurses and other allied health-care specialists for collaboration in care.

HUMANITY

8. Discuss the process of including families in the education and care of patients with altered urinary and renal function.

9. Compare community resources available to patients with urinary and renal problems.

10. Summarize a plan to prevent social isolation and other problems that might result from body image disturbance.

ENVIRONMENT

11. Analyze cultural considerations of patients with alterations in urinary and renal function.

12. Identify the impact of low income and homelessness on patients with altered urinary and renal problems.

13. Discuss the impact of physical environment (home, transportation, etc.) on urinary and renal function.

HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN

NURSING ASSESSMENT OF HEMATOLOGICAL FUNCTION

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Review the anatomy and physiology of the hematological system.
2. Relate the anatomy and physiology of the hematological system to the assessments that need to be made to detect deviations from normal.

NURSING

3. Plan questions for obtaining a personal, family, socioeconomic, and dietary history that will assess factors that might affect the patient with altered hematological function.
4. Plan a focused physical assessment for patients with hematological impairment.
5. Identify abnormalities in complete blood count, prothrombin time, partial thromboplastin time and bleeding time laboratory examinations and identify their significance to patients.
6. Compare the dependent/interdependent nursing roles related to other diagnostic hematological exams, such as bone marrow aspiration.

NUTRITIONAL-METABOLIC PATTERN

THE PATIENT WITH ALTERED HEMATOLOGICAL FUNCTION

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology and clinical symptoms involved in the following hematological problems:
 - a. Iron deficiency anemia and Anemia caused by blood loss
 - b. Aplastic Anemia
 - c. Pernicious anemia (vitamin B 12 deficiency)
 - d. Folic acid deficiency anemia
 - e. Hemolytic anemia
 - f. Sickle Cell Anemia
 - g. polycythemia
 - h. Thrombocytopenia
 - i. hemophilia
 - j. leukemia
 - k. Non-Hodgkin's lymphoma
 - l. Hodgkin's lymphoma
 - m. transfusion reactions
2. Develop teaching plans appropriate to adult/elderly patients with hematological impairments considering advocacy, prevention, medications, diet, diagnostic procedures, rest, exercise, transfusions and other treatments. Practice reading a CBC and what tests to look at both with normal and abnormal results.

NURSING

3. Determine possible complications in patients with impaired hematological function and plan assessments that will prepare for early detection and treatment.
4. Compare the dependent/interdependent nursing roles related to patients with altered hematological function such as diet therapy, drug therapy, blood transfusions, and bone marrow transplantation. Discuss how these will be communicated to the professional team, patient and family.
5. Explain the nurse's role in the administration, supervision and education of patients using the following medications:
 - a. ferrous salts such as ferrous fumarate

- b.folic acid
 - c.iron dextran
 - d.albumin and other blood products such as packed red blood cells
6. Summarize the independent nursing roles and develop treatment plans for patients with nursing diagnoses of:
 - a. Activity Intolerance
 - b. Altered Nutrition: Less than body requirements
 - c. High risk for infection
 - d. High risk for injury
 7. Compare medications that cause altered hematological functioning as a side effect or adverse reaction.

HUMANITY

8. Discuss the process of including families in the education and care of patients with hematological problems.
9. Identify community resources available to patients with altered hematological function.
10. Analyze how cultural considerations and religious preferences impact patients with altered hematological function.
11. Identify the impact of low income and homelessness on patients with altered hematological function.
12. Discuss the impact of physical environment (home, transportation, altitude, etc.) on patients with altered hematological function.

CONCEPTS OF HEALTH AND ILLNESS THE PATIENT IN SHOCK

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology involved in patients with the following types of shock:
 - a. Hypovolemic shock
 - b. Cardiogenic shock
 - c. Distributive shock
 - d. Obstructive shock
2. Develop teaching plans appropriate to adult and elderly patients who are at risk for shock concerning early detection, medications, treatments, fluid therapy and oxygen therapy. Know who is prone to develop shock.

NURSING

3. Summarize the stages of shock and their complications and signs. Plan assessments that are necessary to detect shock, such as postural vital signs, urine output, level of consciousness, etc.
4. Compare the dependent/interdependent nursing roles related to patients in shock such as fluid replacement, drug therapy, early detection, airway maintenance, oxygen therapy, monitoring and laboratory assessments.
5. Make appropriate plans for collaboration with respiratory therapy and other allied health-care specialists.
6. Analyze the nurse's role in the administration, supervision and education of patients using the following medications:
 - a. Dopamine hydrochloride
 - b. epinephrine
 - c. norepinephrine
 - d. dobutamine hydrochloride
 - e. sodium nitroprusside

NUTRITIONAL-METABOLIC PATTERN THE PATIENT WITH BURNS

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology (and variations with burn etiology) involved in patients with burns of various depths, including the body's compensatory responses to burns.
2. Develop teaching plans appropriate to adult and elderly patients with burns concerning prevention of infection, medications, diet, and exercise, prevention of contracture, surgery, positioning, comfort measures, pressure dressings and prosthetic devices.
3. Discuss how age might influence a patient's recovery from a burn.

NURSING

4. Review emergency management of burns. Identify possible complications of patients with burns and plan assessments that will prepare for early detection and treatment.
5. Compare the dependent/interdependent nursing roles related to patients with burns, such as skin grafts, escharotomy, fasciotomies, drug therapy, debridement, dressings, plasma exchange, monitoring lab values, and discharge
6. Analyze the nurse's role in the administration, supervision and education of patients using the following medications:
 - a. Fluid Volume replacement
 - b. Topical Drug therapy with silver sulfadiazine.
7. Explain the independent nursing roles and develop treatment plans for patients with nursing diagnoses of:
 - a. Pain
 - b. High risk for infection
 - c. Fluid volume deficit
 - d. Impaired skin integrity
 - e. Altered nutrition: less than body requirements
 - f. Impaired physical mobility
 - g. Body image disturbance
 - h. Altered tissue
8. Make plans for appropriate referrals to physical therapy, occupational therapy, and other allied health-care specialists for collaboration in care. Explain how these plans would be communicated.

HUMANITY

9. Discuss the process of including families in the education and care of patients with burns.
10. Determine community resources available to patients with burns.
11. Plan to prevent social isolation and other problems that might result from body image disturbance.

ENVIRONMENT

12. Compare cultural considerations of patients with burns.
13. Explain the impact of the physical environment (home, transportation, etc) on patients with burns.

ACTIVITY-EXERCISE PATTERN THE PATIENT WITH ALTERED CARDIAC FUNCTION

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology involved in the patient with the following altered cardiac function:
 - a. Heart Failure (CHF)
 - b. Mitral and Aortic stenosis and insufficiency
 - c. Endocarditis
 - d. Pericarditis
 - e. Rheumatic
 - f. Cardiomyopathy

2. Develop teaching plans appropriate to adult and elderly patients with altered cardiac function concerning prevention, medications, diet, diagnostic procedures, early detection, exercise, rest and monitoring fluid balance.

NURSING

3. Determine possible complications of altered cardiac function and plan assessments that will prepare for early detection and treatment. Know who is prone to develop Heart Failure.

4. Compare the dependent/interdependent nursing roles related to patients with altered cardiac function, such as laboratory analysis of renal function, arterial blood gases, ECG, MUGA scans, echocardiography, sodium and fluid restriction, central venous pressures, pulmonary artery pressures, and heart transplantation.

5. Relate the concepts of preload, afterload and cardiac contractility to the medications, diet and other treatments of patients with altered cardiac function.

6. Discuss the nurse's role in the administration, supervision and education of patients using the following medications:
 - a. furosemide
 - b. isosorbide dinitrate
 - c. nitroglycerin
 - d. digoxin
 - e. angiotensin-converting enzyme (ACE) inhibitors
 - f. long-term and prophylactic use of antibiotics

7. Describe the independent nursing roles, develop treatment plans, and discuss how these are communicated to patients with nursing diagnoses of:
- a. Decreased cardiac output
 - b. Impaired gas exchange
 - c. Activity intolerance
 - d. High risk for inability to sustain spontaneous ventilation
 - e. Fluid Volume Excess

HUMANITY

8. Discuss the process of including families in the education and care of patients with altered cardiac function.
9. Discuss ways to encourage early detection and prevention of altered cardiac function in the community
10. Determine community resources available to patients with altered cardiac function.

ENVIRONMENT

11. Analyze cultural considerations of patients with altered cardiac function.
12. Relate the impact of low income and homelessness on the treatment of patients with altered cardiac
13. Explain the impact of physical environment (home, transportation, etc.) on patients with altered cardiac function.

ACTIVITY-EXERCISE PATTERN

THE PATIENT WITH ALTERED RESPIRATORY FUNCTION

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology involved in patients with the following altered respiratory function:
 - a. Bronchitis
 - b. Pneumonia
 - c. Tuberculosis
 - d. Bronchiectasis
 - e. Lung Abscess
2. Develop teaching plans appropriate to those with altered respiratory function concerning advocacy, prevention, medications, diet, smoking cessation, diagnostic procedures, exercises, rest, oxygen therapy and other treatments.

NURSING

3. Determine possible complications of altered respiratory function and plan assessments that will prepare for early detection and treatment.
4. Compare the dependent/interdependent nursing roles related to patients with altered respiratory function such as oxygen therapy, use of inhalers, drug therapy, pulmonary function tests, arterial blood gas tests, chest xrays, breathing techniques, exercise and energy conservation.
5. Relate the nurse's role in the administration, supervision and education of patients using the following medications:
 - a. Xanthine derivatives such as theophylline
 - b. Beta-agonists such as albuterol, metaproterenol and epinephrine
 - c. Anticholinergic -Atrovent
 - d. Corticosteroids -beclomethasone, dexamethasone, flunisolide, and triamcinolone
 - e. Cromolyn and nedocromil
 - f. Antitubercular agents such as Ethambutol, Isoniazid, Phrazinamide, Rifampin and Streptomycin.
6. Describe the independent nursing roles and develop treatment plans, and discuss how these are communicated to patients with nursing diagnoses of:
 - a. Activity Intolerance (differentiate with Impaired physical mobility)
 - b. Ineffective breathing pattern
 - c. Ineffective airway clearance
 - d. Altered Gas Exchange
 - e. Self-care deficit

HUMANITY

7. Discuss the process of including families in the education and care of patients with altered respiratory function.
8. Determine community resources available to patients with respiratory problems.

ENVIRONMENT

9. Analyze cultural considerations of altered respiratory function.
10. Relate the impact of low income and homelessness on patients with altered respiratory function.
11. Explain the impact of physical environment (home, transportation, etc.) on patients with altered respiratory function

ACTIVITY-EXERCISE PATTERN

THE PATIENT WITH OBSTRUCTIVE PULMONARY DISEASES

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology involved in patients with the following Obstructive Pulmonary Diseases:
 - a. Asthma
 - b. Emphysema
 - c. Chronic Bronchitis
2. Review teaching plans appropriate to those with altered COPD concerning advocacy, prevention, medications, diet, smoking cessation, diagnostic procedures, exercises, rest, oxygen therapy and other treatments.

NURSING

3. Determine possible complications of COPD and plan assessments that will prepare for early detection and treatment.
4. Compare the dependent/interdependent nursing roles related to patients with COPD such as oxygen therapy, use of inhalers, drug therapy, pulmonary function tests, arterial blood gas tests, chest xrays, breathing techniques, exercise and energy conservation.
5. Review the nurse's role in the administration, supervision and education of patients using the following medications:
 - a. Xanthine derivatives such as theophylline
 - b. Beta-agonists such as albuterol, metaproterenol and epinephrine
 - c. Anticholinergic -Atrovent
 - d. Corticosteroids -beclomethasone, dexamethasone, flunisolide, and triamcinolone
 - e. Cromolyn and nedocromil
 - f. Antitubercular agents such as Ethambutol, Isoniazid, Phrazinamide, Rifampin and Streptomycin.

6. Describe the independent nursing roles and develop treatment plans, and discuss how these are communicated to patients with nursing diagnoses
- a. Activity Intolerance (differentiate with Impaired physical mobility)
 - b. Ineffective breathing pattern
 - c. Ineffective airway clearance
 - d. Altered gas exchange
 - e. Altered sexuality patterns
 - f. Self-care deficit

HUMANITY

7. Discuss the process of including families in the education and care of patients with COPD.
8. Determine community resources available to patients with COPD.

ENVIRONMENT

9. Analyze cultural considerations of COPD.
10. Relate the impact of low income and homelessness on patients with COPD.
11. Explain the impact of physical environment (home, transportation, etc.) on patients with COPD.

**HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN
NURSING ASSESSMENT OF THE NEUROLOGICAL FUNCTION**

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Review the anatomy and physiology of the nervous system.
2. Relate the anatomy and physiology of the nervous system to the assessments that need to be made to detect deviations from normal.

NURSING

3. Plan questions for obtaining a personal, family, and socioeconomic history that will assess factors that might affect the neurological function.
4. Plan a focused physical assessment for patients with alterations in neurological function, including level of consciousness.
5. Describe abnormalities in cranial nerve function, sensory function, motor function, and reflexes.
6. Compare the dependent/interdependent nursing roles related to other diagnostic exams, such as x-rays, angiography with and without contrast, myelography, computed tomography, lumbar puncture, encephalography, and magnetic resonance imaging

**ACTIVITY-EXERCISE PATTERN
THE PATIENT WITH ALTERED NEUROLOGICAL FUNCTION
SPINAL CORD
AND PERIPHERAL NERVOUS SYSTEM**

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology involved in patients with the following alterations in neurological function:
 - a. Trigeminal Neuralgia
 - b. Bell's Palsy
 - c. Polyneuropathy
 - d. Guillian-Barre syndrome
 - e. Spinal cord injury (also Spinal shock and Autonomic dysreflexia)
 - f. Spinal tumors
2. Develop teaching plans appropriate to adult and elderly patients with these alterations in neurological function concerning disease process, prevention of complications, adaptive devices, medications, diet, exercise, rest, heat and ice therapy, body mechanics, and other safety measures.

NURSING

3. Determine possible complications of these alterations in neurological function and plan assessments that will prepare for early detection and treatment.
4. Compare the dependent/interdependent nursing roles related to patients with these alterations in neurological function such as surgery, diagnostic procedures, drug therapy, plasmapheresis, bowel and bladder training, traction, and safety.
5. Explain the independent nursing roles and develop treatment plans for patients with nursing diagnoses of:
 - a. Altered (spinal cord) tissue perfusion
 - b. Impaired physical mobility
 - c. Self care deficit
 - d. Altered urinary elimination
 - e. Constipation
 - f. Impaired adjustment
 - g. Sensory-perceptual alterations
 - h. Body image disturbance
 - i. Powerlessness
 - j. Pain

6. Summarize the nurse's role in the administration, supervision and education of patients using the following medications:
 - a. Steroids such as prednisone
 - b. Anticholinesterases such as neostigmine, pyridostigmine, and ambenonium
 - c. Edrophonium chloride (Tensilon)
 - d. Immunosuppressants such as azathioprine and cyclophosphamide
7. Make plans for appropriate referral to physical therapy, discharge planners, home health nurses and other allied health-care specialists for collaboration in care. Explain how they will be communicated.

HUMANITY

8. Discuss the process of including families in the education and care of patients with these alterations in neurological function.
9. Compare community resources available to patients with these CNS problems.

ENVIRONMENT

10. Determine cultural considerations of patients with these alterations in neurological function.
11. Explain the impact of low income and homelessness on patients with these alterations in neurological function.
12. Discuss the impact of physical environment (home, transportation, occupation, etc.) on these patients with altered neurological function.

ACTIVITY-EXERCISE PATTERN
THE PATIENT WITH ALTERED NEUROLOGICAL FUNCTION
CHRONIC PROBLEMS

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology involved in patients with the following alterations in neurological function:
 - a. Headaches
 - b. Epilepsy
 - c. Multiple Sclerosis
 - d. Parkinson's disease
 - e. Myasthenia Gravis
2. Develop teaching plans appropriate to adult and elderly patients with alterations in neurological function concerning prevention, medications, diet, diagnostic procedures, and safety.

NURSING

3. Summarize possible complications of these altered neurological function and plan assessments that will prepare for early detection and treatment.
4. Compare the dependent/interdependent nursing roles related to patients with altered neurological function with surgery, drug therapy, diagnosis, and safety.
5. Explain the independent nursing roles and develop treatment plans for patients with nursing diagnoses of:
 - a. High risk for injury
 - b. Ineffective individual coping
 - c. Ineffective family coping
 - d. Self care deficit
 - e. Impaired physical mobility
 - f. Impaired verbal communication
 - g. Altered thought process
6. Identify the nurse's role in the administration, supervision and education of patients using the following medications:

Antiepileptics:

 - a. carbamazepine
 - b. clonazepam
 - c. phenobarbital
 - d. phenytoin
 - e. ethosuximide
 - f. valproic acid

Antiparkinsonian agents:

- a. Dopaminergics like levodopa and carbidopa
- b. amantadine
- c. bromocriptine and pergolide
- d. Anticholinergics like trihexyphenidyl and benztropine mesylate

7. Make plans for appropriate referral to physical therapy, discharge planners, home health nurses and other allied health-care specialists for collaboration in care. Explain how plans/referrals be communicated.

HUMANITY

8. Discuss the process of including families in the education and care of patients with altered neurological function.

9. Determine community resources available to patients with altered neurological function.

ENVIRONMENT

10. Compare cultural considerations of patients with altered neurological function.

11. Summarize the impact of low income and homelessness on patients with altered neurological function.

12. Discuss the impact of physical environment (home, transportation, occupation, etc.) on patients with altered neurological function.

NUTRITIONAL-METABOLIC PATTERN

THE PATIENT WITH CANCER

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology involved in patients with cancer and the effects on the rest of the body.
2. Develop teaching plans appropriate to adult and elderly patients with cancer concerning prevention, early detection, radiation, chemotherapy, medications, diagnostic procedures, diet, exercise, and other treatments.

NURSING

3. Determine possible complications of cancer and its treatment. Plan assessments that will prepare for early detection and treatment of these complications.
4. Compare the dependent/interdependent nursing roles related to cancer patients with interventions such as surgery, chemotherapy, radiation, hormonal manipulation, and immunotherapy; with complications such as sepsis, DIC, SIADH, spinal cord compression, hypercalcemia, superior vena cava syndrome, and tumor lysis syndrome; and with the side effects of treatment such as alopecia, nausea and vomiting, mucositis, bone marrow suppression.
5. Analyze the independent nursing roles related to caring for cancer patients with immunosuppression, thrombocytopenia and anemia. Develop treatment plans for patients with nursing diagnoses of:
 - Altered nutrition: less than body requirements
 - High risk for infection
 - High risk for injury
 - Body image disturbance
6. Make plans for appropriate referrals and collaboration with discharge planning, home care, hospice, and other allied health-care specialists.

HUMANITY

7. Discuss the process of including families in the education and care of patients with cancer.
8. Determine community resources available to patients with cancer.

ENVIRONMENT

9. Compare cultural considerations of cancer patients.
10. Explain the impact of physical environment (home, small children, transportation, pets, etc.) on patients with cancer.
11. Summarize some economic considerations of cancer treatment.

NUTRITIONAL-METABOLIC PATTERN THE PATIENT WITH BREAST DISORDERS

OBJECTIVES:

Upon completion of this class, the student will be able to:

HEALTH

1. Describe the pathophysiology/etiology involved in patients with Breast cancer and the effects on the rest of the body.
2. Develop teaching plans appropriate to adult and elderly patients at risk or with a diagnosis of breast cancer concerning prevention, early detection, radiation, chemotherapy, medications, diagnostic procedures, diet, exercise, and other treatments.

NURSING

3. Determine possible complications of breast cancer and its treatment. Plan assessments that will prepare for early detection and treatment of these complications.
4. Review the dependent/interdependent nursing roles related to patients with breast cancer.
5. Explain the nurse's role in the administration, supervision, and education of patients using the following medications:
 - a. Alkylating agents such as busulfan, chlorambucil, cyclophosphamide, mechlorethamine, and cisplatin
 - b. Antimetabolites such as methotrexate, cytarabine, fluorouracil and mercaptopurine
 - c. Cytotoxic antibiotics such as bleomycin, doxorubicin
 - d. Mitotic Inhibitors such as vincristine, vinblastine, etoposide, and paclitaxel
 - e. Biologic response modifiers such as interferon alfa
 - f. Colony-stimulating factors such as epoetin alfa, filgrastim, and sargramstim
 - g. Ondansetron and other antiemetic agents
6. Analyze the independent nursing roles related to caring for breast cancer patients with immunosuppression, thrombocytopenia and anemia. Develop treatment plans for patients with nursing diagnoses of:
 - a. Altered nutrition: less than body requirements
 - b. High risk for infection
 - c. High risk for injury
 - d. Body image disturbance
7. Make plans for appropriate referrals and collaboration with discharge planning, home care, hospice, and other allied health-care specialists.

HUMANITY

8. Discuss the process of including families in the education and care of patients with breast cancer.
9. Determine community resources available to patients with breast cancer.

ENVIRONMENT

10. Compare cultural considerations of breast cancer patients.
11. Explain the impact of physical environment (home, small children, transportation, pets, etc.) on patients with breast cancer.
12. Summarize some economic considerations of breast cancer treatment.

NURSING IV
NURS 221

CLINICAL SYLLABUS

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6.CLINICAL EXPERIENCE -PATIENT EDUCATION

7.BASIC IV THERAPY

Potential Complications for Common Medical Diagnoses

Angina/myocardial infarction

- Dysrhythmias
- Congestive heart failure/pulmonary edema
- Shock (cardiogenic, hypovolemic)
- Infarction, infarction extension formation pulmonary emboli, CVA, peripheral)
- Hypoxemia
- Electrolyte imbalance (be specific)
- Acid-base imbalance
- Pericarditis
- Cardiac tamponade
- Cardiac arrest

Renal Failure

- Fluid overload
- Hyperkalemia
- Electrolyte/acid-base imbalance
- Anemia

Asthma/COPD

- Hypoxemia
- Acid-base/electrolyte imbalance (be specific)
- Respiratory failure
- Cardiac failure
- Infection

Diabetes

- Hypoglycemia
- Delayed wound healing
- Retinal hemorrhage
- MI

Fractures

- Hemorrhage
- Fracture displacement
- Thrombus/embolus formation
- Compartment syndrome
- Infection
- Nerve compression

Head trauma

Increased intracranial pressure
Respiratory depression Shock
Shock
Hyper/hypothermia
Coma

Hypertension

CVA
Renal failure
Hypertensive crisis
MI

Pneumonia

Respiratory failure
Sepsis/septic shock

Surgery or other invasive procedures

Hemorrhage/hypovolemia/shock
Respiratory depression/atelectasis
Urinary retention
Fluid/electrolyte imbalances
Thrombus/embolus formation
Paralytic ileus
Infection
Wound dehiscence/evisceration
Sepsis/septic shock
Peritonitis

Cardiac catheterization

Hemorrhage/shock
Thrombus/embolus formation
Dysrhythmias

Chest tubes

Hemo/pneumothorax
Hemorrhage/shock
Atelectasis
Chest tube malfunction/blockage
Infection/ Sepsis

Foley catheter

Infection/sepsis
Catheter malfunction/blockage

Intravenous therapy

- Phlebitis/thrombophlebitis
- Infiltration/extravasation
- Fluid overload/pulmonary edema
- Infection/sepsis
- Hemorrhage or bleeding
- Air embolism

Medications

- Allergic response
- Exaggerated effects
- Side effects
- Drug interactions
- Overdose/toxicity

Nasogastric suction

- Electrolyte imbalance (be specific)
- Tube malfunction/blockage
- Aspiration

NURSING CARE PLAN

Student Name

Date

Pt. Initials	Age Gender	Code status	Physician	Admission Date
Primary and secondary Diagnosis and any current surgery or invasive procedure				
Chronic Health problems and past unrelated problems or surgeries				
Significant History related to admission(include surgery and procedures)				
Diet	I&O	Treatments and procedures		
Saline lock or continuous IV solution		IV Rates	Gtts/min	
Pathophysiology of Diagnosis				
Potential critical complications with signs and symptoms				
Nursing Diagnosis 01			Nursing Diagnosis 02	
Patient education				

Clinical Experience: Intensive Care Unit

Overall Objective:

To expose the student to critical care nursing. Under the direct supervision of an ICU RN, the student will participate in the care of one patient, while observing and exploring the role of the nurse in this setting.

Outcome Objectives:

1. Describe the role of the nurse in the intensive care unit.
2. Identify key assessments made by the nurse in critical care during the shift.
3. Identify critical factors related to the assessment, diagnosis and treatment of critical care clients with one or more of the following problems
 - a. Cardiac (Congestive Heart Failure)
 - b. Respiratory (Pneumonia, ventilators, etc.)
 - c. Hematological (Anemia, DIC, etc.)
 - d. Shock
 - e. Burns
 - f. Urinary/Renal (Kidney stones)
4. Identify actions and potential side effects of pharmacologic agents and treatments commonly used in intensive care situations
5. Discuss ethical and legal implications of critical care with RN staff, including issues related to right to life, right to die, code status, organ donation, reportable and reportable diseases.
6. Identify appropriate communication skills and key psycho/social and spiritual interventions used by critical care nurses with the client and significant others in the critical care setting.
7. Review cultural and ethical variations and their possible impact on clients and families in critical care.
8. Compare and contrast critical care of persons of various age groups.
9. Participate in documentation of nursing care using the forms used in the intensive care unit.

Clinical Experience -Out-Patient Surgery

Overall Objectives

To expose students to pre-operative and postoperative care in a one-day clinical experience. The student will also observe the role of the operating room nurse and participate in the admission, preparation and recovery of surgical clients.

Outcome objectives

1. Describe the role of the nurse in the admission unit, operating room and recovery room.
2. Identify key assessments made by the nurses in these Para surgical areas during the day.
3. Identify common nursing diagnoses and treatment of surgical clients.
4. Describe surgical procedure observed with related pathophysiology.
5. Observe and contrast the roles of the circulating nurse and the scrub nurse in the operating room.
6. Identify actions and potential side effects of pharmacologic agents and anesthesia used in the surgical situation.
7. Discuss ethical and legal implications of surgery, consents and permits.
8. Identify concerns of families and significant others during the surgical process.
9. Identify cultural differences that could affect the surgical experience.

Out-Patient Surgery Experience Record

Name _____

Date _____

Diagnosis of patient _____

Scheduled surgery of patient

Preoperative teaching (Be sure to include education about pain, deep breathing, assessment)

Subject	Specific Instructions

1. What are the advantages of doing postoperative teaching before surgery?
2. What risk factor does the patient have that would affect prognosis in surgery?
3. How does age affect the risk in surgery?
4. Describe the operative procedure:

5. Describe the Para surgical Assessments made and their purpose.

	Assessments needed	Purpose of assessments	Changes in assessments with surgery
Preoperative			
Intraoperative			
Postoperative			

6. Anesthetic agents used (action and side effects):

7. Describe an ethical or legal issue of surgery:

8. What were the concerns of the client about having surgery? Why? Did the family have concerns?

9. How could culture affect the surgical experience?

10. Evaluation of the clinical experience

Clinical Experience: Oncology Nursing

Overall Objective:

To allow a student to observe and participate in Oncology Nursing

Outcome Objectives:

1. Describe the role of the nurse in an oncology office.
2. Identify the key assessments made by the nurse of the patients receiving chemotherapy.
3. Compare the types of chemotherapy given with the side effects anticipated for the patient.
4. Discuss the relationship of the patient's insurance to the treatment of cancer.
5. Discuss the role of the nurse to families of the patients in this office.
6. Consider the role of hospice in the care of cancer patients and when it should be initiated and chemotherapy discontinued.

Oncology Experience Record

Name _____

Date _____

1. What responsibilities does the nurse have in the oncology clinic?
2. What teaching is necessary for patients receiving chemotherapy?
3. What medications did you give and what are the actions and side effects of these medications?
4. What issues of treatment are related to the patient's type of insurance
5. What considerations are necessary in deciding when to discontinue chemotherapy?
6. What is the role of hospice in the treatment of cancer patients?
7. Evaluation of the clinical experience:

Clinical Experience -Patient Education

Objectives

1. Describe the role of the nurse in patient education.
2. Describe the resources available for patient education.
3. Discuss plans for empowerment of patients.
4. Observe the format used in teaching patients with alterations in patterns of health.
5. Describe ways to involve families in the process of teaching.
6. Describe the impact of the home environment on health education
7. Discuss how the educational and socioeconomic background of the patients affected the health education.
8. Discuss methods that could be used to overcome the barriers that might be present because of cultural differences.

Basic IV Therapy

GOAL

To review the basic physiologic principles of fluid and electrolyte balance.

OBJECTIVES

1. Define the two fluid compartments in the body.
2. Identify the major intracellular cation.
3. Identify the major intracellular anion.
4. Identify the major extracellular cation.
5. Identify the major extracellular anion.
6. Define the four Routes of Transport between cellular and intracellular compartments.
7. Define isotonic, hypertonic, and hypotonic.
8. Analyze the systemic effects of administration of isotonic, hypotonic, and hypertonic solutions into the intravascular space.
9. Describe the function of protein in the intravascular space.
10. Discuss the signs and symptoms of ECF volume deficit and excess.
11. Describe the nurse's role in assuring the safe and therapeutic administration of IV fluids.

GOAL

To review basic principles of IV therapy in order to safely administer parental solutions/medications in an ambulatory care setting.

OBJECTIVES

1. Discuss the legal responsibilities of initiating and maintaining therapy.
2. Identify the components of a physician's order for IV therapy administration.
3. Define the information necessary on the IV fluid label.
4. Identify the correct formula to calculate gtts/hr
5. Identify the correct formula to calculate cc/hr
6. Compare/contrast the purpose and function of controller and pump.
7. Outline the procedure to flush a Saline Lock.
8. Describe the procedure to care for the IV injection site.
9. Describe signs and symptoms of phlebitis.
10. Describe the signs and symptoms of infiltration.
11. Describe the nursing responsibilities in relation to phlebitis and infiltration of a peripheral IV.
12. List the medications an RN may administer intravenously.
13. List the medications an RN may administer IV push.

GOAL

To demonstrate safe and correct techniques to perform venipuncture in a clinical situation.

OBJECTIVES

1. Determine the correct catheter size, dependent on type of IV fluid.
2. Identify the most appropriate anatomical site for catheter insertion.
3. Palpate for firm, straight, pale blue, smooth, non-cord like vein.
4. Prepare limb for insertion of catheter, using Universal Precautions.
 - apply tourniquet
 - encourage venous distention
 - clean skin thoroughly
 - insert catheter into vein
 - observe for blood return
 - remove stylet
 - connect IV tubing
 - initiate IV fluid flow
 - tape catheter/dress injection site
 - set drip rate
 - label fluid correctly
 - document initiation of fluid in member's medical record

FLUIDS AND ELECTROLYTES

Humans are 60 to 80 percent fluid by weight, depending upon sex, age, and body fat content. In general, the younger the person, the higher the percentage of body fluid. Women have less body fluid than men do, and a fat person contains less fluid than does a thin person, since fat has little water associated with it.

The body fluid is divided into TWO major compartments. The first compartment, the cellular (or Intra-Cellular) fluid, comprises the fluid contained within billions of body cells and accounts for about three-fourths of the total body fluid. We might think of it as a vast sea of tiny, encapsulated droplets suspended in the second department, the extracellular fluid (composed of interstitial fluid and the blood). Extracellular fluid (ECF) constitutes about one-fourth of the total body fluid.

Let's consider the microscopic anatomy of the body fluids. If one were to take a cross section of solid tissue, such as muscle, one might see something like this: Cellular fluid would be seen inside each of the body cells, including both the cells inside and those outside the blood vessels (again, about 3/4 of total body fluid). ECF (again, about 1/4 of total body fluid) includes plasma (within the blood vessels), and interstitial fluid, located outside the blood vessels and surrounding and bathing the outside of the cells.

COMPOSITION OF BODY FLUIDS

Body fluids consist chiefly of water and certain dissolved substances sometimes referred to as salts, minerals, or crystalloids, but more correctly called electrolytes.

Water is the most essential nutrient to life. No known form of plant or animal life can exist for very long without it. Water possesses unique chemical and physical characteristics, and there is no substitute for it in the life cycle. Water is required for the countless chemical reactions of the body; no major physiological function can proceed without it.

Electrolytes are so named because they ionize (develop electrical charges) when they are dissolved in water. Some electrolytes, including sodium (Na^+), potassium (K^+), calcium (Ca^{+2}), and magnesium (Mg^{+2}) develop positive charges (cations); other electrolytes, including chloride (Cl^-), phosphate (PO_4), bicarbonate (HCO_3^-), and sulfate (SO_4^{-2}) develop negative charges (anions).

Each body fluid has its own normal composition of water and electrolytes. Cellular fluid contains large amounts of potassium, magnesium, and phosphate. The major intracellular cation is potassium. The major intracellular anion is phosphate. Extracellular fluid contains large amounts of sodium, chloride, bicarbonate, and calcium. The major extracellular cation is sodium. The major extracellular anion is chloride. The differences in electrolyte composition between cellular and ECF are so important that the body uses up one fifth of its energy stored in adenosine triphosphate (ATP) in maintaining the balances.

The chief difference between the plasma and interstitial fluid is that plasma contains a much greater amount of protein, which acts as a to prevent excess plasma from seeping, in to interstitial fluid.

FUNCTIONS OF BODY FLUIDS

The main function of body fluids is to maintain healthy living conditions for the body cells. Although we may regard ourselves as highly complex, highly civilized organisms, the cells remain the basic units of life. A living body could no more exist without cells than could a brick building exist without bricks. Unlike bricks, however, our cells are alive, dynamic, working units that must be nourished and hydrated. The cellular fluid, which normally contains all the nutrients the cells need, serves as the supply source to replenish nutrients as they are used up. In addition, the be cleared of wastes, such as carbon dioxide and breakdown products of protein metabolism. The EXTRACELLULAR FLUID (ECF) performs these services. Nutrients and other materials seep from the plasma into the interstitial fluid at the arterial end of the capillary beds, which exist in every part of the body, and are carried to the cells by means of the interstitial fluid. Waste materials pass from the cellular fluid into the interstitial fluid and back to the plasma through the venous capillaries. The plasma then sorts the waste products for storage or excretion and carries them to their proper destinations.

In addition to transporting nutrients and wastes, ECF transmits enzymes and hormones, plus many additional substances. It carries red blood cells and white blood cells throughout the body to perform their specialized functions.

ROUTES OF TRANSPORT

Materials are transported between cellular and extracellular fluid by several including osmosis, diffusion, filtration, and active transport (See Table for a summary of these Routes of Transport).

OSMOSIS

Osmosis is the movement When two solutions are separated by a semi-permeable membrane (a membrane which allows fluids but not the dissolved substance to pass through it), the solution with the greatest concentration of particles draws water from the solution with the lesser concentration of particles. It is almost as if there was an effort on the part of each electrolyte particle to surround itself with its fair share of available fluid.

Osmosis is highly important in the body. If pure water not containing electrolytes were injected directly into the bloodstream, the red blood cells would absorb water and would swell and burst. If an extremely salty solution were injected into a vein, the red blood cells would lose water to their salty environment and would shrink, just as your fingers do if they have been in water too long. Osmosis occurs when the ECF develops an electrolyte content lower or higher than normal, such as the result of disease or trauma.

DIFFUSION

The physical transport of ions and molecules, resulting in an equalization of concentration on both sides of a membrane, is called diffusion. This occurs through the random movement of ions and molecules, which move incessantly, bump into each other, and bounce away. They scatter from regions where their concentration is high and pass to regions where their concentration is low. Exchanges of oxygen and carbon dioxide by the lung alveoli and capillaries is an example of diffusion.

TRANSPORT

When it is necessary for ions to move through certain membranes, some energy must be applied to the ions to cause their movement. During active transport, ATP is released from a cell to enable certain substances to acquire the energy needed to pass through the cell membrane. The "Sodium Pump" in cardiac muscle, in which Sodium and Potassium ions exchange locations and cause the electrical activity of the heart, is an example of active transport.

FILTRATION

The transfer of water AND dissolved substances through a PERMEABLE membrane from a region of high pressure to a region of low pressure is called filtration. The force behind the filtration is hydrostatic pressure, produced by the pumping action of the heart. Examples of filtration include the passage of water, electrolytes, glucose, amino acids, and fatty acids from the arterial end of the capillary beds to the interstitial fluid and the passage of water and small molecules from the glomerular capillaries of the kidneys into the tubules. Opposing the hydrostatic pressure, which tends to force water and electrolytes out of the capillaries, is oncotic pressure of the plasma proteins, which tends to hold them back.

ROUTES OF TRANSPORT

ROUTE	WHAT MOVES	MECHANISM
OSMOSIS	Fluid only	SEMI-PERMEABLE MEMBRANE
DIFFUSION	Ions and Molecules	RANDOM MOVEMENT TO EQUALIZE CONCENTRATION
ACTIVE TRANSPORT	Ions	ENERGY APPLIED TO CAUSE MOVEMENT
FILTRATION	Water and Dissolved Substances	PERMEABLE MEMBRANE, HYDROSTATIC PRESSURE

CHANGES VOLUME OF ECF

Total Body Water constitutes about 60 percent of the body weight. Its distribution is illustrated in Table I (see page 5). The most important determinant of ECF volume is the sodium content. Abnormalities of ECF volume are due to net gain or loss of sodium and an accompanying gain or loss of water.

EXTRACELLULAR FLUID VOLUME DEPLETION results when losses of both sodium and water occur. The character of the fluid lost will dictate the clinical picture. Causes of ECF volume depletion include gastrointestinal losses (vomiting, diarrhea, fistula drainage, nasogastric suction), diuretics, renal or adrenal disease, and sequestration of fluids (burns or peritonitis).

Manifestations of ECF Volume Depletion depend on the degree of the deficit and plasma concentration of sodium lost. Symptoms include anorexia, nausea, vomiting, apathy, weakness, orthostatic light-headedness and syncope. The degree of weightloss is not only an important sign of volume loss but also provides a valuable quantification of net volume deficit to be replaced. Other physical findings include orthostatic hypotension, poor skin turgor, sunken eyes, absence of axillary sweat, oliguria, and tachycardia. A rise in hematocrit and serum protein (signs of hemoconcentration) may also be seen.

Treatment should be directed at restoration of the ECF volume deficit with solutions containing the lost water and electrolytes. During replacement, daily assessments of weight, further fluid losses, and serum electrolyte concentrations are mandatory to evaluate the progress therapy. The initial treatment in this situation should be aggressive isotonic fluid replacement until clinical stability is obtained. Some clinicians, however, prefer a hypotonic solution because it³ provides the additional water needed for urinary excretion and for water lost through the skin (perspiration) and through the lungs (respiration).

EXTRACELLULAR FLUID VOLUME EXCESS often results from clinical states of renal sodium and water retention (heart failure, nephrotic syndrome, renal failure, and cirrhosis). The ECF volume accumulation can be further aggravated in these conditions if unnecessary salt is administered as IV line flushing, parenteral drugs solutions, or dietary excess.

Manifestations: Weight gain is the most sensitive and consistent sign of ECF volume excess. Edema, another important manifestation, is usually not apparent until 2-4kg of fluid has been retained. Other clinical findings include circulatory overload (dyspnea, tachycardia, venous engorgement, pulmonary congestion) in patients with heart disease or renal disease, and ascites in patients with cirrhosis.

Treatment must be directed at the primary pathologic process in addition to correcting the ECF volume excess. Regardless of the cause, assessing the weight of the patient is essential in guiding therapy.

PARENTERAL FLUID ADMINISTRATION

NURSING IMPLICATIONS

Intravenous therapy is a major component of patient care. Millions of patients receive this treatment each year. The nurse plays a major role in the administration of parenteral fluids. The nurse shares in the responsibility of assuring the safe and therapeutic administration of parenteral fluids. The nurse shares in the responsibility of assuring the safe and therapeutic administration of IV therapy. To be able to assume this responsibility, the nurse must understand the basic principles of safe fluid administration to make important observations during parenteral infusion, including the purpose, contraindications, and complications associated with IV Therapy. Strict attention to physician orders, factors influencing the rate of administration, and mechanical factors which influence gravity are important nursing implications of IV therapy.

PHYSICIAN'S ORDERS

The physician should order the type and amount of solution, and its rate of flow and route of administration. In turn, the nurse is responsible for initiating most infusions and maintaining the proper flow rate. Nurses must be aware of the composition of the prescribed solution, its desired effects, and its usual rate of administration, and complications that may be associated with its use.

FACTORS INFLUENCING THE RATE OF ADMINISTRATION

The following are some of the factors to be considered in determining the best flow rate for infusion:

- Type of fluid
- Need for fluids
- Cardiac and renal status
- Body size
- Age
- Patient's reaction during infusion
- Size of the vein

The desired rate for the infusion varies with the type of fluids used. For example, isotonic solutions (having the same concentration as normal body fluids) can be ³ given more rapidly than hypertonic (having higher concentration of solute than normal body fluids). Although the other variables must also be considered, it is helpful for the nurse to know the usual infusion rates for various solutions.

The patient's need for fluids influences the desired rate of administration. For example, a patient in hypovolemic shock needs fluids in a hurry. The infusion in this instance is much faster than usual.

Because both the heart and kidneys play a major role in the utilization of fluids introduced intravenously, the presence of cardiac or renal damage can greatly alter the desired infusion rate. If the pumping action of the heart is inadequate, a rapid infusion of fluids could cause dangerous fluid excess. The failure of the kidneys to excrete unneeded water and electrolytes can also result in excessive amounts of these substances in the body.

Elderly patients will usually have some degree of cardiac and renal impairments; therefore, fluids are administered more slowly to them than younger adults.

One of the best guides to safe flow rate is the patient's reaction to the infusion. The fact that persons respond differently to parenteral fluid infusions, just as they do to other medications, must never be forgotten. For this reason, the patient should be checked at least every 30 minutes during an infusion. The nurse should be aware of symptoms associated with the improper administration of various solutions so that he/she can know what to look for.

CALCULATION OF FLOW RATE

If the nurse knows the amount of fluid to be given in the prescribed time interval, then the desired cc per hour can be calculated. The following formula is used:

$$\frac{\text{Total volume}}{\text{Total hours}} = \text{cc/hour}$$

Sample Problem: Give 1000cc D5W over 4 hours.

$$1000/4 = 250\text{cc/hr}$$

If the nurse knows the amount of fluid to be given in a prescribed time interval, plus the drop factor of the administration set to be used, the desired drops per minute can be easily calculated. The following formula is used:

$$\frac{\text{Total time infused (ml)} \times \text{drop factor(drops/ml)}}{\text{Total time of infusion in minutes}} = \text{drops/minute}$$

Total time of infusion in minutes

Sample Problem: Infuse 1000 ml of D5W in 2 hours; infusion set has a drop factor of 10 gtt/ml.

Total Volume = 1000ml; Drops/ml= 10gtt; Total infusion time =120 minutes.

$$\frac{1000 \text{ ml} \times 10\text{gtt/ml}}{120 \text{ minutes}} = 83\text{gtt/min}$$

MECHANICAL FACTORS INFLUENCING

After the desired flow rate has been regulated, there are several mechanical factors that may alter it. As follows:

1. Change in needle position. A change in the needle position may push the bevel against or away from the venous wall. An adequate flow rate becomes diminished when the needle is pushed against the vein, whereas, it may increase when the needle moves away from the venous wall. Care must be taken to adjust the desired flow while the solution is flowing freely.

2. Height of the solution bottle. Because infusions flow in by gravity, a change in the height of the infusion bottle or patient can increase or decrease the rate. The greater the distance between the patient and the bottle, the faster the rate.

3. Patency of the needle. A small clot may occlude the needle lumen and decrease or stop the flow rate. When released, the rate increases. Clot formation may occur when an increase in venous pressure in the infusion forces blood back into the needle. Causes of this include lying on the infusion arm, constriction with blood pressure cuff, and the improper placement of parenteral solution containers when a continuous flow administration set is used. A plugged needle should NEVER be irrigated since the dislodged clot could cause an embolism and/or infarction. To check for a plugged needle, kink the tubing a few inches above the injection site, pinch the tubing "flash ball" immediately above the needle. If resistance is met, and if there is no flashback of blood, the needle is probably plugged and should be removed. [NB: With smaller lumen needles, such as a 22 gauge, blood return may NOT occur even when patent.] Another technique to check for patency of the needle is to aspirate the catheter by attaching a syringe and attempting to aspirate the clots.

4. Venous spasm. A cold or irrigating solution may retard flow rate by producing venous spasm. A warm pack placed proximal to the infusion site will relieve this condition.

5. Plugged air vent. A plugged air vent can cause infusion to stop. Thus, patency of the air vent should be checked when no other cause is apparent for the stopped infusion.

6. Condition of final filter. Final filters can cause decreased flow rates if particulate matter block the filtering surface, or if an air lock develops.

7. Crying infants. The physical exertion that occurs during crying will raise venous pressure and, thus, slow the rate of infusion in the crying child.

BASIC IV THERAPY EQUIPMENT

PLASTIC CONTAINERS

Plastic bags reduce the potential for air emboli because they are not vented. Also, the possibility of contamination by way of an air filter is eliminated. They are lighter, easier to handle, and more easily stored and discarded than glass bottles. The use of plastic containers has reduced the incidence of particulate contamination because there are no rubber closures or glass particles.

PLASTIC CONTAINERS SHOULD NEVER BE WRITTEN ON WITH PEN, PENCIL OR MAGIC MARKER. A label, containing the following information, should be made out and attached to the outside of the plastic IV bag:

- Date
- Patient's name
- Type of fluid
- Rate per hour
- Time taped

ELECTROLYTE SOLUTIONS

Types

A wide variety of electrolyte solutions are available for parenteral administration. Electrolyte fluids are considered isotonic when the concentration of dissolved particles is equal to that of intracellular fluid. Isotonic fluids such as D5W or NS are used to expand ECF volume. D5W is recommended for infusion during

a Code Blue. Electrolyte fluids are considered hypertonic when the concentration of dissolved particles is greater than that of intracellular fluid. Hypertonic solutions such as 0.45NS (1/2 Normal Saline) are used to shift extracellular fluid from the plasma into interstitial fluid from the plasma into interstitial fluid.

ADMINISTRATION OF POTASSIUM SOLUTIONS

Potassium may be given in the form of commercially prepared electrolyte solutions. The nurse should keep the following facts in mind when containing solutions are administered:

1. Ampules of concentrated solutions of potassium for addition to IV fluids are meant to be mixed with at least 500 to 1000 ml of solution. They should never be directly administered in concentrated form by IV push because of the danger of cardiac arrest.

2. When potassium chloride (KCL) is added to an IV solution, it should be thoroughly mixed by shaking the bag to prevent "crowning" or "layering" of the KCL. Crowning of the KCL allows the administration of a large bolus of the drug, which may result in phlebitis, tissue necrosis and worst of all, cardiac arrest. It is important to squeeze the medicine parts of plastic bags while they are in the upright position and then to mix the solution thoroughly. Remember that KCL should NEVER be added to an IV container in the hanging position.

3. It is wise to limit the potassium concentration in one liter of fluid to between 20 and 40 since an accidental rapid infusion rate is less dangerous when potassium content is moderate.

4. Rate of administration:

- For usual IV replacement therapy, 5 to 10 (suitably diluted) may be given as a constant infusion.
- The maximum infusion rate should not exceed 20 (suitably diluted).
- During a code situation, the maximum recommended rate should not exceed 40 for an adult.

5. Solutions containing potassium should be conspicuously labeled so that other personnel can readily note its presence.

6. Potassium should be administered only after adequate urine flow has been established. A decrease in urine volume to less than 20 ml/hr for two consecutive hours is an indication to stop potassium infusion until the situation is evaluated. Urinary suppression may be due either to inadequate fluid intake or renal impairment; the rapid infusion of a hydrating solution (such as 5% or hypotonic electrolyte solution) should cause an increase in urine output if the problem is fluid volume deficit. Once urinary output is adequate, potassium infusion may be resumed. However, failure of the hydrating solution to increase urinary output indicates renal impairment and is an indication to withhold potassium. Recall that potassium is mainly excreted by way of the kidneys. When the kidneys are non-functional, a high potassium level (hyperkalemia) builds up in the bloodstream.

7. A solution containing sizable amounts of potassium (30 to 40 is sometimes associated with pain in the vein it is entering, especially if infused into a vein where a previous venipuncture has been performed. Slowing the rate usually relieves this sensation. Because administration of a potassium solution into the subcutaneous tissues is painful, care should be taken to avoid concentrated potassium solutions, since severe tissue damage may result.

INCOMPATIBILITIES

The nurse is frequently required to add medications to parenteral fluids. There is a fast-growing number of medications and types of parenteral fluids on the market, and it is impossible, without help, to know which medications can be safely mixed with certain IV fluids. The pharmacist at your medical center can be of valuable assistance. The nurse should keep the following points in mind when adding medications to parenteral fluids:

1. Thoroughly review the literature provided by the manufacturer of the IV fluid. Most companies have prepared charts noting the compatibility of various medications with their solutions. Also, review the literature provided by the manufacturer of the additive.
2. When possible, it is best to add only one medication to each solution bottle, as the complex interaction between two additives may render the solution incompatible.
3. When in doubt, the nurse should check with the pharmacist.
4. Use freshly prepared solutions whenever possible and monitor infusing fluids periodically for physical changes. Some incompatibilities do not become apparent until the solution has been mixed for a while. A physical incompatibility may be manifested by a haze, color change, or effervescence. Chemical incompatibilities are more difficult to detect because they do not always produce a visible change.
5. The formation of a precipitate when a medication is added to an IV Fluid is an indication to discard the solution unless the directions accompanying the medication state otherwise. The IV administration of a solution containing insoluble matter may result in embolism or other damage to the heart, liver and kidneys.
6. Dilantin and Valium should not be mixed with any IV solution OTHER THAN NORMAL SALINE, since they precipitate out. They are both incompatible with ANY other drug in a syringe or a solution.

ADMINISTRATION SETS

Manufacturers of IV equipment provide administration sets delivering a specified number of drops/ml. The macro drip sets are available in 10, 12, or 15 drop/ml. The micro drip sets deliver 60 drops/ml and allow for greater control of fluid rate.

Intermittent infusion of an IV medication into an established IV line is referred to as a "piggyback." The secondary setup (piggyback) is connected to the primary line at the "Y site." The primary solution is clamped off while the secondary solution is infusing. (Remember that there is danger of air embolism if two vented containers are allowed to infuse simultaneously.) This method has several advantages over the direct introduction of a concentrated medication into the vein by means of a syringe (IV push):

- The medication can be diluted in a larger volume of diluents, thus reducing the possibility of chemical phlebitis.
- The nurse does not have to be constantly present during an administration of piggyback infusions.
- The diluted medication can be delivered more slowly, allowing time for observation for adverse reactions before the entire dose is given.

INFUSION PUMPS AND CONTROLLERS

PUMPS

A number of infusion pumps are available commercially and are used in many patient care areas. Their purpose is to actually push fluid into the tubing, and to provide a more accurate method of administration of fluids and critical drugs than is possible with routine gravity flow setups. Their precise rate of flow is particularly desirable in the administration of TPN, chemotherapy, and other potent medications.

Pumps that have flow rates calibrated in terms of ml/hr rather than in gtt/min are called volumetric infusion pumps. These pumps provide greater accuracy than those measuring drops, since many factors can affect drop size (such as fluid viscosity and drop rate formation). Most pumps require individualized special administration sets, although a few use standard IV sets.

Circulatory overload is less apt to occur when infusion pumps are used to control the flow rate. Also, needles are less apt to clog with the use of infusion pumps since the pressure generated by the pumps exceeds maximum venous pressure.

CONTROLLERS

A controller is an electronic device used to regulate intravenous flow rates. It relies on gravity rather than exertion of pressure. Intravenous controllers are whenever the force of gravity is sufficient to provide the desired flow rate. They are appropriate for a large percentage of infusions that do not require the accuracy of a volumetric pump. Controllers are limited by the fact that drop rate is not a completely accurate reflection of volume infused due to variations in drop size.

Nursing considerations in the use of infusion pumps include the following:

1. Read the manufacturer's directions carefully prior to using any infusion pump or controller, since there are many variations in available models.
2. Check the venipuncture site for infiltration, since most pressure pumps keep infusing fluid even though the tissue may be greatly distended, unlike the markedly diminished flow rate accompanying infiltration of gravity flow solution.
3. Check infusion rates closely when batteries are the power source, since low batteries may greatly affect the flow rate.
4. Check the function of occlusion detectors by periodically pinching the tubing shut several times. Recall that an occlusion detector senses increased backpressure due to pinched tubing, clogged final filter, or an unopened tubing clamp.

5. When using drop-sensitive pumps, always check the sensor eye to be sure it is clean and dry. The sensor eye should be cleansed only with water.
6. NEVER purge an IV pump when it is connected to the patient.

ROUTES AND TECHNIQUES OF IV FLUID ADMINISTRATION

INDICATIONS FOR USE

Veins provide an excellent route for the quick administration of water, electrolytes, other nutrients, and medications. The intravenous route is essential when nutrients are needed in a hurry, such as glucose in severe hypoglycemia, or potassium chloride in severe potassium deficit. Relatively large volumes of fluids can be given by the IV route, provided care is exercised. IV medications may be administered as an additive to the IV solution, as a piggyback or direct IV pushes

GENERAL CONSIDERATIONS

Few persons are without some fear or dread of a needle being introduced into their veins, and normal fears are exaggerated in illness. Since some patients associate intravenous fluids with serious illness, they are disturbed when such therapy is ordered. It is the nurse's responsibility to explain the procedure, length of time and expected outcomes. The nurse must always remember that although IV therapy is commonplace to the health care team, it is far from routine for the patient. The patient should always be approached with an explanation of what is to occur. The fear of not knowing what is to happen can be worse than the most painful Venipuncture.

VENIPUNCTURE. SITE SELECTION

Criteria for Selection: Selection of a vein depends upon a number of factors, including:

- Availability of sites (depends on the conditions of the veins)
- Size of needle to be used
- Type of fluids to be infused
- Volume, rate, and length of infusion
- Degree of mobility desired
- Disease process
- Past surgery
- Dominant extremity

Hand Veins

Because of their small diameter, hand veins do not accommodate large needles—a small gauge scalp vein needle is sometimes used for venipuncture in the hand.

Small veins cannot tolerate hypertonic or otherwise irritating fluids because less blood is present in small veins to dilute such solutions. These peripheral veins collapse sooner in the presence of shock than do more centrally located veins. And finally, extravasation of blood may occur in venipuncture in this area, particularly when there is thin skin and inadequate connective tissue.

Forearm Veins

The cephalic vein flows upward along the radial border of the forearm and is an excellent site for venipuncture. Also, the size of the vein will accommodate a large needle. The accessory cephalic vein joins the cephalic vein below the elbow, and it too is a good site for venipuncture. Both veins are frequently used for blood administration. When prominent, the median antebrachial vein can be used for venipuncture. The location of superficial veins of the forearm is somewhat variable and not always well defined.

Venipuncture in a forearm allows the patient some arm movement without the risk of puncturing the posterior venous wall.

Elbow Veins

The median cephalic and median basilic veins are found in the antecubital fossa; both veins are readily accessible to venipuncture because they are large and superficially located. In addition, they are kept from rolling and sliding by surrounding tissues. They will accommodate large needles, large volumes of fluids, and all but the most irritating IV fluids.

When frequent blood specimens are necessary, it is wise to save the veins in the antecubital area for this purpose; large quantities of blood can be obtained from them. These veins can be used many times without damage if good technique is used.

A disadvantage of using veins in the antecubital area is the restriction of elbow flexion during infusion. Therefore, when long-term infusions are anticipated, it is best to use the veins in the forearm because the patient can be moved and ambulated with less danger of dislodging the needle.

A right-handed person has more freedom if the infusion is given in the left arm; however, the need for multiple venipunctures is an indication to employ alternate sites in both arms.

Lower Extremity Veins

Lower extremity veins are not recommended for venipuncture because their use can result in dangerous complications. Thrombus formation at the venipuncture site can occur in any venipuncture. When leg veins are used, the thrombus can extend to deep veins and may result in pulmonary embolism.

GENERAL CONSIDERATIONS

1. Use only veins in the upper part of the body.
2. When multiple punctures are anticipated, it is best to make the first venipuncture distally and work proximally with subsequent punctures.
3. Avoid venipuncture in the affected arm of patients with axillary dissection, as in radical mastectomy (decreased circulation affects the flow of the infusing, causing increased edema).
4. Avoid checking the blood pressure on the arm receiving an infusion because the cuff interfere with fluid flow, forces blood back into the needle, and may cause a clot to form.
5. When the patient is on his side, the upper arm should be used for venipuncture. The lower arm has increased venous pressure, which interferes with fluid flow and may cause clot formation in the needle.
6. Restraints should not be placed on the infusion site.
7. An arm board should be used when the venipuncture site is over an area of flexion (such as the wrist or elbow).
8. Hold the infusion bottle sufficiently high during ambulation of the patient and transport by wheelchair or stretcher to maintain a constant flow rate. When the patient is ambulating, the arm receiving the infusion should be placed across the abdomen to immobilize it and the IV pole should be rolled with the other hand.

METHODS FOR VENOUS ENTRY

The scalp vein needle (butterfly needle) is approximately $\frac{3}{4}$ inch long and has attached plastic wings, used for holding the needle during venipuncture. This needle has a thin wall and provides a larger lumen with a small needle diameter. Because the bevel is short, there is less danger of accidentally puncturing the posterior wall of the vein.

Scalp vein needles are available in two types: one has a variable length of plastic tubing attached to an adaptor that accommodates an administration set, and the other has a short length of tubing ending in a resealable injection site (saline lock). An intravenous catheter can be converted to an intermittent infusion set by attaching an injection cap to the catheter. Patency of the needle or converted catheter is maintained by periodically flushing the device with a saline solution. Each time medication is injected into the resealable site, it is important to cleanse the area thoroughly with a sterile alcohol wipe. Prior to injecting the medication, it is imperative to confirm that the needle is still in the vein. Never automatically inject medication without first proper positioning of the needle.

The size of the needle to be used depends on the vein as well as on the type of solution. Scalp vein needles range in size from a 25 gauge to a 16 gauge. (The smaller the gauge number, the larger the internal diameter of the needle.) The gauge of the needle should be appreciably smaller than the lumen of the vein to be entered. Thus, hemodilution of the infusing solution is ensured. When a large needle occludes the flow of blood, irritating solutions will probably produce chemical phlebitis. If a small needle is used, irritating fluids can mix readily with blood, decreasing the chances of phlebitis. A larger lumen (and thus, smaller gauge number) needle is required for high viscosity fluids, such as blood.

A plastic needle (e.g. an Angiocath) is a catheter mounted on a metal stylet. When the venipuncture is made, the catheter is slipped off the needle into the vein and the metal stylet is removed. Plastic catheters do not infiltrate as easily as metal needles because of their pliability. It is recommended that plastic catheters be radiopaque so that they can be located by X-Ray in the event of catheter dislodgement, and subsequent foreign body embolus.

TECHNIQUES OF INSERTION

VENIPUNCTURE WITH A METAL NEEDLE

After a suitable site has been located, the next step is to distend the vein by using a Tourniquet. The Tourniquet also prevents the vein from "rolling," so it is important to place the tourniquet **NO MORE** than 2 inches above the chosen puncture site.

It may be necessary to distend the vein by placing it in a dependent position for several minutes. Sometimes a light tap with the nurse's fingers over the proposed site of venipuncture helps. Exercising the muscles distal to the site of puncture is also helpful.

Seventy percent alcohol is used first to prepare the injection site. While a "clean to dirty" circular motion is good to remove contaminants from the venipuncture site, it may be useful to stroke the vein only in the direction towards the tourniquet, causing some more distention of the vein to occur.

The bevel of the needle should be facing upward during insertion, and an approximate 45-degree angle to the skin utilized until the needle has pierced the skin. The needle should pierce the skin to one side of, and approximately ½ to 1 inch below the point where the needle will enter the vein. Once the needle is through the skin layer, the angle of insertion can be decreased.

You will often feel (and sometimes "hear") a pop when the needle enters the vein. Then less resistance will be felt on the advancement of the needle. At this point, proceed very slowly with the insertion of the needle threading it into the lumen approximately ½ to 1 inch. The tourniquet is then released. A small amount of blood may be seen in the tubing when the needle enters the vein. If in doubt, pinch the tubing just above the needle and release it. Usually this will cause a flashback of blood into the tubing. Fluid should be allowed to run in, and the area should be observed for swelling.

Once the infusion is running, the next step involves anchoring the needle comfortably and safely. A piece of tape should be diagonally wrapped around the needle hub to prevent movement of the needle. Then a piece of tape is applied over the entry site. Tape should never be allowed to completely encircle the extremity, since it will cause a tourniquet effect. A loop of the tubing should be secured with tape independent of the tape over the needle so that an accidental tug on the tubing will not dislodge the needle. The date and time of the insertion should be written on the tape to alert personnel to the need to remove the device within a safe period of time (usually 72 hours). The name or initials of the person performing the venipuncture should also be noted.

An abnormal may be necessary at times to immobilize the involved extremity and decrease the likelihood of infiltration. An arm board is always required when the site is an area of flexion of the fingers. At no time should the fingers be flattened out on the arm board.

ANGIOCATH

A venipuncture is performed in the usual manner, with the needle inserted far enough to ensure safety of the catheter into the vein. After the catheter is advanced into the vein to the desired length, the needle is carefully removed. The should NEVER be reinserted into the catheter once it has been removed. This poses a danger of shearing off a small piece of plastic and causing a catheter embolism.

When removing any plastic device from a vein, do not use scissors to remove tape, since it is possible to cut the device accidentally. Always check the length of the plastic device when it is removed.

ADMINISTRATION OF IV MEDICATION BY IV PUSH (BOLUS)

An IV push is the IV administration of a medication that cannot be diluted or that is needed in an emergency. Also, some drugs are administered this way to achieve ³ maximum effects. It is important to remember that the medication is administered rapidly with an IV push, and this could be dangerous to the patient.

An IV push can be administered directly into a vein through venipuncture, into an existing IV apparatus (as through an injection port), or through an intermittent infusion set (e.g., saline lock). [Saline locks are used for patients who require intermittent IV medications but not the fluid volume of an IV infusion.]

ESSENTIAL STEPS IN THE PROCEDURE

1. Explain the procedure and reassure the patient. Draw up the prescribed dose of medication.
2. All dosages, dilutes, diluents amounts and administration time span must coincide with the pharmaceutical manufacturer's recommendations for an Registered Nurse to administer.
3. Check physician's order. Check the patient's identification and ask his/her name.
Check the insertion site for signs of infiltration:
 - Bruising
 - Bleeding
 - Swelling
 - Pain
 - Absence of blood return (although blood return is not always possible with 22gauge catheter)
 - Clot formation
 - Redness
 - Palpable vein
4. Scrub the injection site thoroughly with alcohol and allow to dry. Draw up the ordered amount of medication into the syringe with a needled needle. Flush the saline lock with 3cc of 0.9 percent sodium chloride solution to insure patency. Insert needle into lock port and administer medication IV push at recommended rate. Flush the lock with 3cc of 0.9 percent sodium chloride solution.

COMPLICATIONS OF IV FLUID ADMINISTRATION

Patients receiving parenteral fluids should be observed often to detect the early appearance of complications. The nurse should periodically check the rate of flow, the amount of solution in the bottle, the appearance of the injection site, and the patient's general response to the infusion.

Complications that can occur with IV infusions may be classified as pyrogenic reactions, local infiltration, circulatory overload, thrombophlebitis, or air embolism.

PYROGENIC REACTIONS

The presence of pyrogenic substance (foreign proteins capable of producing fever) in either the infusion solution or the administration setup can induce a febrile reaction. Such a reaction is characterized by the following:

- Abrupt temperature elevations (100 to 106 degrees F) accompanied by severe chills. The reaction usually begins about 30 minutes after the start of the infusion.
- Backache
- Headache
- General malaise
- Nausea and vomiting
- Vascular collapse with hypotension may occur when the reaction is severe. The severity of the reaction depends upon the amount of pyrogen infused, the rate of flow, and the patient's susceptibility. Patients having fever or liver disease are more susceptible than others.

If these symptoms occur, the nurse should stop the infusion at once, check the vital signs, and notify the physician. The solution, administration set, and the venipuncture device should be saved so they can be cultured if necessary.

Prior to initiating an infusion, the nurse should squeeze the plastic IV container to detect leaks. If a leak is present, the solution is no longer sterile and must be discarded.

A final filter is another safety device to prevent the infusion of bacteria and particulate matter. The filter is situated between the infusion tubing and the needle, allowing for final filtration immediately before the solution enters the bloodstream.

LOCAL INFILTRATION

The dislodging of a needle and the local infiltration of solution into the subcutaneous tissue is not uncommon, especially when a small thin-walled vein is used and the patient is active.

- Edema at the site of the injection. Skin around the insertion site is cooler than the rest of the skin because the IV fluid is cooler than the body.
- Discomfort in the arena of the injection. The degree of discomfort depends on the type of solution.
- Significant decrease in the rate of infusion, or a complete stop in the flow of the fluid.
- Failure to get blood return into tubing when the bottle is lowered below the needle. (This method is not always foolproof. Sometimes the needle lumen is partially in the vein with its tip in the subcutaneous tissue.)

The infusion should be discontinued immediately when the infiltration is apparent. When in doubt, an infiltration can be confirmed by applying a tourniquet (or applying pressure with the fingers) to restrict venous flow proximal to the injection site. If the flow continues, regardless of the venous obstruction, the needle is obviously not in the vein.

Close observation with early detection of infiltration will greatly reduce the severity of this all too common complication. Below is a summary of factors that frequently contribute to infiltration:

- Lack of proper patient education concerning care of extremity receiving IV.
- Hyperactive patient.
- Improperly taped venipuncture device.
- Improper technique of person initiating therapy, such as pushing the bevel of the needle through the posterior wall of the vein.
- Poor selection of venipuncture site, such as over an area of flexion or in the hand.
- Improper handling of extremity or equipment during transportation.

CIRCULATORY OVERLOAD

Overloading the circulatory system with excessive IV fluids may cause the following symptoms:

- Rise in blood pressure
- Venous distention (engorged neck veins)
- Wide variance between fluid intake and output (higher intake than output)
- Coughing
- Shortness of breath, increased respiratory rate
- Pulmonary edema with severe dyspnea and cyanosis

The nurse should be particularly alert for circulatory overload in patients with cardiac decompensation. If the above symptoms occur, the infusion should be slowed to a "keep open" rate and the physician notified immediately. If necessary, the patient can be raised to a sitting position to facilitate breathing.

THROMBOPHLEBITIS

The condition associated with clot formation in an inflamed vein is known as thrombophlebitis. Although some degree of venous irritation accompanies all IV infusion, it is usually only of significance in infusions kept going in the same site for more than 72 hours. Thrombophlebitis at an infusion site may be manifested by:

- Pain along the course of the vein.
- Redness and edema at the injection site - a red streak may form above the site.
- Vein may feel hard, warm and cordlike to touch.
- Flow rate may be sluggish due to venous spasm.
- If severe, systemic reactions to the infection - tachycardia, fever and general malaise — may occur.

Mechanical factors can produce thrombophlebitis. Needle movement can cause venous irritation when the infusion site is near a joint. Careless technique during venipuncture or in removing an infusion needle can seriously traumatize the vein.

Irritating solutions, such as alcohol, can be instrumental in causing thrombophlebitis. Hypertonic solutions are often associated with venous irritation. Carbohydrate solutions in excess often percent almost always produce this reaction.

Most water, electrolyte and dextrose solutions are acidic, with the pH usually ranging from 3.5 to 6.7. Solutions with an alkaline or acid pH are more frequently associated with thrombophlebitis than are the solutions with the approximate body pH. Reportedly, this problem can be reduced by adding buffers to raise the pH. Commercial products are available for this purpose. The small amount of basic solution will not alter the patient's plasma pH. However, increasing the pH of solutions containing additives can produce incompatibility problems, since some additives are stable only at a low pH.

Once thrombophlebitis is detected, the infusion is stopped and restarted in another site to allow the traumatized vein to heal. Usually, cold compresses are applied to the thrombophlebitic site, after which warm, moist compresses can be used to relieve discomfort and promote healing.

Nursing interventions to minimize the occurrence of thrombophlebitis include the procedures below:

- Changing the intravenous device (needle or angiocath); it is recommended that a peripheral venipuncture device not be left in place longer than 96 hours.

- Infusing irritating fluids in large veins - large veins have a higher blood flow and thus can quickly dilute the irritant.
- Generally speaking, irritating additives should be diluted with more fluid than non-irritating substances, keeping the manufacturer's guidelines in mind.
- Stabilizing the venipuncture device with proper taping and an arm board when the venipuncture is in an area of flexion.

AIR EMBOLISM

The danger of air embolism is present in all intravenous infusions, even though it does not occur frequently. Cannulation of central lines is far more likely to be associated with air embolism than is cannulation of peripheral veins. The exact quantity of intravenous air that can lead to death in humans is unknown, but appears to be related to the rate of entry.

Measures to be taken to prevent the occurrence of air embolism include:

- Tightly secure all connections in the administration setup to prevent air from being drawn into it. If a stopcock is part of the IV setup, the outlets in use should be completely shut off. Avoid tightening connections so much that forceps are needed to loosen them, which can cause cracking of the tubing or plastic IV device, and create an entry site for air.
- Inspect plastic bags for cracks or other defects.
- Discontinue an infusion before the bag and tubing are completely empty.

The presence of an air embolism is manifested by the following:

- Dyspnea and cyanosis
- Hypotension
- Weak rapid pulse
- Loss of consciousness
- Loud continuous churning sound over the precordium (not always present)

The occurrence of these symptoms in a patient receiving an infusion should lead the nurse to suspect air embolism.

If an air embolism occurs, administration tubing should be promptly clamped. The patient should be immediately turned on his left side with his head down and the lower extremities elevated.

This allows the air to rise into the right atrium and away from the pulmonary outflow tract.

Oxygen is administered by mask to achieve a high oxygen concentration.

The nurse should be aware that the presence of air in the administration set, no matter how small the bubble, is frequently a cause of apprehension in the patient receiving IV fluids

SOME IMPORTANT DRUGS GIVEN BY IV

ATROPINE (ADULT)

Initial Dose: 0.5 mg IV push

Repeat Dose: 0.5 mg repeated at 3-5 minute intervals up to a total of 2 mg

Administration: IV push over 20-30 seconds

Commercial Form: 0.1 mg/ml, 1 mg/10mg syringe

Notes: 2 mg considered a vagolytic dose. Must be given rapidly (over 20-30 Sec) to avoid paradoxical vagal activity.
DO NOT GIVE WHEN HEART RATE <60 BPM.

ATROPINE (PEDIATRIC)

Initial Dose: 0.02 mg/kg IV push or in ET tube
(minimum dose 0.1 mg, maxi dose 0.5 mg)

Repeat Dose: Above repeated at 3-5 minute intervals, to a maximum of 1 mg (children) to 2 mg (adolescents)

Administration: IV push over 20-30 seconds, or placed in ET tube Commercial Form: 0.05 mg/ml; 0.25 mg/5 ml pediatric syringe

Notes: 2 mg considered a complete vagolytic dose. Must be given rapidly (over 20-30 seconds) to avoid paradoxical vagal activity.
DO NOT GIVE WHEN HEART RATE <60 BPM.

EPINEPHRINE (ADULT)

Initial Dose: 0.5-1 mg IV push (1:10,000 concentration)

Repeat Dose: May repeat at 3-5 minute intervals

Administration: IV push, or via ET tube Commercial Form: 1:10,000 (1 mg/10 ml);
prefilled syringe

Notes: Do not mix with sodium bicarbonate. May increase myocardial oxygen demand.

EPINEPHRINE (PEDIATRIC)

Initial Dose: 0.1 ml/kg (1:10,000 concentration)

Repeat Dose: 0.1 ml/kg repeated at 5-10 minute intervals

Administration: IV push, or via ET tube Commercial Form: 1:10,000 (1 mg/10 ml);
prefilled syringe

Notes: Do not mix with sodium bicarbonate. May increase myocardial oxygen demand.

LIDOCAINE (ADULT)

Bolus Dose:	1 mg/kg IV over 30-60 seconds
Infusion Dose:	Begin infusion immediately, 1-4 mg/minute
Repeat Dose:	0.5 mg/kg IV, 10 minutes after initial dose if ectopy still present
Administration:	IV bolus, 30-60 seconds IV infusion: 4 mg/ml solution (2 g syringe in 500 ml of D5W) Using <u>Micro-Drip</u> Tubing: <u>MG/Minute = Drops/Minute</u> 1 15 2 30 3 45 4 60
Commercial Form:	20 mg/ml (2%), prefilled syringe 5 ml, 200 mg/ml (20%), prefilled syringe, 10 ml.
Notes:	Decrease loading (initial) dose by half in CHF. Infusion not indicated during CPR (bolus doses only).

LIDOCAINE (PEDIATRIC)

Bolus Dose:	1-2 mg/kg IV over 30-60 seconds
Repeat Dose:	May repeat Q5-10 minutes PRN to maximum of 3-4.5 mg/kg/hr
Administration:	IV bolus, 30-60 seconds
Commercial Form:	20 mg/ml (2%), prefilled syringe 5 ml, 200 mg/ml (20%), prefilled syringe, 10 ml.
Notes:	Decrease loading (initial) dose by half in CHF .

VERAPAMIL (ADULT)

Initial Dose: 5-10 mg (0.15 mg/kg) over 2-3 minutes

Repeat Dose: 5-10 mg, 30 minutes after the first dose

Administration: Slowly, IV over at least 2-3 minutes

Commercial Form: 2.5 mg/ml, 2 ml vial

Notes: Indicated for treatment of supraventricular tachyarrhythmias

VERAPAMIL (PEDIATRIC)

Initial Dose: 1-15 years: 0.1-0.3 mg/kg (usually 2-5 mg) IV over 2-3 minutes. DO NOT EXCEED 5 mg.

Repeat Dose: 0.1-0.3 mg/kg, 30 minutes after the first dose.
DO NOT EXCEED 10 mg AS SINGLE DOSE.

Administration: Slowly, IV over at least 2 minutes. Commercial Form: 2.5 mg/ml, 2 mg vial.

Notes: Age < 2 years: Use with extreme caution and always with continuous EKG monitoring.

NURSING V
NURS 222

COURSE DESCRIPTION

Nursing V integrates the concepts of wholeness, nursing, health and while utilizing the nursing process in the independent care of clients with complex acute and chronic multiple health problems. The roles of the Associate Degree members are utilized while collaborating with other health care team members in a variety of settings. The course focuses on the Elimination, Nutritional /Metabolic, Sexual/Reproductive, Cognitive/Perceptual. Include caring, critical thinking, lifelong learning, and professional excellence are interwoven.

COURSE OBJECTIVES

Upon completion of this course the student will be able to:

1. Demonstrate independent nursing roles by providing safe nursing care to patients with complex acute and chronic multiple health problems in various settings.
2. Integrate the parts of the PUC nursing conceptual framework with concepts from previous Nursing, cognate and general education courses while functioning in the roles of the Proficiency in Nursing course.
3. Assess and evaluate all areas included in the functional health patterns while exploring and collaborating with the patient, family, and/or other health care members for the formation of plans to promote optimum wellness.
4. plans, revise, and implement nursing care to patients with complex problems related to;
 - 4.1 Altered functions
 1. Respiratory
 2. Cardiac
 3. Neurologic
 4. Renal
 5. Endocrine
 6. Hematologic
 7. Immunologic
 8. Reproductive
 - 4.2 Ethical and legal dilemmas

THEORY SYLLABUS

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ALTERATIONS IN ACTIVITY/EXERCISE PATTERN

Upon of this unit the student will be able to:

HUMANITY

1. Describe the impact conditions which effect alterations in activity/exercise pattern have on the client during different phases of life span, the client's significant other and and the community with which the client interacts.
2. Describe the impact of community, the client's significant other and family and the client's components of wholeness have on the outcome of conditions which effect alterations in pattern functional health pattern.

HEALTH

1. Explain how alterations in pattern affects and are affected by other functional health patterns and nursing diagnoses.
2. Describe how the pathophysiologies of conditions discussed in this unit cause alterations in functional health patterns and influence nursing diagnoses.

NURSING

1. Use the nursing process to create a care plan addressing the whole person during diagnosis, acute and intermediate intervention, rehabilitation and long term living phases of care for clients with alterations in their health caused by the injuries or diseases outlined in this unit.
2. Using an understanding of nutrition and the other unit objectives, formulate a plan to assure an optimal nutritional outcome for clients with conditions outlined in this unit.
3. Anticipate possible effects alterations in body functions caused by the injuries or diseases in this unit and chronological development have on the function of pharmacological agents.
4. Advocate for clients with multiple and critical conditions by safeguarding privacy, upholding their stated wishes, protecting them injurious treatments, assuring appropriate pain relief, and respecting their spiritual beliefs.
5. Create a teaching plan for the client and client's family who have the conditions studied in this unit, outlining the disease processes and their interventions, the possible complications and how to avoid them, and how the client can optimize their health during the disease and it sequela.

ENVIRONMENT

Outline how the nurse, client, and can manage the environment to the quality of life for the individual with the conditions studied in unit.

ALTERATIONS IN ACTIVITY/EXERCISE PATTERN

Gas Exchange Impaired

Upon completion of this section the student will be able to complete the applicable unit objectives and:

HUMANITY

1. Discuss how alterations in gas exchange effect the client, his/her significant other and family and their interaction with and in the community.
2. Alternatively discuss the effect of family and community on the client with impaired gas exchange.

HEALTH

1. Describe the etiology and pathophysiology in the following conditions that effect gas exchange:
Pulmonary Embolism (PE), Lung CA, Acute respiratory failure and Chest Trauma.
2. Explain the relationship of impairment of gas exchange and other Nursing

NURSING

1. Use the nursing process to effect the care of the client with alterations in gas exchange.
2. Coordinate and prioritize independent, interdependent, and dependent nursing roles related the diagnostics and interventions for clients with any of the conditions listed in three above.
3. Explain the risks to gas exchange by the use of resuscitative fluids, medications and blood products.

ENVIRONMENT

1. Organize how environmental factors influence the health of clients with impaired gas exchange and discuss how to control or positively influence these changes.

ALTERATIONS IN ACTIVITY/EXERCISE PATTERN

Altered Cardiac Tissue Perfusion

Upon completion of this section the student will be able to complete the applicable unit objectives and:

HUMANITY

1. Discuss the interrelatedness of altered coronary artery to the client, significant other and family and the community.

HEALTH

1. Differentiate causes and contributory factors in the pathophysiology of coronary artery disease.
2. Explain how altered cardiac tissue effects or may be effected by other Nursing Diagnoses or Functional Health Patterns.

NURSING

1. Use the nursing process to effect the care of the client diagnosed with coronary artery disease.
2. Describe the importance of appropriate pain management for the client with altered cardiac tissue
3. Prioritize and coordinate independent, interdependent, and dependent nursing roles related to diagnostic assessments and interventions for the client with coronary artery disease.
4. Explain the use and risks in using anticoagulants, and antilipemics.

ENVIRONMENT

Describe the effects and how to manage modify the effects of environment on client hospitalized for acute interruption in coronary artery

ALTERATIONS IN ACTIVITY/EXERCISE PATTERN
Altered Renal Tissue Perfusion

Upon completion of this section the student will be able to complete the applicable unit objectives arid:

HUMANITY

1. Discuss the prevalence of renal failure and its impact on society.

HEALTH

1. Identify and discuss the causative and contributing factors of renal disease.

NURSING

- 1) Use an understanding of the pathogenesis of renal failure to formulate and coordinate appropriate interventions.
- 2) Anticipate, identify and prioritize interventions for possible complications in each of the components of wholeness that may be caused by altered renal tissue perfusion.
- 3) Explain the effect of changes in renal function
- 4) Describe the lifestyle changes (dietary, activity, recreation, travel for a person with end stage renal disease (ESRD).
- 5) Compare methods used to "clean" the blood and rid the body of excess water including renal transplant.

ENVIRONMENT

Recognize dangers to the client's physical safety, in and out of their home, and instruct the client, family,

UNIT 2
ALTERATIONS IN: SEXUALITY/REPRODUCTIVE PATTERN
HEALTH PERCEPTION/HEALTH MANAGEMENT PATTERN
COGNITIVE/PERCEPTUAL PATTERN

Upon completion of this unit the student will be able to:

HUMANITY

1. Describe the impact conditions which effect alterations sexuality/reproductive, health perception, health management, and cognitive/perceptual patterns have on the client during different phases of his/her life span, the client's significant other and family and the community with which the client interacts.
2. Describe the impact of community, the client's significant other and family and the client's components of wholeness have on the outcome of conditions which effect alterations in sexuality/reproductive, health perception, health management, and cognitive/perceptual patterns.

HEALTH

1. Explain how alterations in sexuality/reproductive, health perception, health management, and cognitive/perceptual patterns effect and are effected by other functional health patterns and nursing diagnoses.
2. Describe how the pathophysiologies of conditions discussed in this unit cause alterations in functional health patterns and influence nursing diagnoses.

NURSING

1. Use the nursing process to create a care plan addressing the whole person during diagnosis, acute and intermediate intervention, rehabilitation and long term living phases of care for clients with alterations in their health caused by the injuries or diseases outlined in this unit.
2. Using an understanding of nutrition and the other unit objectives, formulate a plan to assure an optimal nutritional outcome for clients with conditions outlined in this unit.
3. Anticipate possible effects alterations in body functions caused by the injuries or diseases outlined in this unit and chronological development have on the function of pharmacological agents.
4. Advocate for clients with multiple and critical conditions by safeguarding privacy, upholding a their stated wishes, protecting them from injurious treatments, assuring appropriate pain relief, and respecting their spiritual beliefs.
5. Create a teaching plan for the client and client's family who have the conditions studied in this unit, outlining the disease processes and their interventions, the possible complications and how to avoid them, and how the client can optimize their health during the disease and its sequela.

ENVIRONMENT

Outline how the nurse, client, and community can manage the environment to enhance the quality of life for the individual with the conditions studied in this unit.

ALTERATIONS IN SEXUALITY/REPRODUCTIVE PATTERNS

Sexual Dysfunction

Altered Sexuality patterns

Upon completion of this section the student will be able to complete the applicable unit objectives arid:

HUMANITY

1. Communicate the importance society places on sexuality and sexual function and discuss the effect disease of the organs of reproduction has on the individual and his or her family.

HEALTH

1. Explain methods of early detection of reproductive organ cancer and the regular practice of these Methods.

2. Using and understanding of the pathophysiology in the reproductive organs and the sexuality reproductive functional health pattern, explain their impact on the client in terms of other functional health patterns and nursing diagnoses.

NURSING

1. Using the nursing process design an intervention plan for the client with problems identified in number three above.

2. Understand the effects and side effects of pharmacological agents used to treat client s with problems identified in number three above

3. Design a teaching plan for male and female clients to disseminate the information from number two to the general population

4. Identify the client with a need for advocacy in dealing with health care providers

5. and the public who have diseases of the reproductive system.

ENVIRONMENT

Provide a safe environment for the client to express his/her self and protect the client privacy in dealing with these disease processes.

**ALTERATIONS IN HEALTH PERCEPTION,
HEALTH MANAGEMENT PATTERN
Effective Management of Therapeutic Regimen
(HIV and AIDS)**

Upon completion of this section the student will be able to complete the applicable unit objectives and:

HUMANITY

1. Discuss attitudes and stereotypes related to Human Virus infections and how that has affected research, screening, diagnosis and treatment of Auto-Immune Deficiency Syndrome (AIDS).
2. Understand ones own feelings about and persons with AIDS.
3. Recognize appropriate and inappropriate responses and treatments for persons infections.

HEALTH

1. Describe the etiology and pathophysiology involved with infections and relate them to the impact on the whole person

NURSING

1. Use the Nursing process to create a of care for persons in various stages of infection.
2. Identify, plan for and teach the client how to avoid the most common complications of being positive.
3. Identify, plan and teach the client how to minimized and manage the common side effects of the pharmacological interventions for infections.
4. Demonstrate appropriate ethics in dealing with clients who are HN positive and advocate for them in situations identified in number three above.
5. Explain how the nurse manipulates or teaches the client to manipulate the environment to promote optimal health for the client who is HIV positive

ALTERATIONS IN COGNITIVE/PERCEPTUAL PATTERN

Altered Cerebral Tissue Perfusion

Upon completion of this section the student will be able to complete the applicable unit objectives and:

HUMANITY

1. Discuss the effect and long term consequences of cerebral damage to the client, caregiver
2. Identify community resources available to the and client's family in dealing with the effects of permanent altered cerebral tissue perfusion

HEALTH

1. Discuss the etiology and pathophysiology of conditions that alter cerebral blood flow.
2. Examine how alterations in cognitive/perceptual pattern interact with other functional health patterns and nursing diagnoses.

NURSING

1. Identify the causes of in cere bral blood flow and how these can be identified and treated before causing cerebral damage.
2. Using the Nursing Process, create a plan of care for the client, including the components of wholeness, with alterations in cerebral tissue the dependent, interdependent, and independent roles.
3. Recognize the vulnerability of the client with alterations in cerebral tissue perfusion will advocate for this client the client's dignity and follow the client's informed choices where these have been identified.

ENVIRONMENT

Create a safe environment for the client with disabilities caused by alterations in cerebral tissue perfusion.

UNIT 3
ALTERATIONS IN NUTRITION/METABOLIC PATTERN

Upon completion of this unit the student will be able to:

HUMANITY

1. Describe the impact conditions which effect alterations in nutrition/metabolic pattern have on the client during different phases of his/her life span, the client's significant other and family and the community with which the client interacts.
2. Describe the impact of community, the client's significant other and family and the client's components of wholeness have on the outcome of conditions which effect alterations in nutrition/metabolic pattern functional health pattern.

HEALTH

1. Explain how alterations in nutrition/metabolic pattern effects and are effected by other functional health patterns and nursing diagnoses.
2. Describe how the pathophysiologies of conditions discussed in this unit cause alterations in functional health patterns and influence nursing diagnoses.

NURSING

1. Use the nursing process to create a care plan addressing the whole person during diagnosis, acute and intermediate intervention, rehabilitation and long term living phases of care for clients with alterations in their health caused by the injuries or diseases outlined in this unit.
2. Using an understanding of nutrition and the other unit objectives, formulate a plan to assure an optimal nutritional outcome for clients with conditions outlined in this unit.
3. Anticipate possible effects alterations in body functions caused by the injuries or diseases outlined in this unit and chronological development have on the function of pharmacological agents.
4. Advocate for clients with multiple and critical conditions by safeguarding privacy, upholding a their stated wishes, protecting them from injurious treatments, assuring appropriate pain relief, and respecting their spiritual beliefs.
5. Create a teaching plan for the client and client's family who have the conditions studied in this unit, outlining the disease processes and their interventions, the possible complications and how to avoid them, and how the client can optimize their health during the disease and it sequela.

ENVIRONMENT

Outline how the nurse, client, and community can manage the environment to enhance the quality of life for the individual with the conditions studied in this unit.

ALTERATIONS IN NUTRITION/METABOLIC PATTERN

Body Image Disturbances

Fluid Volume Excess or Fluid Volume Deficit

High Risk for Injury

Pituitary/Adrenal

Upon completion of this section the student will be able to complete the applicable unit objectives and:

HUMANITY

1. Describe the impact physical and mental changes in the client with impaired pituitary or adrenal function have on their significant others, families, and their communities.

HEALTH

1. Describe how changes in pituitary hormone secretion effect the client during different phases of the lifespan.

2. Identify the etiology and describe the pathophysiology for clients with the following medical

Diagnosis:

Hypo-and Hyperpituitarism

Diabetes Insipidus

Syndrome of inappropriate Ant diuretic Hormone Secretion (SLADH)

Adrenal Hyper-or Hypofunction

Hyper-and Hypocortisolism

Hyperaldosteronism

Pheochromocytoma

3. Relate how alteration in Nutrition/Metabolic Functional Health Pattern effects other functional health patterns and nursing diagnoses.

NURSING

1. Use the nursing process to coordinate the dependent, interdependent and independent cares related to The diagnosis and interventions for clients listed in number three above.
2. Describe the unique pre and post operative cares and concerns for the transphenoidal hypophysectomy patient

ALTERATIONS IN NUTRITION/METABOLIC PATTERN
Altered Nutrition, Less than Body Requirements
Liver & Pancreas

Upon completion of this section the student will be able to complete the applicable unit objectives and:

HUMANITY

- I. Explore the social pressures that contribute to diseases of the pancreas and liver and community involvement in altering these pressures.
 - 1 Discuss the stigma attached to cirrhosis of the liver.
 - 2 Discuss societal mores and norms that contribute to or distract from possible effective interventions for the complications of liver and pancreas disease.

HEALTH

- 1 Identify the etiology and discuss the pathophysiology of diseases of the pancreas and Liver
- 2 Discuss how diseases of the liver and pancreas affect the functional health pattern and how alterations effect other functional health patterns and nursing diagnoses.

NURSING

- 1 Using the information in the above objectives create an interdisciplinary nursing care independent,interdependent and dependent roles.
- 2 Discuss how alterations in liver function may alter the medications these clients may need.
- 3 Discuss specific conventional and alternate methods of pain control for the patient with pancreaticdisease.
- 4 Formulate different methods of enhancing the nutrition of an individual with pancreatic and liver disease.
- 5 Create a teaching plan for clients with liver or pancreas disease outlining possible complications,how to prevent or delay them and when to seek further medical attention.

ENVIRONMENT

Discuss how the nurse, client, or caregiver can maintain a safe environment.

MAJOR AREAS OF EMPHASIS/DIAGNOSES

Make every effort at every clinical to assign yourself at least one patient from this list.

Altered Tissue Perfusion

Coronary Artery Disease, Angina, Myocardial Infarction, Cardiogenic Shock

Impaired Gas Exchange

Pulmonary Embolism; Acute Respiratory Failure
Acute Respiratory Distress Syndrome; Lung CA
Chest Trauma - Flail Chest, Tension Pneumothorax, Hemothorax

Impaired Renal Tissue Perfusion

Acute/Chronic Renal Failure; Renal Transplantation
Hemodialysis; Peritoneal Dialysis

Altered Sexuality Pattern/Sexual Dysfunction-Gynecologic

Primary Dysmenorrhea; Amenorrhea; Premenstrual Syndrome
Endometriosis; Endometrial Cancer
Toxic Shock Syndrome; Simple Vaginitis; Vulvitis
Uterine Prolapse; Cystocele; Uterine Leiomyomas
Cervical CA; Ovarian CA

Altered Sexuality Pattern/Sexual Dysfunction - Male Reproductive

Benign Prostatic Hyperplasia (BPH); Testicular CA
Prostatitis; Prostate CA; Epididymitis/Orchitis

Alteration in Health Perception/Health Management

Acquired Immune Deficiency Virus

Altered Cerebral Tissue Perfusion

Cerebrovascular Accident (CVA); Carotid Endarterectomy
Head Injury; Craniotomy; Brain Tumor; Brain Abscess
Arteriovenous Malformation

Body Image Disturbance/Fluid Volume Excess or Deficit

Hypopituitarism/Hyperpituitarism; Hypophysectomy
Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH)
Hyperaldosteronism; Pheochromocytoma; Diabetes Insipidus
Hypercortisolism (Cushing's Syndrome); Adrenalectomy

Altered Nutrition, Less than Body Requirements

Cirrhosis; Portal Hypertension; Portal/Systemic Encephalopathy
Bleeding Esophageal Varices; Viral Hepatitis; Chemical Hepatitis
Hepatic Abscess; Liver CA; Liver Transplantation
Acute/Chronic Pancreatitis; Pancreatic Abscess; Pancreatic CA

CLINICAL SYLLABUS

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4. CRITICAL CARE CLINICAL EXPERIENCE
 - ICU CLINICAL EXPERIENCE
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 - EMERGENCY DEPARTMENT CLINICAL EXPERIENCE
 - DIALYSIS CLINICAL EXPERIENCE

CLINICAL UNIT 1

Alterations in Activity/Exercise Pattern

Upon completion of this clinical unit, the student will have applied the corresponding course unit and section objectives the applicable expected clinical competencies, and be able to:

HUMANITY

Recognize how interpersonal interactions alter a client's activity/exercise pattern noting how these contribute to or distract from his or her wellness.

HEALTH

Observe how the pathophysiologies of coronary artery disease, adult respiratory failure, and acute and chronic renal failure influence various functional health patterns and nursing diagnoses.

NURSING

Function in the role of the Associate Degree Nurse as the:

Provider of Care:

Assure an optimal nutritional outcome for clients with conditions outlined in this unit.

Manager of Care:

Use the nursing process to create and implement a care plan addressing the whole person and his/her family during diagnosis, intervention, and long term living phases of care for clients with alterations in their health caused by the injuries or diseases outlined in number 2 above.

Member Within the Profession:

- a. Advocate for clients with multiple and critical conditions by safeguarding privacy, upholding a their stated wishes, protecting them from injurious treatments, assuring appropriate pain relief, and respecting their spiritual beliefs.
- b. Create a teaching plan for the client and client's family who have the conditions studied in this unit, outlining the disease processes and their interventions, the possible complications and how to avoid them, and how the client can optimize their health during the disease and its sequela.

ENVIRONMENT

1. Manage the environment within the scope of a nursing student to enhance the quality of life of the client with conditions studied in this unit.
2. Explain how the client and community can manage the environment to enhance the quality of life for the individual with the conditions studied in this unit.

Manager of Care

Use the nursing process to create and implement a care plan addressing the whole person during diagnosis, intervention, rehabilitation and long term living phases of care for clients with alterations in their health caused by the injuries or diseases outlined in this unit.

Member Within the Profession

Advocate for clients with multiple and critical conditions by safeguarding privacy, upholding a their stated wishes, protecting them from injurious treatments, assuring appropriate pain relief, and respecting their spiritual beliefs.

ENVIRONMENT

1. Manage the environment within the scope of a nursing student to enhance the quality of life of the client with conditions studied in this unit.
2. Explain how the client and community can manage the environment to enhance the quality of life for the individual with the conditions studied in this unit.

CLINICAL UNIT 2
Alterations in: Sexuality - Reproductive Pattern
Health Perception, Health Management Pattern
Cognitive - Perceptual Pattern

Upon completion of this clinical unit, the student will have applied the corresponding course unit and section objectives the applicable expected clinical competencies, and be able to:

HUMANITY

1. Identify and explain the impact conditions which effect alterations sexuality/reproductive, health perception, heath management, and cognitive/perceptual patterns have on the client during different phases of his/her life span, the client's significant other and family, and the community with which the client interacts.
2. Identify and explain the impact of community, the client's significant other and family and the client's components of wholeness have on the outcome of conditions which effect alterations in sexuality/reproductive, health perception, heath management, and cognitive/perceptual patterns.

HEALTH

1. Recognize how alterations in sexuality/reproductive, health perception, heath management, and cognitive/perceptual patterns effect and are effected by other functional health patterns and nursing diagnoses.
2. Use an understanding of how the pathophysiologies of conditions discussed in this unit cause alterations in functional health patterns and influence nursing diagnoses to develop a plan of care to modify these alterations for the clients benefit.

NURSING

Function in the role of the Associate Degree Nurse as the:

Provider of Care

- a. Using an understanding of nutrition and the other unit objectives, use a plan to assure an optimal nutritional outcome for clients with conditions outlined in this unit.
- b. Anticipate possible effects alterations in body functions caused by the injuries or diseases outlined in this unit and chronological development have on the function of pharmacological agent.
- c. Teaching the client and client's family who have the conditions studied in this unit, outlining the disease processes and their interventions, the possible complications and how to avoid them, and how the client can optimize their health during the disease and it sequela.

CLINICAL UNIT 3

Alterations in Nutrition - Metabolic Pattern

Upon completion of this clinical unit, the student will have applied the corresponding course unit and section objectives the applicable expected clinical competencies, and be able to:

HUMANITY

1. Identify and explain the impact conditions which effect alterations in nutrition/metabolic pattern have on the client during different phases of his/her life span, the client's significant other and family and the community with which the client interacts.
2. Identify and explain the impact of community, the client's significant other and family and the client's components of wholeness have on the outcome of conditions which effect alterations in nutrition/metabolic pattern functional health pattern.

HEALTH

1. Recognize when and how alterations in nutrition - metabolic pattern effect and are effected by other functional health patterns and nursing diagnoses.
2. Use an understanding of how the pathophysiologies of conditions discussed in this unit contribute to alterations in functional health patterns and influence nursing diagnoses to develop a plan of care to modify these interactions for the clients benefit.

NURSING

1. Function in the role of the Associate Degree Nurse as the:
Provider of care
 - a. Using an understanding of nutrition and the other unit objectives, implement a plan to assure an optimal nutritional outcome for clients with conditions outlined in this unit.
 - b. Initiate the appropriate in interventions for the anticipated effects that alterations in body functions caused by the injuries or diseases outlined in this unit and a client's chronological development have on the function of pharmacological agents.
2. Teach clients and clients family who have the conditions studied in this unit, the disease processes and interventions, the possible complications and how to avoid them, and how the they can optimize their health during the disease and it sequela.
Manager of care

Use the nursing process to create and implement a care plan addressing the whole person during diagnosis, acute and intermediate intervention, rehabilitation and long term living phases of care for clients with alterations in their health caused by the injuries or diseases outlined in this unit.

Member Within the Profession

Advocate for clients with multiple and critical conditions by safeguarding privacy, upholding a their stated wishes, protecting them from injurious treatments, assuring appropriate pain relief, and respecting their spiritual beliefs.

ENVIRONMENT

Outline how the nurse, client, and community can manage the environment to enhance the quality of life for the individual with the conditions studied in this unit.

CRITICAL CARE CLINICAL EXPERIENCE

OBJECTIVES

Overall Objective: To expose the student to critical care nursing.

Under the direct supervision of a critical care nurse the student will identify common medical and nursing assessments, diagnoses, and treatments seen in the critical care department. The student will also observe and explore the role of the nurse in this setting, including practice related to teaching, emotional and spiritual support, injury prevention, family concerns, advocacy, and legal and ethical issues.

Outcome Objectives:

With awareness of each client's need for wholeness, utilizing the nursing process and the concepts of the functional health patterns the student, at the end of this experience, will be able to:

1. Describe the role of the nurse in the critical care department.
2. Identify key assessments made by the nurse in the critical care unit.
3. Identify critical factors related to the assessment, diagnosis, and treatment of clients in the critical care unit.
4. Identify the clinical staff's role in a code.
5. Identify actions and potential side effects of pharmacological agents and treatments commonly used in emergency situations.
6. Discuss ethical and legal implications of patient care with RN staff, including issues related to right to life, right to die, code status, organ donation, and use of restraints.
7. Identify appropriate communication skills and key psycho/social interventions used by the nurse with the client and significant others in critical care settings.
8. Compare and contrast critical care of persons of various age groups.
9. Recognize cultural and ethical variations and their possible impact on clients and families in critical care.
10. Assess knowledge deficit needs of clients and potential education methods.

Student Responsibilities:

1. Select a client for care on the evening before lab.
2. Review and integrate previously learned theory related to client problems.
3. Arrive promptly, well groomed, in uniform, with care plan, critical care worksheet and appropriate clinical tools.

4. Review agency policy, protocols, and standardized procedures used by the nurse in the critical care unit.
5. Complete the critical care worksheet and turn it in at the end of the experience.
6. Turn in a mini or major care plan related to the care of your client.

Under the direct supervision of the RN the student may:

1. Assisting the RN with assessments and patient care activities.
2. Observe the RN and medical team in emergency situations.
3. Within the judgement of the RN the student may observe and/or assist any special procedures or treatments performed by the RN or medical staff.
4. Perform any skill or procedure previously learned that does not require agency certification.
5. Administer routine medications.

The student may not:

1. Administer any medication or perform any skill or procedure without direct RN supervision.
2. Take verbal or telephone orders.
3. Be solely responsible for receiving and/or monitoring a client in emergency situations.
4. Administer chemotherapy agents.
5. Administer thrombolytic agents.
6. Remove a central line.
7. Draw blood from any site.
8. Initiate, change, or discontinue a PCA device.
9. Perform any skill or procedure that has not been taught or that requires certification.
10. Carry narcotic keys.
11. Initiate, solely monitor, or change specialized critical care medications, administered as IV drips, such as dopamine, insulin, cardiac drips, narcotic drips, etc.

ICU CLINICAL EXPERIENCE

Preparation Guidelines

A. Read/Review - *Lewis, Medical Surgical Nursing*

1. Chest Trauma
2. Abdominal Trauma
3. Liver Trauma
4. Head Injury
5. Spinal Cord Injury
6. Myocardial Infarction
7. Acute Respiratory Distress
8. Pulmonary Embolism
9. Elder Abuse

B. Review the following IV medications commonly used in the ICU (know indications)

1. Dopamine
2. Dobutamine
3. Nitroprusside
4. Nitroglycerin
5. Diprivan
6. Adenosine
7. Cardizem
8. Lidocaine
9. Heparin
10. Vecuronium
11. Desmopressin-DDAVP

C. Review the following procedures:

1. Hemodynamic monitoring
2. Oxygen saturation
3. Ventilator modes
4. ABG normals and abnormal
5. Chest tubes - nursing care
6. ICP

D. Complete Critical Care Clinical Experience

CRITICAL CARE CLINICAL EXPERIENCE

Name _____ Date _____

Resource RN _____

1. Which roles/responsibilities of the RN in the intensive care unit differ from the roles of the nurse on a med-surg unit?
2. What assessments are made on clients in the ICU that are not routinely made on other hospital units? Why are these necessary?
3. What procedures did you observe in ICU, and what was the nurse's role in these procedures?
4. Name at least two pharmacological agents that can only be given in an ICU setting. Why must these be given in an ICU setting?

5. Discuss at least one ethical or legal issue. What is the nurse's role in dealing with this issue?

6. How could culture or age affect a client's reaction to the care in ICU?

7. What is the difference between standards of practice and standardized procedures? Please research your answer, don't guess.

8. Comments or Concerns:

9. Evaluation of Clinical Experience:

HEMODYNAMIC MONITORING

Overview

Hemodynamic monitoring, an invasive technique requiring right heart catheterization, allows close examination of cardiac function in acutely ill patients.

Indications

- Complicated myocardial infarction
- Heart failure - guides management of conditions r/t from low CO
- Respiratory Failure
- Shock
- Provides direct means of assessing response to fluid and drug management
- Permits careful titration of medications

PULMONARY ARTERY PRESSURES (PAP)

The major determinant of LV function is left ventricular end-diastolic pressure (LVEDP), which cannot be measured directly at bedside. However, LVEDP can be assessed indirectly by measuring the pressure in the pulmonary capillaries and by measuring PAP at the end of diastole.

A catheter is passed through the right side of the heart into the pulmonary artery. There the balloon is inflated, occluding the artery. With the balloon inflated, the catheter is wedged into a distal branch of the pulmonary capillaries. The PCWP reflects left atrial pressure, which corresponds to LVEDP.

INTRA-ARTERIAL PRESSURE (ARTERIAL LINE)

Placement of an indwelling catheter in a major artery (usually radial) connected to a transducer permits continuous monitoring of systemic arterial pressure.

CARDIAC OUTPUT (CO)

The volume of blood pumped per minute is measured by a calibrated thermistor located near the tip of the pressure catheter. A measured amount of solution is injected through the catheter at a specified rate into the right atrium, and the thermistor records the blood temperature as it passes through the catheter. The difference in temperatures between the solution and the blood is calculated, and the CO is then digitally displayed on a computer.

SVR (AFTERLOAD)

SVR is the resistance offered by the systemic arterial circulation to LV ejection. Factors or conditions (such as cardiogenic shock) that cause the SVR to increase will also increase the workload of the heart. SVR is calculated as follows:

$$SVR = (MAP - RAP)/CO \times 80$$

EMERGENCY DEPARTMENT CLINICAL EXPERIENCE

OBJECTIVES

Overall Objective: To expose the student to emergency nursing.

Under the direct supervision of an ER RN the student will identify common medical and nursing assessments, diagnoses, and treatments seen in the emergency department. The student will also observe and explore the role of the nurse in this setting, including practice related to triage, trauma and medical emergency care, evaluation of patient compliance, teaching, marketing, public relations, emotional and spiritual support, injury prevention, family concerns, advocacy, and legal and ethical issues.

Outcome Objectives:

With awareness of each client's need for wholeness, utilizing the nursing process and the concepts of the functional health patterns the student, at the end of this experience, will be able to:

1. Describe the role of the nurse in the emergency department.
2. Describe the primary and secondary survey assessments made by the nurse for triage and treatment.
3. Identify critical factors related to the assessment, diagnosis, and treatment of clients presenting for care with urgent or emergent health conditions.
4. Identify the nurse's role in a trauma code.
5. Identify actions and potential side effects of pharmacological agents and treatments commonly used in emergency care situations.
6. Discuss ethical and legal implications of emergency care with RN staff, including issues related to reportable offenses, injuries, and diseases.
7. Identify appropriate communication skills and key psycho/social interventions used by the nurse with the client and significant others in emergency situations.
8. Compare and contrast emergency care of persons of various age groups.
9. Recognize cultural and ethical variations and their possible impact on emergency health care.
10. Assess knowledge deficit needs of clients and potential education methods.
11. Describe community resources and supportive services used for clients and families in emergency situations.

Student Responsibilities:

1. Read text on selected emergency situations listed below.
2. Review and integrate previously learned theory related to client problems commonly seen in the emergency department.
3. Arrive promptly, well groomed, in uniform, and with worksheet and appropriate clinical tools.
4. Review agency policy, protocols, and standardized procedures used by the nurse in the emergency department.
5. Complete the worksheet while in emergency department and turn it in at the end of the experience.

Under the direct supervision of the RN the student may:

1. Work in the triage, clinic or acute areas of the emergency department, assisting the RN with assessments and patient care activities.
2. Observe the RN and medical team in emergency medical situations.
3. Within the judgement of the RN the student may observe and/or assist any special procedures or treatments performed by the RN or medical staff.
4. Perform any skill or procedure previously learned that does not require agency certification.
5. Administer routine medications.

The student *may not*:

1. Administer any medication or perform any skill or procedure without direct RN supervision.
2. Take verbal or telephone orders.
3. Be solely responsible for receiving and/or monitoring a client in emergency situations.
4. Administer chemotherapy agents.
5. Administer thrombolytic agents.
6. Remove a central line.
7. Draw blood from any site.
8. Initiate, change, or discontinue a PCA device.
9. Perform any skill or procedure that has not been taught or that requires certification.
10. Carry narcotic keys.

DIALYSIS CLINICAL EXPERIENCE

OBJECTIVES

Overall Objective: To expose the student to dialysis care.

Under the direct supervision of a dialysis nurse the student will identify common medical and nursing assessments, diagnoses, and treatments seen in the dialysis unit. The student will also observe and explore the role of the nurse in this setting, including practice related to teaching, emotional and spiritual support, injury prevention, family concerns, advocacy, and legal and ethical issues.

Outcome Objectives:

With awareness of each client's need for wholeness, utilizing the nursing process and the concepts of the functional health patterns the student, at the end of this experience, will be able to:

1. Describe the role of the nurse in the dialysis unit.
2. Identify key assessments made by the nurse in the dialysis unit.
3. Identify critical factors related to the assessment, diagnosis, and treatment of clients on dialysis.
4. Identify the clinical staff's role in a code.
5. Identify actions and potential side effects of pharmacological agents and treatments commonly used for clients on dialysis.
6. Discuss ethical and legal implications of patient care with RN staff, including issues related to right to life, right to die, code status while being dialyzed, and organ transplantation.
7. Identify appropriate communication skills and key psycho/social interventions used by the nurse with the client and significant others in the dialysis unit.
8. Compare and contrast the care of persons of various age groups on dialysis.
9. Recognize cultural and ethical variations and their possible impact on clients and families.
10. Assess knowledge deficit needs of clients and potential education methods.

Student Responsibilities:

1. Read or review chapter on renal failure and integrate previously learned theory related to dialysis.
2. Arrive promptly, well groomed, in uniform, and with care plan and appropriate clinical tools.
3. Review agency policy, protocols, and standardized procedures used by the nurse in the dialysis unit.
4. Complete the dialysis clinical experience form and turn it in at the end of the experience.

Under the direct supervision of the RN the student may:

1. Assist the RN with assessments and patient care activities.
2. Observe the RN and medical team in special procedures and/or emergency situations.
3. Within the judgement of the RN the student may observe and/or assist any special procedures or treatments performed by the RN or medical staff.
4. Perform any skill or procedure previously learned that does not require agency certification.

The student *may not*:

1. Administer any medication or perform any skill or procedure without direct RN supervision.
2. Take verbal or telephone orders.
3. Be solely responsible for receiving and/or monitoring a client.
4. Administer chemotherapy agents.
5. Administer thrombolytic agents.
6. Remove a central line.
7. Draw blood from any site.
8. Perform any skill or procedure that has not been taught or that requires certification.
9. Carry narcotic keys.
10. Initiate, solely monitor, or change specialized medications, administered as IV drips.

DIALYSIS CLINICAL EXPERIENCE

Name _____ Date _____

Resource RN _____

1. Are there any roles of the RN in the dialysis unit that are different from the roles of the nurse in other settings? If so, what are they?

2. What assessments are made on clients in dialysis that are not made in other settings? Why are these necessary?

3. What procedures did you observe in the dialysis unit, and what was the nurse's role in these procedures?

4. Name at least two pharmacological agents that are often given in the dialysis unit.

5. Discuss at least one ethical or legal issue. What is the nurse's role in dealing with this issue?

6. How could culture or age affect a client's reaction to the dialysis?

7. What is the difference between standards of practice and standardized procedures?

8. Comments or Concerns:

9. Evaluation of Clinical Experience:

**MANAGEMENT OF PATIENT
CARE**

THEORY SYLLABUS

Course Description

Management of Patient Care is a nursing course designed to prepare the student to assume the role of a graduate registered nurse in the clinical setting. The theoretical concepts of roles and responsibilities in a structured acute health care organization include 20 hours of basic management and leadership theory. These are translated into the application of clinical concepts of time management, decision making, priority setting, delegation, professional, legal, ethical and career responsibilities during clinical.

COURSE OBJECTIVES

1. Recognize the process of reality shock while making the transition from student to new graduate in the work place. Begin to adjust to the expectation and values in the work place.
2. Analyze hospital and nursing unit organizational structure and define the role of the nurse.
3. Apply principles of the nursing process in managing care for a group of patients including the applications related to pharmacology, nutrition, communication and clinical education.
4. Build on communication skills in the health care organization, contributing to a positive work environment, shift reports, adapting to unit staff, becoming an assertive member of the team, advocating for the patient and for quality patient care.
5. Develop the nursing management role in setting priorities, making decisions, delegating and documenting patient care activities.
6. Recognize components of wholeness in identifying and managing adult and geriatric patient needs as written in patient care plans.
7. Identify clinical situations contributing to spiritual distress and demonstrate effective nursing interventions leading to resolution of that distress.
8. Apply knowledge of legal-ethical principles in contemporary patient care situations.
9. Analyze leadership styles and issues of professional integrity in health care/nursing units.
10. Develop career plans for self with professional growth, and a strategy for wellness and stress management in a changing health care environment with health care reform and its implications

TABLE OF CONTENT

- 1.INCREASING WELLNESS BY MANAGING STRESS AND PREVENTING NURSE BURNOUT
- 2.TENSION RELIEVERS
- 3.NURSING A DEVELOPING PROFESSION
- 4.CHALLENGES OF NURSING MANAGEMENT
- 5.EFFECTIVE COMMUNICATION -SKILLS IN NURSING MANAGEMENT
- 6.TAKING CONTROL OF THE JOB WITH TIME MANAGEMENT
- 7.ECONOMIC AND POLITICAL ASPECTS OF THE HEALTHCARE SYSTEM
- 8.ETHICAL AND LEGAL ISSUES IN NURSING
- 9.STANDARDS OF COMPETENT PERFORMANCE

INCREASING WELLNESS BY MANAGING STRESS AND PREVENTING NURSE BURNOUT

OBJECTIVES

Following completion of this class the student will be able to:

Recognize stress level and identify strategies for self-care.

HEALTH

- 1 Recognize signs of excessive stress in self and others.
- 2 Explain the effects of continued stress on the body.
- 3 Demonstrate some stress reduction activities.
- 4 Develop own stress management and wellness program.
- 5 Evaluate the value of spiritual interventions in coping with stress and discuss any age related implications.
- 6 Discuss priorities in stress management for self and for clients. Relate to: nutritional needs, exercise needs, rest and sleep patterns.

ENVIRONMENT

1. Name the outcomes of occupational stress.
2. Enumerate the various stressors and burnout promoters found in nursing.
3. Discuss stress theory, include theory related to an aging population, and identify stressors across the life cycle.

NURSING

1. State the major approaches to stress management and identify those useful for the elderly.

TENSION RELIEVERS

Talk it out. Don't bottle things up. Confide your worries to someone you can trust. Talking it out helps to relieve your strain, helps you to see your worries in a clearer light, and often helps you to see what you can do about it.

Escape for a While. When things go wrong, just stand there and suffer. It's not a way to solve the problem. Take a walk, lose yourself in a book or a game. Take long enough to recover breath and balance. Deal with the difficulty when you are more composed.

Work Off Anger. While anger may give you a temporary sense of relief, it will generally leave you feeling foolish and sorry in the end. Instead of lashing out, pitch into some physical activity like gardening, cleaning, or some do-it-yourself project. Working the anger out of your system and cooling off for a day or two will leave you much better prepared to handle your problem.

Give In Occasionally. If you find yourself getting into frequent quarrels with people and feeling obstinate and defiant, remember that this is the way frustrated children behave. Stand your ground on what you know is right, but do so calmly. And even if you're dead right, easier on your system to give in once in a while. If you yield, usually find the others will-too.

Do Something for Others. Instead of worrying about yourself all the time, try doing something for somebody else. You'll find that take the steam out of your own worries and give you a fine feeling of having done well.

Take One Thing at a Time. An ordinary work load can sometimes seem unbearable. Remember that it's a temporary condition and that you can work your way out of it. Tackle a few of the most urgent tasks, one at a time, setting aside all the rest. Once you dispose of these, you'll see that the remainder is not such a mess" after all.

Shunt the "Superman" Urge. Some people expect too much from themselves and are constantly stressed by thinking they are not achieving as much as they should. No one can be perfect in everything. Decide which things you do well, and then put your major effort into these. They are apt to be the things you like to do, and hence those that give you the most satisfaction.

Go Easy With Your Criticism. Expecting too much of others can leave you feeling frustrated and disappointed. Each person has his or her own virtues, shortcomings, values, and right to develop as an individual. Instead of being critical about another person's behavior, search out the good points and help him or her to develop them.

Give the Other Fellow a Break. When people are under emotional tension they often feel that they have to "get there first"-to edge out the other person, even if the goal is as trivial as getting ahead on the highway. Competition is contagious, but so is cooperation. When you give the other fellow a break, you very often make things easier for yourself.

Make Yourself Available. Many of us feel that we are being left out, slighted, neglected, or rejected. Often we just imagine that other people feel this way about us, when in reality-they are eager for us to make the first move. Instead of shrinking away and withdrawing, make some of the overtures. Don't always wait to be asked.

(National Mental Health Association)

NURSING A DEVELOPING PROFESSION

OBJECTIVES

Following completion of the class the student will be able to:

NURSING

1. Identify the characteristics of reality shock, in the nursing profession.
2. Discuss the concepts of reality shock.
3. Compare and contrast the phases of reality shock.
4. Identify your perception of reality shock.
5. Describe four possible resolutions for reality shock.
6. Discuss what nurses do.
7. Examine two current nursing issues affecting nursing practice: Advanced practice nursing and community-based practice settings for nurses.
8. Discuss the future of nursing education. Compare and contrast the types of education preparation for nurses.

ENVIRONMENT

1. Identify selected historical educational studies and literature that have influenced the image of professional nursing.
2. Describe the role of credentialing and certification in professional practice.
3. Compare and contrast the alternative options provided by career-ladder, external-degree, BSN -completion, and university-without-walls programs.
4. Describe the purpose of nursing program accreditation.

CHALLENGES OF NURSING MANAGEMENT

OBJECTIVES

Following completion of the class the student will be able to:

HEALTH

1. Discuss various models of health education. Reflect the impact that leadership has on addressing these health care problems.
2. Describe how utilization of research is effective in health maintenance.

NURSING

1. Apply problem-solving strategies to clinical management situations.

ENVIRONMENT

- 1 Differentiate between management and leadership.
- 2 Describe various types of management. Compare and contrast different leadership styles.
- 3 Distinguish between power and authority.
- 4 Define the task and maintenance roles that group members assume to ensure effective group functioning.
- 5 Discuss the change process.
- 6 Discuss the difference between conduction research and research utilization.
- 7 Describe the function of the National Institute of Nursing Research.

HUMANITY

1. Identify the characteristics of effective work groups.

EFFECTIVE COMMUNICATION -SKILLS IN NURSING MANAGEMENT

OBJECTIVES

Following completion of this class the student will be able to:

HEALTH

1. Explain sources of distortion in communication, including those common in the elderly and physical impaired.
2. Define anger, anxiety, and conflict.
3. Explain how anger and anxiety influence our interpersonal relationships.
4. Explain the physical effect anger and conflict has on the body. Flight or Fight.
5. Identify sources of conflict.
6. Demonstrate active listening.

NURSING

1. Identify communication needs of the patients, also families.
2. Identify communication styles of co-workers and physicians.
3. Identify roles and dynamics of the peer group.
4. Discuss techniques to use in dealing with difficult patients, families, peers and physician.

ENVIRONMENT

1. Differentiate between difficult people and difficult, situations and state the importance of, the differentiation.
2. Enumerate the six steps for effectively coping with difficult people. Formulate appropriate conflict resolution strategies for the major types of difficult people (the hostile, aggressive, the complainer, the silent and unresponsive, the super agreeable, the negativism, the know-it-all-expert, the indecisive).
3. Identify situations of sexual harassment in the workplace and discuss possible solutions.

TAKING CONTROL OF THE JOB WITH TIME MANAGEMENT

OBJECTIVES

Following completion of this class the student will be able to:

NURSING

1. Describe the principle of priority setting for managing care of a group of patients.
2. Set appropriate priorities for patient care and write a work schedule of assigned shifts.
3. Differentiate between nursing tasks that may and may not be delegated. Demonstrate effective delegation and describe rationale (principles used) .
4. Identify the steps in the Process of Research.

HUMANITY

1. Describe the function of the National Institute of Nursing Research.
2. Identify time adjustments added in caring for geriatric populations.
 - Time for slow movements
 - Time for instructions/clarifications
 - Time for Time for walkers and wheel chairs

ENVIRONMENT

1. Describe your individual time styles.
2. Identify time wasters.
3. Enumerate time saving techniques, devices and-methods
4. Increase your organizational skills.
5. Apply principles of time management to schedule use of school and personal time effectively.
6. Identify time management strategies for increasing payoff, high-priority activities.

ECONOMIC AND POLITICAL ASPECTS OF THE HEALTHCARE SYSTEM

OBJECTIVES

Following completion of this class the student will be able to:

NURSING

1. Identify the conditions that may cause nurses to seek collective bargaining representation.
2. Discuss the impact of quality improvement activities on nursing practice.
3. Identify two problems on a nursing unit in which quality improvement efforts would improve patient outcomes.

ENVIRONMENT

1. Discuss how current trends will affect your future nursing practice.
2. Describe two nursing practice activities that have been influenced by computers.
3. List specific strategies needed to begin to affect the laws that govern the practice of nursing and the healthcare system.
4. Describe the function of a political action committee.
5. Discuss selected issues affecting nursing:
 - Substitution of less-prepared care givers for
 - Team leading. Primary care.
 - Equal pay for work of comparable value.
6. Discuss different types of power and how it is obtained.

ETHICAL AND LEGAL ISSUES IN NURSING

OBJECTIVES

Following completion of this class the student will be able to apply knowledge of legal-ethical principles in patient care. Each student will complete the task delegation exercise.

NURSING

1. Identify the basic concepts central to most ethical situations
2. Determine principles of Christian behavior that lend themselves to management skills.
3. Evaluate the effectiveness of moral actions.
4. Discuss the legal implications of nurses diagnosing human responses to health problems.

ENVIRONMENT

1. Differentiate between common, statutory, civil and criminal law.
2. Define liability, negligence, and malpractice.
3. State standards of competent performance
4. Identify the specific rights of patients as stated in the Patients Bill of Rights
5. Discuss the meaning of informed consent.
6. Name the nursing actions in the Code for Nurses.

STANDARDS OF COMPETENT PERFORMANCE

A registered nurse shall be considered to be competent when consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

- (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
- (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
- (3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
- (4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
- (5) Evaluates the effectiveness of the care plan through observation of the physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and the health team members, and modifies the plan as needed.
- (6) Acts as the client's advocate, as circumstances require by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

PRECLINICAL SYLLABUS

ANATOMY AND PHYSIOLOGY

SYLLABUS

ANATOMY AND PHYSIOLOGY

OBJECTIVES

Anatomy and Physiology introduces the structure and function of the normal human body which enable the nurse to apply theoretical knowledge in to the health care setting. It also develops the nurses' ability to perform procedures efficiently and qualitatively.

COURSE DESCRIPTION

- ❖ Total allocated time for theory 140hrs and covered in two terms.
- ❖ Lecturer should be a qualified Medical Officer.
- ❖ Methods of instructions are lectures, atlases, videos and tutorials.
- ❖ Performances are evaluated by quizzes and assignments.
- ❖ Term exams will include MCQ, structured essays and essays questions.

REFERENCES

1. Anne.W,Allison.G, Anatomy and Physiology,Ross & Wilson, 10th ed, Elsevier, 2006.
2. Elaine.N.M, Jon.M, Human Anatomy, 2nd ed, Benjamin Cummings, 1997.
3. Stuart.I.F, Human Physiology, 6th ed, Mc Graw Hill, 1999.

COURSE OUTLINE

1. Introduction

- Introduction to Anatomy
- Introduction to Physiology

Time allocated 01hr

2. Cells and Tissues

- Structure of the Cell
- Characteristics of Cells
- Cell Division
- Transportation
- Types of Tissues

Time allocated 06hrs

3. The Body as a whole

- The Skull
- The Thorax
- The Abdomen

Time allocated 04hrs

4. The Skeletal System

- Structure and functions of the Skeletal System
- Bones of the Shoulder girdle and Upper limbs
- Bones of the Pelvic girdle
- Bones of the Lower limbs
- The Skull
- The Vertebral Column
- Bones of the Thorax
- Joints of the body

Time allocated 10hrs

5. The Nervous System

- Structure of the Nervous System
- Neurones
- Central Nervous System
- Brain
- Spinal Cord
- Peripheral Nervous System
- Autonomic Nervous System
- Response of nervous tissue to injury

Time allocated 10hrs

6. The Muscular System

- Structure and functions of the Muscular System
- Skeletal muscles
- Muscles of the Head and Neck
- Muscles of the Shoulder girdle and Upper limbs
- Muscles of the Trunk
- Muscles of the Lower extremity

Time allocated 10hrs

7. Body Defences:Immunity

- Innate Immunity
- Acquired Immunity

Time allocated 05hrs

8. The Respiratory System

- Structure and functions of the Respiratory System
- Regulatory mechanisms in the Respiratory System

Time allocated 10hrs

9. The Haemopoietic System

- Components of Blood
- Functions of blood cells
- Plasma
- Blood Groups

Time allocated 10hrs

10. The Circulatory System

- Structure and function of the Heart
- Structure and functions of Blood Vessels
- Electrical conductivity System of the heart
- Blood pressure

Time allocated 12hrs

11. The Lymphatic System

- Structure and function of the Lymphatic System
- Lymphatic organs and tissues

Time allocated 10hrs

12. The Digestive System

- Basic structure of the Elementary canal
- Mouth
- Salivary glands
- Pharynx
- Esophagus
- Stomach
- Small intestine ,large intestine and anal canal
- Pancreas
- Liver
- Biliary Tract
- Digestion and Absorption of nutrients

Time allocated 12hrs

13. The Endocrine System

- Structure and function of the Endocrine System
- Pituitary gland and hypothalamus
- Thyroid gland
- Parathyroid glands
- Adrenal glands
- Pancreatic Islets
- Pineal gland
- Thymus gland
- Local hormones

Time allocated 08hr

14. The Integumentary System

- Structure of the Skin
- Functions of the Skin
- Wound healing

Time allocated 06hrs

15. The Urinary System

- Structure of the Urinary System
- Kidneys
- Ureters
- Urinary bladder
- Urethra
- Micturition

Time allocated 06hrs

16. Sensory Organs

- Structure of the Ear
- Physiology of hearing and equilibrium
- Structure of the Eye
- Physiology of sight
- Sense of Smell
- Physiology of smell
- Sense of Taste
- Physiology of taste

Time allocated 10hrs

17. The Reproductive System

- Structure of the Female Reproductive System
- Functions of the Female Reproductive System
- Structure of Male Reproductive System
- Functions of the Male Reproductive System

Time allocated 10hrs

INTRODUCTION TO NURSING

SYLLABUS

INTRODUCTION TO NURSING

OBJECTIVES

Introduction to Nursing provide an insight for the historical perspectives of nursing and how the profession of Nursing develop through out these years and the current situation in the Nursing profession.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 20hrs
- ❖ Lecturer should be a qualified Nurse
- ❖ Methods of instructions are lectures, researches and assignments
- ❖ Performances are evaluated by through quizzes and assignments
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

1. LindaC.A.,PatriceK.N., Karen.A.W., A History of Nursing Ideas,Jones and Bartlett,2006

COURSE OUTLINE

1. Historical Perspectives

- Importance of study History of Nursing
- Treatment modalities
- Initial Image of the Nurse

Time allocated 02hrs

2. Development of Nursing

- Florence Nightingale and her contribution
- Early history of Nursing

Time allocated 02hrs

3. Modern Nursing

- Formation of Professional Health Team
- Progression in Nursing Profession
- A code of Ethics

Time allocated 03hrs

4. International Agencies

- International Council of Nursing
- World Health Organization
- Red Cross
- UNICEF

Time allocated 02hrs

5. Nursing Organizations

- American Nursing Association
- Bill of Rights and Responsibilities for Students of Nursing
- North American Nursing Diagnosis Association

Time allocated 02hrs

6. Nursing Education

- Incorporating Computer Technology
- Distance Learning
- Continuing Education
- Practical Nurse Education
- Diploma Education

Time allocated 03hrs

7. Professional Nurse

- Functions of a Nurse
- As a Care giver
- As a Client Advocate
- As a Health Care Team Member
- As a Nursing Manager and Executive

Time allocated 04hrs

8. Credentialing in Nursing

- Licensure
- Certification
- Accreditation

Time allocated 02hr

BIOCHEMISTRY

SYLLABUS

BIOCHEMISTRY

OBJECTIVES

This session introduces the language of Biochemistry and the structure and function of the most important classes of biological molecules. This aid in nurses to understand the concepts of Nutrition and Pharmacology through out the course.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 26.
- ❖ Lecturer should be a qualified Medical Officer.
- ❖ Methods of instruction are lectures and presentations.
- ❖ Performances are evaluated by through quizzes and assignments during the sessions.
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

1. Jeremy.M.B.,John.L.T.,Lubert S.,Biochemistry, 15th ed,Freeman,2002

COURSE OUTLINE

1. Introduction

- The Cell and the Body
- Transport mechanisms

Time allocated 04hrs

2. Nucleic Acids

- DNA
- RNA

Time allocated 03hrs

3. Carbohydrates

- Structure
- Metabolism
- Energy production

Time allocated 03hrs

4. Proteins

- Structure
- Amino Acids
- Plasma Proteins
- Metabolism

Time allocated 03hrs

5. Lipids

- Structure
- Classification
- Metabolism

Time allocated 03hrs

6. Enzymes

- Structure
- Function

Time allocated 02hrs

7. Hemoglobin

- Structure
- Function

Time allocated 02hrs

8. Homeostasis

- Blood-glucose homeostasis

Time allocated 02hrs

9. Neurotransmitters

- Structure and function

Time allocated 01hr

10. Oxidants and Antioxidants

- Structure and function

Time allocated 01hr

11. Liver

- Bilirubin metabolism
- Jaundice

Time allocated 02hrs

GENERAL PSYCHOLOGY

SYLLABUS

GENERAL PSYCHOLOGY

OBJECTIVES

General Psychology utilizes a beginning knowledge in psychology which helps for the nursing functions in the assessment of the client in both hospitals and community settings.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 30.
- ❖ Lecturer should be a qualified Medical Officer.
- ❖ Methods of instruction are lectures and presentations.
- ❖ Performances are evaluated by through quizzes and assignments during the sessions.
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

1. Benjamin.L.T, Hopkins.J.R, Nation.J.R.,(1987)Psychology, McMillan
2. Zimbardo.P.G, Gerrig.R.J, (1999) Psychology and Life, 15th edition, Addison Wesley Longman.
3. Bernstein.D.A, RoyE.J, SrullT.K, WickensC.D, (1991) Psychology, 2nd edition, Houghton Mifflin.
4. Zimbardo, Weber, (1994) Psychology, Harper Collins.

COURSE OUTLINE

1. Introduction to Psychology

- Definition of Psychology
- Early ideas about human behavior
- What is behavior

Time allocated - 02 hours.

2. Biological bases of behavior

- The link between human behavior and biological processes

Make an assignment.

3. Critical thinking

- The human Information –Processing system
- Decision Making
- Thinking ability
- Concepts
- Reasoning and problem solving

Time allocated -03hrs.

4. Intelligence Tests

- Scoring IQ Tests
- The Stanford-Binet Tests

Time allocated - 02hrs.

5. Emotion

- Emotion and the Autonomic Nervous System
- Consciousness and Autonomic Nervous System
- Self-observations: James-Lange Theory
- Functions of Emotional Expressions

Time allocated -02hrs

6. Developmental Theories

- Piaget's Period of Cognitive Development
- Erickson's Stages of Psychosocial Development

Time allocated -02hrs.

7. Hypnosis

- Induction of Hypnosis
- Indication of Hypnosis

Time allocated -01hr.

8. Psychoactive Drugs

- Depressants
- Stimulants
- Narcotics
- Psychedelics and Hallucinogens

Time allocated -03hrs.

9. Learning-

- Classical conditioning- Ivan Pavlov's Experiment
- Instrumental/Operant Conditioning- Stimuli, Reinforcements, Punishments, Applications
- Social learning- Vicarious and observational

Time allocated -05hrs.

10. Gender Identity

- Gender Identification

Time allocated-01hr

11. Memory

- Types of memory
- Basic memory process
- Three stages of memory
- Sensory memory

Time allocated- 02hrs

12. Abnormal Psychology

- Normal and abnormal behavior
- Major mental disorders

Time allocated- 03hrs

13. Treatments of Psychological Disorders

- Types of treatment
- Indication for treatment
- Theories that affect treatments

Time allocated- 02hrs

ENGLISH

ENGLISH

OBJECTIVES

To be confident and fluent in English language to carry out effective nursing care.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 100hrs.
- ❖ Lecturers should be a qualified English Teacher.
- ❖ Methods of instruction are lectures, presentations and listening activities.
- ❖ Performances are evaluated by through quizzes and assignments during the sessions.
- ❖ Term exam paper includes structured essays and essay questions.

HUMAN DEVELOPMENT

SYLLABUS

HUMAN DEVELOPMENT

OBJECTIVES

This course provides the basic knowledge of Human Development and help nurses to apply these concepts in the hospital setting.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 48hrs.
- ❖ Lecturer should be a qualified Nurse.
- ❖ Methods of instructions are lectures and presentations.
- ❖ Performances are evaluated by through quizzes and assignments during the sessions.
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

1. John.W.S, Life Span Development, 7ed, Mc Graw-Hill, 1999.

COURSE OUTLINE

1. Beginnings

- Principles of growth and development
- Psychological theories of Human Development
- Conception and developmental stages

Time allocated 08hrs

2. Infancy

- Physical development
- Cognitive development
- Socioemotional development

Time allocated 06hrs

3. Childhood

- Development in Early Childhood
- Development in Middle Childhood
- Development in Late Childhood

Time allocated 10hrs

4. Adolescence

- Physical and Cognitive development
- Socioemotional development

Time allocated 10hrs

5. Adulthood

- Development in Early Adulthood
- Development in Middle Adulthood
- Development In Late Adulthood

Time allocated 10hrs

6. Death and Dying

- Death and Dying

Time allocated 04hrs

MEDICAL TERMINOLOGY

SYLLABUS

MEDICAL TERMINOLOGY

OBJECTIVES

This session introduces the common medical terms to understand the language of medicine and to improve knowledge by reading new trends in health sector. When dealing with medical instruments and procedures also it gives the confidence to the nurse.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 24.
- ❖ Lecturer should be a qualified Nurse.
- ❖ Methods of instruction are lectures and word games.
- ❖ Performances are evaluated by through quizzes and assignments during the sessions.
- ❖ Term exam papers include MCQ and structured essays

REFERENCES

2. Jeremy.M.B.,John.L.T.,Lubert S.,Biochemistry, 15th ed,Freeman,2002

COURSE OUTLINE

1. Building Medical Terms

- Prefixes
- Suffixes
- Roots

Time allocated 04hrs

2. Directional Terms

- Anatomical positions

Time allocated 04hrs

3. Anatomical Terms

- Anatomical structure of Systems

Time allocated 04hrs

4. Disease Terms

- Main categories of diseases

Time allocated 04hrs

5. Pharmacology Terms

- Abbreviations
- Routes of drug administration

Time allocated 04hrs

6. Laboratory Test Terms

- Common laboratory tests

Time allocated 04hrs

NUTRITION

SYLLABUS

NUTRITION

OBJECTIVES

Nutrition builds up the knowledge of basic concepts of nutritional needs, beneficial and harmful foods and setting the foundation for the nurse to take part in teaching therapeutic diets for the needed clients in the hospital setting.

COURSE DESCRIPTION

- ❖ Total allocated time for classes 60hrs
- ❖ Lecturer should be a qualified Medical Officer.
- ❖ Methods of instructions are lectures, videos and presentations
- ❖ Performances are evaluated by quizzes and assignments.
- ❖ Term exams will include MCQ, structured essays and essays questions

REFERENCES

1. Susan.G.D.,Nutrition Hand Book for Nursing Practice, 2nd ed,Lippincott,1993
2. Peggy.S.S., Hui.Y.H., Nutrition and Diet Therapy, 4th ed,Jones and Bartlett,2003

COURSE OUTLINE

1. Digestion and Absorption

- Mechanical process
- Chemical process

Time allocated 02hrs

2. Major Nutrients

- Carbohydrate requirements
- Protein requirements
- Nitrogen balance
- Protein deficiencies
- Nutritional aspects of Fats and Oils

Time allocated 06hrs

3. Vitamins

- Types of Vitamins
- Importance of Vitamins
- Deficiencies and Toxicity
- Dietary sources

Time allocated 02hrs

4. Water

- Importance and dietary sources

Time allocated 01hr

5. Minerals

- Types
- Deficiencies
- Dietary sources

Time allocated 01hr

6. Dietary Fiber

- Function

- Dietary sources

Time allocated 01hrs

7. Phytochemicals

- Types
- Function
- Dietary sources

Time allocated 02hrs

8. Anthropometry

- Body Mass Index
- Basal Metabolic Rate
- Recommended Daily Allowances
- Physical Measurements
- Energy Expenditure

Time allocated 02hrs

9. Protein-Energy Malnutrition

- Marasmus
- Kwashiorkor

Time allocated 01hr

10. Feeding a child

- Importance in Breast milk
- Formulas
- Feeding ill child

Time allocated 02hrs

11. Obesity

- Causes
- Dietary management

Time allocated 01hr

12. Diet and Cardiovascular Diseases

- Hyperlipidemia and diet management
- Hyperkalemia

Time allocated 02hrs

13. Liver disorders and Diet therapy

- Hepatitis
- Cirrhosis
- Cancer of the liver
- Diet therapies

Time allocated 04hrs

14. Nutrition during Pregnancy and Lactation

- Importance of diet
- Dietary sources

Time allocated 02hrs

15. Diseases of the Gall bladder and pancreas and diet

- Gall stones
- Cholecystitis
- Diet therapies

Time allocated 03hrs

16. Gastrointestinal disorders and diet

- Diarrhea and diet management
- Constipation and diet
- Other GI disorders

Time allocated 04hrs

17. Sport and Nutrition

- Aerobic exercises

- Anaerobic exercises

Time allocated 02hr

18. Eating disorders and diet therapy

- Anorexia Nervosa
- Bulimia Nervosa

Time allocated 02hrs

19. Food Allergy

- Precipitating factors
- Diet management

Time allocated 02hrs

20. Diet therapy and Renal disorders

- Acute and chronic Renal Failure
- Acute Glomerulonephritis
- Renal stones
- Hemodialysis
- Peritoneal dialysis
- Diet management

Time allocated 04hrs

21. Cancer and diet therapy

- Special dietary considerations

Time allocated 02hr

22. Diet therapy in Mentally Ill patients

- Special dietary considerations

Time allocated 02hr

23. Immobilized patient and diet

- Special dietary considerations

Time allocated 02hrs

24. Nutritional Requirements in Burn patient

- Special dietary considerations

Time allocated 03hrs

25. Phenylketonuria and diet therapy

- Special dietary considerations

Time allocated 01hr

26. Diabetes Mellitus

- Special dietary considerations

Time allocated 02hrs

27. Pre and Postoperative nutrition

- Special dietary considerations

Time allocated 02hrs

SOCIOLOGY

SYLLABUS

SOCIOLOGY

OBJECTIVES

Sociology provides a clear picture of various social structures in the world which helps nurse to interact more efficiently when dealing with clients from different cultures.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 45hrs
- ❖ Lecturer should be a qualified Nurse
- ❖ Methods of instructions are lectures, debates and group discussions
- ❖ Performances are evaluated by through quizzes, assignments and vivas during the sessions.
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

2. David.M.N.,Sociology-Exploring the Architecture of Everyday Life, 4thed, Pine Forge, 2002
2. Roger.E., The ways of Religion-An introduction to the Major Traditions, Oxford, 1999

COURSE OUTLINE

1. Introduction to Sociology

- What is Sociology
- Definitions of Sociology
- Importance of Study Sociology

Time allocated 02hrs

2. Culture, Society and the Individual

- What is culture
- Language
- Elements of Culture
- Organization of a culture
- Norms and Values

Time allocated 03hrs

3. Family

- Characteristics of Family
- Family Patterns
- Forms of Family

Time allocated 03hrs

4. Marriage

- Definition of Marriage
- Forms of Marriage

Time allocated 02hrs

5. Socialization

- Socialization
- Development in children
- Resocialization

Time allocated 04hrs

6. Gender and Sexuality

- Sexual Differentiation
- Sex Vs Gender
- Gender roles over the Life span
- Social Inequalities between Men and Women
- Feminist Theories

Time allocated 06hrs

7. Social Interaction and Everyday life

- Civil Inattention
- Non Verbal Communication
- Face and culture
- Social rules and Talk
- Encounters
- Impression management

Time allocated 04hrs

8. Stratification and Class Structure

- Social Stratification
- Basic Systems of Stratification
- Theories of Stratification

Time allocated 03hrs

9. Ethnicity and Race

- Ethnicity
- Racism
- Prejudice and Discrimination
- Stereotypes and Scapegoats

Time allocated 03hrs

10. Deviance and Crime

- Norms, Conformity
- Social Control
- Deviance
- Crimes

Time allocated 04hrs

11. Education

- Development of Literacy and Schooling
- Origins of Development of Education System
- Functions of Education
- Consequences of Education

Time allocated 04hrs

12. Religion

- What is Religion
- Characteristics of Religion
- Major Religions of the World

Time allocated 03hrs

13. Population

- Statistical measures
- Industrial revolution
- The third world
- Population Growth, Environment and Poverty

Time allocated 04hrs

FIRST AID

SYLLABUS

FIRST AID

OBJECTIVES

First Aid gives the basic knowledge to act competently in emergency situations in the hospital sector and in day today life.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 35.
- ❖ Lecturer should be a qualified nurse.
- ❖ Methods of instruction are lectures, demonstrations and videos.
- ❖ Performances are evaluated by through quizzes, assignments and return demonstrations during the sessions.
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

1. Kirby.N.G.,Mather.S.J.,Baillier's Handbook of First Aid,7th ed, AITBS, 2004

COURSE OUTLINE

1. Introduction to First Aid

- Introduction
- Indications

Time allocated 02hrs

2. Prevention Of Accidents

- Accidents
- Prevention

Time allocated 02hrs

3. Hemorrhage

- Managing hemorrhage

Time allocated 02hrs

4. Wounds and bleeding

- First aid for wounds
- Managing a bleeding victim

Time allocated 02hrs

5. Dislocation

- Management

Time allocated 01hr

6. Sprains

- First aid for sprains

Time allocated 01hr

7. Fractures

- Types of fractures
- First aid for fractures

Time allocated 02hrs

8. Burns and scalds

- First aid for burns

Time allocated 02hrs

9. Asphyxia

- First aid

Time allocated 02hrs

10. Drowning

- First aid for drowning victim

Time allocated 02hrs

11. Strangulation

- First aid

Time allocated 02 hrs

12. Electric Shock

- Electric shock
- Management of the victim

Time allocated 02hrs

13. Poisoning

- Types of poisoning
- First aid for poisoning

Time allocated 02hrs

14. Convulsions, fainting attacks, hysteria and motion sickness

- First aid

Time allocated 02hrs

15. Cardio Pulmonary Resuscitation

- CPR
- Indications

Time allocated 06hrs

16. Principles of applying slings and bandages, blinders and splints

- Applying slings and bandages
- Applying splints

Time allocated 03hrs

INTRODUCTION TO PAIN MANAGEMENT

SYLLABUS

INTRODUCTION TO PAIN MANAGEMENT

OBJECTIVES

Upon completion of this course the nurse get practical suggestions for the relief of pain and emphasis more on what nurse can actually do bring comfort and relief to the patient who experience pain.

COURSE DESCRIPTION

- ❖ Total allocated time for classes 24hrs
- ❖ Lecturer should be a qualified Nurse
- ❖ Methods of instructions are lectures, assignments and presentations
- ❖ Performances are evaluated by quizzes and assignments.
- ❖ Term exams will include MCQ, structured essays and essays questions

REFERENCES

1. Margo, M, Nursing Management of the patient with Pain, 2nd ed, Lippincott, 1979

COURSE OUTLINE

1. Pain Management

- Introduction
- Types of Pain
- Pain in the Context of Nursing Care

Time allocated 01hr

2. Misconceptions about pain

- Acute pain model Vs Adaptation
- Psychological causes of Pain
- Predictability Vs Variability of Duration and Severity
- High Vs Low Pain Tolerance
- Pain Assessment Method

Time allocated 02hrs

3. Pain Relief

- Concepts of Pain Relief
- Specific Theories of Pain Relief
- Guidelines for Using and Individualizing Pain Relief Measures

Time allocated 04hrs

4. Nurse patient Relationship

- Establishing the Relationship
- Methods for build up relationship

Time allocated 03hrs

5. Noninvasive pain Relief Methods

- Distraction
- Relaxation
- Cutaneous Stimulation
- Guided Imagery

Time allocated 10hrs

6. Invasive Pain Relief Methods

- Analgesics and related medications
- Placebos

Time allocated 04hrs

PHARMACOLOGY

SYLLABUS

PHARMACOLOGY

OBJECTIVES

The study of Pharmacology helps nurse to gain knowledge in safe drug administration, potential reactions and accurate calculations. Which also enable the nurse to be an adviser to their clients in the hospital.

COURSE DESCRIPTION

- ❖ Allocated total number of hours 80
- ❖ Lecturer should be a qualified Medical Officer and a Nurse
- ❖ Methods of instructions are lectures, assignments and presentations
- ❖ Performances are evaluated by quizzes and assignments.
- ❖ Term exam will include MCQ, structured essays and essays questions

REFERENCES

4. Linda.S.R.,Mosby's Nursing Drug Reference,Elsevier,2006
- 5.LindaL.L.,Robert S.A., Joseph A.A.,Pharmacology and the Nursing Process, Mosby, 1996.
6. Clayton.B.D., Yvonne N.S.,Basic Pharmacology for Nurses, 12ed,Mosby,2001

COURSE OUTLINE

1. Introduction

- Introduction to Pharmacology
- Pharmacodynamics
- Pharmacognosy
- Pharmacokinetics
- Pharmacotherapeutics
- Toxicology
- Introduction to Drugs

Time allocated 02hrs

2. Legal considerations of the Drugs

- Drug standards
- Pharmacopoeia
- Food, Drug and Cosmetic Act

Time allocated 02hrs

3. Terminology refer to Drugs

- Prescription drug
- Nonprescription drug
- Controlled drug
- Drug abuse
- Drug dependence
- Drug misuse
- A recreational drug
- Synergism
- Antagonism
- Teratogenic effect
- Idiosyncrasy
- Hypersensitivity
- Tolerance
- Lethal dose
- Toxic dose

Time allocated 02hrs

4. Systems of Measurements

- Apothecary system
- Metric system
- Abbreviations of measurements

Time allocated 02hrs

5. Absorption of Drugs

- Absorption methods
- Factors affecting absorption
- Bioavailability
- Drug storage
- Distribution

Time allocated 02hrs

6. Drug metabolism and Excretion

- Biotransformation
- Detoxification
- Routes of elimination

Time allocated 02hrs

7. Drug interactions

- Adverse drug effects
- Hypersensitivity
- Anaphylactic reactions

Time allocated 02hrs

8. Poison Control

- Define poison
- Methods of poisoning
- Client education

Time allocated 02hrs

9. Mechanism of Drug Action

- Mechanism
- Action through physical properties
- Action through chemical properties

Time allocated 02hrs

10. Routes of Drug Administration

- Oral route
- Sublingual route
- Intradermal route
- Intramuscular route
- Subcutaneous route
- Inhalations
- Local applications
- Types of Drug forms
- Devices use in drug administration

Time allocated 04hrs

11. Principles of Drug Administration

- Five rights
- Medication errors

Time allocated 01hrs

12. Dosage preparation and calculation

- Safe dosage preparation
- Accurate calculation

Time allocated 02hrs

13. Cardiovascular Drugs

- Cardiac glycosides
- Antiarrhythmic drugs
- Antihypertensive drugs
- Coronary vasodilators
- Antilipemic drugs
- Vasoconstrictors
- Anticoagulants
- Thromobolytic agents

Time allocated 04hrs

14. Renal Drugs

- Diuretics
- Medications for Gout
- Antispasmodics
- Cholinergics
- Treatment of Benign Prostatic Hypertrophy
- Alfa blockers

Time allocated 04hrs

15. Reproductive Drugs

- Androgens
- Impotence drugs
- Estrogens
- Progestines
- Contraceptives
- Infertility agents
- Drugs used in labor and delivery

Time allocated 04hrs

16. Psychotropic Medications

- CNS Stimulants
- Antidepressants
- Antimanic agents
- Anxiolytics
- Tranquilizers
- Alcohol
- Amphetamines
- Marijuana and cocaine
- Hallucinogens

Time allocated 06hrs

17. Drugs used in the Nervous System

- Adrenergics
- Cholinergics
- Opioid analgesics
- Non Steroidal Anti Inflammatory Drugs
- Barbiturates
- Anticonvulsants
- Antiparkinsonian Drugs
- Agents for Alzheimer's disease

Time allocated 06hrs

18. Endocrine Drugs

- Pituitary hormones
- Adrenal hormones
- Corticosteroids
- Thyroid agents
- Antidiabetic agents

Time allocated 04hrs

19. Drugs used in the Respiratory System

- Oxygen
- Bronchodilators
- Asthma prophylaxis
- Mucolytics and Expectorants
- Antitussives
- Antihistamines
- Decongestants
- Smoking cessation

Time allocated 05hrs

20. Drugs used in the Musculoskeletal System

- Skeletal muscle relaxants
- Anti-inflammatory drugs
- Drugs for Osteoporosis

Time allocated 04hrs

21. Anti-infective Drugs

- Aminoglycosides
- Cephalosporins
- Macrolides
- Penicillin
- Quinolones
- Tetracycline
- Antifungal agents
- Anti Tuberculosis agents
- Antiviral agents
- Treatment of HIV infections
- Sulfonamides

Time allocated 04hrs

22. Drugs used in the Gastrointestinal system

- Antacids
- Drugs used in Ulcers and GERD
- Antispasmodics
- Antidiarrheal agents
- Antiflatulents
- Laxatives and Cathartics

Time allocated 04hrs

23. Vitamins ,minerals and Herbs

- Vitamins
- Minerals
- Antioxidants
- Herbs

Time allocated 02hrs

24. Antineoplastic Drugs

- Antimetabolites
- Alkylating agents
- Plant alkaloids
- Anti-tumor antibiotics
- Hormone therapy
- Radio Active Isotopes

Time allocated 04hrs

25. Skin medications

- Antipruritics
- Emollients and Demulcents
- Keratolytics
- Scabicides
- Pediculicides
- Antifungals
- Burn medications

Time allocated 02hrs

26. Eye medications

- Anti-infective agents
- Anti-inflammatory agents
- Anti Glaucoma agents
- Local anesthetics

Time allocated 02hrs

MICROBIOLOGY

SYLLABUS

MICROBIOLOGY

OBJECTIVES

Microbiology incorporates the basic knowledge of microorganisms and infections caused by different types of pathogens. It also enables the nurse to impart knowledge in to the nursing management of patients with infections and to keep the hospital setting free of infections

COURSE DESCRIPTION

- ❖ Total allocated time for classes 60hrs
- ❖ Lecturer should be a qualified nurse from the internal staff
- ❖ Methods of instructions are lectures, pictures, slides and videos
- ❖ Performances are evaluated by quizzes, assignments and vivas.
- ❖ Term exams will include MCQ, structured essays and essays questions

REFERENCES

1. Richard.C.B., John.E.P., Medical Microbiology, 14ed, ELBS,1992
2. Seema.S, Microbiology for Nurses, 2nded, Elsevier, 2006.
3. Nagoda.B.S, Microbiology for Nurses, BI, 2006.
4. Ichhpujani.R.L,Rajesh.B, Microbiology for Nurses, 2nd ed, Jaypee,2002

COURSE OUTLINE

1. Introduction

- Introduction to Microbiology
- History
- Microscopes and functions

Time allocated 02hrs

2. Staining methods

- Simple staining
- Differential staining
- Gram stains

Time allocated 02hrs

3. Bacteria

- Structure of Bacteria
- Morphological arrangement of bacteria

Time allocated 02hrs

4. Classification of Bacteria

- Spirochetes
- Gram negative bacteria
- Rickettsia and Chlamydia
- Mycoplasma
- Gram positive Cocci
- Mycobacteria

Time allocated 02hrs

5. Basic Mycology

- Structure and Growth of fungi
- Pathogenesis
- Fungal toxins and allergies
- Antifungal therapy

Time allocated 02hrs

6. Basic Virology

- Structure of virus
- DNA Enveloped and Non-Enveloped viruses
- RNA Enveloped and Non-Enveloped viruses
- Clinical Virology

Time allocated 04hrs

7. Sterilization and Disinfection

- Chemical agents
- Mechanism of agents

Time allocated 02hrs

8. Host-Parasite Relationship

- Normal flora
- Pathogenic microorganisms
- Infection
- Endotoxins
- Exotoxins

Time allocated 02hrs

9. Antibacterial agents

- Types of agents
- Inhibitors of Cell-wall synthesis
- Inhibitors of Protein synthesis
- Inhibitors of Nucleic acid synthesis
- Resistance to antibacterial agents
- Inactivation of antibacterial agents
- Adverse reactions in agents

Time allocated 08hrs

10. Skin and soft tissue infections

- Normal flora
- Infections of the skin

Time allocated 02hrs

11. Oral and Dental infections

- Normal flora in Oral cavity
- Infections in oral cavity
- Dental infections

Time allocated 02hrs

12. Central nervous System Infections

- Bacterial infections
- Fungal infections

Time allocated 04hrs

13. Infection of the Heart

- Infective Endocarditis
- Myocarditis
- Pericarditis

Time allocated 02hrs

14. Respiratory Tract Infections

- Normal flora
- Infections in the Upper Respiratory Tract
- Infections in the Lower Respiratory Tract

Time allocated 06hrs

15. Miscellaneous Infections

- Mumps
- Measles
- Chickenpox
- Shingles
- Herpes Simplex Virus
- Rubella
- CMV Virus
- EBV infection

Time allocated 04hrs

16. Urinary Tract Infections

- Etiology
- Clinical features
- Laboratory Diagnosis
- Management

Time allocated 02hrs

17. Genital Infections

- Gonorrhea
- Syphilis
- Candidiasis
- Non-specific Urethritis
- Granuloma Inguinale
- Chancroid
- Genital Herpes
- Genital Warts

Time allocated 04hrs

18. Gastrointestinal Infections

- Infective gastroenteritis
- Food poisoning

Time allocated 04hrs

19. Liver and Biliary Infections

- Cholecystitis
- Cholangitis
- Viral Hepatitis

Time allocated 04hrs

PATHOPHYSIOLOGY

SYLLABUS

PATHOPHYSIOLOGY

OBJECTIVES

Disease Physiology that enhance nurses knowledge about diseases which aid in comprehensive nursing care.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 60.
- ❖ Lecturer should be a qualified Medical Officer.
- ❖ Methods of instruction are lectures and presentations.
- ❖ Performances are evaluated by through quizzes and assignments during the sessions.
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

1. Michael.S.,Incredibly Easy!,SpringHouse,1998

COURSE OUTLINE

1. Fluid and Electrolyte Balance and Imbalance

- Fluid volume changes due to pressure
- Hormonal regulation of fluid balance
- Fluid volume deficit
- Fluid volume excess
- Water intoxication

Time allocated 03hrs

2. Acid-Base Balance and Imbalance

- Buffering system

Time allocated 02hrs

3. Injury

- Inflammatory response

Time allocated 03hrs

4. Immune Response

- Hypersensitivity Disorders
- Allergic disorders

Time allocated 04hrs

5. Haemostatic Response

- Haemostasis
- Blood coagulation

Time allocated 02hrs

6. Neoplasia

- Precipitating factors
- Physiology of neoplasm

Time allocated 03hrs

7. Lithiasis

- Factors promote stone formation
- Process of calculus formation

Time allocated 02hrs

8. Cardiovascular System Disorders

- Atherosclerosis
- Ischemia and Infarction
- Cardiac arrhythmias and conduction abnormalities
- Heart Failure
- Cardiomyopathy
- Valvular Heart Dysfunction
- Hypertension
- Phlebitis and Thrombophlebitis
- Arterial occlusion

Time allocated 12hrs

9. Respiratory System disorders

- Obstructive Respiratory Disorders
- Acute Respiratory Failure

Time allocated 04hrs

10. Haematological Disorders

- Anemia
- Bleeding disorders
- Neoplastic disorders

Time allocated 04hrs

11. Disorders in the Urinary System

- Acute Renal Failure

Time allocated 02hrs

12. Neurological Disorders

- Seizures
- Cerebrovascular diseases
- Intracranial and Spinal cord Tumors

Time allocated 04hrs

13. Endocrine Disorders

- Diabetes Mellitus
- Thyroid gland disorders
- Disorders of Adrenal gland
- Disorders of Pituitary and Hypothalamus

Time allocated 04hrs

14. Gastrointestinal Disorders

- Infectious and Inflammatory diseases

Time allocated 03hrs

15. Musculoskeletal Disorders

- Connective Tissue Disorders
- Neoplastic conditions

Time allocated 03hrs

16. Integumentary Disorders

- Inflammatory skin Diseases
- Burns

Time allocated 03hrs

17. Reproductive System Disorders

- Male reproductive disorders
- Female reproductive disorders

Time allocated 02hrs

EPIDEMIOLOGY

SYLLABUS

EPIDEMIOLOGY

OBJECTIVES

This session gives the knowledge about the diseases and their process of spreading, prevention and treatments.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 24.
- ❖ Lecturer should be a qualified nurse.
- ❖ Methods of instruction are lectures and assignments.
- ❖ Performances are evaluated by through quizzes and assignments
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

1. William A., Arles W., Sharon H., Rick N., Epidemiology and Prevention of Vaccine-preventable Diseases, 6th ed, CDC, 2000
2. Park.K., Preventive and Social Medicine, 17th ed, K.Park, 2002

COURSE OUTLINE

1. Introduction to Epidemiology

- Introduction

Time allocated 01hr

2. Principles of Epidemiology

- Aims of epidemiology
- Epidemiological approach
- Rates and ratios
- Measurement of mortality
- Measurement of morbidity
- Infectious disease epidemiology
- Disease Transmission
- Immunizing agents
- Disease prevention and control
- Disinfection
- Investigation of an epidemic

Time allocated 03hrs

3. Screening for disease

- Concept of screening
- Criteria for screening

Time allocated 02hrs

4. Epidemiology of communicable disease

- Respiratory infections
- Intestinal infections
- Arthropod-borne infections
- Zoonoses
- Surface infections
- Hospital acquired infections

Time allocated 12hrs

5. Epidemiology of chronic non-communicable diseases and conditions

- Coronary Heart Disease
- Hypertension
- Stroke
- Rheumatic Heart Disease
- Cancer
- Diabetes

Time allocated 06hrs

COMMUNITY HEALTH NURSING

SYLLABUS

COMMUNITY HEALTH NURSING

OBJECTIVES

Community Health Nursing introduces the nursing aspects related to community health education which enable the nurse to promote health in community.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 40hrs.
- ❖ Lecturers should be a qualified Medical Officer and a qualified Nurse.
70% of lectures should presented by the Medical Officer and 30% by the Nurse.
- ❖ Methods of instruction are lectures and presentations.
- ❖ Performances are evaluated by through quizzes and assignments during the sessions.
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

1. Wurzbach.M.E.,Community Health Education and Promotion,2nd ed,Jones and Bartlett,2004
2. Basavanthappa.B.T.,Community Haelth Nursing,Jaypee,1998

COURSE OUTLINE

1. Introduction to Community Health

- Concepts of Community health

Time allocated 02hr

2. Demography and Family Planning

- Demographic Cycle
- World population Trends
- Fertility
- Fertility related Statistics
- Family Planning

Time allocated 06hrs

3. Environment and Health

- Introduction
- Water
- Air
- Light
- Noise
- Humidity
- Disposal of waste

Time allocated 08hrs

4. Occupational Health

- Health of the Worker
- Occupational Hazards
- Occupational Diseases
- Occupational Cancer
- Accidents in Industry
- Health problems due to Industrialization
- Measures for Health Protection of Workers

Time allocated 06hrs

5. Genetics and Health

- Genetics
- Chromosomal Disorders
- Rhesus system
- Prevention and Social measures

Time allocated 04hrs

6. Health planning and management

- Health planning
- Management

Time allocated 06hrs

7. Health Programmes in Srilanka

- Health programmes

Time allocated 02hrs

8. Communication for Health Education

- The communication process
- Types of communication
- Health communication
- Health education

Time allocated 06hrs

CLINICAL SYLLABUS

**MATERNAL AND NEW BORN
NURSING**

THEORY SYLLABUS

OBJECTIVES

Normal Functional Health Patterns r/t Pregnancy

Upon completion of this the student will be able to:

1. Discuss the changes in childbirth practices during the nineteenth and twentieth
- 2.. Discuss the role of the registered nurse and the advanced practice nurse (nurse midwife) in caring for the perinatal woman and her family.
3. Review and describe the normal anatomical and physiological changes occurring in the female throughout the perinatal period.
4. Evaluate the normal changes that occur during: puberty. postpartum and newborn, and the implications for health management.
5. Integrate the components of wholeness (e.g: intellectual, physiological. Psychological,sociological, spiritual) in the care of the woman, her family and the newborn infant related tohealth promotion, health. perception and health management.
6. Evaluate nutritional needs of the pregnant lactating woman, and the newborn infant.
7. Appropriately nursing process in providing holistic health care to the perinatal family.

Normal Functional Health Patterns

Normal Pregnancy

HUMANITY

1. Identify various bioethical issues related to the perinatal period that decision-making the client and the nurse.
2. Assess the needs of the perinatal family, related to variants in family structure across the developmental stages of the expanding family.

HEALTH

3. Review the historical perspective for childbirth practice and changes that occurred in the nineteenth and twentieth century.
4. Summarize the physical, psychosocial, and behavioral changes that usually occur as the mother and other family members adapt to pregnancy.
5. Explain the expected maternal anatomic and physiologic adaptations to pregnancy.

NURSING

6. Discuss the process of childbirth education and the role of the nurse educator in preparing the expanding family to meet the developmental crisis of pregnancy.
7. Outline the patterns of health care provided to assess maternal and fetal health status at the initial visit and at follow-up visits during pregnancy.
7. Formulate a nursing care plan that assesses / identifies, plans, priorities, implements, and evaluates the client during the antenatal period.
9. Explain common methods used to assess fetal well being during pregnancy

ENVIRONMENT

10. Discuss current trends and issues in maternal/child health practice related to health promotion.
11. Discuss the benefits of prenatal care and problems of accessibility for some women. The education that is needed for pregnant women to understand physical discomforts related to pregnancy and to recognize the signs and symptoms of potential complications.
13. Explain the effect of culture, age, parity, and number of fetuses on the response of the mother to the pregnancy and on the prenatal care provided.
14. Explain family-centered nursing care during the perinatal period.

15. List five nutritional risk factors during pregnancy.

16. Give examples of cultural food patterns and possible dietary problems for two ethnic groups or for two alternative eating patterns.

Normal Pregnancy

Health Assessment

1. Female Reproductive System

1.1. External structures

1.2. Internal structures

2. Breasts

Anatomy and of Pregnancy

3. Gravidity and Parity

4. Pregnancy Tests

5. Adaptations to Pregnancy

5.1. Signs of pregnancy

5.2. Reproductive system and breasts

5.1.1 Uterus

5.1.2. Vagina and Vulva

5.1.3. Breasts

5.3. General Body Systems

5.1.1. Cardiovascular system

5.1.2. Respiratory system Renal system

5.1.4. Integumentary system

5.1.5. Musculoskeletal system

5.1.6. Neurologic system

5.1.7. Gastrointestinal system

5.1.8. Endocrine system

Nursing Care During Pregnancy

6. Diagnosis of Pregnancy and symptoms

6.1 Signs and symptoms

6.2 Estimating date of birth

7. Adaptations to Pregnancy

7.1. Maternal adaptation

7.2. Paternal adaptation

7.3. Sibling adaptation

7.4. Grandparent adaptation

8. Care Management

8.1. Assessment

8.1.1. Initial visit

8.1.2.1. Interview

8.1.2.2. Physical examination

Laboratory tests

8.1.2. Follow-up visits

8.1.2.1. Interview Physical examination

8.1.2.3. Fetal assessment

8.1.2.4. Laboratory tests

8.2. Nursing diagnoses

8.3. Expected outcomes

8.4. Plan of care and implementation

8.1.1. Carepaths

8.1.2. Education for self-care

8.1.3. Normal discomforts

8.1.4. Recognizing potential complications

8.1.5. Recognizing preterm labor

8.1.6. Sexual counseling

8.1.7. Psychosocial support

8.5. Evaluation

9. Plan of Care

10. Variations in Prenatal Care

10. I. Cultural influences

10.2. Age

1 0.3. Multi fetal pregnancy

11. Prebirth Education

11.1. Childbirth education programs

1 1.2. Options for care providers

1 1.3. Birth setting choices

1 1.1.1 Pain management

Maternal and Fetal Nutrition

12. Nutrient Needs Before Conception

13. Nutrient Needs During Pregnancy

13.1. Energy needs

13.1.1. Pattern Weight gain

13.1.2 Hazards of restricting adequate weight gain

13.2. Protein

13.3 Fluids

13.4. Minerals and vitamins

13.5. Nutrient supplements

13.6. Other nutritional issues during pregnancy

14. Nutrient Needs During Lactation

15. Management

15.1. Assessment

1 5.2. Nursing diagnoses

1 5.3. Expected outcomes

15.4. Plan of care and implementation

1 5.4.1 1. Adequate dietary intake

15.4.1.2. Coping with nutrition-related discomforts of pregnancy

15.4.1.3. Cultural influences

15.4.1.4. Vegetarian diets

15.5. Evaluation

Normal Functional Health Patterns

Normal Labor and Delivery

HUMANITY

1. Discuss the importance of support such as family or a doula during labor.

HEALTH

2. Explain the five factors that affect the labor process.
3. Describe fetal adaptations to labor.
4. Explain the significance of the molding of the fetal head during labor.
5. Describe the cardinal movements of the mechanism of labor.
6. State the physical and psychosocial findings indicative of maternal progress during labor.
7. Examine the influence of cultural and religious beliefs and practices on the process of labor and birth.

NURSING

8. Assess the maternal anatomic and physiologic adaptations to labor
9. Explain the baseline fetal heart rate (FHR) and evaluate periodic changes.
10. Compare nursing interventions used for managing specific FHR patterns including tachycardia and bradycardia; increased and decreased variability; and late and variable decelerations.
11. Review the factors included during the initial assessment of the woman in labor.
12. Describe the ongoing assessment of maternal progress during first, second and third stages of labor.
13. Discuss fetal assessment during labor.
14. Describe the roles and responsibilities of the nurse during an childbirth situation.
15. Discuss the nurse's role in reducing the incidence of routine
16. Describe preventive measures that can be used to maintain FHR patterns within normal limits.
17. Describe family-centered nursing care during the period.

Normal Labor & Delivery

Labor and Birth Processes

1. Factors Affecting Labor

1.1. Passenger

1.1.1. Size of fetal head

1.1.2. Fetal presentation

1.1.3. Fetal lie Fetal attitude

1.1.5. Fetal position Station

1.2. Passageway

1.2.1. Bony pelvis

1.2.2. Soft tissues

1.3. Powers

1.3.1 Primary powers

1.3.2. Secondary powers

1.4. Position of the woman in labor

2. Process of Labor

2.1. Signs preceding labor

2.2. Onset of labor

2.3. Stages of labor

2.4. Mechanism of labor

3. Physiologic Adaptation to Labor

3.1. Fetal adaptation

3. 2. Maternal adaptation

Fetal Assessment

4. Basis for Monitoring

4.1. Fetal response

4.2. Fetal compromise

5. Monitoring Techniques

5.1. Intermittent auscultation

5.2. Electronic fetal monitoring

5.2.1. External monitoring

5.2.2. Internal monitoring

6. Fetal Heart Rate Patterns

6.1. Baseline fetal heart rate

6.2. Periodic and episodic changes in fetal heart rate

6.2.1. Accelerations

6.2.2. Decelerations

7. Care Management

7.1. Assessment

7.2. Nursing diagnoses

7.3. Expected outcomes

7.4. Plan of care and implementation

7.4.1. Electronic fetal monitoring pattern recognition

7.4.2. Nursing management of nonreassuring patterns

7.4.3. Other methods of assessment

7.4.3.1. Fetal scalp blood sampling

7.4.3.2. Fetal heart rate response to stimulation

7.4.3.3. Fetal pulse oximetry

7.4.3.4. Umbilical cord

7.4.4. Other interventions

7.4.4.1. Amnioinfusion

7.4.4.2. Tocolytic therapy

7.4.4.3. Patient and family teaching Discouraging Valsalva maneuver

7.4.4.4. Discouraging valsalva maneuver

7.4.4.5. Maternal positioning

7.4.5. Documentation

7.5. Evaluation

Nursing Care During Labor and Birth

8. First Stage of Labor

9. Care management

9.1. Assessment

9.1.1.1. Admission to labor unit

9.1.1.2. Admission data Prenatal data

9.1.1.4. Interview

9.1.1.5. Psychosocial factors

9.1.1.6. Stress in labor

9.1.1.7. Cultural factors Physical examination

9.1.1.8.1 General systems assessment

9.1.1.8.2 Leopold's maneuvers

- 9.1.1.8.3. Assessment of and pattern
- 9.1.1.8.4. Assessment of uterine contractions
- 9.1.1.8.5. Vaginal examination
- 9.1.1.9. Laboratory and diagnostic tests

9.2. Nursing diagnoses

9.3 Expected outcomes

9.4. Plan of care and implementation

9.4.1 . Standards of care

9.4.2. Physical nursing care during labor

9.4.3.Support measures

9.4.4. Emergency interventions

9.4.5. Preparation for giving birth

9.4.6. Birth setting

10. Second stage of labor

1 0.1. Duration of the second stage

10.2. Maternal position

1 0.3. Bearing down efforts

10.4. Fetal heart rate and pattern .

10.5. Supplies, instruments, and equipment

10.6. Birth in a delivery room or birthing room

10.8. Mechanism of birth: vertex presentation Birth in a delivery room or birthing room

1 0.7. Birth in an LDR or LDRP

10.9. Immediate assessment and care of newborn

10.10. Perineal trauma related to childbirth

10.11. Emergency childbirth

11. Third Stage of Labor

11. 1. Maternal physical status

12. Supportive Care During Labor and Birth

12.1. Doula

12.2 Support of father or coach

12.3. Support of grandparents

12.4 Siblings during labor

13. Interactions with the Newborn Following Birth

14. Parent-Newborn Relationships

15. Evaluation

Normal Functional Health Patterns Normal Postpartum

HUMANITY

1. Discuss ways to facilitate parent-infant adjustment.
2. Describe sensual responses that strengthen attachment.
3. Describe grandparent adaptation and sibling adjustment.

HEALTH

4. Describe the anatomic and physiologic changes that occur during the postpartum period.
5. Identify infant behaviors that facilitate and that inhibit parental attachment.
6. Differentiate the three periods of parental role change after childbirth.

NURSING

7. Identify characteristics of uterine involution and lochial flow and describe how to measure it.
8. List expected values for signs and blood pressure and describe deviations from normal findings and their probable causes.
9. Identify the priorities of maternal care given during the fourth stage of labor.
10. Summarize nursing interventions to prevent infection and bleeding, to promote normal bladder and bowel patterns, and to care for the breasts of women who are breast- or bottle-feeding.
11. Compare and contrast episiotomy and perineal lacerations as to depth, repair and perineal discomfort.
12. Describe the meaning for the acronyms BUBBLE HE and REEDA when performing an assessment.
13. Formulate the nursing care plan that assesses / identifies, plans, implements and evaluates the client during the postpartum period
14. Identify indications and nursing considerations for pharmacological medications during the fourth stage of labor and the postpartum period

ENVIRONMENT

15. Explain the influence of cultural expectations on postpartum adjustment.
16. Discuss discharge teaching and postpartum care.
17. Discuss the effects of the following on parental response: parental age (adolescence and more than 35 years of age), social support, culture, socioeconomic conditions, personal aspirations, and sensory impairment)
18. Assess the availability of resources needed by the new mother and infant.

Normal Postpartum Maternal

1. Reproductive System and Associated Structures

1.1. Uterus

1.1.1. Involution process

1.1.2. Contractions

1.1.3. Afterpains

1.1.4. Placental site

1.1.5. Lochia

1.2. Cervix

1.3. Vagina and perineum

1.4. Pelvic muscular support

2. Endocrine System

2.1. Placental hormones

2.2. Pituitary hormones and ovarian function

3. Abdomen

4. Urinary System

4.1. Urine components

4.2. Postpartal diuresis

4.3. Urethra and bladder

5. Gastrointestinal System

6. Breasts

6.1. Breastfeeding mother

6.2. Non-breastfeeding mother

7. Cardiovascular System

7.1. Blood volume

7.2. Cardiac output

7.3. Vital signs

7.4. Blood components

7.5 Varicosities

8. Neurologic System

9. Musculoskeletal System

10. Integumentary System

11. Immune System

Nursing Care During Fourth Trimester

Fourth Stage of Labor

12.1. Assessment

12.2. Postanesthesia recovery

12.3. Transfer from the recovery area

13. Discharge--Before 24 and After 48 Hours

13.1 Laws related to discharge

.

13.2 Criteria for discharge

14. Care Management-Physical Needs

14.1. Assessment

14.1.1 Ongoing physical assessment

14.1.2. Signs of potential complications

14.1.3. Routine laboratory tests

14.2. Nursing diagnoses

14.3. Expected outcomes

14.4. Plan of care and implementation Prevention of infection

14.4.2. Prevention of excessive bleeding

14.4.3. Promotion .of comfort, rest, ambulation, and exercise

14.4.4. Promotion of nutrition

14.4.5. Promotion of bladder and bowel patterns

14.4.6. Breastfeeding promotion and lactation suppression

14.4.7. Health promotion of future pregnancies and children

14.5 Evaluation

15. Care Management-Psychological Needs

15.1. Assessment

15.1.1. Impact of the birth experience

15.1.2. Maternal self-image

15.1.3. Adaptation to parenthood and parent-infant interactions

15.1.4 Family structure and functioning

15.1.5 Impact of cultural diversity

15.1.6. Signs of potential complications

15.2. Nursing diagnoses

15.3. Expected outcomes

15.4. Plan of care and implementation

Evaluation

16. Discharge Teaching

- 16.1. Self care, signs of complications
- 16.2. Sexual
- 16.3. Prescribed medications
- 16.4. Routine mother and baby check ups
- 16.5. Dealing with visitors

17. Follow-Up After Discharge

- 17.1. Home visits
- 17.2. Telephone follow-up
- 17.3. Support groups

18. Referral to community resources

Transition to Parenthood

19. Parenting Process

20. Parental Attachment, Bonding, and Acquaintance

- 20.1. Assessment of attachment behaviors

21. Parent-Infant Contact

- 21.1. Early contact
- 21.2. Extended contact

22. Communication between Parent and Infant

- 22.1. Touch
- 22.2. Eye-to-eye contact
- 22.3. Voice
- 22.4. Odor
- 22.5. Entrainment

22.6. Biochemistry

22.7. Reciprocity and synchrony

23. Parental Role After Childbirth

23.1. Transition to parenthood

23.2. Parental tasks and responsibilities

23.2.1 Maternal adjustment

23.2.2 Dependent phase Dependent-independent phase

23.2.1.3. Postpartum blues

23.2.1.4. Interdependent phase

23.2.2. Paternal adjustment

23.2.2.1 Father-infant relationship

23.2.2.2. Impact of fatherhood

24. Factors Influencing Parental Responses

24.1. Age

24.2. Culture

24.3. Socioeconomic Conditions

25. Parental Sensory Impairment

25.1 Visually impaired parent

25.2. Hearing impaired parent

26. Sibling Adaptation

27. Grandparent Adaptation

28. Care Management: Practical Suggestions for the First Weeks at Home

28.1. Assessment

28.2. Nursing diagnoses

28.3. Expected outcomes

28.4. Plan of care and implementation

28.4.1. Instructions for first days at home

28.4.2. Infant care

28.4.3. Anticipatory guidance regarding the newborn

28.5. Evaluation

Normal Functional Health Patterns Normal Newborn

HUMANITY

1. Explain attachment and the importance of maternal infant attachment and bonding that occurs at birth and in the neonatal period.

HEALTH

2. Describe the changes in the biologic system of the neonate during the transition to extrauterine life.
3. Describe the behavioral adaptations of the newborn, including periods of reactivity and awake states.
4. Describe the sensory and perceptual functioning of the neonate.
5. Compare and contrast the characteristics of term, postterm, and postmature
6. Discuss pain in the newborn based on physiologic changes and behavioral observations.
7. Describe nutritional needs of infants.
8. List Newborn feeding readiness cues.
9. Describe the anatomy and physiology of breastfeeding.

NURSING

10. Describe the sequence to follow when assessing the newborn.
11. Recognize and deviations from normal findings during examination of the newborn.
12. List normal vital signs and identify potential causes of vital signs out of the norm in the
13. Identify the purpose and components of the score.
14. Identify nursing interventions to facilitate and promote successful
15. List signs of adequate intake in the breastfed infant.
16. Identify common problems associated with breastfeeding and nursing interventions to help resolve them.

17. Formulate the nursing care plan that assesses/identifies prioritizes, implements, and evaluates the newborn during the neonatal period.
18. Identify indications and nursing considerations for pharmacologic medications given the infant at birth (e.g. phytonadione, erythromycin ointment, naxolon, hepatitis B immune globulin, hepatitis B vaccine).

ENVIRONMENT

19. Explain what is meant by: a "safe environment."
20. Discuss phototherapy and the for teaching parents about this treatment.
21. Explain the purposes and methods of circumcision, the postoperative care of the circumcised infant, and parent teaching information about circumcision.
22. Review the anticipatory guidance nurses provide parents before discharge.
23. Describe current recommendations for feeding infants.
24. Discuss benefits of breastfeeding for infants, mothers, families, and society.
25. Discuss patient teaching for the family using feeding.
26. Describe common community resources available to moms for affordable infant follow-up care and assistance with breastfeeding problems, etc.

Normal Newborn

Physiological Adaptations Newborn

1. Transition to Life
2. Physiologic Adjustments
 - 2.1. Respiratory system
 - 2.2. Cardiovascular system
 - 2.3. Thermogenic system
 - 2.4. Renal system
 - 2.5. Gastrointestinal system
 - 2.6. Hepatic system
 - 2.7. Immune system
 - 2.8. Integumentary system
 - 2.9. Reproductive system
 - 2.10. Skeletal system
 - 2.11. Neuromuscular
3. Physical Assessment
 - 3.1. General appearance
 - 3.2. Vital signs
 - 3.3. Baseline measurements of physical growth
 - 3.3.1. Weight Circumferences and length
 - 3.4 Neurologic assessment
4. Behavioral Characteristics
 - 4.1. Sleep-wake states
 - 4.2. Other factors influencing behavior of newborns

4.3. Sensory behaviors

4.4. Response to environmental stimuli

4.4.1 Temperament

6.4.3. Therapeutic and surgical procedures

6.4.3.1 Intramuscular injection

6.4.3.2 Therapy for hyperbilirubinemia

6.4.3.2 Circumcision

6.4.4. Pain in neonates

6.4.5. Discharge planning and teaching

6.5. Evaluation

Newborn Nutrition and Feeding

7. Recommended Infant Nutrition

7. I. Benefits of breastfeeding

7.2. Choosing an infant feeding method

Nutrient needs

8. Overview of Lactation

8.1. Milk production

8.2 Uniqueness of human milk

9. Care Management: The Breastfeeding Mother and Infant

9.1. Assessment: infant and mother

9.2. Nursing diagnoses

9.3. Expected outcomes

9.4. Plan of care and implementation

9.4.1. Positioning

9.4.2. Latch-on

9.4.3. Milk ejection or let-down Frequency of

9.4.5. Duration of feeding

9.4.6. Supplements bottles, and pacifiers

9.4.7. Special considerations

9.4.8. Expressing and storing breast milk

9.4.9 Weaning

9.4.10. Care of the mother

9.4.11 Role of the nurse in promoting successful lactation

9.5. Evaluation

I **10. Formula Feeding**

10.1. Reasons for formula feeding

11. Parent education

OBJECTIVES

Normal and Alterations in Fetal Development Alterations in Functional Health Patterns during Pregnancy, Labor and Delivery

Upon completion of this unit, the student will be able to:

1. Review physiology of the menstrual cycle, conception, embryonic and fetal development.
2. Discuss alterations in fetal development resulting from: microbiological, environmental, and teratogens during the developmental stages of fetal growth
3. Describe methods used to assess fetal well-being during the perinatal period.
4. Evaluate the effectiveness of child birth education as it relates to the perinatal as well as the implications to health management during the perinatal period.
5. Discuss different types of analgesia and anesthesia used for pain management the intrapartum period.
6. Identify factors placing women at risk for alterations in health during pregnancy.
7. Appropriately apply the nursing process in providing wholistic health care to families experiencing alterations in health during the antepartum and intrapartum periods of pregnancy.
8. Identify the role of the nurse as advocate in assisting families with alterations in normal health patterns during the perinatal period.

Normal and Alterations in Fetal Development

Fetal Development

1. Discuss how assessment and physical examination can be adapted for women special needs.
2. Explore the scope of high risk pregnancy.

HEALTH

2. Summarize the menstrual cycle in relation to hormonal, ovarian, and endometrial response.
4. Explain basic principles of genetics.
5. Examine ethical dimensions of genetic screening.
6. Summarize the process of fertilization.
7. Describe the development, structure, and functions of the placenta, umbilical cord, and amniotic fluid.
8. Summarize the significant changes in growth and development of the embryo and fetus.
9. Examine risk factors identified through history, physical and diagnostic techniques

NURSING

10. Describe the nurse's role in genetics.
11. Formulate a nursing care plan that plans, implements. and the woman who is undergoing diagnostic testing.
12. Describe diagnostic techniques and implications of findings.
13. Describe the nursing role in antepartal risk assessment.

ENVIRONMENT

14. Identify the potential effects of teratogens during vulnerable periods of embryonic and fetal development.
15. Discuss the effect of drug use and abuse on the fetus during pregnancy.

Feral Development

Health Assessment

1. Menstruation

1.1. Menarche and puberty

1.2. Menstrual cycle

1.1.1. Endometrial cycle

1.1.2. Hypothalamic-pituitary cycle

1.1.3. Ovarian cycle

1.3. Prostaglandins

1.4. Climacteric

2. Sexual Response

3. Health Assessment Interview Biographic

3.3. Cultural and communication variations

3.4. Women with special needs

3.5. Abused women

3.6. Adolescents

3.7. History

3.8. Physical examination Pelvic examination

3.10. Laboratory and diagnostic

Genetics, Conception, and Fetal Development

4. Genetics

- 4.1. Relevance of genetics to nursing
- 4.2. Genetics counseling services
 - 4.1.1 Ethical considerations
 - 4.1.2. Human Genome Project
 - 4.1.3. Management of genetic disorders
- 4.3. Genes and chromosomes
- 4.4. Chromosomal abnormalities Patterns of genetic transmission

Factors Influencing Development

6.-Conception

- 6.1. Cell division
- 6.2. Gametogenesis
- 6.3. Conception
- 6.4. Fertilization
- 6.5. Implantation

7. The Embryo and Fetus

- 7.1. Primary germ layers
- 7.2. Development of the embryo
- 7.3. Membranes
- 7.4. Amniotic fluid
- 7.5. Yolk sac
- 7.6. Umbilical cord
- 7.7. Placenta-structure and functions

8. Fetal Maturation

- 8.1. Respiratory system
- 8.2. Fetal circulatory system
- 8.3. Hematopoietic system
- 8.4. Hepatic system
- 8.5. Gastrointestinal system

- 8.6. Renal system

- 8.7. Neurologic system
- 8.8. Endocrine system

- 8.9. Reproductive system
- 8.10. Musculoskeletal system
- 8.11. Integumentary system
- 8.12. Immunologic system

9. Multifetal Pregnancy

Assessment for Risk Factors

10. Definition and Scope of the Problem

- 10.1. Maternal health problems
- 10.2. Fetal and neonatal health problems
- 10.3. Regionalization of health care services
- 10.4. Assessment of risk factors

11. Antepartum testing/Biophysical Assessment

- 11.1. Daily fetal movement count
- 11.2. Ultrasonography
- 11.3. Doppler blood flow analysis

1 1.4. Biophysical profile

1 1.5. Magnetic resonance imaging

12. Biochemical Assessment

12.1. Amniocentesis

12.2. Percutaneous umbilical blood sampling

12.3. Chorionic villus sampling

12.4. Maternal assays

13. Assessment Using Electronic Fetal Monitoring

13.1. Indications

1 3.2. Fetal response to hypoxia or asphyxia

13.3. Variability

13.4. Nonstress test (Fetal Activity Determination)

13.5. Fetal acoustic stimulation

13.6. Contraction stress test

14. Nursing Role in Antenatal Assessment for Risk

Alterations in Functional Health Patterns During Pregnancy High Pregnancy

HUMANITY

1. Discuss the stress experienced by the woman and her when a pregnancy is at risk and relate possible referrals and interventions.

HEALTH

3. Differentiate the types of diabetes and their respective risk factors
4. Compare insulin requirements during pregnancy, the postpartum period, and lactation.
5. Explain the effects of thyroid disorders on pregnancy.
6. Differentiate the management of various cardiovascular disorders in
7. Discuss the different types of anemia and their effects during
8. Describe the effect of gastrointestinal disorders on pregnancy.
9. Review the effects of neurologic disorders on pregnancy.
10. Describe the pathophysiology of preeclampsia and eclampsia.
11. Discuss the implications of trauma on the mother and fetus during
12. Describe the signs, symptoms, and management of pregnant women TORCH infections
13. Identify how the nurse's beliefs, values, and reaction to abnormal outcomes may influence ability to provide support and guidance to the high risk client and family.

NURSING

14. Discuss care management for the pregnant woman with pregestational or gestational diabetes.
15. Explain the care of pregnant women with pulmonary disorders.
16. Describe the care of women whose pregnancies are complicated by autoimmune disorders or human immunodeficiency virus.
17. Differentiate the management of the woman with mild preeclampsia and the woman preeclampsia.
18. Describe HELLP syndrome and appropriate associated nursing actions.
19. Compare and contrast placenta previa and abruption placentae with regard to signs and symptoms, complications, and management.
20. Explain the basic principles of care for a pregnant woman who is undergoing abdominal
21. Identify priorities in assessment and stabilization measures for the pregnant trauma
22. Review the indications and nursing implications of the following medications used during pregnancy: betamethasone, ritodrine, terbutaline, magnesium sulfate, nifedipine, and various antibiotics.
23. Formulate the nursing care plan that plans, implements, and evaluates the risk pregnant client.

ENVIRONMENT

23. Discuss the care of women who use, abuse, or are dependent on alcohol or illicit or prescription drugs.
24. Differentiate common sexually transmitted infections with regard to the signs and symptoms; effects on pregnancy, the fetus, and the newborn: and management during pregnancy.

High Risk Pregnancy

Preexisting Conditions

1. Metabolic Disorders

1.1. Diabetes mellitus

1.5.1 Pathogenesis

1.5.2 Classification

1.5.3. Metabolic changes associated with pregnancy

1.2. Pregestational diabetes mellitus

1.5.1 . Preconception counseling I

1.5.2. Maternal risks and complications

1.5.3. Fetal and neonatal risks and complications

1.3. Care management (Pregestational diabetes mellitus)

1.5.1Assessment

1.5.2 Interview

1.5.3 Physical examination

1.5.4 Laboratory tests

1.5.5 Nursing diagnoses

1.5.6 Expected outcomes

1.5.7 Plan of care and implementation

1.3.7.1. Antepartum

1.3.7.1.1. Diet

1.3.7.1.2. Exercise

1.3.7.1.3. Monitoring blood glucose levels

1.3.7.1.4. Insulin therapy

1.3.7.1.5. Urine testing

1.3.7.1.6. Complications requiring hospitalization

1.3.7.1 .7. Fetal surveillance

1.3.7.1.8. Determination of birth date and mode of birth

1.3.7.2. Intrapartum

1.3.7.3 Postpartum

1.5.8.Evaluation

1.4. Gestational diabetes mellitus

1.5.1. Maternal and fetal risks

1.5.2. Screening for gestational diabetes

1.5.3. Interventions

1.5.4. Intrapartum

1.5.6 Postpartum

1.5. Thyroid Disorders

1.5.1. Hyperthyroidism

1.5.2. Hypothyroidism

1.6. Maternal Phenylketonuria

Cardiovascular Disorders

2.1. Peripartum cardiomyopathy

2.2. Rheumatic heart disease

2.3. Mitral valve stenosis

2.4. Mitral valve prolapse

2.5. Infective endocarditis

2.6. Eisenmenger's syndrome

2.7. Care management

2.5.1. Assessment

2.7.1.1. Interview

2.7.1.2. Physical examination

2.7.1.3 Laboratory and diagnostic tests

2.5.2. Nursing diagnoses

2.5.3. Expected outcome

2.5.4. Plan of care and implementation

2.5.5. Antipartm

2.5.6. Intrapartum

2.5.7 Postpartum

2.5.8. Cardiopulmonary resuscitation

3. Anemia

3.1. Iron deficiency anemia

3.2. Folic acid deficiency anemia

3.3 Sickle cell hemoglobinopathy

3.4. Thalassemia

4. Pulmonary Disorders Asthma Cystic fibrosis

5. Gastrointestinal Disorders

5.1 Cholelithiasis and cholecystitis

6. Integumentary Disorders

7. Neurologic Disorders

7.1. Epilepsy

7.2. Multiple sclerosis

7.3 Bell's palsy

8. Autoimmune Disorders

8.1. Systemic lupus

8.2 Myasthenia gravis

9. Human Virus and Acquired Immunodeficiency Syndrome

9.1. Preconception counseling

9.2. Incidence

9.3. Pregnancy risks

9.4. Care management

10. Substance

10.1. Barriers to treatment

10.2. Legal considerations

10.3. Care management

Gestational Conditions

11. Hypertension in Pregnancy

1 1.1. Significance and incidence

11.2 Morbidity and mortality

11.3. Classification

1 1.3.1. Preeclampsia

1 1.3.2. Severe preeclampsia

11. 3. 3. Eclampsia

11.3.4. HELLP syndrome

11.3.5. Chronic hypertension

11.5.6. Transient hypertension

11.4. Etiology

11.4.1. Pathophysiology

11.4.2 HELLP syndrome

11.5.1 Care Management

1 1.5.1. Assessment

1 1.5.1.1. Interview

1 1.5.1.2. Physical examination

11 .5.1.3.Laboratory tests

11.5.2 Nursing diagnoses

1 1.5.3. Expected outcomes

11.5.4. Plan of care and implementation

1 1.5.4.1. Preeclampsia

11.5.4.1.1 Mild preeclampsia and home care

11.5.4.2.2 Severe preeclampsia and HELLP syndrome

11.5.4.2.1 Magnesium sulfate

11.5.4.2.2. Control of blood pressure

1 11.5.4.3. Eclampsia

11.5.4.3.1. Immediate care

11.5.4.4. Postpartum nursing care

1 11.5.5. Evaluation

12. Hyperemesis Gravidarum

12.1. Etiology

12.2. Clinical management

1 12.3. Collaborative care

12.5.1 Initial care

12.5.2 Home care

13. Hemorrhagic Disorders

13.1. Early pregnancy bleeding

13.5.1. Miscarriages

13.5.2 Recurrent premature dilation of the cervix

13.5.3. Ectopic pregnancy

13.5.4. Hydatidiform mole

13.2. Late pregnancy bleeding

13.5.1. Placenta previa

13.5.2. Premature separation of placenta

13.5.3. Cord insertion and placental variations

1 13.3 Clotting disorders in pregnancy

13.5.1. Normal clotting

13.5.2. Clotting problems

13.5.3. Disseminated intravascular coagulation (DIC)

13.5.4. Von Willebrand's disease

14. Infections in Pregnancy

14.1 Sexually transmitted infections

14.2. TORCH Infections

14.3. Infection control

15. Surgery During Pregnancy

15.1. Appendicitis

15.2. Intestinal obstruction

5.3. Gynecologic problems

5.4. Care management

16. Trauma During Pregnancy

1 6.1. Significance

16.2. Etiology

16.3. Care management

Alterations in Functional Health Patterns During Labor High Risk Labor and Delivery

HUMANITY

1. Examine the idea of birth choice and birth plan and the implications for the nursing role in assisting the high risk intrapartal family.

HEALTH

2. Compare various childbirth preparation methods.
3. Describe breathing and relaxation techniques used for each stage of labor.
4. Identify strategies to enhance relaxation and decrease during labor
5. Describe the deleterious effects of on pregnant women.

NURSING

6. Discuss types of analgesia and anesthesia used during labor.
7. Compare methods of relief of discomfort in the different stages of labor and for different methods of birth
8. Describe nursing responsibilities appropriate for a woman receiving analgesia and anesthesia labor.
9. Discuss current interventions to prevent preterm birth.
10. Discuss the use of tocolytics and antenatal glucocorticoids in birth.
11. Describe nursing management of a trial of labor, induction and of and vacuum-assisted birth, cesarean birth, and vaginal birth after a cesarean birth.
12. Discuss the criteria for evaluating the nursing care of women experiencing labor and complications.
13. Discuss the care of a woman experiencing pregnancy.
14. Discuss obstetric emergencies and their appropriate management.
15. Identify indications and nursing considerations for drugs used during labor and immediately postpartum (e.g. dinoprostone, oxytocin, methylergonovine, carboprost, meperidine, nalbuphine, butorphanol, naloxone, lidocaine).

ENVIRONMENT

16. Differentiate between preterm birth and low birth weight.
17. Identify risk factors for preterm birth.
18. Define preterm premature rupture of the membranes.

High Risk Labor

Delivery of Discomfort

1. Discomfort During Labor and Birth

1.1. Neurologic origins

1.2. Factors influencing the pain response

1.2.1. Culture

Anxiety and fear

1.2.3. Previous experience

1.2.4. Childbirth preparation

1.2.5. Comfort

1.2.6. Support

2. Nonpharmacologic Management of Discomfort

2.1. Childbirth preparation methods

3. Pharmacologic Management of Discomfort

3.1. Sedatives

3.2. Analgesia and anesthesia

3.2.1 Systemic analgesia

3.2.2. Nerve block analgesia and anesthesia

3.2.2.1. Local infiltration anesthesia

3.2.2.2. Pudendal block

3.2.2.3 Spinal anesthesia

3.2.2.4 Epidural block

3.2.2.5 Epidural and intrathecal narcotics

3.2.2.6 Paracervical (uterosacral) block

4. General Anesthesia

4.1 Inhalation analgesia and anesthesia

5. Care Management

5.1. Assessment

5.2. Nursing diagnoses

5.3. Expected outcomes

5.4. Plan of care and implementation

5.4.1. Nonpharmacologic interventions

5.4.2. Informed consent Timing of administration

5.4.4. Preparation for procedures

5.4.5. Administration of medication

5.4.6. Signs of potential problems

5.4.7. Safety and general care

5.5. Evaluation

Labor and Birth at Risk

6. Preterm Labor and Birth

6.1. Preterm birth versus low birth weight

6.2. Predicting preterm labor and birth

Causes of preterm labor and birth

7. Care Management of Preterm Labor and Birth

7.1 . Assessment

7.2. Nursing diagnoses

7.3. Expected outcomes

7.4. Plan of care and implementation

7.4.1 Prevention

7.4.2. Early recognition and diagnosis

7.4.3. Lifestyle modifications

7.4.4. Home care

7.4.5. Suppression of uterine activity

7.5.6 Promotion of fetal lung maturity

7.5.7 Management of inevitable preterm birth

Evaluation

8. Preterm Premature Rupture of the Membranes

8.1 Incidence and etiology

8.2. Care management: home hospital care

9. Dystocia

9. 1 Dysfunctional labor

9.1.1. Hypertonic uterine dysfunction

9.1.2. Hypotonic uterine dysfunction

9.1.3. Secondary powers

9.2. Alterations in pelvic structure

9.2.1. Pelvic dystocia

9.2.2. Soft tissue dystocia

9.3. Fetal causes

9.3.1. Anomalies Cephalopelvic disproportion

9.3.3. Malposition

9.3.4. Malpresentation

9.3.5. pregnancy

9.4. Position of the woman

9.5. Psychologic responses

9.6. labor patterns

10. Care Management

10.1. Assessment

10.2. Nursing diagnoses

10.3. Expected outcomes

10.4. Plan of care and implementation

10.4.1. Version

10.4.2. Trial of labor

10.4.3. Induction of labor

10.4.3.1. Cervical ripening methods

10.4.3.1.1. Chemical agents

10.4.3.1.2. Mechanical methods

10.4.3.2. Oxytocin

10.4.3.3. Forceps-assisted birth

10.4.3.4. Vacuum-assisted birth

10.4.3.5. Cesarean
birth

10.4.3.6 Vaginal birth
after
cesarean

10.5. Evaluation

11. Pregnancy, Labor, and Birth

1 1.1. Maternal and fetal risks

1 1.2. Care management

12. Obstetric Emergencies

12.1. Shoulder dystocia

12.2. Prolapsed umbilical cord

1 2.3. of uterus

12.4. Amniotic fluid embolism

OBJECTIVES

Alterations in Functional Health Patterns r/t Postpartum and the Neonatal

Period Alterations in reproductive/ sexual Health Patterns

Upon completion of this unit the student will be able to:

1. Appropriately apply the nursing process in providing wholistic health care to families experiencing alterations in health during the postpartum period.
2. Identify the role of the nurse as advocate in assisting families with alterations in normal health patterns during the postnatal period.
3. Appropriately apply the nursing process in providing holistic health care families experiencing alterations in health of the newborn during the neonatal period.
4. Identify the role of the nurse in assisting families experiencing alterations in normal health patterns and coping related to family crisis with the at risk infant.
5. Describe available resources and the referral process needed families in coping with crisis resulting from infants born prematurely, or with conditions such as sepsis, distress syndrome, genetic defects, a maternal history of substance abuse or AIDS.
6. Review the role of the nurse in providing spiritual support to the family perinatal loss including advocacy and referral to appropriate personnel or agencies.
7. Discuss women's health care issues across the life span related to health perception. health promotion and health maintenance including contraception.
8. Identify alterations in sexual, reproductive health for men and women including transmitted infections, cancer and benign disorders of sexual function.

Alterations in Functional Health Patterns During Postpartum

High Risk Postpartum

HUMANITY

1. Describe emotional, behavioral, cognitive, and physical responses experienced during the grieving process associated with perinatal loss.
2. Identify major issues affecting the family in crisis during the fourth trimester mother is experiencing postpartum depression or psychosis.

HEALTH

3. Identify causes, signs and symptoms, possible complications, and medical and nursing management of postpartum hemorrhage.
4. Differentiate among the causes of early and late postpartum hemorrhage.
5. Differentiate among the causes of postpartum infection.
6. Discuss emotional complications during pregnancy including management of mood disorders.

NURSING

7. Summarize the role of the nurse in assessing potential problems and managing the care of with postpartum complications in the home setting.
8. Differentiate among postpartum emotional complications incidence, risk factors, signs and symptoms, and management.
9. Identify specific nursing interventions to meet the special needs of parents and their families related to perinatal loss and grief.
10. Differentiate among helpful and unhelpful responses in caring for parents experiencing loss and grief.
11. Formulate a nursing care plan that plans, implements, and evaluates the high risk postpartum client during the fourth trimester.

ENVIRONMENT

12. Evaluate the new mother's knowledge of postpartal self-care measures, including measures to prevent occurrence and reoccurrence of complications postpartum.
13. Identify appropriate community resources and referrals for the postpartum family experiencing complications postpartum.

High Risk Postpartum Postpartum Complications

1. Postpartum Hemorrhage

- 1.1. Definition and incidence
- 1.2. Etiology and risk factors
- 1.3. Uterine atony
- 1.4. Lacerations of the genital tract
- 1.5. Retained placenta
- 1.6. Inversion of the uterus
- 1.7. Subinvolution of the uterus

2. Care Management

- 2.1. Assessment
- 2.2. Nursing diagnoses
- 2.3. Expected outcomes
- 2.4. Plan of care and implementation
 - 2.4.1. Medical management
 - 2.4.2. Nursing interventions
- 2.5 Evaluation

3. Hemorrhagic (Hypovolemic) Shock

- 3.1. Medical management
- 3.2 Nursing interventions

4. Coagulopathies

5. Thromboembolic Disease

- 5.1. Incidence and Etiology
- 5.2. Clinical Manifestations
- 5.3. Medical
- 5.4 Nursing Interventions

6. Postpartum Infections

- 6.1. Endometritis
- 6.2. Wound Infection
- 6.3. Urinary Tract Infection
- 6.4. Mastitis

7. Care Management

- 7.1 Nursing diagnoses
- 7.2. Plan of care and implementation

8. Sequelae of Childbirth Trauma

- 8.1. Uterine displacement and prolapse
- 8.2. Cystocele and rectocele
- 8.3. Urinary incontinence
- 8.4. Genital fistula

9. Care Management

- 9.1. Assessment
- 9.2. Nursing diagnoses
- 9.3. Plan of care and implementation

10. Postpartum Psychologic Complications

- 10.1. Postpartum depression without psychotic features
- 10.2. Postpartum depression with psychotic features
- 10.3. Assessment
- 10.4. Nursing diagnoses
- 10.5. On the postpartum unit
- 10.6. In the home and community

11. Loss and Grief

1 1.1. Conceptual model of parental grief

1 1.1.1 Acute distress

11.1.2 Intense grief

11.1.3. Reorganization

1 1.2. Anticipatory grief

1 1.3. Care management

11.3.1 Assessment

11.3.2 Nursing diagnoses

11.3.3 Expected outcomes

11.3.4 Plan of care and implementation

11.3.4.1 Communicating and caring techniques

11.3.4.2 Actualize the loss

11.3.4.3. Provide time to grieve

11.3.4.4 .Interpret normal feeling

11.3.4.5 Allow for individual differences

11.3.4.6. Cultural and spiritual needs of parents

11.3.4.7 Physical comfort

11.3.4.8 . Options for parents

11.3.4.9. Documentation

11.3.4.10 Follow-up after discharge

11.3.4. 11 Maternal death

11.3.5. Evaluation

Alterations in Functional Health Patterns of the Neonate High Risk Newborn

HUMANITY

1. Identify the needs of and support for the family members who are dealing with the birth of a risk infant or infant with a defect.

HEALTH

2. Compare and contrast the characteristics of preterm, term, postterm, and postmature neonates.
3. Discuss the pathophysiology of retinopathy of prematurity and bronchopulmonan and identify risk factors that predispose preterm infants to these problems.
4. Describe meconium aspiration syndrome.
5. Compare Rh and ABO incompatibility.

NURSING

6. Discuss respiratory distress syndrome and the approach to treatment.
7. Describe nursing interventions for nutritional care of the infant.
8. List the signs and symptoms of perinatal asphyxia.
9. Describe the assessment of infants for birth trauma and for of a diabetic pregnancy.
10. Plan developmentally appropriate care.
11. Summarize the assessment and care of the newborn with tissue. skeletal. and nervous system injuries caused by birth trauma.
12. Describe the assessment of a newborn for infection.
13. Describe the assessment of a newborn experiencing drug withdrawal.
14. Describe the assessment, prevention, and management of hyperbilirubinemia
15. Describe preoperative and postoperative nursing care of the newborn.
16. Describe common congenital disorders seen in the newborn, and identify priorities of care for each.
17. Discuss the effects of maternal use of alcohol, heroin, methadone, marijuana. cocaine, and smoking tobacco on the fetus and newborn.
18. Identify community resources available to help families with home care of high-risk infants.

**High Risk Newborn
Infants with Age-Related Problems**

1. Preterm Infants-Care Management

- 1.1. Assessment
 - 1.1.1 Respiratory function
 - 1.1.2. Cardiovascular function
 - 1.1.3 Maintaining body temperature
 - 1.1 .4. Central nervous system function
 - 1.1.5 Maintaining adequate nutrition
 - 1.1.6. Maintaining renal function
 - 1.1.7. Maintaining hematologic status
 - 1.1.8. Resisting infection
 - 1.1.9. Protection from infection
 - 1.1.10. Skin care
 - 1 .1.11 Growth and development potential
 - 1.1.12 Parental adaptation to preterm infant
- 1.2. Nursing diagnoses
- 1.3. Expected outcomes
- 1.4. Plan of care and implementation
 - 1.4.1. Physical care
 - 1.4.2. Maintaining body temperature

1.4.3. Oxygen therapy

1.4.3.1. Hood therapy; nasal cannula

1.4.3.2. Continuous positive airway pressure therapy

1.4.3.3. Mechanical ventilation

1.4.3.4. Surfactant administration

1.4.3.5. Extracorporeal membrane oxygenation therapy

1.4.3.6. High-frequency ventilation

1.4.3.7. Weaning from respiratory assistance

1.4.4. Nutritional care

1.4.4.1. Types of nourishment

1.4.4.2. Weight and fluid loss or gain

1.4.4.3. Elimination patterns

1.4.4.4. Oral feeding

Gavage feeding

1.4.4.6. Gastrostomy

1.4.4.7. Parenteral fluids

Advancing infant

1.4.4.9. Nonnutritive sucking

1.4.4.10. Environmental concerns

1.4.5. Developmental care

1.4.5.1. Positioning Reducing inappropriate stimuli Infant communication

1.4.5.4. Infant stimulation Kangaroo care

1.4.5.6. Parental support Parent education

1.5. Evaluation

1.6. Complications associated with prematurity

1.6.1. Respiratory distress syndrome

1.6.2. Complications associated with oxygen therapy

2. Postmature Infants

- 2.1. Meconium aspiration syndrome
- 2.2. Persistent pulmonary hypertension of the newborn

3. Other Problems Related to Gestation

- 3.1. Small for gestational age and intrauterine growth restriction
 - 3.1.1 Perinatal asphyxia
 - 3.1.2 Hypoglycemia
 - 3.1.3 Heat loss

- 3.2 Large for gestational age

4. Infants of Diabetic Mothers

- 4.1 Pathophysiology
- 4.2. Congenital anomalies
- 4.3. Macrosomia
- 4.4. Birth trauma and perinatal asphyxia
- 4.5. Respiratory distress syndrome
- 4.6. Hypoglycemia
- 4.7. Hypocalcemia and hypomagnesemia
- 4.8. Cardiomyopathy
- 4.9. Hyperbilirubinemia and polycythemia
- 4.10 Nursing care

5. Discharge Planning

6. Transport to a Regional Center

7. Transport From a Regional Center

The Newborn at Risk: Acquired and Congenital Problem

8. Birth Trauma-Care Management

- 8.1. Soft tissue injuries
- 8.2. Skeletal injuries
- 8.3. Peripheral nervous system injuries
- 8.4 Central nervous system injuries

Neonatal Infections-Care Management

- 9.1. Sepsis
- 9.2. Assessment
- 9.3. Nursing diagnoses
- 9.4. Expected outcomes
- 9.5. Plan of care and implementation
 - 9.5.1. Preventive measures
 - 9.5.2. Curative measures
 - 9.5.3. Rehabilitative measures
- 9.6. Evaluation
- 9.7. TORCH infections
- 9.8. Bacterial infections
- 9.9. Fungal infections

10. Substance Abuse

- 10.1. Alcohol
- 10.2. Tobacco
- 10.3. Marijuana
- 10.4. Cocaine
- 10.5. Phencyclidine
- 10.6. Heroin
- 10.7 Methadone

10.8 Miscellaneous substances

10.9. Care management

11. Hemolytic Disorders

1 1.1. Hyperbilirubinemia

11.1 .1. Physiologic jaundice

1 1.1.2. Pathologic jaundice

11.1.2.1. Hemolytic disease of the newborn

11.2.2. 2Rh incompatibility

11.1.2.3. ABO incompatibility

1 1.1.2.4. Kernicterus

1 1.2. Care management

12. Congenital Anomalies

12.1. Central nervous system anomalies

12.2. Cardiovascular system anomalies

1 2.3. Respiratory system anomalies

12.4. Gastrointestinal system anomalies

12.5. Musculoskeletal system anomalies

1 2.6. Genitourinary system anomalies

12.7. Teratoma

Care Management

13.1. Genetic diagnosis

13.1.1. Biochemical tests

13.1.2. Cytologic studies Dermatoglyphics

1 3.2. Nursing care

13.2.1. Newborn

13.2.2. Parents and family

Alterations in Health Reproduction/ Sexual Health Patterns

Reproductive Health

HUMANITY

1. Discuss the spiritual implications to women experiencing loss of reproductive function.

HEALTH

3. Discuss the incidence of battering in pregnant women.
4. Discuss the pathophysiology and emotional effects of select benign breast conditions and malignant neoplasms of the breasts found in women.
5. List common causes of infertility.
6. State the advantages and disadvantages of methods of contraception. Recognize ethical, legal, cultural, and religious considerations of infertility, contraception, and elective abortion.
7. Delineate factors influencing attitudes about sex and reproduction.
8. Summarize the physiologic and psychological effects of infertility on a couple.

NURSING

9. Explain the cycle of violence and its use in assessment and for women.
10. Demonstrate the various methods for doing a breast self-examination.
11. Describe the prevention and treatment of sexually transmitted infections in women.
12. List common diagnoses and treatments for infertility.
13. Describe the techniques used for medical and surgical interruption of pregnancy.

ENVIRONMENT

14. Suggest community resources to combat violence against women.
15. Describe the concept of the feminization of poverty.

Reproductive Health Health Promotion and Prevention

1. Reasons for Entering the Health Care System

1 . I. Preconception counseling

1.2. Pregnancy

1.3. Well-woman care

2. Conditions and Characteristics that increase health risks in the childbearing years

2.1 Demographics

2.1.1. Age

2.1.2. Socio/cultural

2.1.3. Health behaviors

2.1.3.1. Smoking

2.1.3.2. Substance use and abuse Nutrition Physical fitness and exercise

2.1.3.5. Stress

2.1.4. Sexual practices

2.1.5. Medical conditions

2.1.6. Environmental and workplace hazards

2.1.7. Violence against women

3. Anticipatory Guidance for Health Promotion and Prevention

3.1. Substance use cessation

3.2 Health screening schedule

3.3. Health risk prevention

3.4 Health protection

Common Health Problems

4. Menstrual Problems

4.1. Amenorrhea

4.2. Dysmenorrhea

4.3. Premenstrual syndrome (PMS)

4.4. Dysfunctional uterine bleeding (DUB)

5. Sexually Transmitted Infections

5.1. Prevention of STIs.

6. Sexually Transmitted Bacterial Infections

6.1. Chlamydia

6.2. Gonorrhea

6.3. Syphilis

6.4 Pelvic inflammatory disease

7. Sexually Transmitted Viral Infections

7.1 Human papillomavirus

7.2. Herpes simplex virus

7.3. Viral hepatitis

7.4. Human immunodeficiency virus

8. Group B Streptococcus

9. Vaginal Infections

9.1. Bacterial

9.2. Candidiasis

9.3. Trichomoniasis

10. Infection Control: Standard Precautions

11. Problems of the Breast-Benign

1 1.1. Fibrocystic changes

11.2. Fibroadenomas

11.3. Lipomas

1 1.4. Nipple discharge

1 1.5. Mammary duct ectasia

12. Malignant Conditions of the Breast

12.1. Etiology

12.2. Clinical manifestations and diagnosis

12.3. Management

12.1.1. Surgery

12.1.2. Breast reconstruction

12.1.3. Radiation

12.1.4. Adjuvant therapy

1 2.1.4. Care management

Infertility, Contraception, and Abortion

13. Infertility

13.1. Incidence

13.2. Factors associated with infertility

14. Care Management

14.1. Assessment

14.1.1. Assessment of female infertility

14.1.2. Assessment of male infertility

14.1.3. Assessment of the couple

14.2. Nursing diagnoses

14.3. Expected outcomes

14.4. Plan of care and

14.1 Psychosocial Nonmedical therapies

14.1.3. Medical therapies

14.1.4. Surgical therapies Reproductive alternatives

14.1.6. Adoption

14.5 Evaluation

15. Contraception

16. Care Management

16.1. Assessment

16.2. Nursing diagnoses

16.3. Expected outcomes

16.4. Plan of care and implementation

16.1.1. Coitus interruptus

16.1.2. Periodic abstinence

16.1.3. Barrier methods

16.4.3.1 Spermicides

16.4.3.2 Condoms

16.4.3.3. Diaphragm

16.4.3.4 Cervicalcap

1 6.4.3.5. Contraceptive sponge

16.1.4. Hormonal methods

16.4.4.1. Combined estrogen and progesterone contraceptives

16.4.4.2. Progestin- only contraception

16.1.5. Intrauterine devices (IUD) I6.5. Sterilization

16.5.1.1. Types of sterilization (female and male)

16.5.1.2. Tubal reconstruction

16.5.1.3. Laws and regulations'

16.6 Evaluation

17.Abortion

1 7.1.1. First trimester abortion

17.1.2. Second trimester abortion

17.1.3 Complications after abortion

CLINICAL SYLLABUS

CLINICAL SYLLABUS

Upon completion of NURS 252 Clinical, the student will be able to:

- A. Relate theoretical knowledge and nursing skills to given clinical situations.
- B. Function in the roles of the associate degree nurse in the following areas.

HUMANITY

Demonstrate progressive skills in communication in order to:

- 1. Communicate effectively with perinatal clients and their families.
- 2. Communicate effectively with members of the health team, instructor and peers. both orally and in writing.
- 3. Contribute to own and group learning (participate in pre and post conference).

HEALTH

Use advanced assessment skills to:

- 1. Integrated assessment skills to recognize patient / family status. variations in health patterns and changes.
- 2. Perform a complete neonatal assessment including attachment and bonding with mother and significant family members.

NURSING

Demonstrated expanded skills in the nursing process by:

- 1. Assessing information from patients' records, patients, family and health team.
- 2. Analyzing data to form nursing diagnosis in relationship to acute alteration in health patterns. components of wholeness he life span.
- 3. Writing nursing care plans, integrating concepts from pharmacology, nutrition. advocacy. legal and ethical issues, communication, health promotion, education, and pain mana,
- 4. Implementing nursing care to the postpartum client and the neonate at the dependent, interdependent and beginning independent level.
- 5. Demonstrating correct and safe patient care, skills and medication administration. Providing education based upon assessed learning needs.
- 6. Evaluating expected outcomes and modifying nursing care plans related to individual and family needs.

7. Reporting and documenting assessment, observation, and nursing care accurately and in a timely manner.
8. Setting priorities and organizing patient care.
9. Using the spirit of inquiry to seek learning experience based on assessment of own learning needs.
10. Demonstrating professional responsibility in areas of preparation, conduct, confidentiality, punctuality, and personal appearance; and following policies, standards, and procedures of clinical agency and nursing department.

ENVIRONMENT

Provide safe physical and emotional environment for patient and family.

Mother/Baby Skills and Procedures

Surgigator Use / Perineal Care

1. Obtain personal surgigator tip
2. Insert into tip; insert tip urgigator handle, which is attached to wall unit. Holes in tip should face upward.
3. Pointing the tip into the toilet, turn on water until
2. Instruct patient to sit on the toilet, and place surgigator tip under the vaginal/perineal area.
3. Do not insert the tip into the body. The tip is designed only to direct a flow of water over the external tissue in order to cleanse.
4. Maintain water flow for about five minutes.
5. Place surgigator tip with personal (tip may be used at home).
6. Gently pat tissue dry.
7. Apply dermoplast spray as ordered.
8. Apply ice and clean peri-pads.
- 9.

Staple Removal

1. Once order received, instruct patient to call after showering.
2. Obtain staple removal kit, packages of inch steri-strips, scissors
3. Wash your hands (this is a clean, not sterile, procedure)
4. Explain procedure to the patient Count the staples
5. Remove other staple, placing removed staples in the plastic box the staple remover came in.

6. Cut each strip in half, making **2** inch strips
 - Leave strips 4 inches long for patient with large, pendulous abdomen or a classical incision
7. Place steri-strips over incision; leave a small amount of space between strips to allow air circulation
 - Make sure that skin is well approximated and not overlapping
 - Center the strip vertically over the incision
8. Remove remaining staples and place steri-strips as before, making certain steri - strips do not overlap
9. Leave incision open to air
10. Count staples to verify that all removed staples are present: discard in sharps container.
11. Document procedure
Rubella Vaccine

1. Confirm order
 - Confirm patient's rubella titer
2. Provide patient teaching regarding rubella and pregnancy
3. Verify patient allergies
4. Obtain rubella vaccine, verifying that it is only rubella. Check expiration date.
5. Together with verify patient's consent prior to administration.
6. Administer total reconstituted contents SQ.
7. Document administration of vaccine on medication record, nurse's notes and on progress notes.

RhoGAM

1. Confirm order
 - Confirm patient's blood type. Rh, and coombs
 - Confirm baby's blood type, and coombs
2. Note patient's religious affiliation
3. Label a card with mother's admission information, blood type, Rh, and copy of the physician's order for RhoGAM
4. Take the card to the lab to pick up RhoGAM
5. Confirm all information on the blood transfusion sheet with the lab tech. Sign the sheet as "person receiving blood"
6. Return to the floor with the RhoGAM.
7. Verify all information with your patient's and your instructor upon return to the floor. Sign the blood transfusion sheet as "Personal responsible for starting transfusion."
8. Wash your hands Assemble the Complete white administration card for patient (include baby's blood type and Rh).
9. Explain the procedure, provide patient teaching as indicated.
10. Verify the information on the blood transfusion slip against the patient's armband information.
11. Administer RhoGAM deep IM (RhoGAM should be administered 20 minutes of pick-up from the lab)
12. Document administration of RhoGAM on medication record, nurses notes, notes, and on Kardex.
13. Observe patient for any adverse reactions (fever, headache, flushing, itching, rash, etc.)
14. Complete blood transfusion record including post-administration V/S and assessment.
 - Place original in lab section of patient's chart
 - Return lab copy of blood transfusion sheet along with RhoGAM bag to lab.

Patient Discharge

1. Confirm discharge order for both mother and baby.
2. Check for any outstanding lab work. Note any prescriptions or special instructions.
3. Confirm that infant photo has been taken
4. If indicated and ordered, administer Rubella. Hepatitis B
5. Verify that birth certificate worksheet is complete
6. Provide any other discharge materials
7. Complete patient teaching sheet complete discharge forms:
8. Confirm with patient's RN that patient is ready for discharge
9. Assist patient in dressing infant if necessary; if diapers or clothes are needed for the infant, check the nurse. Have family bring car seat to room to make any necessary adjustments
10. Remove security band (do this with the nurse or instructor)
11. Discharge mother and baby. Belongings may be loaded on the unit cart
11. Document time of discharge

Patient Discharge Checklist

1. Discharge order written for mom
2. Discharge order written for baby
3. Follow-up appointments for both mother and baby
4. Prescription (called to pharmacy if needed)
5. PKU done (baby at least 12 hours old)
6. Photo taken
7. Birth certificate complete
8. Baby fully assessed by MD
9. Umbilical cord clamp removed
10. Discharge packs given
11. Rubella Depo-Provera RhoGAM given as ordered
12. Staples out Saline lock out
13. Baby's ID band confirmed with mother's number and stapled to release form
14. Alarm band deactivated and removed

Post Discharge Checklist

1. Document discharge on nurses notes and on teaching sheet
2. Write date and time of discharge on the discharge sheet
3. Complete discharge board
4. Add medication sheets
5. Get Kardex papers and file in discharge file

PEDIATRIC NURSING

SYLLABUS

PEDIATRIC NURSING

OBJECTIVES

Pediatric Nursing incorporates the nursing concepts of health patterns applied to the child with normal and alterations in health.

Emphasis is on the needs of the child from one month to adolescence.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 60hrs.
- ❖ Lecturers should be a qualified Medical Officer and a qualified Nurse.
70% of lectures should be presented by the Medical Officer and 30% by the Nurse.
- ❖ Methods of instruction are lectures and presentations.
- ❖ Performances are evaluated by through quizzes and assignments during the sessions.
- ❖ Term exam papers include MCQ, structured essays and essay questions.

REFERENCES

5. Neff.C, Martha.S, Introduction Maternal and Child Health Nursing (1996), Lippincott.

COURSE OUTLINE

1. Newborn

- Preterm infant
- Neonatal Jaundice
- Respiratory Distress Syndrome
- Meconium Aspiration
- Asphyxiated baby
- Neonatal convulsions
- Neonatal sepsis

- Time allocated 04hrs

2. Examination of a Child

- General examination
- Vital signs
- Anthropometric measures

Time allocated 02hrs

3. Growth and Development

- Factors affecting growth
- Brain growth and development
- Sexual development
- Short stature
- Neurodevelopment

Time allocated 04hrs

4. Hematological and Immunological Diseases in children

- Assessment
- Anemia
- Sickle cell Anemia
- Thalasemia
- Hemophilia
- Idiopathic Thrombocytopenic Purpura
- Leukemia
- Systemic Lupus Erythematosus
- Sudden Infant Death Syndrome

- Nursing management

Time allocated 06hrs

5. Child with alterations in GI function

- Assessment
- Cleft Lip and Cleft Palate
- Esophageal Atresia
- Tracheo-Esophageal Fistula
- GERD
- Pyloric Stenosis
- Appendicitis
- Constipation
- Hirschsprung's disease
- Parasitic Worms
- Imperforated Anus
- Infant colic
- Biliary Atresia
- Viral Hepatitis
- Nursing management

Time allocated 06hrs

6. Renal Disease in Pediatrics

- Idiopathic Nephrotic Syndrome
- Acute Glomerulo Nephritis
- Nursing management

Time allocated 02hrs

7. Respiratory problems in children

- Assessment
- Common cold
- Croup
- Epiglottitis
- Influenza
- Bronchiolitis
- Pneumonia
- Asthma
- Tonsillitis
- Nursing management

Time allocated 06hrs

8. Congenital Heart Diseases

- Cyanotic and Acyanotic CHD
- Ventricular Septal Defect
- Atrial Septal Defect
- Artrioventricular Septal Defects
- Coarctation of Aorta
- Patent Duct Arteriosis
- Pulmonary stenosis
- Aortic stenosis
- Tetrolgy of Fallots
- Abnormal Blood mixing
- Nursing management

Time allocated 08hrs

9. Neuromuscular Dysfunction in Pediatrics

- Cerebral palsy
- Congenital Neural Tube Defects
- Guillain-Barre Syndrome
- Tetanus
- Infantile Meningitis
- Febrile fits
- Epilepsy
- Reyes Syndrome
- Hydrocephalus
- Down's Syndrome
- Nursing management

Time allocated 08hrs

10. Musculoskeletal Disorders

- Assessment
- Care of a child with cast
- Care of a child with traction and braces
- Fractures
- Sprains and strains
- Torticollis
- Congenital dislocation of Hip
- Osteogenesis Imperpecta
- Muscular Dystrophy
- Talipes

- Scoliosis and Kyphosis
- Juvenile Rheumatoid Arthritis
- Nursing management

Time allocated 06hrs

11. Skin problems in children

- Impetigo
- Pediculosis
- Eczema
- Diaper Rash
- Ring worm infections
- Mongolian spots
- Acne
- Burns
- Nursing management

Time allocated 04hrs

12. Disorders of the Reproductive system

- Amenorrhea
- Dysmenorrhea
- Testicular problems
- Nursing management

Time allocated 02hrs

13. Dehydration and IV Fluids

- Dehydration
- Fluid therapy
- Parenteral fluid

Time allocated 02hrs

MENTAL HEALTH NURSING 1

COURSE OBJECTIVES

Learning activities in this course are designed so that upon satisfactory completion, the student will be able to:

HUMANITY

1. Identify anxiety and level of anxiety in self and patients.
2. Recognize effects of anxiety in self and patients.

HEALTH

1. Define and summarize selected defense mechanisms and their purpose in limiting feelings of anxiety.
2. Identify constructive and destructive use of defense mechanisms in patient situations.
3. List potential disturbances in physiologic functioning for level of anxiety.
4. List potential disturbances in psychological for level of anxiety.

NURSING

1. Identify the steps of the nursing process as applied to communicating with patients.
functioning
2. Define and use components of the therapeutic nurse – patient relationship.
3. Define and utilize therapeutic communication techniques.
4. Recognize and revise non – therapeutic communication techniques.
5. Identify nursing interventions to assist in management of anxiety.

ENVIRONMENT

1. Develop a beginning awareness of nurse's role in providing a safe emotional environment.

Table of content

Therapeutic Communication

Non Therapeutic Communication
Group Therapy

Therapeutic Communication
Student Presentations

Test #1
Nurse – Patient Relationship

The Nurse – Patient Relationship

The Nurse – Patient Relationship
Students Presentations

Test #2

Anxiety

Comprehensive FINAL EXAM

ROLE – RELATIONSHIP PATTERN

The Patient with Potential for Impaired Communication

Topic: Therapeutic Communication

Content / Focus:

- Review of Components of Communication
- One – to – one communication
- Group Communication (Group Dynamics)
- Curative Factors Related to Communication Techniques

Upon the completion of these classes, the student will be able to:

ENVIRONMENT

1. Define communication.
2. Identify environmental factors which affect communication.
3. Discuss the interrelatedness of verbal and nonverbal communication.

HUMANITY

1. Define “Group”
2. Identify phases of group development
3. Explain how group communication (therapy) helps people.
4. Identify types of groups.

NURSING

1. Differentiate between therapeutic (constructive) and non – therapeutic (destructive) communication techniques.
2. Apply therapeutic communication techniques to patient situations.
3. Explain the relationship between the nursing process and therapeutic communication.
4. Discuss how communication may be altered across the lifespan.

HEALTH

Identify patient’s basic communication needs.

ROLE – RELATIONSHIP PATTERN

The patient with Potential for Disturbance in Role Performance

Topic: The therapeutic nurse – patient relationship

Content / Focus:

Therapeutic (Helping) Relationships
Curative Elements
Advocacy

Upon completion of these classes, the student will be able to:

HUMANITY

1. Discuss the phases of one – to – one relationship.
2. Differentiate between a social and a therapeutic relationship

HEALTH

Recognize basic human needs for supportive relationships.

ENVIRONMENT

List environmental factors which can impact on relationships.

NURSING

1. Discuss the concepts of transference and counter – transference in the nurse – patient relationship.
2. Apply relationship concepts to given patient situations.
3. Identify the nurse's role as an advocate for the patient.
4. Discuss how the relationship itself may be therapeutic.
5. Demonstrate appropriate boundaries in therapeutic relationship.

SELF – PERCEPTION - SELF – CONCEPT PATTERN

The Patient with Potential for Anxiety

Topic: Anxiety

Concept / Focus:

Anxiety, Lifespan, Pharmacology

Upon completion of these classes, the student will be able to:

HEALTH:

1. Identify levels of anxiety in self.
2. Discuss how anxiety affects each of the components of the wholeness of man; psychological, physiological, intellectual, sociological, and spiritual.
3. Relate anxiety to lifespan development.

ENVIRONMENT

Discuss the impact of environmental factors on anxiety.

NURSING

Apply the nursing process to patient situations for patients experiencing anxiety.

Review: Growth and development (focus on phallic period family triangle)
Anxiolytic drugs

**MENTAL HEALTH NURSING
II**

THEORY SYLLABUS

Course Description

Mental Health II provides students with an opportunity to expand knowledge and skills in the functional Health Patterns:

Self-perception – Self –Concept; Cognitive – Perceptual; Coping-Stress Tolerance; and Health Perception – Health Management. Focus is on communication and coping pattern of the students and of selected patients who are identified as having specific mental health needs.

This course focuses on the interrelationship of the emotional and physical components of man. The clinical experience is provided in several different settings with patients who have identified needs and diagnoses.

COURSE OBJECTIVES

HUMANITY

1. Recognize the impact of family, culture, heredity, and religion on the needs of patients with altered patterns of emotional health.
2. Compare and contrast the normal aging process and normal and abnormal manifestations of behavior.
3. Identify a developing self-awareness of personal needs, patterns of behavior, strengths, and weaknesses.
4. Discuss how alterations in patterns of communication and coping may alter patient's ability to meet spiritual needs.

HEALTH

1. Identify patients whose patterns of communication and coping interfere with their optimal functioning.
2. Identify the pharmacological agents usually prescribed for specific psychiatric disorders.
3. Provide appropriate nutritional support for patients with common psychiatric disorders.

NURSING

1. Discuss the etiology, special characteristics, typical symptoms, and usual treatment modalities for selected psychiatric modalities.
2. Discuss transference and counter-transference and their application to the nursing process.
3. Discuss appropriate dosage, desired effects, side effects, and adverse effects of common psychotropic medications.
4. Implement appropriate teaching interventions for patients with alteration in communication and/or coping patterns.
5. Summarize and discuss how self-awareness affects patient care.

Table of Content

1. KNOWLEDGE DEFICIT / RT/ PSYCHOPATHOLOGY OVERVIEW
2. PERSONAL IDENTITY CONFUSION /RT/ THOUGHT DISORDERS:
SCHIZOPHRENIA
3. IMPAIRED SOCIAL INTERACTION / RT/ PERSONALITY DISORDERS
(BORDERLINE PERSONALITY DISORDER AND ANTISOCIAL PERSONALITY
DISORDER)
4. MILD, MODERATE, OR SEVERE ANXIETY / RT/ ANXIETY DISORDERS
5. INEFFECTIVE, AVOIDANCE OR DEFENSIVE COPING /RT/ CRISIS PROBLEMS
6. INEFFECTIVE COPING/RT/SUBSTANCE ABUSE
7. DECREASED ADAPTIVE CAPACITY /RT/ORGANIC DISORDERS

Main Functional Health Pattern: **COGNITIVE-PERCEPTUAL**

Nursing Dx

Medical Dx

KNOWLEDGE DEFICIT / RT/ PSYCHOPATHOLOGY OVERVIEW

Content/focus : Roots of Psychopathology

Relationship of Impaired Growth and Development to the Mental Illness

Relationship of Anxiety and Defense Mechanisms in Mental Illness

Nursing Functions: The student will be able to:

HEALTH

1. Contrast and compare Medical Psychiatric theories with Nursing Theories
2. Analyze and discuss the structure of the personality using the terms; id, ego, super ego
3. Explain the purpose of defense mechanisms
4. Define and give examples of selected defense mechanism in operation
5. Define anxiety

NURSING

1. Compare and contrast levels of anxiety and how they contribute to and interfere with anxiety functioning
2. Plan an assessment and list symptoms frequently associated with anxiety, then determine which level of anxiety produces the various symptoms.

HUMANITY

1. Discuss the nursing independent role in the different “levels of prevention” for mental illness.
2. Explain the roles of the various mental health professionals and how they relate to each other and to the patient.

ENVIRONMENT

1. Identify various environment and/or cultural factors that may affect the Mental illness- - Mental Health continuum

Main Functional Health Pattern: **SELF-PERCEPTION -SELF-CONCEPT**

Nursing Dx

Medical Dx

PERSONAL IDENTITY CONFUSION /RT/ THOUGHT DISORDERS: Schizophrenia

Content/focus : Psychosis: Assisting a Patient to Maintain Contact with Reality

Nursing Functions: The student will be able to:

HEALTH

1. Analyze and compare the relationship between neurobiological, genetic, psychological, family theories which attempt to explain schizophrenia
2. Explain the dynamics (steps) of the development of schizophrenia.
3. Illustrate the connection between paranoid thinking and the use of projection as a defense mechanism

NURSING

1. Assess and Discuss typical signs and symptoms of schizophrenia.
2. Discuss nursing approaches for handling problems of living often seen in schizophrenic patients and plan interventions that address the following problems:
 - a. *providing for activities of daily living
 - b. *communication and interaction with others
 - c. *dealing with perceptual distortions (hallucinations, delusions)
 - d. *complying with the medication regime
 - e. *participating in work, hobbies, etc. *maintenance of nutritional requirements.
3. Discuss nursing management of the schizophrenic patient who is paranoid.
4. Address the do's and don'ts of spiritual care with the schizophrenia patients.
5. Formulate and demonstrate a nursing care plan for a schizophrenic patient integrating concepts from pharmacology, nutrition, life span development, communication and clinical education.
6. Analyze the independent role of the nurse in "mutual withdrawal" and explain how the nurse can avoid making this mistake.
7. Define the dependent and interdependent nursing roles when giving medication to patients with thought disorders.
8. Identify common Psychotropic medicines used for patients with thought disorders.
9. Be able to identify common side effects of psychotropic medicine and intervene appropriately.

Main Functional Health Pattern: **ROLE-RELATIONSHIP**

Nursing Dx

Medical Dx

IMPAIRED SOCIAL INTERACTION / RT/ PERSONALITY DISORDERS

(Borderline Personality Disorder and Antisocial Personality Disorder)

Content/Focus:

Maladaptive Life-Styles

Separation -Individuation

Nursing Functions: The student will be able to:

HEALTH

1. Define "personality disorder."
2. Compare personality "traits" with personality "disorders"

NURSING

1. Identify typical characteristic assessment symptoms of patients with borderline or antisocial features.
2. Identify nursing diagnosis and interventions likely to be effective for a patient with antisocial personality disorder.
3. Discuss interventions and treatments available, including interpersonal, behavioral and pharmacological.
4. Identify nursing diagnoses and interventions likely to be effective for a patient with borderline personality disorder.
5. Define interventions likely to be effective for a patient with antisocial personality disorder.
6. Formulate and demonstrate a nursing care plan integrating concepts pharmacology, nutrition, life span development, communication, and clinical education.
7. Analyze and discuss the expected counter-transference reaction to be found in the nurse and other staff.

HUMANITY

1. Discuss problems with growth and development across the life span that may lead to the development of a personality disorder.
2. Develop a teaching -communication plan that includes family, when appropriate

Main Functional Health Pattern: **SELF-PERCEPTION -SELF-CONCEPT**

Nursing Dx
MILD, MODERATE, OR SEVERE ANXIETY / RT/ ANXIETY DISORDERS

Medical Dx

Content/Focus:

Neurotic Level Disorders

Nursing Functions: The student will be able to:

HEALTH

1. List major characteristics of anxiety disorders.
2. Contrast and define:
 - a. -panic disorders
 - b. -phobia
 - c. -obsessive-compulsive
 - d. post-traumatic stress disorder
 - e. -generalized anxiety disorder
 - f. -dissociative disorders
3. Analyze the effects of stress in mental and physical illnesses.

NURSING

1. Define assessment criteria of how conflict leads to anxiety.
2. Formulate and demonstrate a nursing care plan integrating concepts pharmacology, nutrition, life span development, communication and clinical education for a pattern with anxiety.
3. Identify pharmacological agents commonly used to intervene in anxiety disorders.
4. Identify the nurse's independent and interdependent role related to: usual dosage, SE precautions of pharmacological agents.
5. Discuss how the of anxiety influences each of the 5 components of the wholeness of man; spiritual, intellectual, psychological, physiological and sociological.

HUMANITY

1. Develop a teaching plan for with severe anxiety that includes family.

ENVIRONMENT

1. Define therapeutic milieu for moderate to severe anxiety
2. Explain why psychotherapy is more likely to help the patient more dedply than will care in a short-term inpatient
3. Discuss the special importance of the milieu in treating the personality disorder patient.

Main Functional Health Pattern: **SELF-PERCEPTION -SELF-CONCEPT**

Nursing Dx
INEFFECTIVE, AVOIDANCE OR DEFENSIVE COPING /RT/ CRISIS PROBLEMS

Medical Dx

Content/Focus:

Crisis as a temporary state
Relationship of coping to mental health

Coping skill

Nursing Functions: The student will be able to:

HEALTH

1. Identify developmental crisis

NURSING

1. Discuss appropriate team intervention in relationship to wholeness of man and spiritual care for clients and families experiencing crisis states
2. Define the nurse's independent role as Patient Advocate in connection with the following:
 - a. Define crisis
 - b. Identify developmental crisis
 - c. Identify situational crisis
 - d. List sequential phases of a crisis state
 - e. Discuss techniques of crisis intervention
 - f. Explain the goals of crisis intervention
 - g. List possible outcomes of crisis state

HUMANITY

1. Develop a teaching plan for patient in crisis that includes family

ENVIRONMENT

1. Considering the hospital environment, define areas of care that are most likely to need to provide team crisis interventions.

Main Functional Health Pattern: **SELF-PERCEPTION –SELF-CONCEPT**

Nursing Dx	Medical Dx
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INEFFECTIVE COPING AFFECTIVE DISORDERS: Depression and/or Mania

Content/Focus:

Depression

Introjections of Anger

Mania as Defense

Learned-Helplessness

Nursing Functions: The student will be able to:

HEALTH

1. Compare and contrast psycho-pathological foundation of depression mania and bipolar disorder.
2. Discuss causative factors (etiology) of mood disorders.
3. Explain how mania may be considered a psychological defense against depression.

NURSING

1. List typical assessment symptoms of depression and mania
2. Identify selected nursing diagnoses for the underactive (depressed) patient and for the overactive (manic) patient.
3. List and explain the steps of how a person becomes depressed.
4. Discuss available treatments, including specific nursing interventions for manic or depressed patients.
5. Determine the nurse's role/s(dependent, interdependent and independent) in care of patient undergoing ECT
6. List and plan nursing interventions for care of the patient undergoing ECT: during and post-treatment.
7. Summarize appropriate interdisciplinary-team interventions for the spiritual component of depressed patients and their significant others.
8. Explain mechanism of action, dosage, and precautions in the use of common antidepressant and medications.
9. Discuss nursing approaches for maintenance of nutritional requirements often seen in depressed patients.

HUMANITY

1. Develop a teaching-communication plan that prepares the patient and family for ECT.
2. Explore community services that provide intervention for patients with mood disorders

ENVIRONMENT

1. Summarize what is a safe hospital environment for the patient receiving ECT.
2. Identify elements of a safe environment for a suicidal or severely depressed patient
3. Identify elements of a safe environment for a patient exhibiting manic behavior.

Main Functional Health Pattern: **COPING-STRESS TOLERANCE**

Nursing Dx Medical Dx
INEFFECTIVE COPING/RT/SUBSTANCE ABUSE

Content/Focus:

Substance Abuse and Dependency

Focus on Alcohol (a Depressant), Cocaine (a Stimulant) and prescription drugs narcotics & sedatives.

Nursing Functions: The student will able to:

HEALTH

1. Discuss the biologic, psychosocial and genetic etiology of chemical dependency.
2. Understand the epidemiology of chemical dependency throughout the growth and development cycle, e.g. prenatal to senescence.
3. Explain how the obsessive-compulsive personality characteristic may be involved in the development of an addiction.

NURSING

1. Discuss symptoms of overdose and withdrawal from cocaine.
2. List typical nursing diagnoses often identified in a person addicted to a chemical substance. Identify and explain a treatment protocol for a patient detoxing from alcohol.
3. Apply the nursing process to caring for patient/clients with chemical dependency throughout the life span.
4. Prepare, distribute, and explain a comprehensive nursing care plan for a person being treated for alcoholism.
5. Demonstrate knowledge of treatment alternatives for chemical dependency.
6. Discuss common prescriptive drugs that have high addictive potential.
7. Discuss phenomenological issues related to psychosocial re-entry of chemically dependent persons.
8. List usual symptoms and time for withdrawal from opiates.

HUMANITY

1. Understand primary/ secondary/tertiary intervention modes and explore agencies that these interventions' for chemical dependency.

ENVIRONMENT

1. Explain how chemicals, food, sex and work can all become addictions.
2. Discuss other environmental factors that may influence chemical dependency.

CLINICAL SYLLABUS

“PSYCH” DRUGS TO KNOW

Dosage range/mechanism of action/side effects/precautions/indications.
Know what terms mean in regard to medications, such as SR, XR ER.

Cylert
Ritalin
Tegretol
Depakote

Risperidone
Clozaril
Thorazine
Haldol
Cogentin
Artane
Zyprexa

Ativan
Xanax
Valium
Librium
Buspar

Lithium
Nardil
Elavil
Prozac
Zoloft
Paxil
Effexor
Welbutrin
Celexa
Luvox
Serzone

Antabuse
Barbiturates
Alcohol
Cocaine
Morphine
Vicodan

"NON-PSYCH" DRUGS FREQUENTLY ENCOUNTERED

Know about the following list of drugs:

- Dosage

- Range /mechanism of action/side effects/precautions/indications
 - Nitroglycerin (SL)
 - Digitalis Digoxin(Lanoxin)
 - Premarin
 - Inderal
 - Colace
 - Nicotine patch
 - Synthroid
 - Symmetrel
 - Catapres
 - Verapamil
 - Procardia
 - Prednisone
 - Phenytoin
 - Phenobarbital
 - Vitamin B
 - Atrovent
 - Albuterol

SAFETY ISSUES

1. Pay attention. Be alert. Take patients seriously. Listen to what they tell you.
2. Be aware of who is near you and how near they are. Be sure you do not allow a patient to block your exit. Stay between the patient and the exit.
3. Don't go into a room alone with a patient.
4. Watch the staff to see how they interact with the patients. Listen to report when appropriate to which patients have the most potential for or acting-out.
5. If a patient begins to be verbally or physically aggressive or abusive, LEAVE THE-SCENE. Notify your instructor or staff. Yell for help if you cannot leave.
6. If a patient or resident becomes violent and the staff need to intervene, please do not attempt to assist. Withdraw from the scene of the altercation and put your into spending time with the other patients. Other patients will be upset and will need some help to calm
7. Generally speaking, plan to stay at least an arms length away from patients. Do not get into a patient's or resident's personal space. Do not out and touch patients. This he interpreted by the patient as an or an attack. If you are an arms length away and a patient does strike you, the blow will have less force.
8. NEVER close the door to a room or go behind the cubicle curtains alone with a patient.
9. Does not touch a patient to wake People may suddenly and strike out before they are totally oriented.
10. Always know who or what is behind you. Keep your back to the wall when possible; this will prevent patients from approaching you from behind and will give you a better advantage point to observe what is happening around you.
11. Be aware that patients may be at danger from each other. Be aware of patients who are becoming increasingly anxious or agitated. Report this to your instructor or a staff member.

PSYCHIATRIC INFORMATION

Mental Commitment Criteria

Psychiatric patients may be voluntary or may be confined against their will. If a patient is to be held involuntarily, he/she must meet one of the following criteria because of a mental illness:

1. A danger to self (acutely suicidal)
2. A danger to others
3. Gravely disturbed (unable to provide food, clothing, or shelter, or unable to utilize these if provided)

Patient's Rights

A patient does not automatically lose his/herrights because of being mentally ill. Generally, patients retain at least the following rights, which may not be taken away without just cause.

1. Right to communicate by writing letters, sending and receiving sealed mail, and by having access to writing materials and stamps or postage.
2. Right to make and receive phone calls by reasonable access to telephone.
3. Right to wear own clothing.
4. Access to own personal possessions.
5. Religious freedom
6. Private storage area
7. Have a written treatment plan that is discussed with him/her, including information about medications and side effects.
8. Right to be represented when his/her rights are affected.

Safety Precautions

Patients are searched on admission. Certain items are removed from the patient's possession for the safety of the patient, other patients and staff. The following items are some of the things not allowed to be in the patient's possession:

Sharp items, such as nail files, knitting needles, scissors, keys and glass items or containers including makeup, mirrors, matches, cigarettes, or any smoking materials, razor blades or razors, plastic bags, soda in cans -pour into Styrofoam or cardboard cup. Anything you question---ASK.

Privacy

Do not give out ANY information over the phone, including the presence or absence of a specific patient on the unit. Consult with the staff or your instructor. If you the phone, do not say, "Psych Unit". Do not discuss any patients in any area where you may be overheard, such as the elevator or in the dining room.

Psychiatric Nursing Care Plan

Date _____

Student Name _____

1. Pt.Initials _____ Sex _____ Age _____

Facility _____ Unit _____

Name of Religion _____ Marital Status _____

2. Significant history and/or events leading to hospitalization:

3. Psychiatric Diagnosis:

4. Overall interdisciplinary Treatment Plan:

Problems Identified

Goals/Approaches

OBJECTIVES FOR THE INTERPERSONAL PROCESS RECORDING

1. Demonstrates awareness of own as well as patient's feeling.
2. Makes accurate interpretations of apparent themes.
3. Interprets verbal and nonverbal behavior correctly.
4. Utilizes a variety of appropriate communication and techniques.
5. Recognizes patient's and own defense mechanisms.
6. Identifies non-therapeutic techniques and describes alternative techniques.
7. Identifies and names therapeutic communication techniques.
8. Includes appropriate rationale for interventions and techniques utilized.
9. Length of interaction is adequate for evaluation. Follows format as outlined in syllabus including grammar, spelling and neatness.
10. Evaluates effectiveness of the interactions and includes an adequate summary

REMINDERS FOR PROCESS RECORDING

1. Report your own feelings as well as of the patient.
2. Report accurately the themes discussed.
3. Interpret verbal and nonverbal behavior.
4. Recognize patients and your own defense mechanisms.
5. Show use and awareness of varied communication techniques.
6. Be aware of non-therapeutic techniques and make suggestions as to how to change to therapeutic techniques.
7. Share your rationale for the techniques and interventions you used.
8. Include an interaction of appropriate length. Report on interactions of 5 minutes or longer. It must be legible and use appropriate grammar, spelling, punctuation, etc.
9. Summarize your evaluation of whether and what is effective or not so effective. Make suggestions for future interactions.
10. Make sure your Process Recording is readable. Leave space for instructor's comments

SUGGESTED TOPICS OF CONVERSATION FOR PROCESS RECORDING

1. Patients view of problems: Priority, definition
2. Goals for change—how patient perceives he/she could take responsibility for self
3. Patient's view of treatment plan
4. Patient's description of family

TOPICS TO GENERALLY AVOID

1. Blaming other, including self
2. Detailed discussion of their personalities in MPD
3. Long exploration of childhood issues—generally focus on here and now
4. Details of abuse suffered
5. Exploration of delusion and hallucinations

AREAS TO INCLUDE ON PROCESS RECORDING

Verbal and Non-Verbal Nurse - Including thoughts and Feelings	Verbal and Non-Verbal Behavior of Client	Interpretation of Behavior-Theoretical Rationale for Techniques
1. Recall specific, pertinent observations made	1. Recall specific, pertinent observations made	Relate: What is the meaning of this observation in this situation at this time?
2. Include nurse's thoughts, reactions, actual words, and feelings	2. Include non-verbal observations as well as actual words said	Relate your theoretical content to this situation
3. Include that which is pertinent to the interaction situation	3. Include periods of silence, learn to judge the length of silences in your P.R.	List the communication techniques that you did use or <u>should have used.</u>
	4. Include that which is pertinent to the interaction situation	

Summary: brief- of what followed this segment of interaction.

Evaluation of the Interaction - your communication techniques—were objectives met—learning you gained from interaction.

Remember: This is confidential material. Be judicious with whom you discuss this. Guard your papers with this material on it

HOSPITAL MANAGEMENT

SYLLABUS

HOSPITAL MANAGEMENT

OBJECTIVES

Hospital Management introduces the basic concepts of managing a hospital, role of the nurse and other inter related roles.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 193.
- ❖ Lecturer should be a qualified Medical Officer or Human Resource Manager.
- ❖ Methods of instruction are presentations and videos.
- ❖ Performances are evaluated by through assignments during the sessions.
- ❖ Term exam papers include MCQ and structured essays

COURSE OUTLINE

1. Case studies

Time allocated 02hrs

2. All about hospitals

Time allocated 03hrs

3. Customer care

Time allocated 03hrs

4. Public Relations

Time allocated 01hr

5. Problem Solving

Time allocated 01hr

6. Quality & exceeding expectations

Time allocated 03hrs

7. Quality assurance

Time allocated 03hrs

8. Motivation

Time allocated 02hrs

9. Quality & exceeding expectations

Time allocated 03hrs

10. The process analysis

Time allocated 03hrs

11. Human Resource Management

Time allocated 02hrs

12. Performance management

Time allocated 02hrs

13. Superior Supervision

Time allocated 03hrs

14. Team Building

Time allocated 02hrs

15. Leadership

Time allocated 02hrs

16. Delegation

Time allocated 02hrs

17. Training & TNA

Time allocated 04hrs

18. Organizational Behavior

Time allocated 02hrs

19. Project management

Time allocated 03hrs

20. Disaster Management

Time allocated 03hrs

21. Medical Ethics

Time allocated 02hrs

22. Hospital departments in Detail

Allocated time 12hrs

23. Policy , protocols & procedures

Allocated time 12hrs

24. Conflicts and conflict management

Time allocated 03hrs

25. Risk Management

Time allocated 02hrs

26. Financial Management

Time allocated 03hrs

27. Health Promotion

Time allocated 03hrs

28. Disciplinary procedures

Time allocated 03hrs

29. Medical regulations

Time allocated 02hrs

30. Medico-Legal activities in a hospital

Time allocated 02hrs

31. Research in health care

Time allocated 03hrs

32. Business communication

Time allocation 12hrs

33. Quality Standards

Time allocated 03hrs

34. ISO compatibility in a hospital services

Time allocated 03hrs

35. Hospital service quality

Time allocated 03hrs

36. Customer care

Time allocated 03hrs

37. Marketing

Time allocated 02hrs

38. Health care marketing

Time allocated 1.5 hrs

39. Medico Legal activities and a Nurse

Time allocated 1.5 hrs

40. Hospital Financial Management

Time allocated 03hrs

41. Hospital Equipment Management

Time allocated 08hrs

42. Hospital laboratory management

Time allocated 03hrs

43. Hospital Construction

Time allocated 1.5 hrs

44. Hospital M& E

Time allocated 03hrs

45. Modern Pharmacology

Time allocated 1.5 hrs

46. Modern Obstetrics & Gynecology

Time allocated 1.5 hrs

47. Laparoscopic surgery & modern inventions

Time allocated 1.5 hrs

48. Modern Medicine

Time allocated 1.5 hrs

49. Management of ICU patient

Time allocated 1.5 hrs

50. Management of Anesthetized patient

Time allocated 1.5 hrs

51. Management of ETU

Time allocated 1.5 hrs

52. Management of Blood bank

Time allocated 1.5 hrs

53. Eye unit

Time allocated 03hrs

54. Public health services and it is Relationships

Time allocated 1.5 hrs

55. Public Hospitals and relationships with private sector

Time allocated 1.5 hrs

56. Common eye problems and management of a eye unit

Time allocated 03hrs

57. Modern orthopedic procedures

Time allocated 03hrs

58. Medical Law & Nursing

Time allocated 1.5 hrs

59. New trends in HRM

Time allocated 03hrs

60. Rehabilitation care

Time allocated 1.5 hrs

61. Preventive medicine & is importance hospital

Time allocated 03hrs

62. Healthcare Soft Ware

Time allocated 12hrs

PERSONALITY DEVELOPMENT

SYLLABUS

PERSONALITY DEVELOPMENT

OBJECTIVES

Personality development builds up the nurses' personality to suit the hospital environment by improving communication skills and team building.

COURSE DESCRIPTION

- ❖ Allocated total number of hours is 31.
- ❖ Lecturer should be a qualified Medical Officer or Human Resource Manager.
- ❖ Methods of instruction are presentations and videos.
- ❖ Performances are evaluated by through assignments during the sessions.
- ❖ Term exam papers include MCQ and structured essays

COURSE OUTLINE

1. Grooming & Deportment

Time allocated 03

2. Smiling

Time allocated 01

3. Communication

Time allocated 03

4. Presentation skills

Time allocated 02

5. Writing skills

Time allocated 01

6. Negotiation

Time allocated 01

7. Team Building

Time allocated 02

8. Emotional Intelligence

Time allocated 03

9. Meditation

Time allocated 03

10. Presentation skills

Time allocated 03

11. Personality

Time allocated 03

12. How to be innovative

Time allocated 03

13. Have a caring heart

Time allocated 03

**EXAMINATION METHOD
AND
EVALUATION**

CLINICAL EVALUATION POLICY

Clinical evaluations are done at mid-term or at the end of a rotation, and at the last week of clinical experience and are based on the clinical objectives for the course. In order to successfully pass the clinical portion of the course, there are no zero ratings allowed on the final evaluation.

The determination of competence is derived from evaluation of:

1. Simulated lab situations (role playing)
2. Direct and indirect observation by instructor or clinical agency personnel, of patient care given to assigned patients
3. Charting
4. Pre- and post-conference discussions and reports
5. Care plans
6. Drug cards and bibliography cards
7. Quizzes
8. Skills Performance Tests
9. Other assigned clinical learning experiences

Progress notes indicating both student behavior and records of conferences held student and teaching team are kept in order to assist in facilitating the evaluation process.

SKILLS PERFORMANCE COMPETENCY TESTS

Student performance will be tested on a skill or part of a skill learned in the previous one or two weeks of skills labs. The student should be prepared to perform any of these skills, but only one will be tested.

Skills tests will be administered by the Skills Lab Coordinator. Students are expected to come to the skills lab on their own initiative to practice the skills prior to being tested.

Students must perform the procedure:

- So that the purpose of the procedure is accomplished
- So that there is no danger to the safety of the patient or nurse.
- So that all critical elements for the procedure are met.

Should the student fail the skills test:

- Make an appointment for a retake. The procedure originally failed plus another selected at random must be successfully performed.
 - Subsequent retake appointments, if needed, will have to be made. Two retakes may be given. Failure of the second retake constitutes a failure for the class.
 - Failure to pass all skills tests by the last week of the term prior to the final examination week will result in a failing grade for the course
- Missed retake appointments: In the event of missing an appointment for a skills test, it will be the student's responsibility to make arrangements for another appointment. A missed appointment without notice of cancellation or with less than one hour notice is equivalent to one failure

ICHS Teaching Style, Evaluation and Grading:

1. Class time : ½ lecture / or ½ Tutorial (Active learning)

Teacher is responsible for student learning.

Ways of learning: a) Hearing – lecture, audio cassettes, discussion

b) Sight – lecture notes, visual aids, observation

c) Touch – hands – on work (doing an activity)

2. Evaluation:

Class participation

Assignments – group / individual

Written papers

Midterm exam

Final Term exam

There will be above 5 short quizzes per subject every term. Each quiz will compose of 15 or 20 questions. These include response MCQs, true / false questions, or pictures for identifications and some times short answers.

There will be a mid-term examination for each subject covering all the material up to that day.

This examination will have 50 questions. Of these 40 will be single response MCQs and the balance will be true / false questions, or pictures for identification of parts etc.

All subjects will have the above format except for English and Computer studies. These two subjects will have different formats and will be arranged by the lecturers who will be teaching these subjects.

Students who fail can be allowed to repeat the term exam once.

If a student fails only one / two papers he / she can be allowed to follow the regular course and given a chance to sit the exam for those papers failed with all the possible support provider by the staff. If the student is found unfit to follow the course i.e., failing repeatedly in the spite of rendering supportive measures, he / she is advised to repeat the entire course with the next batch.

GRADING DISTRIBUTION

Attendance: 10%
Lab / assignments: 10%
Quizzes: 10%
Mid-term exam: 30%
Final exam: 40

GRADING SCALE

90 ----- 100-----A
85----- 89-----A-
80-----84-----B+
75-----79-----B
70-----74-----B-
65-----69-----C+
60-----64-----C
56-----59-----C-
50-----55-----D
BELOW--50-----F

PREPARATION GUIDELINES

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18. WURZBACH.M.E.,COMMUNITY HEALTH EDUCATION AND
PROMOTION,2ND ED,JONES AND BARTLETT,2004
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