Course Number: NURS 124
Course Title: Humans as Adaptive Systems: Promotion of Adaptation in Physiologic Mode
Course Term and Year: Spring 2010

Course Section: NURS 124
Meeting Time and Place: See attached lecture schedule for specific site information
Course Credit Hours: 5 credit hours

FACULTY CONTACT INFORMATION:
Course Coordinator: Melissa Humfleet MSN, RN, 606-523-8655, melissa.humfleet@lmunet.edu
Blount: Kimberly Wilks, MSN, RN, 865-273-1538, kimberly.wilks@lmunet.edu
BRMC: Melissa Humfleet, MSN, RN, 606-523-8655, melissa.humfleet@lmunet.edu
Harrogate: Teresa Brooks, MSN, RN, 423-869-6316, teresa.brooks@lmunet.edu
SMMC: Hope Bruce, MSN, RN, 865-273-1539, louisa.bruce@lmunet.edu
Joan Eiffe, MSN, RN, 865-545-7914, joan.eiffe@lmunet.edu

I. COURSE DESCRIPTION:

A 3 hour lecture/2 hour clinical course focusing on recognition of adaptive human responses versus ineffective responses related to the physiologic mode of human adaptive systems. The RAM nursing process is utilized for delivery of basic nursing care for human persons focusing on the adaptive/ineffective responses of the identified physiologic mode needs. Builds upon knowledge acquired in study of anatomy, physiology, and developmental psychology. In addition to the classroom and campus laboratory, clinical learning experiences occur in community and hospital settings with adults. **Prerequisite**: NURS 115 or its equivalent. **Pre- or co-requisite**: NURS 126, BIOL 262, PSYC 221.

II. COURSE OBJECTIVES:

Students who successfully complete NURS 124 will be able to demonstrate, in clinical/campus laboratory setting, in individual and group conferences, and on written materials, the ability to:

1. Identify adaptive human responses to behavior or stimuli that affect identified physiologic mode needs: perioperative, elimination, fluid, electrolyte and acid-base balance, and endocrine function.
2. Recognize adaptive versus ineffective responses in relation to the adult human person's current state of health.
3. Utilize the Roy Adaptation Model (RAM) nursing process for delivery of basic nursing care to adults experiencing adaptive versus ineffective responses of the identified physiologic modes.
4. Perform technical skills necessary to provide nursing care for adults who have adaptive and/or ineffective responses within the identified physiologic modes.
5. Utilize therapeutic communication skills when providing nursing care.
6. Identify teaching/learning strategies when providing care to adult human persons

with selected physiologic mode needs.

7. Utilize knowledge acquired in anatomy, physiology, and developmental psychology to build upon basic nursing skills in the development of individualized care.
8. Apply legal/ethical principles in provision of nursing care for adult human persons.
9. Identify research findings relevant to adult human persons experiencing adaptive and/or ineffective responses in selected physiologic modes.

III. TEXTS/MATERIALS FOR THE COURSE:

Ackley, B. & Ladwig, G. (2008). *Nursing diagnosis handbook: A guide to planning care* (8th ed.). St. Louis, MO: Mosby.

Comerford, K. C., & Labus, D. (Eds.). (2010). *Nursing 2010 student drug handbook*. Philadelphia: Lippincott Williams & Wilkins.

Dirckx, J. (2008). *Stedman's concise medical dictionary for the health professions* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

Fischbach, F. & Dunning, M. (2006). *Nurses' quick reference to common laboratory and diagnostic tests* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Kee, J. L., Hayes, E.R., & McCuistion, L.E. (2009). *Pharmacology: A nursing process approach* (6th ed.). St. Louis, MO: Mosby.

Lynn, P. (2008). *Taylor's clinical nursing skills: A nursing process approach (*2nd ed*)*. Philadelphia: Lippincott Williams & Wilkins.

Silvestri, L. A. (2008). *Saunders comprehensive review for NCLEX-RN* (4th ed.). Philadelphia: W.B. Saunders Company.

Smeltzer, S.C., Bare, B. G., Hinkle, J.L., & Cheever, K.H. (2008). *Brunner and Suddarth's textbook of medical – surgical nursing* (11th ed.). Philadelphia: Lippincott Williams & Wilkins.

Smeltzer, S.C. Bare, B. G., Hinkle, J.L., & Cheever, K.H. (2008). *Handbook for Brunner & Suddarth's textbook of medical-surgical nursing* (11th ed.). Philadelphia: Lippincott Williams & Wilkins.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Fundamentals of nursing: The art and science of nursing care* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Study guide to accompany fundamentals of nursing*: *The art and science of nursing care* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

Wissman, J. (2000-2007). *Adult medical surgical nursing RN edition 7.1. Current mastery series review module*. Assessment Technologies Institute.

Wissman, J. (2000-2007). *Fundamentals for nursing edition 6.1. Current mastery series review module*. Assessment Technologies Institute.

IV. Course Requirements, Assessment (Learning Outcomes) and Evaluation Methods:

A. Fulfill course requirements. (See LMU Nursing Student Handbook Online 2009- 2010.)

1. Attendance requirements:
   a. Attendance will be taken each class period (lecture/exam). To be counted present, the student must be present for the ENTIRE class period.
   b. Study labs will be provided in each ASN clinical course for faculty to expand on content presented in lecture. Attendance at these study labs is mandatory for ALL students until after the first course exam. After this time, the study labs are mandatory for students who do not have a course average of 83 or greater. Students with course averages of 83 or greater are encouraged to attend the study labs. Attendance will be taken at each study lab. To be counted present, the student must be present for the ENTIRE study lab.
   c. After two (2) absences (lecture/exam/study lab) in one semester, it may necessitate that the student withdraw from this NURS course. The student is to contact the Lead Faculty to arrange for withdrawal from this NURS course.

2. **Cell phone usage is NOT permitted in the classroom or clinical area.** This includes, but not limited to, talking on the phone, checking messages and text messaging. If a student uses a cell phone during class or clinical, they will be asked to leave and counted absent for that day.

3. Taping of lectures is a privilege, which may be granted by the individual faculty member, but it is up to students who wish to tape lectures to ask permission, and not simply assume permission. Students should ask for permission at the beginning of the semester with each individual faculty member.

B. Written Requirements:

1. **Tests and Examinations:**
   a. Five (5) exams, a comprehensive final and one course assessment exam are scheduled. Test dates and times are specified on the lecture schedule. Completion of ALL exams (classroom and course assessment exam) is required to receive credit for NURS 124.

   Instructions regarding Course Assessment Exams:
   1. The student must register and get a user name and password for Course Assessment Exams.
   2. If technical assistance is needed call: 1-800-292-2273. Office hours of support are Monday – Friday, 7 am-6 pm Central Time.
   3. The faculty at each site will assign the Course Assessment Exam. Some exams will be administered via paper/pencil and some via the computer.
   4. If the Course Assessment Exam is for completion only, the student will be required to take the exam and turn in the grade sheet by a date specified by the faculty. If the Course Assessment Exam is not taken, completed and turned in by the specified time, the student will not be allowed to take a specific scheduled course exam and will receive a zero for that course exam.

5. If the Course Assessment Exam is for a % of the course grade and the student does not complete the exam at the scheduled time, a grade of zero (0) will be recorded.
6. If a student scores level 1 or below 1 on the Focused RN Med/Surg Perioperative Exam or the Focused RN Med/Surg Fluid and Electrolytes Exam the student will be required to complete remediation listed on the individual students report. This must be submitted to the Lead Teacher for NURS 124 within one week of taking the exam. If this is not completed, the student must have a mandatory meeting with the Lead Teacher.

b. A dosage calculation quiz must be taken and the student must achieve a score of 80% before being allowed to pass medications in the hospital. If the student does not achieve 80% on the second attempt and is not allowed to pass medication, the student will receive an unsatisfactory grade in clinical and will NOT be allowed to continue in the course. **The dosage calculation quiz will be administered the first or second week of class. Students will have a maximum time limit of 30 minutes.**

Rules regarding tests and examinations:

1. All students are expected to take exams as scheduled. Students are required to notify the faculty by phone or email prior to the scheduled exam time if they are not going to be present. Students are given faculty contact information in each NURS course syllabi and are expected to have it available at all times. If for any reason a student is unable to leave a message for the faculty member via the contact information provided, it is the student's responsibility to contact the Nursing Office on campus (1-800-325-0900, ext. 6324) and talk to the Nursing Secretary or leave a message on her voice mail. Please remember to state you are unable to take the exam and be specific as to the course, the faculty's name and the site you attend. **Any student that does not notify the appropriate faculty will receive a zero for the exam.**
2. The faculty will determine the date and time of any alternate make-up exam. **If the student does not make up the exam on the scheduled date and time, the student will get a zero on the exam.**
3. All electronic devices (pagers, cell phones, PDA's, etc), personal belongings (book bags, purses, coats) are prohibited during examination times. Students may only bring into the exam room pencils and a simple calculator. Students must make arrangements for their other personal belongings during test time.
4. Ball caps or hats with any type of brim will not be allowed to be worn during exam administration.
5. Simple calculators are the ONLY calculators allowed during test time. Scientific calculators or those combined with cellular phones, PDA's, or other electronic devices are not permitted. If a student presents to an exam with any calculator other than a simple calculator the faculty will collect the calculator and the student will be required to do mathematic calculations by hand only. Calculators collected prior to the exam will be returned after the exam is completed.
6. Editorial corrections will be given at the beginning of the exam. If corrections to the exam are needed once the exam has started, the faculty will interrupt the exam and announce the correction and also write it on the board.

7. Any student who has questions during the exam must raise his/her hand and stay seated.
8. The student must not leave his/her seat until the exam is finished, except for emergencies.
9. The exam will be timed. The time for exam booklets to be turned in and for class to resume will be written on the board. Any student entering late will be required to turn his/her exam at the stated time.
10. **Violation of ANY of the above policies will result in a zero (0) for that exam**:
11. After the exam is finished, the student has the following options:
    a) Return to his/her seat, and remain quiet until class resumes.
    b) Leave the classroom. (If the student chooses to leave the room, he/she may not reenter until class resumes.)
12. Nursing Faculty will review and score exams during the week after the exam is given. Individual student grades will be available and posted one week after the exam has been given. Faculty will post exam grades on Blackboard.
13. Faculty reserves the right to correct any clerical error. This includes both increases and decreases to adjusted exam grades.
14. Exam reviews will be scheduled outside of class time. Attendance for exam review is strongly recommended. No books, pencils or taping are allowed during the exam review.
15. Students have one calendar week after the test review to meet with their instructor for clarification of any exam related issue. For the last exam of the (final unit exam or final comprehensive exam), students must contact the instructor within 24 hours for clarification of any exam related issue. If a student wants to appeal any exam related issue, it must be presented via email within the time frame listed above and addressed to the instructor who taught the content.

.

2. **Clinical Written Work:** Assigned by the clinical instructor, these works shall be college level submissions.

a. **Daily Written Work (concept mapping) with Drug Cards** will be required on daily patient assignments in clinical. If a student reports to the clinical area unprepared, he/she will be sent home and the absence will be recorded as an unexcused absence**. Internet-based or pre-printed drugs cards are NOT acceptable.**

b. **Comprehensive Clinical Work**
One comprehensive nursing project which will be in the format of concept mapping must be completed for one medical-surgical rotation this semester. These works shall be college level submissions. The student will be allowed one rework of the assignment. It will be graded according to the rubric grading scale. **If after the 2nd attempt, a student has not scored 80%, this will constitute an unsatisfactory grade for the clinical and will result in an "F" for the course.** One point per day will be subtracted for late assignments. Any late assignment will not be accepted if turned in greater than one week past the assigned date. IF THE STUDENT'S FIRST ATTEMPT IS TURNED IN LATER THAN ONE WEEK FOLLOWING THE DUE DATE, THE ASSIGNMENT

WILL RECEIVE A ZERO AND A SECOND ATTEMPT WILL NOT BE ACCEPTED. The comprehensive nursing project will be completed during the first or second med-surgical rotation.

3. **Review Questions from Saunders Comprehensive Review for NCLEX-RN:**
   Please see each lesson plan, which includes the chapters for the review questions.

4. **Coaching Material:**
   Coaching material is available through the ATI Review Modules, ATI DVD's and student customized review guides generated through practice ATI exams. Students are expected to utilize this ATI material to supplement all NURS course material in order to successfully complete this course. **See lesson plans for required readings.**

.

C. **Campus Lab/Clinical Requirements:** There will be a total of 90 campus lab/clinical hours for NURS 124. Attendance is required in clinical/campus lab experiences. (See LMU Nursing Student Handbook Online 2009-2010). All clinical/campus lab absences must be made up. A make up day will be required for excused or unexcused absences. (A doctor's excuse will be required.)

1. **Campus Lab – Begins the week of January 11th, 2010**. There will be a total of 3 campus lab days (7 1/2 hours each) and 3 seminar days (7 1/2 hours each). ATTENDANCE IS MANDATORY. During the first few weeks of class, NURS 124 campus lab, seminar days, and clinical will be coordinated with NURS 126 clinical. Students will be notified on the first week of classes as to whether they will first attend campus lab or NURS 126 clinical. Skills lab absence is no different than clinical absence.

   Critical Thinking Stations & Dosage Calculations: Critical thinking stations will be assigned the final week of campus lab. The stations will cover material from all three-campus lab days and will include advanced dosage calculation problems. **The critical thinking stations which also include advanced dosage calculation will be 2% of the overall grade for Nursing 124. Students will work in groups of 2 and must agree to receive the same grade for the assignment. Group assignments will be made by the lead teacher.**

2. **Clinical:** Each clinical day in a health care facility will be 7 1/2 hours in length including a ½ hour lunch break. Students will be in the clinical setting two days per week. Clinical group assignments will be made at the individual sites by the nursing faculty. Depending upon campus site clinical days will be Tuesday/Wednesday or Thursday/Friday beginning February 2 – April 9, 2010. Clinical make-up days are scheduled for April 13th and 14th or April 15th and April 16th, 2010.
   a. After two (2) clinical/campus lab absences (excused and/or unexcused) in one semester, it may necessitate that the student withdraw from this NURS course. The student is to contact the Lead Faculty to arrange for withdrawal from this course.

   b. A tardy is defined as arriving to the clinical facility ANY time after the

scheduled start time. If a student is more than 15 minutes late to the clinical area the clinical instructor has the right to inform the student to go home and the absence will be counted as an unexcused absence.

c. A student who has unexcused absences and/or tardies will have a point for each absence and each tardy deducted from his/her final exam grade. The only absences that will be recognized as an excused absence will be illness accompanied by a doctor's excuse or a death in the immediate family.

d. In order to receive a satisfactory grade in clinical, the student must perform the critical behaviors identified in the Clinical Outcomes Tool.

e. In order for a student to be eligible to go into the clinical areas, he/she must produce evidence of an annual negative PPD or negative chest x-ray, record of Hepatitis B vaccination or declination form, a Rubella titer and/or second MMR, and current CPR certification the first time this course meets this semester. **If this documentation is not on file before the first clinical day of the semester, the student will not be allowed to attend clinical and the absence(s) will be counted as unexcused.**

f. Students are reminded that any time they are in the clinical setting for pre-planning, pre-conference, clinical and/or post-conference, they are to adhere to the department of nursing uniform policy.

D. Methods of Evaluation:

Perioperative Unit Exam	16%
Fluid & Electrolytes Unit Exam	16%
Diabetes Unit Exam	16%
GU Unit Exam (100 questions)	16%
GI Unit Exam	16%
Comprehensive Final Exam	15%
Critical Thinking Stations	2%
Fundamentals Course Assessment Exam	3%
Focused RN Med/Surg: Fluid, Electrolyte & Acid-Base Exam	Satisfactory/Unsatisfactory
Focused RN Med/Surg: Perioperative Exam	Satisfactory/Unsatisfactory
Clinical Evaluation	Satisfactory/Unsatisfactory
Clinical Attendance	Satisfactory/Unsatisfactory

E. Incomplete Policy:

Students are expected to complete all requirements as assigned during the semester. Incompletes are only given in extreme circumstances deemed by the instructor. If the request for an "I" is approved, the work must be completed within the first six weeks of the following semester (excluding summer terms); otherwise the grade automatically becomes an "F". The grade of "I" is calculated in the grade point average with zero points.

F. Department of Caylor School of Nursing Grading Scale:

A = 90-100%
B = 80-89%
C = 70-79%
D = 60-69%
F = below 60%

The minimal acceptable grade in nursing is a "B" in theory, and a satisfactory in clinical. An unsatisfactory grade in clinical will result in an "F" for the course. See the LMU Student Handbook Online 2009-2010 or obtain one from the secretary of the Caylor School of Nursing.

A failing grade for either theory or clinical performance will result in a failing grade for the course. The student must attain an overall average of 80% to pass NURS 124 with a "B". **There will be NO rounding of earned grades within the course and NO rounding of final grades for the course.**

F. Clinical Facilities:

Tennessee Facilities

Baptist West	865-218-7011
Blount Memorial Hospital	865-983-7211
Claiborne County Hospital	423-626-4211
Ft. Loudon Medical Center	865-271-6000
St. Mary's Medical Center	865-545-8000
St. Mary's Medical Center, Campbell Co.	423-907-1200
Sweetwater Hospital Association	423-337-6171

Kentucky Facilities

Baptist Regional Medical Center	606-528-1212
Middlesboro ARH	606-242-1100
Pineville Community Hospital	606-337-3051

V. METHODS OF INSTRUCTION:

Lecture
Discussion
Audiovisual Materials
Campus/Clinical Laboratory Experiences
Self-Evaluation
Guest Lecturers
Computer Assisted Learning
Small Group Activities
Independent Study
Required & Recommended Readings
Written Assignments
Role Playing
Individual Guidance & Assistance form Instructors
Case Studies

VI. INFORMATION LITERACY/TECHNOLOGICAL RESOURCES:

Blackboard will be used for this course to post announcements and individual course grades. In addition the student's email address will be used for all correspondences. Students are required

to check their LMU email account on a daily basis and respond to faculty communication within 24 hours. Students must have computer skills necessary to participate in this course.

VII. UNIVERSITY POLICIES:

Students with Disabilities Policy: As a rule, all students must read and comply with standards of the LMU Student Handbook and LMU catalogue**.** Any student needing assistance in accordance with the Americans Disabilities Act (1990 as amended) should contact the instructor and the LMU ADA Compliance Officer, Donna Treece-Paul, in order to make appropriate arrangements. Contact information: donna.treece-paul@lmunet.edu and/or 423-869-6251 (800-325-0900 ext. 6251). Office is located on the third floor of the Student Center.

Discrimination Policy: Lincoln Memorial University is committed to maintaining study and work environments that are free from discriminatory harassment based on sex, race, color, national origin, religion, pregnancy, age, military status, disability or any other protected discriminatory factor. Sexual or other discriminatory harassment of its students is strictly prohibited, whether by non-employees (such as contractors or vendors), other students, or by its employees, and LMU will take immediate and appropriate action to prevent and to correct behavior that violates this policy. Likewise, students are strictly prohibited from engaging in harassing behavior directed at LMU's employees, its visitors, vendors and contractors. All students must comply with this policy and take appropriate measures to create an atmosphere free of harassment and discrimination. Appropriate disciplinary action, up to and including, as appropriate, suspension, expulsion, termination from employment or being banned from LMU properties, will be taken against individuals who violate this policy.

Scholastic Dishonesty: It is the aim of the faculty of LMU to foster a spirit of complete honesty and a high standard of integrity. The attempt of any student to present work as his/her own that he/she has not honestly performed is regarded by the faculty and the administration as a very serious offense and renders the offender liable to several consequences and possible suspension.

Cheating: LMU prohibits dishonesty of any kind on examinations or written assignments. These include unauthorized possession of examination questions, the use of unauthorized notes during an examination, obtaining information during an examination from another student, assisting others to cheat, altering grade records, or entering any campus office without permission. Violations will subject the students to disciplinary action.

Plagiarism: LMU prohibits offering the work of another as one's own without proper acknowledgment. Any student who fails to give credit for quotations or essentially identical material taken from books, magazines, encyclopedias, or other reference works, or from the themes, reports or other writings of a fellow student has committed plagiarism.

LMU's Inclement Weather Policy: Local radio and television stations will be contacted and every effort made to have morning or daytime cancellations posted/announced by 6:00 a.m., along with a recorded announcement on the LMU main campus telephone number: (423) 869-3611. You may also check the university's website for class cancellation notices; they will be posted on http://www.lmunet.edu/curstudents/weather.html.

VIII. Lincoln Memorial University Mission Statement:

This may be found at http://www.lmunet.edu/about/mission.html

IX. Caylor School of Nursing Mission Statement:

In conjunction with the University's mission, the Faculty of the Caylor School of Nursing strives to instill responsibility and high moral/ethical standards in the preparation of quality nurses, at multiple levels of nursing education, through superior academic programs at the undergraduate and graduate level. Specifically, the mission of the Faculty is to prepare nurses with the Associate of Science in Nursing (ASN) degree, the Registered Nurse to Baccalaureate of Science in Nursing (RN-BSN) degree, and Master of Science in Nursing (MSN) degree to assist individuals, families, communities, and society as they adapt to changes in physiological needs, role function, self-concept, and interdependent relationships during health and illness. The Caylor School of Nursing seeks to respond to the needs of nursing education and healthcare in the surrounding communities by preparing nurses at multiple levels and by providing continuing education/professional development opportunities that are rooted in knowledge, research, and other scholarly activities.

X. COURSE OUTLINE/ASSIGNMENT OR CLINIC SCHEDULE:

NURS 124/125 LECTURE SCHEDULE – Spring 2010

Blount, BRMC, Harrogate, SMMC Campus

Scheduled class: Monday 9:00 -11:50 am (Blount, BRMC, Harrogate)
Monday 12:00 – 2:50 pm (SMMC)

Bolded dates/times below = deviations from scheduled class time

Date	Lecture Content
Monday 1/4 All Campuses	**10:30 am – 12 pm (BLOUNT CAMPUS ONLY)** **12 pm – 2 pm Syllabus Review (BRMC, Harrogate, SMMC)**
Tuesday 1/5 & Thursday 1/7 (Blount)	**12 pm – 3 pm Begin Perioperative Unit** **9 am – 12 pm Continue Perioperative Unit**
Tuesday 1/5 & Thursday 1/7 (SMMC)	**9 am – 12 pm Begin Perioperative Unit** **12 pm – 3 pm Continue Perioperative Unit**
Wednesday 1/6 & Friday 1/8 (Harrogate)	**9 am – 12 pm Begin Perioperative Unit** **9 am – 12 pm Continue Perioperative Unit**
Thursday 1/7 & Friday 1/8 (BRMC)	**9 am – 12 pm Begin Perioperative Unit** **9 am – 12 pm Continue Perioperative Unit**
Monday 1/11	Finish Perioperative Unit Begin Fluid & Electrolytes
Monday 1/18	**HOLIDAY: NO CLASSES**
Monday 1/25	**Exam I Perioperative Unit** **Foucsed RN Med/Surg: Perioperative Exam due prior to exam** Continue Fluid & Electrolytes
Monday 2/1	Continue Fluid & Electrolytes
Monday 2/8	Finish Fluid & Electrolytes Begin Metabolic/Endocrine
Monday 2/15	**Exam II Fluid & Electrolytes** **Focused RN Med/Surg: Fluid & Electrolytes Exam due prior to exam** Continue Metabolic/Endocrine
Monday 2/22	Finish Metabolic/Endocrine

COURSE OUTLINE/ASSIGNMENT OR CLINIC SCHEDULE:

NURS 124/125 LECTURE SCHEDULE – Spring 2010
Blount, BRMC, Harrogate, SMMC Campus
Scheduled class: Monday 9:00-11:50 am (Blount, BRMC, Harrogate)
Monday 12:00 – 2:50 pm (SMMC)

Bolded dates/times below = deviations from scheduled class time

Monday 3/1	**Exam III Metabolic/Endocrine** Begin Genitourinary
Monday 3/8	Continue Genitourinary
Monday 3/15-Friday 3/19	**SPRING BREAK: NO CLASSES**
Monday 3/22	Finish Genitourinary
Monday 3/29	**Exam IV Genitourinary** Begin Gastrointestinal
Monday 4/5	Continue Gastrointestinal
Monday 4/12	Continue Gastrointestinal **Fundamentals Course Assessment Exam (1 pm – 2:30 pm)**
Monday 4/19	**Exam V Gastrointestinal Part I** Finish Gastrointestinal Part II

Final Exam: April 26, 2010 10:30 am – 12:30 pm
Clinical: February 2 – April 9, 2010 Time - TBA per clinical instructor.
Make-up days scheduled for April 13th and 14th or April 15th and 16th, 2010.

XI. Important Dates in the Academic Calendar SPRING 2010:

Spring Semester 2010	
Residence halls open (8 a.m.)	January 3
Registration/New Student Orientation	January 4
Classes begin	January 5
Last day to complete registration/add classes without late fee	January 13
Martin Luther King Day (no classes)	January 18
Convocation (9:30 a.m. in session classes and resident students)	February 2
Lincoln Day/Founders Day (special activities)	February 12
Last day to drop course without "WD"	February 19
Mid-term	Feb 22-26
Last day to drop course without "F"	March 10
Residence halls close (5 p.m.)	March 12
Spring Break (no classes)	March 15-19
Residence halls open (1 p.m.)	March 21
Early registration begins	March 29
Good Friday (no classes)	April 2
Classes end	April 23
Final exams	April 26 - 30
Commencement (11 a.m.)	May 1

XII. THE INSTRUCTOR RESERVES THE RIGHT TO REVISE, ALTER AND/OR AMEND THIS SYLLABUS, AS NECESSARY. STUDENTS WILL BE NOTIFIED IN WRITING AND/OR BY EMAIL OF ANY SUCH REVISIONS, ALTERATIONS AND/OR AMENDMENTS.

Lab #1 (7 1/2 hours)

Students are to view the following CDs prior to class:
ATI CD Basic Nursing Skills (6, 9, 15, 16)
ATI CD Adult Medical-Surgical Nursing Volume One (14)

Skills: **Taylor's Skills Book**

1. Initiate IV catheters and fluids
2. Regulate, monitor and discontinue IV fluids
   (gravity and electronic infusion devices)
   Change or add IV fluids
3. Label and calculate IV intake
4. Add medications to an IV container
5. Administer IV piggyback medications
6. Administer IV bolus and IV push medications
7. Care of the intermittent infusion device (INT or HepLock)
8. Initiate and monitor TPN & lipids
9. Blood product infusions
10. Blood Specimens/Glucometer
11. Care of central venous lines
12. Care of the ostomy
13. Insertion and care of nasogastric tube (N/G)

Patient Examples for Role Play (these can also go along with case study B and F for seminar day). Divide students into groups of 3 or 4. Assign the following roles: Primary nurse, charge nurse, LPN, and certified nursing assistant.

1) A 40-year old is admitted to the hospital with c/o weakness. He reports having tarry stools for the past 3 days at home. Admitting information: B/P 110/70, HR 92, RR 22, and oral temp of 99. Abd. soft and tender with hyperactive bowel sounds Admission lab: Hct 22%, Hgb 10 gm/dL, Na 135 meq/L, K 4.0 meq/L, and a normal bleeding time. The following physician orders are received: Insert #18 N/G tube and connect to low intermittent suction. Type and cross for 4 units of blood. Transfuse 2 units now. Continue to infuse NS @ 125 mL/hr.
    - Who will administer the blood? What is the procedure for administration of blood? How fast should the blood be transfused? What could be delegated to the CNA and LPN?
    - Why is the patient receiving blood?
    - 5 minutes after starting the blood the patient c/o SOB. What is the role of the charge nurse? What should be done for this patient?
    - What possible problems should the nurse assess for?
    - Demonstrate insertion of N/G tube. Explain nursing interventions.
    - What is the purpose of the N/G tube?

2) **See case study B**. The patient is 3 days post-op after a bowel resection with ileostomy. Assessments are normal.
    - Demonstrate c/o ostomy and include teaching.
    - What could the nurse delegate to the CNA r/t care of the ostomy.
    - The morning K is 2.5 meq/L. What nursing interventions should the primary nurse include?
    - As part of your assignment for the day, you have just received a new admission from surgery. What should the role of the charge nurse be at this time? How will you manage your time?

3) **See case study F**. Patient continues to receive TPN @ 100 mL/hr via CVL (triple lumen) in right jugular vein. Lipids are also infusing @ 10 mL/hr. NS infusing @ 110 mL/hr. The physician has ordered, cefepime (Maxipime) 2 gms IV every 12 hours to be started ASAP. You are unable to start an additional peripheral IV.
    - How can you give the cefepime?
    - How long can the lipids infuse?
    - The patient's morning blood glucose is 200. Is this normal and what should be done?
    - 12N vital signs are: B/P 130/80, HR 90, RR 24, and oral temp is 100.8. What should the nurse assess for and what is the most important nursing intervention?

4) See case study F. The physician has ordered to d/c the TPN by decreasing the rate by 50 mL/hr, it is currently infusing @ 100 mL/hr. During am assessment you notice the dressing is not intact and has serous drainage.
    - What assessments should be done during the period of discontinuing the TPN?
    - Demonstrate how to change a CVL dressing.
    - During the dressing change you notice the site is red with some yellow drainage. What should you do?

Seminar #1 (7 1/2 hours)

Case studies, review advanced dosage calculations, charting, and leadership skills (delegation).

PRIORITIZATION, DELEGATION AND LEADERSHIP
Readings: Silvestri (pp. 75-77)
Taylor, Lillis, Lemone, & Lynn (Chapter 23, and pp. 323-324).
CD to be shown in seminar: ATI Community Health/Leadership Nursing RN (Chapter 15 & 16)

Discuss skills needed for leadership including communication, problem-solving, management, and self-evaluation skills. Focus on the role of nursing leadership in all situations and settings.
Discuss priority setting in the clinical situation.
Areas to cover:

- How do you determine what is priority task?
- What is outcome of selection of one task over another?
- What tasks are critical for patient physiological stability?
  -Maslow's hierarchy of needs, ABCs of CPR
- What tasks are essential for patient safety?

DELEGATION
Review five rights of delegation:

- Right task
- Right cirumstances
- Right person
- Right direction/communication
- Right supervision

(Taylor, Lillis, Lemone, & Lynn p. 545)

Review delegation decision tree in textbook p. 546.

Utilize Case Studies in small group activity.

PRIORITIZING:

1. A nurse receives a change-of-shift report at 0700 for an assigned caseload of patients. Number the following patients in the order in which they should be seen.
   __________ A patient who has been receiving a blood transfusion since 0400
   __________ A patient who has an every 4 hr PRN analgesic order and who has last received pain medication at 0430
   __________ A patient who is going for a colonoscopy at 1130 and whose informed consent needs to be verified
   __________ A patient who needs rapid onset insulin when the 0800 trays arrive
   __________ A patient who is being discharged today and needs reinforcement of teaching regarding dressing changes

2. An older adult patient who is on fall precautions is found lying on the floor of his hospital room. Which of the following actions is most appropriate for the nurse to take first?
   a. Call the patient's primary care provider
   b. Carefully move the patient to his bed
   c. Palpate the patient's wrist and evaluate his pulse
   d. Ask the patient why he got out of bed without assistance

3. A nurse is assigned to care for four patients. Number the following patients in the order in which they should be seen.
   __________ 38-year-old female patient with a history of gallstones admitted with right upper quadrant pain that radiates to the right shoulder. No report of pain for the past several hours.
   __________ 59-year-old male admitted with acute pancreatitis. He is reporting a pain level of 8/10 despite medication. He has a glucose level of 225 g/dL and a WBC count of 19, 500/mm3.
   __________ 60-year-old female patient receiving IV antimicrobials every 6 hr via a central line. She has an NG tube in place that it is removed later today.
   __________ 30-year-old male who appears frail and malnourished. He has been experiencing severe diarrhea. He is receiving total parenteral nutrition (TPN) through a central line.

Wissman, J. (2000-2007). *Leadership and Management edition 4.1. Content mastery series review module*. Assessment Technologies Institute.

DELEGATION:

1. You are working with an LPN and UAP today. The following tasks should be performed by which discipline (RN, LPN, UAP).

Task	RN	LPN	UAP
Developing a teaching plan for a patient newly diagnosed with diabetes mellitus			
Assessing a patient admitted for surgery			
Collecting vital signs every 30 min for a patient who is 1 hr post cardiac catherization			
Calculating a patient’s intake and output			
Administering blood			
Monitoring a patient’s condition during blood transfusions and IV administrations			
Providing oral and bathing hygiene to an immobilized patient			
Initiating patient referrals			
Dressing change of an uncomplicated wound			
Routine nasotracheal suctioning			
Receiving report from surgery nurse regarding a patient to be admitted to a unit from the PACU			
Initiating a continuous IV infusion of dopamine with dosage titration based on hemodynamic measurements			
Administering subcutaneous insulin			
Assessing and documenting a patient’s decubitus ulcer			
Evaluating a patient’s advance directive status			
Providing written information regarding advance directives			
Initial feeding of a patient who had a stroke and is at risk for aspiration			
Assisting a patient with toileting			
Developing a plan of care for a patient			
Administering an oral medication			
Assisting a patient with ambulation			
Administering an IM pain medication			
Checking a patient’s feeding tube placement and patency			
Turning a patient every 2 hr			
Calculating and monitoring TPN flow rate			

2. A patient has just returned from the surgical suite following a colon resection. Which of the following tasks is appropriate for a nurse to delegate to a UAP?
   a. Asking the patient about his pain level every hour
   b. Checking the placement of the nasogastric tube at least once a shift
   c. Looking at the patient’s dressing and determining the amount of drainage every other hour
   d. Obtaining the patient’s vital signs every hr X 4 and then every hr X 48 hr

3. Which of the following tasks could be assigned to an UAP?
   __________ Assisting a patient who is experiencing diarrhea with perineal care
   ___________ Vital signs every 2 hr for a patient with pancreatitis
   ___________ Transportation of a patient to the radiology department
   ___________ Cleansing the nares of a patient with a nasogastric tube
   ___________ Assessing a patient for perianal excoriation during perineal care
   ___________ Reporting the quality and color of a patient's nasogastric drainage

4. Toward the end of a shift, an LPN reports to an RN that a recently hired UAP has not totaled the patient's intake and output for the past 8 hr. Which of the following actions should the RN take?
   a. Confront the UAP and instruct him to complete the intake and output measurements
   b. Delegate the task to the LPN since the UAP may not have been educated on this task
   c. Ask the UAP if he needs assistance completing the intake and output records
   d. Notify the nurse manager to include this on the UAP's evaluation

5. Match each delegation principle with the correct delegation

____ Wrong direction	a. Delegate an LPN to develop a care plan for a newly admitted patient
____ Wrong task	b. Delegate a UAP to assist a confused patient to eat
____ Right supervision	c. Delegate a UAP to empty a foley drainage bag
____ Right circumstance	d. Delegate an LPN to administer insulin without providing the patient's blood glucose level
____ Right person	e. Delegate to a UAP to take vital signs for a postoperative patient

Wissman, J. (2000-2007). *Leadership and Management edition 4.1. Content mastery series review module*. Assessment Technologies Institute.

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
NURS 124/125
Advanced Dosage Calculation Review
Spring 2010

To obtain credit for the following dosage calculation questions, the student must:

- **Correctly label the answer.**
- **Round the answer to the appropriate amount that can be administered in the clinical area. For example:**
  - **< 1mL round to the correct hundredths place.**
  - **> 1mL round to the correct tenth place.**
- **Round an IV pump answer to the correct tenth place.**
- **Round weight related answers to the hundredths.**
- **Pediatric questions should be rounded to the hundredths.**
- **Transfer the answer to the green shaded area of the scantron if a scantron form is being used.**

1. 1,000 mL D5LR to infuse in 8 hr. Drop factor 20 gtt/mL. How many gtt/min will the nurse infuse?

2. Infuse an IV medication in 50 mL of 0.9% NS in 40 min. How many mL/hr will the nurse infuse?

3. Order: Heparin 2,000 units/hr IV. Available: Heparin 25,000 units in 1,000 mL of 0.9% NS. How many mL/hr will the nurse infuse?

4. Order: Heparin 1,800 units/hr IV. Available: Heparin 25,000 units in 250 mL D5W. How many mL/hr will the nurse infuse?

5. Esmolol 1.5 g in 250 mL D5W has been ordered at a rate of 100 mcg/kg/min for a patient weighing 102.4 kg. How many mL/hr will the nurse infuse?

6. Nipride 2 mcg/kg/min has been ordered for a patient weighing 80 kg. Nipride is available 50 mg in 250 mL D5W. How many mL/hr will the nurse infuse?

7. Dobutamine 7 mcg/kg/min ordered for a patient weighing 70 kg. Dobutamine is available 500 mg in 250 mL D5W. How many mL/hr will the nurse infuse?

8. Amoxicillin 150 mg po q8h is ordered for an infant weighing 23 lb. The recommended dosage range is 20 to 40 mg/kg/day. Available is Amoxicillin 125 mg/5 mL. What is the safe dose range per dose & per day? Is the ordered dose safe? How many mL will the nurse administer per dose & per day?

Lab #2 (7 1/2 hours)

Students are to view the following CDs prior to class:
ATI CD Basic Nursing Skills (17, 18)
ATI CD Adult Medical-Surgical Nursing Volume Two (10, 11, 15)

Skills: **Taylor's Skills Book**

1. Oxygen administration via cannula and mask
2. Incentive spirometer
3. Coughing and deep breathing exercises
4. Chest physiotherapy
5. Pulse oximetry
6. Sputum specimen
7. Artificial airways (oral, nasopharyngeal, ETT)
8. Oral and tracheal suctioning
9. Care of tracheostomy
10. Care of chest tubes
11. Application of cardiac leads

Mr. Clark is a patient in a rehabilitation facility for management of a closed head injury. He has a tracheostomy tube in place, as he required mechanical ventilation for several weeks after the injury. As the nurse caring for Mr. Clark, it is your responsibility to care for his tracheostomy, including tracheal suctioning and routine tracheal cleaning.

- Describe indications for a tracheotomy.

- When in bed, what is the rationale for placing the patient in a semi-Fowler's position?

- Mr. Clark does not require supplemental oxygenation as his oxygen saturation is 96% on room air. What is the rationale for administering humidified room air to Mr. Clark while in bed?

- In performing routine tracheostomy care, the nurse soaks the inner cannula in hydrogen peroxide and then rinses with normal saline. What is the rationale for these actions? (should be ½ strength peroxide)

- Mr. Clark's respiration deteriorates requiring his transfer back to the acute care facility and placement on a mechanical ventilator. Upon arrival, the nurse checks the tracheostomy cuff pressure, and finds it to be 35 mmHg. What should the nurse do? Why?

Ackley, B. & Ladwig, G. (2008). *Nursing diagnosis handbook: A guide to planning care.* (8th ed.). St. Louis, MO: Mosby.

Seminar #2 (7 1/2 hours)

Care planning (concept mapping) and physical assessment seminar – You will practice creating a comprehensive care plan (concept map) based on the case studies from Seminar Day 1. An overview of concept mapping will be explained. A review of guidelines for daily care plans (concept mapping) will be discussed as well as the comprehensive care plan requirements for NURS 124/125. Students will be assigned a partner and each will perform a physical assessment, charting, and additional role-play as assigned by instructor.
Examples of patients:

- 50-year-old admitted with COPD
- 25-year-old admitted with Crohn's and is to be started on TPN @ 75 mL/hr.
- 80-year-old admitted with vomiting and diarrhea. Order is to start IV @ NS 125 mL/hr.
- 60-year-old admitted for a TURP. Returns from surgery with CBI.
- 45-year-old who is to go to OR in the morning for a bowel resection for cancer. Include all pre-op teaching and prep for surgery.

Lab #3 (7 1/2 hours)

Critical Thinking Stations, which will include advanced dosage calculation (2% of overall NURS 124/125 grade). Students will be divided into groups of 2 for this assignment. Groups will be assigned by the lead teacher. Each group will have 45 minutes at each station.

Seminar #3 (7 1/2 hours)

1. Clinical orientation to facilities specific to sites – to be scheduled by site instructors. Students may be required to visit more than one facility on this orientation day. Please make arrangements accordingly.
2. Each clinical facility may have additional requirements necessary prior to starting clinical.

Case Study A
NURS 124/125

A 70-year-old female patient is admitted to a medical floor with congestive heart failure (CHF). The following orders are received from the admitting physician.

- Heart monitor
- Insert INT needle
- Heparin drip at 1200 units per hour – the pharmacy sends a heparin drip that contains 25, 000 units of heparin in 250 mL D5W.
- VS q 4 hours and prn
- OOB TID
- Low Na+ diet
- Insert foley catheter
- I & O
- Lasix (furosemide) 40 mg IV now
- Lanoxin (digoxin) 0.25 mg po

The admitting nurse assesses the following:

- BP 100/60, HR 80 and regular, RR 26, Temp 97
- Alert x 3, color pale, skin warm and dry, heart rate regular with S1 & S2, abd soft and non-tender, 2+ pedal edema and pedal pulses present (2+ PT and DP). Patient denies any pain or discomfort. O2 sat is 94% on room air.

Answer the following questions:

1. What abnormal assessment findings are present?
2. What should the nurse do after assessing the patient?
3. What potential problems could occur?
4. Include at least 2 nursing diagnoses.
5. Include nursing interventions for this patient.
6. Calculate how many mL/hour the heparin drip should infuse to deliver 1200 units per hour.
7. Include rationale for Lasix and Lanoxin.
8. Include possible side effects and nursing considerations in administering ordered medications.

Case Study B
Nursing 124/125

A 50-year-old male is admitted to the surgical floor after a bowel resection with ileostomy. The following orders are received from the admitting physician.

- NS to infuse @ 150 mL/hr
- Hourly UOP from foley cath
- NG tube to low suction
- VS q 2 hr and prn
- Measure drainage from JP drain q shift
- O2 2/L by nasal cannula
- Ceftin (cefuroxime) 1.5 grams piggyback
- PCA pump with morphine

The admitting nurse assesses the following:

- B/P 80/50, HR 120, RR 26, Temp 98
- Patient restless & alert, c/o abd. pain (8), BS clear & equal, heart rate regular with S1 & S2, abd. tender with no bowel sounds, abd. dressing dry and intact, N/G draining moderate amount of bile colored drainage, stoma beefy red with small amount of green liquid drainage from ostomy, foley draining small amount of dark yellow urine, no pedal edema, & pedal pulses 3+. INT # 18 in RA is patent with no redness. NS infusing @ 150 mL/hr. Lab results: Hct 24, K 3.8, Glucose 150, & Na. 145

Answer the following questions:

1. What abnormal assessment findings are present?

2. What should the nurse do about the abnormal assessments?

3. What potential problems could cause the abnormal assessments?

4. Include nursing interventions for this patient.

5. Include rationale for abnormal labs.

6. Include 2 nursing diagnoses.

7. Include rationale for medications. Include nursing considerations for care of patient's with a PCA pump.

8. The patient is diagnosed with dehydration and hypovolemia. The physician orders a NS bolus of 500 mL. This does not help increase his B/P. The physician orders Dopamine at 2mcg/kg/min. The dopamine comes 400 mg in 250 mL patient weighs 180 lbs. Calculate how many mL/hr will be necessary to deliver 2 mcg/kg/min.

Case Study C
NURS 124/125

Your patient, a type II diabetic for 5 years, presents to the physician's office with a non-healing ulcer on his left foot. Laboratory studies at that time revealed a blood glucose of 356 per fingerstick. Because of distance from medical provider and lack of local community services, he is admitted to the hospital.

Admitting Orders:

- Culture/sensitivity and Gram stain of foot ulcer
- Random blood glucose on admission and finger stick blood glucose qid
- CBC, electrolytes, and glycosylated Hgb in AM
- Chest x-ray and ECG in AM
- Diabeta 10 mg PO bid
- Glucophage 500 mg PO qd to start, will increase gradually
- Humulin N insulin 10 units q AM and HS. Begin insulin instruction for post-discharge self-care
- Dicloxacillin 500 mg PO q6 hours: start after culture obtained.
- Darvocet-N 100 mg q4h PRN pain
- Diet – 2400 calories ADA/ three meals with two snacks
- Up in chair ad lib with feet elevated.
- Foot cradle for bed.
- Irrigate lesion L foot with NS tid, then cover with wet-to-dry sterile dressing.
- Vital signs bid

Assessment findings:

- Patient states, "The doctor is admitting me because of this sore on my foot. It was a blister that I got from my new shoes. I lanced it and it has only gotten worse."
- VS – T 101°F (oral), HR 98, RR 18, BP 164/96. Heart sounds S1 S2 noted.
- Alert and oriented x 3. PERRLA @ 3mm. States, "My feet feel cold and tingling like sharp pins poking the bottom when I walk." Skin and legs warm and dry. Feet cool to touch. Cap refill > 3 seconds in feet. < 3 seconds hands.
- Lungs – few wheezes that clear with cough. Smokes "1/2 pack per day" for 25 years.
- Bowel sounds active x 4 quads. Last BM yesterday evening. No change in bowel or urinary elimination.
- C/O pain to medial aspect, heel of L foot. "4 – 5" on scale of 1 – 10. Hurts "all the time."

Answer the following questions:

1. What abnormal assessment findings are present?

2. What additional information do you want from the patient?

3. What should the nurse do after assessing the patient?

4. What potential problems could occur?

5. Include 2 nursing diagnoses.

6. Include nursing interventions for this patient.

7. Include rationale and nursing considerations for meds.

Case Study D
NURS 124/125

Your patient is a 22-year-old Asian female who is in her last year of premed at the local university. Although her grades were poor her first year of college, she is currently an honor student and plans to take the medical school entrance exam in 2 weeks. She presents to the clinic with the following assessment findings:

- History of diarrhea since high school. Self treats with Pepto Bismol and Kaopectate. She also limits food and fluid intake because "stress makes my diarrhea worse." During the last week she has had 3 – 4 loose bowel movements per day and believes this is related to anxiety about the upcoming exam. She states, "I'm always thirsty but I don't want to drink too much." Urinary output has decreased and has become dark in color with a strong odor.

- Nursing examination: temperature 99.8°F (oral), HR 92, RR 18, BP 90/60. Skin and mucous membranes are pale and dry. Weight is 5 pounds less than usual (current weight 125 pounds).

Answer the following questions:

1. What abnormal assessment findings are present?

2. What additional information would the nurse want?

3. What should the nurse do after assessing the patient?

4. What potential problems could occur?

5. Identify 2 nursing diagnoses for this patient. One must be either, role function, self-concept, or interdependence mode.

6. Include goals, interventions, and expected outcomes for this patient.

Case Study E
NURS 124/125

A college freshman who, on the night she had her wisdom teeth removed, had an oral temperature of 103.1°F. She had a sore throat several days before her surgery but didn't mention it to her surgeon. Because of her sore throat, she reported that her oral intake of food and fluids had been greatly decreased. She took Tylenol, which brought her temperature down. Her friends encouraged her to drink more fluids. The next morning when her friends checked on her, her temperature was again elevated and she said "I was too weak last night to drink anything." She was brought to the student health service, where the admitting nurse noticed her dry mucous membranes, decreased skin turgor, and rapid pulse. She was 5' 2" and weighed 98 pounds – 4 pounds less than last week.

Answer the following questions:

1. Identify stimuli for this patient's current condition.

2. Identify behaviors of this patient's current condition.

3. Identify at least 2 nursing diagnoses for this patient.

4. Set at least 1 short term goal for this patient.

5. List at least 5 interventions to help this patient reach the goal(s) that you have set with her.

6. Provide rationale for each intervention.

Case Study F
NURS 124/125

A patient has just been diagnosed with small bowel strictures from Crohn's disease and requires preoperative TPN (total parenteral nutrition). The physician has ordered the TPN to be started at 50 mL/hr for 12 hours then increase to 100 mL/hr after insertion of a central line. The patient is sent to the holding room for insertion of a central line.

Answer the following questions:

1. Explain the reason for TPN:

2. What are the nursing responsibilities prior to sending the patient for insertion of central line? What are the nursing interventions post-op (after the central line has been inserted)?

3. Explain the nursing responsibilities while the TPN is infusing. (Include all routine orders)

4. Explain possible complications while TPN is infusing and include nursing interventions.

5. Include two nursing diagnosis with interventions.

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Nursing 115, 124, 125, 241, 245, 246

DAILY CONCEPT MAPPING GUIDELINES

1. A daily concept map must be completed on each assigned patient in order to receive a grade of satisfactory in the clinical area. This is to be original work – copied work from anyone else = cheating!!

2. Daily concept maps are due on the last clinical day of each week unless the instructor states otherwise.

3. Fully address all areas of the concept map:
   a. **Nursing Diagnosis**
      NURS 115 - Write 2 nursing diagnoses in complete form, i.e., nursing diagnosis related to etiology as evidenced by signs and symptoms (There should be three (3) parts.) Write these on the concept map.

      NURS 124, 125, 241, 245 & 246 - Write 4 nursing diagnoses in complete form, i.e., nursing diagnosis related to etiology as evidenced by signs and symptoms (There should be three (3) parts.) Write these on the concept map

   b. **Assessment**
      Include the following: assessments, lab data, diagnostic test results, medications and past medical/psych history if appropriate.

   c. **Interventions**
      State interventions for each nursing diagnosis. These interventions should be realistic and individualized to the specific patient. Include interventions that you as the nurse would implement. Include rationale for nursing interventions. Your nursing care plan book is a great resource to find interventions but you need to individualize the interventions to your patient**.** DO NOT copy word for word from your text book or any other book or journal. **This = plagiarism!!!**

   d. **Patient Outcomes**
      State short-term goals and long term goals for the nursing diagnoses. These goals should be measurable and written in terms of patient behavior, not nurse behavior. Evaluate the goals.

4. Medication cards or medication sheet must be completed for each medication your patient is receiving. These are to be turned in with concept map.

LMU Daily Clinical **STUDENT:** **DATE:**

RM#	Pt last initial:	Age:	Hometown:	Marital Status:	Religious Preference:
Occupation:			Insurance:		Allergies:
Date of Admission:		Primary HCP:		MD Consults:	
Current Diagnosis:				Surgery:	
Medical History:				Psychosocial History:	

Day 1					Day 2				
Height:		Weight:			Height:			Weight:	
AM/PM Assessment		AM/PM Care			AM/PM Assessment			AM/PM Care	
VS	T	P	R	BP	VS	T	P	R	BP
VS	T	P	R	BP	VS	T	P	R	BP
Diet:	Method:				Diet:		Method:		
Activity:	Positioning:		CSM:		Activity:		Positioning:		CSM:
Seizure Precautions:	Fall Risk:		Restraints:		Seizure Precautions:		Falls Risk:		Restraints:
O2:	Trach:		ETT		O2:		Trach:	ETT	
VT	Rate	FIO2	Peep	Pressure	VT	Rate	FIO2	Peep	Pressure
Cardiac Monitor:					Cardiac Monitor:				
IV Site	Size	IVF	Rate	Pump	IV Site	Size	IVF	Rate	Pump
IV Site	Size	IVF	Rate	Pump	IV Site	Size	IVF	Rate	Pump
IV Site	Size	IVF	Rate	Pump	IV Site	Size	IVF	Rate	Pump
Intake	Oral	IVF	Irrigant		Intake	Oral	IVF	Irrigant	
Output	Urine	Stool	Drains		Output	Urine	Stool	Drains	
Dressings		Drains			Dressings		Output		
Dressings		Drains			Dressings		Output		
Urinary Elimination Method:		Bowel Elimination Method:			Urinary Elimination Method:		Bowel Elimination Method:		

Rev 12/15/09

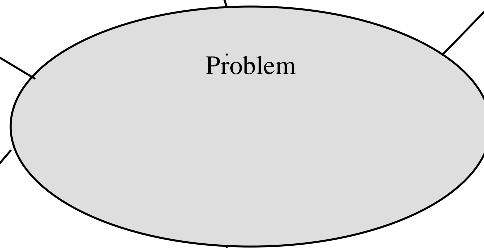
Miscellaneous Information

Signs and Symptoms

Nursing Diagnosis:

Goal:

Interventions:



Nursing Diagnosis:

Goal:

Interventions:

Nursing Diagnosis:

Goal:

Interventions:

Nursing Diagnosis:

Goal:

Interventions:

Rev 12/15/09

Name of Medication (generic & trade)____
Drug Classification____________________________Route__________________________
Time/frequency___________________________Dosage_____________________________
Recommended Safe Dose (calculate for peds)_____________________________________
____
Reason YOUR patient is receiving medication___________________________________
____
MOA____
____
____
Adverse Effects____
____
____
____
____
Nursing Considerations____
____
____
____
____
____

Name of Medication (generic & trade)____
Drug Classification_______________________Route________________________________
Time/frequency___________________________Dosage_____________________________
Recommended Safe Dose (calculate for peds)_____________________________________
____
Reason YOUR patient is receiving medication___________________________________
____
MOA____
____
____
Adverse Effects____
____
____
____
____
Nursing Considerations____
____
____
____
____

Lincoln Memorial University
Caylor School of Nursing

Student ______________________ Date __________ Room # ________ Pt. Initials: _______ Age: ___
Diagnosis(es) ____

Name (generic & trade), **Time, Route, Recommended SafeDose** (calculate for peds)	**Drug Classification**	**MOA (Mechanism of Action)**	**Reason YOUR client is receiving**	**Adverse Effects**	**Nursing Considerations**

Please make photocopies as needed. This form must be completed & submitted to the clinical instructor for each clinical day. Revised 6/09

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Laboratory Value Sheet

Laboratory Test	Normal Values	Admission	Date/Time	Date/Time	Reason for Abnormal Values
CBC					
White Blood Cells (WBC)					
Red Blood Cells (RBC)					
Hemoglobin (Hgb)					
Hematocrit (Hct)					
Platelets					
Coagulation Studies					
Prothrombin time (PT)					
International normalized ratio (INR)					
Activated partial thromboplastin time (PTT)					
Comprehensive Metabolic Panel					
Sodium (Na)					
Potassium (K)					
Chloride (Cl)					
Calcium (Ca)					
Magnesium (Mg)					
Phosphorus					
Glucose (FBS)					
Hemoglobin A1C					
BUN					
Creatinine					
Lipid Panel					
Cholesterol					
HDL					
LDL					
Triglycerides					
Liver Function Tests (LFT)					
Albumin					
Bilirubin					
ALT					
AST					
GGT					
Ammonia					
Cardiac Enzymes					
CPK					
CK MB					
Troponin					
B natriuretic peptide BNP					

Arterial Blood Gasses (ABG)					
pH					
PCO2					
P02					
HCO3					
Urinalysis					
Color					
Appearance					
Specific Gravity					
pH					
Glucose					
Ketones					
Nitrates					
Bacteria					
RBC					
WBC					
Crystals					
Culture Results					
Sensitivity					
Therapeutic Drug Level (ex. Digoxin, Dilantin, Theophylline, etc)					
Sputum Culture and Sensitivity					
Biopsy					
CT Scan					
X-Ray					
EKG					

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Nursing 115, 124/125

Comprehensive Nursing Project Guidelines

1. The clinical instructor will set a due date for the comprehensive care plan. As stated in the syllabus, if a nursing project is not turned in on the assigned date, a point will be deducted for each day late. This deduction remains as a part of the grade. **This is to be original work – copied work from anyone else = cheating!!**

2. The first portion of the comprehensive nursing project contains several sections that must be addressed. These include, the nursing history and physical assessment; definition of all diagnoses (a thorough definition – not just copied from a dictionary); symptom comparison; Erickson developmental comparison; lab value sheet with patient findings compared to normal and rationale for abnormal lab values. If any section is not addressed, the nursing project will be handed back to the student, not graded, and this will count as the first attempt.

3. The last portion of the comprehensive nursing project addresses the nursing process:
   a. Assessment
      This should include thorough assessment specific for each nursing diagnosis. It should include objective as well as subjective data. In addition, lab values, medications and diagnostic test results specific to that nursing diagnosis should be included.

   b. Nursing Diagnosis
      These nursing diagnoses must be stated in correct 3 part form, i.e., nursing diagnosis related to etiology as evidenced by signs and symptoms. Short-term and long-term goals should be stated for each nursing diagnosis. These goals should be measurable and written in terms of patient behavior, not nurse behavior. An expected outcome should be stated for each goal. For NURS 115 there should be a minimum of 3 nursing diagnoses, 2 can be from the physiological mode and the 3rd from either the self-concept, role function or interdependence mode. For NURS 124/125 there should be a minimum of 4 nursing diagnoses, 3 can be from physiological mode and the 4th can be from either self-concept, role function or interdependence mode.

   c. Nursing Interventions
      These should be realistic and individualized to the patient. Include interventions that you as a nurse would implement. DO NOT copy from a textbook or use standardized care plans.

   d. Rationale
      All rationale must be documented from a resource book. You must cite the source at the end of each stated rationale. **At least one rationale must be documented with an article from an accepted nursing journal.** You were given the list of accepted journals in your first semester course. Internet information is not acceptable unless it is a full-text article from one of the accepted nursing journals. A copy of the article must accompany the nursing project.

   e. Evaluation
      There should be an evaluation statement for each expected outcome. Simply state the outcome, i.e., Did it happen? Did it not happen? Why? Why not? What changes will you make to your nursing interventions?

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
NURS 124/125
Grading Rubric Comprehensive Nursing Project

Student:______________________________ **Faculty:**______________________________

I. Assessment of data (40 points) Comprehensive assessment of patient which includes the following sections:

A. Nursing History
B. Nursing Physical Assessment
C. Definition of medical diagnosis
D. Symptom Comparison
E. Erickson Developmental comparison
F. Laboratory Value Sheet with rationales for abnormal lab values
G. Medication Cards or Medication Sheet

40 points	35 points	30 points	25 points	20 points	0 points	Points Earned
All areas with NO errors	1-2 areas with errors	3-4 areas with errors	5-6 areas with errors	All areas with errors	Not the student's original work.	

II. Nursing Process (40 points)

A. Assessment
B. Nursing diagnoses, goals, outcomes
C. Nursing interventions
D. Rationale
E. Evaluation

40 points	35 points	30 points	25 points	20 points	0 points	Points Earned
All areas with NO errors	1 area with errors	2 areas with errors	3-4 areas with errors	All areas with errors	Not the student's original work	

III. References - (5 points) must have at least 5 references documented.

5 points	4 points	3 points	2 points	1 points	0 points	Points Earned
5 references documented	4 references documented	3 references documented	2 references documented	1 reference documented	No references documented	

IV. Journal (5 points)

5 points	3 points	0 points	Points Earned
Appropriate article/journal chosen AND article documented in project	Inappropriate article/journal OR article not documented in project	Inappropriate article/journal AND article not documented in project	

V. Professionalism (10 points) Includes, but not limited to, APA format, correct grammar, spelling, punctuation, spacing, and neatness.

10 points	8 points	6 points	4 points	2 points	0 points	Points Earned
No errors in professionalism	1-3 errors in professionalism	4-6 errors in professionalism	7-9 errors in professionalism	10-12 errors in professionalism	>12 errors in professionalism	

Points Earned	Days Late (1 point per day deducted) Later than 1 week = zero for entire care pla	Final Grade

Lincoln Memorial University
Caylor School of Nursing
Nursing Health History Guideline
NURS 115 & 124/125 Spring 2010

Biographical Data

- Patient/Resident Initials only in compliance with HIPPA
- Age Gender Marital Status Religion Occupation
- Access to Healthcare (How is the healthcare paid for?) Fixed Income (Yes or No)

Present Illness

- Date of Admission to Facility
- Health Care Provider (Include name of MD, NP, etc.)
- Reason for Admission in the words of the Patient or Resident
- Medical Diagnosis on Admission (May include more than one)

Health History

- Advance Directive (Living Will, DNR, Power of Attorney)
- Medication/Food Allergies (Must include the reaction type)
- Tobacco Use to include Pack Per Day, years, and the years quit if former usage
- ETOH Use to include type, amount, and frequency
- Recreational Drug Use to include type, amount, and frequency
- Childhood Illnesses (Chicken pox, meningitis, polio, and whooping cough)
- Immunizations up to date (Include childhood immunizations, Flu, PPD, and pneumonia)
- Prior Hospitalizations (Include reason, year, and the length of stay)
- Surgeries (Include reason, year, and the length of stay)
- Personal/Family History (Include type of disease for each body system affected)

Self-Concept Mode

- Body Sensations (How does the individual physically feel: Tired, weak, or rested?)
- Physical Sensations (What physical sensations are being felt: Hot, cold, or pained?)
- Sexual Sensations (Does the individual have sensations, how often, & is there satisfaction?)
- Body Image (How does the individual perceive his/her body? Satisfied? Changes to Make?)
- Age Appropriate Physical Development (Has the individual met growth and development milestones for age?)
- Erickson's Developmental Stage (**See Taylor, Lillis, LeMone, & Lynn p. 399-400**)
- Describe Self as a person (What is the individual's self-perception? Personal characteristics?)
- Goals (What goal(s) does the individual have?)
- Changes in goals (Has the individual experienced a change in those goals?)
- Describe Spiritual Beliefs (What belief(s) does the individual hold?)
- Satisfied with spiritual self?
- Current/Past Coping Mechanisms (How does the individual cope? Crying, Laughter, Prayer, Talking)

- Recent Major Life Changes (Has the individual experienced life changes? Birth, Death, Divorce, Marriage, Move)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Role Function Mode

- Primary/Secondary Role (Primary: Age, Sex, & Developmental Stage) (Secondary: Husband, wife, father, mother, sister)
- Able to meet roles (Is the individual able to meet these roles? If not, why?)
- Anticipate change in role (Does the individual anticipate a change in these roles?)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Interdependence Mode

- Significant other (Does the individual have a significant other? If naming, use initials only)
- Support system (Who does the individual rely on for support? Remember to include staff if in an acute or long term setting)
- Independent aspects (In what aspect(s) does the individual feel independent?)
- Family structure (**See Taylor et. al, p. 31**)
- Gravida (How many times a female has been pregnant including current pregnancy if any?)
- Para (How many deliveries a female has had?)
- AB (How many abortions either elective or spontaneous?)
- Adopted Children (How many?)
- Living Children (How many? Include adopted children and step-children)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit

Physiologic/Physical Mode

Neurosensory

- Visual Aids (Contacts, Glasses, Magnifier, or Prosthetic)
- Hearing Aids (Hearing Aids or Cochlear Implants)
- Pain (Location, quality, intensity, onset, duration, referred, relief measures, acute/chronic, exacerbations)
- Sensation (Test the senses for decreased sensation)
- Neurosensory Exams (CT, EEG, MRA/MRI to include date & result)

Oxygenation

- Respiratory Exams (ABG, CT, CXR, PFT, VQ scan to include date and result)

Cardiac

- Cardiac Exams (Cardiac Catherization, Echo, EKG, Stress Test and to include date and results)

Nutrition

- Recent Gains/Losses & Amount (Has there been recent gains/losses? If so, what is the amount?) **Remember to include unit of measure**.
- Type of diet (Diabetic, mechanical soft, pureed, regular, soft, or tube feeding)
- Dietary Supplements (Does the patient/resident require supplements: ensure, magic cup, etc?)
- Dietary Restrictions/Preferences (Does the patient/resident have dietary restrictions or preferences?)
- Pain or Discomfort r/t Oral Intake (Does the patient/resident have pain or discomfort r/t oral intake? If so, describe)
- Chewing/Swallowing Difficulty (Does the patient/resident have chewing/swallowing difficulty? If so, describe)
- Gastrointestinal Exams (Colonoscopy, CT of the abdomen & pelvis, Esophagogastroduodenoscopy (EGD), Upper/lower GI series, Swallowing Evaluation, Video Esophagram and to include date and results)

Elimination

Gastrointestinal

- Daily Dietary Fiber Intake (Estimate from the 24 hour sample diet the daily dietary fiber intake)
- Daily Fluid Intake (Calculate the oral intake for the clinical day). **Remember to record the unit of measure.**
- Gastrointestinal Exams (Barium Enema, Colonoscopy, CT of the abdomen & pelvis, Esophagogastroduodenoscopy (EGD), Upper/lower GI series, Stool Specimens and to include date and results)

Genitourinary

- Genitourinary Exams (Urine culture/specimen and to include date and results)

Protection

- Burns, Lacerations, Lesions, Incisions, Scars, & Ulcerations (Does the patient/resident have any of the following? If so, include the location, appearance, and treatment)

Activity and Rest

Mobility

- Physical Activity (What is the activity level of the patient/resident: Independent, assisted, or dependent?)
- Strength (What is the strength of the upper and lower extremities: Strong or weak, equal or unequal?)
- Mobility (What is the ROM ability of the patient/resident: Full, active, passive, or limited?)
- Posture (Observe and describe the posture of the patient/resident: Upright or other)
- Gait (Observe and describe the gait of the patient/resident: Balanced, equal, unequal, or limp)
- Aids (Does the patient/resident require any mobility aids? If so, describe the type?)
- Current Exercise Regimen (What is the current exercise regimen for the patient/resident?)

- Leisure Activities (Does the patient/resident have leisure activities? If so, how often does the patient/resident engage in those activities?)

Sleep

- Sleep (Describe the patient/resident's hours of nighttime sleep, quality, and frequency and duration of naps)
- Environmental disturbances (Are there environmental disturbances?)
- Appearance (What is the appearance of the patient/resident in relation to sleep: Rested, red eyes, puffy eyes, or yawns frequently?)
- Sleep Rituals (Does the patient/resident have sleep rituals? If so, describe)

References

Roy, C. & Andrews, H. (1999). *The Roy Adaptation Model*. (2nd ed.). Stamford, CT. Appleton & Lange.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Fundamentals of Nursing: The Art and* science *of nursing care.* (6th ed.). Philadelphia: Lippincott Williams & Wilkins

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Nursing Health History
NURS 115 & 124/125
Spring 2010

Directions: Please fill in each space. Nothing should be left blank. Submissions for grading should be 12 font typed or handwritten in black ink. Submissions in pencil or colored ink will not be accepted. Refer to course syllabus for further submission guidelines. For additional comments or data, please use the back of each page.

Student Name: ______________________________ **Date of Care**: ________________________

Facility: ___________________________________ **Clinical Supervisor**: __________________

Biographical Data

Patient/Resident Initials: __________ Age: __________ Gender: __________ Marital Status: ___

Religion: _______________________________________ Occupation: ______________________

Access to Healthcare: Insurance ____________________ Fixed Income: ____________________

Present Illness

Date of Admission: ______________________________ Health Care Provider: _______________

Reason for Admission: ____

Medical Diagnosis on Admission: ____

Health History

Advance Directive (Include Type): ____

Medication/Food Allergies (Include Reaction Type): _____________________________________

Tobacco Use: # PPD ____________________ # Years _______ # Years Quit ________________

ETOH Use: Type/Amount __________________________ Frequency _______________________

Recreational Drugs: Type/Amount ____________________ Frequency _______________________

Childhood Illnesses: ____

Immunizations Up To Date: ____

Prior Hospitalizations (Reason, Year, & LOS):_______________________________________

Surgeries (Reason, Year, & LOS): ____

Personal/Family History (Include Type of Disease in Each Column):

	Deceased (Age)	Neuro Disease	Cardiac Disease	Endo Disease	GI Disease	GU Disease	MS Disease	Resp Disease	Chronic Pain	Mental Illness
Self										
Mother										
Father										
Sibling (s)										

Self-Concept Mode

Body Sensations: ________ Physical Sensations: ___________ Body Image (Self-description): _____________

Age Appropriate Physical Development: ___________ Erikson's Developmental Stage: _________________

Describe Self as a Person: _____________________ Goals: ____________ Changes in Goals______________

Describe Spiritual Beliefs: _____________________ Satisfied With Spiritual Self: ______________________

Current/Past Coping Mechanisms: ____

Recent Major Life Changes: ____

Deficit: Yes ___ No ___ Nursing Diagnosis: ____

Role Function Mode

Primary/Secondary Role: ____

Able to Meet Roles: _________________ Anticipate Change in Role: _________________________________

Deficit: Yes ___ No ___ Nursing Diagnosis: ____

Interdependence Mode

Significant Other: ___________________________ Support System ______________________________

In Which Aspects do you feel Independent? ____

Family Structure: ____________ Gravida ___ Para ___ AB ___ Adopted Children ___ Living Children ____

Deficit: Yes ___ No ___ Nursing Diagnosis: ____

Physiologic/Physical Mode

Neurosensory

Visual Aids: ______________________________ Hearing Aids: ____________________________________

Pain: Location _____________ Quality _____________ Intensity _________ Onset ____________________

Duration __________________ Referred ____________ Relief Measures ___________________________

Acute _____________________ Chronic _____________ Exacerbation _____________________________

List Area of Decreased Sensation: ____

Neurosensory Exams (Include Date & Result): ____

Oxygenation

Respiratory

Respiratory Exams (Include Date & Result): ____

Cardiac

Cardiac Exams (Include Date & Result): ____

Nutrition

Gastrointestinal

Recent Gains & Amount: _____________________ Recent Losses & Amount: _________________________

Type of Diet: _____________ Supplements: __________ Restrictions: _________ Preferences: __________

Pain or Discomfort r/t Oral Intake: ____

Chewing/Swallowing Difficulty: ____

Gastrointestinal Exams (Include Date & Result): ____

Elimination

Intestinal

Daily Dietary Fiber Intake: ____________________ Daily Fluid Intake: _______________________________

Gastrointestinal Exams (Include Date & Result): ____

Genitourinary

Genitourinary Exams (Include Date & Result): ____

Protection

Burns, Lacerations, Lesions, Incisions, Scars, & Ulcerations: (Include Location, Appearance, & Treatment):

____

____

Activity and Rest

Mobility

Physical Activity: _______________ Strength of Extremities: _______________ ROM: ____________________
Posture: ________________________ Gait: ________________________________ Mobility Aids: _____________

Current Exercise Regimen: ___________________________________ Leisure Activities: ______________________

Sleep

Hours of Nighttime Sleep ___________ Quality ___________ Naps: Frequency _________ Length ____________

Environmental Disturbances: ____

Appearance: ________________________________ Sleep Rituals: ____

References

Roy, C. & Andrews, H. (1999). *The Roy Adaptation Model*. (2nd ed.). Stamford, CT. Appleton & Lange.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Fundamentals of Nursing: The Art and* science *of nursing care.* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Physical Assessment Guideline
NURS 115 & 124/125 Spring 2010

Physiologic/Physical Mode

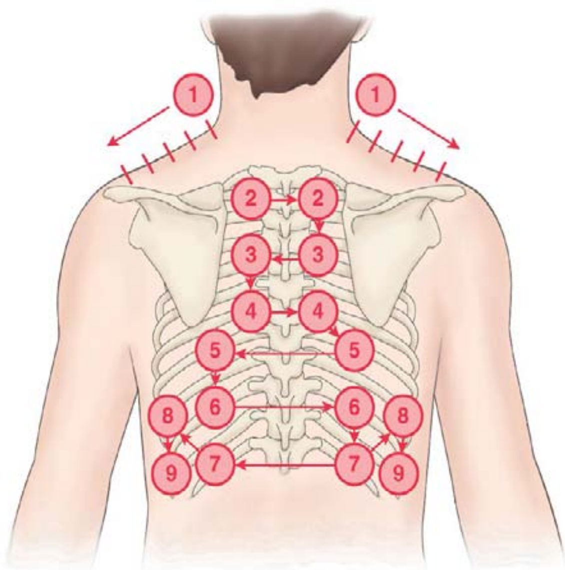
Neurosensory

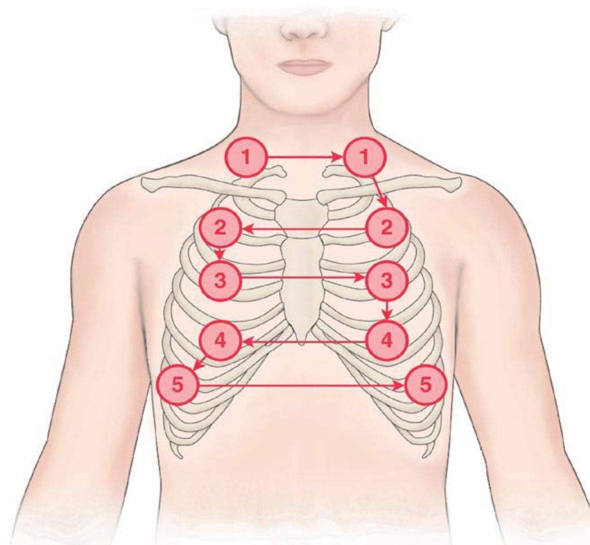
- LOC (Level of Consciousness. Patient/Resident's degree of wakefulness or ability to be aroused.) (**See Taylor et al. p. 1022 Box 34-1**)
- Orientation (Patient response to questions regarding person, place, & time)
- Memory (Question immediate recall and recall of past events)
- Pupils (PERRLA: Pupils equal, round, reactive to light and accommodation) (**See Taylor et al., p. 619 Guidelines for Nursing Care 25-2**)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Oxygenation

Respiratory

- Rate (What is the rate of the respirations?) (**See Taylor et al., pp. 571-572**).
- Rhythm (Irregular, regular)
- Effort (Observe for difficulty versus normal relaxed breathing)
- Abnormal pattern (**See Taylor et al., p. 572 Table 24-7**)
- Cough (How often? Non-productive or productive? If productive, describe color and consistency)
- Breath Sounds (Auscultate breath sounds & determine if normal or abnormal) (**See Taylor et al., p. 631 Table 25-8 & p. 632 Table 25-9**)

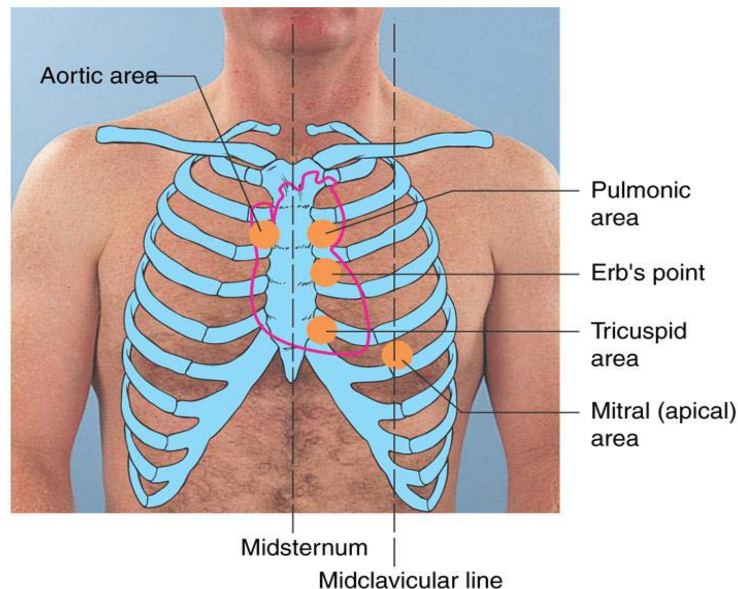




- Subjective Data (What the Patient/Resident complains of in own words)
- Oxygen (How many liters per minute and what delivery device?)
- Pulse Oximetry (What is the pulse oximetry reading? Include if taken on oxygen or at room air)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Cardiac

- Apical pulse (Rate and rhythm) (**See Taylor et al., p. 566**)
- Capillary refill: Observe light pink nail bed coloring. Depress the nail bed with finger to lighten nail bed coloring. Observe and time the return of circulation to the nail bed.
- Heart sounds (Auscultate heart sounds & determine if normal or abnormal) (**See Taylor et** al**., p. 634 Box 25-5**)



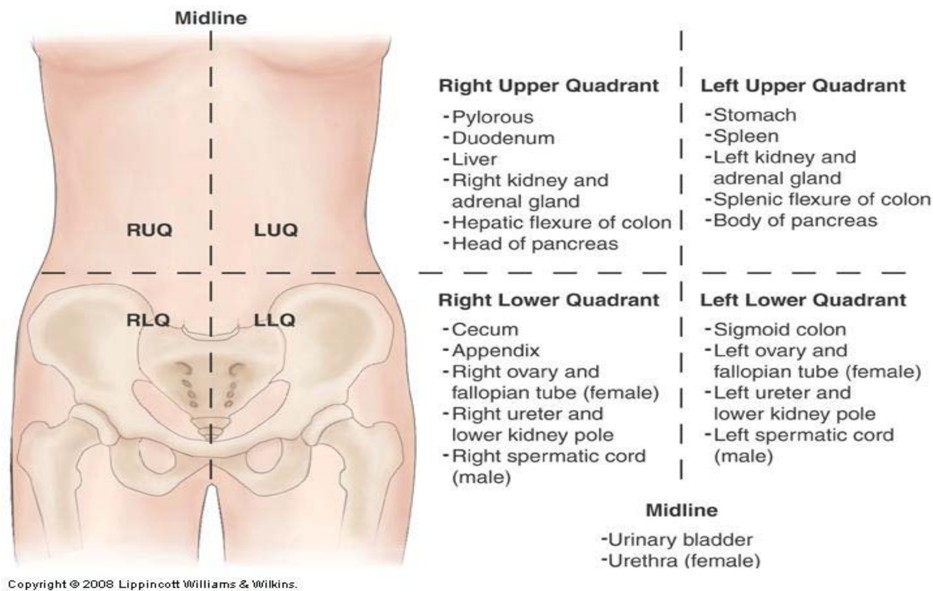
Copyright © 2008 Lippincott Williams & Wilkins.

- Blood pressure (What is the blood pressure? Automatic or manual? What arm?)
- Edema (Location, pitting or non, and degree if pitting) (**See Taylor et al., p. 612**)
- Peripheral Pulses (Location, rate, rhythm, & amplitude) (**See Taylor et al., p. 567 Table 24-6**)
- Extremity Color (Coloring of upper and lower extremities)
- Extremity Temperature (Palpate temperature of the upper and lower extremities)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Nutrition

- Height, Weight, IBW/BMI (What is the height, weight, ideal body weight/body mass index of the patient/resident?) **Remember to include unit of measure**.

- Mucous Membranes (Describe the color and texture of the mucous membranes)
- Teeth (Does the patient/resident have teeth? If so, describe condition)
- Dentures (Does the patient/resident have dentures? If so, describe condition)
- Dental Caries (Does the patient/resident have dental caries?)
- Abdomen (Palpate the abdomen and describe)
- Bowel Sounds (Auscultate the abdomen and describe)
  - Absent: No sounds
  - Hyperactive: More than 35 bowel sounds per minute
  - Hypoactive: Less than 5 bowel sounds per minute
  - Normoactive: 5-34 bowel sounds per minute



- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the def

Elimination

Gastrointestinal

- Stool (What is the frequency, color, and consistency of the patient/resident stool?)
- Continent (Is the patient/resident continent of bowel?)
- Ostomy (Does the patient/resident have an ostomy? If so, where is the site, what is the stoma appearance, and what type of collection device does the patient/resident use?)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Genitourinary

- Urine (What is the frequency, amount, and color of the urine?)
- Ostomy (Where is the site, what is the stoma appearance, & what type of collection device does the patient/resident use?)
- Foley Catheter (What is the size and insertion date of the foley catheter?)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Protection

- Body Temperature (What is the body temperature of the patient/resident? Include the route and result?) (**See Taylor et al., p. 561 Table 24-3**)
- Braden Score (What is the Braden Scale Score? (**See Taylor et al. p. 1205**)
- Skin Color (What is the color of the skin?) (**See Taylor et al., pp. 610-611**)
- Skin Condition (What is the condition of the skin: Turgor, dry, moist, intact, or rash?)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit.)

Narrative Summary of Findings

- Write or type a detailed narrative summary of findings in a head to toe manner.
  - Alert and oriented X 2. Disoriented to time of day. PERRLA with glasses noted in place. O2 at 2 LPM/NC. Pink, moist, mucous membranes noted. Upper and lower dentures noted to be clean and intact. Apical heart rate 60 beats per minute, regular rhythm, S1 and S2 audible. Respiratory rate 16 breaths per minute, regular, and unlabored. Rhonchi noted in BUL. Denies cough or SOB. Nail beds pink, brisk capillary refill. Abdomen soft with active bowel sounds X 4. FC # 18 to BSD with 500 mL of clear yellow urine. Active ROM with equal strength bilaterally. NAD noted. Lying supine watching TV. Side rails up X 2. M. Humfleet, SN, LMU.

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Nursing Physical Assessment
NURS 115 & 124/125 Spring 2010

Physiologic/Physical Mode

Neurosensory

LOC: ______________________ Orientation: _____________________ Memory: _____________________
Pupils: PERRLA _____________________ Unequal _____________ Unresponsive ______________________
Education/Discharge Needs ____
____
Deficit: Yes _____ No _____ Nursing Diagnosis: ____

Oxygenation

Respiratory
Rate: ____________ Rhythm: ___________ Effort: ____________ Abnormal Pattern: _________________
Cough: __________ Frequency: _________ Nonproductive: _____ Productive: ______________________
Breath Sounds: ________________________ Subjective Data:_______________________________________
Oxygen: Liters/Minute (Include Delivery) ______________________ Pulse Oximetry ___________________
Education/Discharge Needs ____
____
Deficit: Yes _____ No _____ Nursing Diagnosis: ____

Cardiac
Apical Pulse: Rate ______________ Rhythm _______________________ Capillary Refill _______________
Heart Sounds:__________________ Abnormal Sounds:_______________ Blood Pressure: _______________
Edema: Location _______________ Pitting ________________________ Degree _____________________
Peripheral Pulses: Location ____________ Rate ___________ Rhythm ____________ Volume ___________
Extremity Color: ___________________ Extremity Temperature: ____________________________________
Education/Discharge Needs ____
____
Deficit: Yes _____ No _____ Nursing Diagnosis: ____

Nutrition

Gastrointestinal
Height: ________________________ Weight: _______________________ IBW/BMI: __________________
Mucous Membranes: _________________ Teeth __________ Dentures ___________ Dental Caries _______
Abdomen: _______________________________ Bowel Sounds: _____________________________________
Education/Discharge Needs ____
____
Deficit: Yes _____ No _____ Nursing Diagnosis: ____

Elimination

Gastrointestinal
Stool: Frequency _________________ Amount _________ Color _________ Continent ______________
Ostomy: Location ________________ Stoma appearance __________________ Device _________________

Genitourinary

Urine: Frequency _________________ Amount __________ Color __________ Continent ______________

Ostomy: Location ________________ Stoma appearance __________________ Device _________________

Foley catheter: Size ____ Insertion date ____________

Education/Discharge Needs ____

____

Deficit: Yes _____ No _____ Nursing Diagnosis: ____

Protection

Body Temperature (Route & Result): ______________________ Braden Score: ________________________

Skin Color: ____ Skin Condition: ______________________

Education/Discharge Needs ____

____

Deficit: Yes _____ No _____ Nursing Diagnosis: ____

Narrative Summary of Findings

____

____

____

____

____

____

____

____

____

____

References

Roy, C. & Andrews, H. (1999). *The Roy Adaptation Model*. (2nd ed.). Stamford, CT. Appleton & Lange.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Fundamentals of Nursing: The Art and science of nursing care.* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Medical Definition and Symptomatology Comparison Patient/Textbook
NURS 115 & 124/125 Spring 2010

Angina Pectoris
Angina pectoris is characterized by chest pain or pressure. It results from insufficient coronary blood flow resulting in decreased oxygen supply. This decreased oxygen supply occurs when there is increased myocardial demand such as during exercise or emotional stress. The severity of angina is dependent upon the precipitating activity and its effect on activities of daily living (Smeltzer, Bare, Hinkle, & Cheever, 2008, p. 867).

Symptom	Textbook	Patient
Chest pain	X	X
Weakness	X	
Numbness	X	
Shortness of breath	X	X
Pallor	X	
Diaphoresis	X	X
Dizziness	X	
Nausea & vomiting	X	X
Anxiety	X	

(Smeltzer, Bare, Hinkle, & Cheever, 2008, p. 867).

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Erikson's Developmental Comparison
NURS 115 & 124/125 Spring 2010

Comprehensive Nursing Project Example:

Chronological Age - 32 y/o According to Erikson, this client is in the middle adult years and should be dealing with the generativity vs. stagnation conflict. This is the period when a person's interest is toward establishing and guiding the next generation (generativity) or the person may turn inward and become self-absorbed or stagnant (stagnation) (Taylor, Lewis, Lemone, & Lynn, 2008, p. 397).

This client is clearly in the generativity side of Erikson's conflict for the middle adult.
He feels that he has an important role and contribution to make to his children and to the children he teaches. He is active in his church, provides for his family and is concerned about how his illness affects his work, family and the delays to his responsibilities at work. He displays no aspects of stagnation -nonproductive, self-absorbed, personal impoverishment and/or self-indulgence.

Example developed by: Karen C. Stephens, MSN: 10/07; 09/08; 12/12/08

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Laboratory Value Sheet

Laboratory Test	Normal Values	Admission	Date/Time	Date/Time	Reason for Abnormal Values
CBC					
White Blood Cells (WBC)					
Red Blood Cells (RBC)					
Hemoglobin (Hgb)					
Hematocrit (Hct)					
Platelets					
Coagulation Studies					
Prothrombin time (PT)					
International normalized ratio (INR)					
Activated partial thromboplastin time (PTT)					
Comprehensive Metabolic Panel					
Sodium (Na)					
Potassium (K)					
Chloride (Cl)					
Calcium (Ca)					
Magnesium (Mg)					
Phosphorus					
Glucose (FBS)					
Hemoglobin A1C					
BUN					
Creatinine					
Lipid Panel					
Cholesterol					
HDL					
LDL					
Triglycerides					
Liver Function Tests (LFT)					
Albumin					
Bilirubin					
ALT					
AST					
GGT					
Ammonia					
Cardiac Enzymes					
CPK					
CK MB					
Troponin					
B natriuretic peptide BNP					

Arterial Blood Gasses (ABG)					
pH					
PCO2					
P02					
HCO3					
Urinalysis					
Color					
Appearance					
Specific Gravity					
pH					
Glucose					
Ketones					
Nitrates					
Bacteria					
RBC					
WBC					
Crystals					
Culture Results					
Sensitivity					
Therapeutic Drug Level (ex. Digoxin, Dilantin, Theophylline, etc)					
Sputum Culture and Sensitivity					
Biopsy					
CT Scan					
X-Ray					
EKG					

Name of Medication (generic & trade)
Drug Classification Route
Time/frequency Dosage
Recommended Safe Dose (calculate for peds)

Reason YOUR patient is receiving medication

MOA

Adverse Effects

Nursing Considerations

Name of Medication (generic & trade)
Drug Classification Route
Time/frequency Dosage
Recommended Safe Dose (calculate for peds)

Reason YOUR patient is receiving medication

MOA

Adverse Effects

Nursing Considerations

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing

Student ______________________Date _________ Room # _______ Pt. Initials: ______ Age: ___
Diagnosis(es)____

Name (generic & trade), **Time, Route, Recommended SafeDose** (calculate for peds)	**Drug Classificat ion**	**MOA (Mechanism of Action)**	**Reason YOUR client is receiving**	**Adverse Effects**	**Nursing Considerations**

Please make photocopies as needed. This form must be completed & submitted to the clinical instructor for each clinical day.
Revised 6/09

COMPREHENSIVE NURSING PROJECT INTERVENTIONS WITH RATIONALES

Nursing Dx____

Nursing Interventions:	**Rationale:**	**Pt. Response**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		