



INTRODUCTION TO PROFESSIONAL NURSING
COURSE SYLLABUS
HYBRID
NUR 2000LHY

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GENERAL CLASS & COURSE INFORMATION

Course number: NUR 2000L **Class Reference Number:** Multiple **Term:** Fall 2011

Course title: Introduction to Professional Nursing **Credit/Contact hours:** 1 Credit

Course Description: This course must be taken prior to entering the nursing program. This course is designed as a transitional course for the LPN, Paramedic or transfer student who is becoming a professional nurse. This course encompasses the area of role definition; providing/managing care of individuals and groups utilizing goal attainment to reach an optimum state of health and wellness.

Course Learning Outcomes: As a result of taking this course, the student will be able to:

1	Explain King's theory of Goal Attainment with Dossey's Principles of Holism as a theoretical framework for nursing practice.
2	Utilize the nursing process to demonstrate critical thinking in planning for and providing holistic nursing care to clients in relation to the human response patterns to health challenges as evidenced by completion of a Daily Holistic Assessment Tool (DHAT).
3	Demonstrate principles of therapeutic communication appropriate to clients, families, health team members, and professional nursing through completion of an Interpersonal Recording (IPR) videotaped interview with analysis employed techniques for effectiveness.
4	Demonstrate an understanding of the impact of human responses to health challenges in goal attainment by utilizing a comprehensive holistic assessment tool (CHAT) to assess an elder in the community.
5	Display components of professional/personal growth and life-long learning as evidenced by a class presentation utilizing the dynamic principles of Teaching/Learning.
6	Compare and contrast health as it relates to maintaining wellness of self, the individual and family in the ever-changing health care delivery system.
7	Analyze current wellness practices and create a plan for improvement applying the principles of nutrition, multiculturalism, and the influence of generational health practices, as evidenced by satisfactory completion of the wellness paper.
8	Articulate leadership expectations of the professional nurse.
9	Describe ethical and legal concepts relevant to the practice of professional nursing.

[Course Outline for NUR2000LHY - INTRO PROFES NURSING](#)

Class Schedule: Will be available on the first day of class and will be posted on the web site by the instructor.

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Textbooks information: Textbooks are listed as Required and Recommended.

Required:

1. Wilkinson J & Treas, L. (2010) *Fundamentals of Nursing*, 2nd Ed. FA Davis ISBN 13-978-0-8036-2354-5
2. Skills Video: *Fundamentals of Nursing* ISBN 13-978-0-8036-2403-0
3. (2011) *Student Success for Health Professionals Made Incredibly Easy*. 2nd Ed. Baltimore: Lippincott Williams & Wilkins. ISBN 10 1609137841 ISBN 13 978-1609137847
4. Ackley, Betty J. and Ladwig, Gail B.; *Nursing Diagnosis Handbook: A Guide to Planning Care*, 9th ed., 2008, Mosby, St. Louis, Missouri, ISBN 978-032307150-5
5. Palm Beach State College NUR 2000LHY Syllabus is posted online.
6. The Essential Nursing Resources Webpage is mandatory reading as published on assigned Blackboard course or component.

Recommended:

1. Smeltzer, S., et al., (2009) *Brunner & Suddarth's Textbook of Medical Surgical Nursing*, (12th ed), Philadelphia: Lippincott, Williams, & Wilkins. ISBN-10: 1-58255-994-5
ISBN-13: 978-1-58255-994-0 (2 volume set)
2. Wilson, B. et. al. (2011) *Pearson Nurse's Drug Guide* ISBN 0132149265

You may purchase your textbook(s) at any one of Palm Beach State College's campus bookstores or [online](#).

The Electronic [Essential Nursing Resources](#) can be found online. A Video list is recommended & available in [MTIS](#) (Media Technology and Instructional Services) located on the first floor of the LLRC.

Web Content Information: This course has an Internet Component which is on the [Online Learning - Blackboard Campus](#)

To pass the course, you must be able to access this web site. **The course web site will be available three days prior to the start of the semester. Your password will not work until that time.**

It is the student's responsibility to have accessed this site no later than **the semester start date**. **The web site has a security system which requires a *Sign on* and a *Password*. Only registered students will be able to access the course. On-line students are not permitted to attend 'live lecture classes'.**

To login to the course web site:

User Name: Use your Palm Beach State College Student ID Number (no hyphens). Your Palm Beach State College Student ID Number can be found on the back of your student ID card. If you do not have a student ID card, you can obtain one in the bookstore at Lake Worth campus. For obtaining a student ID card on other campuses, check with the campus directly.

Password: The student's Blackboard password will be the student's Palm Beach State College Pin Number.

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What do I do if I forget my password or need assistance with Blackboard?

E-mail the Blackboard administrator. You can also email the Palm Beach State College [Student Help Desk](#) or contact them by phone at (561)868-4000. Be sure you have the following information available:

- your full name
- your Palm Beach State College Student ID number
- course with the reference number
- details of the assistance needed and any error messages

The [Student Help Desk Hours of Operation](#) are posted on the following web page:

On hours and days that the Help Desk is closed, the student may leave a voice message or an e-mail and the issue will be addressed the next business day.

"Netiquette Rule" requirements: Refer to the web site for network application. The faculty expectation is for student adherence to the same standards of behavior online that you follow in real life.

PROFESSOR'S CONTACT INFORMATION

[Deborah Copeland, RN, MSN](#)

Associate Professor

AH 206 (561) 868-3431

[Email](#)

Faculty Office Hours are Posted on Faculty Web Pages and Outside Office

CLASS REQUIREMENTS

Assignments: NUR 2000LHY will have 4 major papers; a presentation; a cumulative final exam; and a class participation grade. See grading scale for details. All students are encouraged to participate fully in online activities. All readings, discussions, AV material, and posted files are testable material. In order to complete this course satisfactorily **all papers, presentations and exams must be completed.**

Late Assignment Policy: Assignments and presentations are due by the assigned deadlines as noted on the course schedule. Any exception to the deadline **must** be approved in **advance** by the instructor. Late papers will not have the opportunity to be redone if unsatisfactory.

Nursing Department Grading Scale and Policy

90 - 100 = A

83 - 89 = B

75 - 82 = C

Below 75 = F

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The minimum score to pass the course is 75%.

Tests, Papers and Final Examination - Your course grade will be determined by the following:

Daily Holistic Assessment Tool (DHAT)	=	15%
Comprehensive Holistic Assessment Tool (CHAT)	=	15%
Interpersonal Recording (IPR)	=	10%
Wellness Assessment Paper	=	15%
Presentation of Issues of Professional Practice	=	15%
Final Exam	=	20%
Participation (Wellness; Discussion; Internet)	=	10%
Total		100%

Make-up Exam Policy: The final exam must be taken at the assigned time in AH 208. Any make-up exam must be approved in advance by the instructor.

Please see Nursing Handbook for standard Nursing policy related to Essay Make-up Exams.

DISTANCE LEARNING CLASS INFORMATION

This course is taken by attending a classroom on campus for 50% of the scheduled classes and via the Internet for the remaining scheduled classes. Before you decide to take the course under these conditions, it is recommended that you:

- take the following assessments to determine if distance learning is best for you:
 1. [Should I take a distance learning class?](#)
 2. [Do I have enough time to take a distance learning class?](#)
 3. [Do I have the technical skills and knowledge to learn online?](#)
- read the [Distance Learning Frequently Answered Questions](#) page which include instructions for logging onto Blackboard, computer requirements, and basic computer skills students must have prior to enrolling a distance learning class.
- read the syllabus description below carefully.
- contact the professor by e-mail or by phone if you have any questions.

Computer Requirements

If you choose to take this course, you must have access to a computer that meets the [basic computer requirements](#)

Computer Competency Component: Each student will, to the satisfaction of the instructor, demonstrate a fundamental understanding of basic computer operations through various instructor-determined exercises and/or assignments. All assignments must be submitted as attachments via the Assignment Tool in .doc or .rtf format.

Specific Testing Requirements: The **Comprehensive Final Exam must be taken on campus** at the scheduled date and time in a designated Computer Testing Lab on the course assigned campus location.

[SLC Computer Lab](#)

If students do not have access to a computer at home, the SLC Computer Lab at a Palm Beach State College campus can be used to complete course assignments. Visit the [SLC Computer Lab](#) web page for location and hours.

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IT IS RECOMMENDED THAT THE STUDENT TAKING THIS COURSE AS A *PURE INTERNET* COURSE NOT BE A NOVICE COMPUTER USER. THE STUDENT SHOULD KNOW HOW TO USE A MOUSE, NAVIGATE THE INTERNET, AND SEND/RECEIVE E-MAIL WITH ATTACHMENTS. VISIT THE FOLLOWING WEB PAGE FOR MORE INFORMATION REGARDING MINIMUM COMPUTER SKILLS STUDENTS MUST HAVE PRIOR TO ENROLLING IN AN ONLINE COURSE - <https://palmbeachstate.blackboard.com/webct/entryPageIns.dowebct>

This course has an Internet web site located at: [Online Learning - Blackboard Campus](#)

The course web site will be available three days prior to the start of the semester. Your password will not work until that time.

It is the student's responsibility to have accessed this site no later than the first scheduled day of class. The web site has a security system which requires a *Sign on* and a *Password*. Only registered students will be able to access the course.

To login to the course web site: This course has an Internet Component which is on the [Online Learning - Blackboard Campus](#)

User Name: Use your Palm Beach State College Student ID Number (no hyphens). Your Palm Beach State College Student ID Number can be found on the back of your student ID card. If you do not have a student ID card, you can obtain one in the bookstore at Lake Worth campus. For obtaining a student ID card on other campuses, check with the campus directly. **Password:** The student's Blackboard password will be the student's Palm Beach State College Pin Number.

What do I do if I forget my password or need assistance with Blackboard?

[E-mail the Blackboard administrator](#). You can also email the Palm Beach State College [Student Help Desk](#) or contact them by phone at (561)868-4000. Be sure you have the following information available:

- your full name
- your Palm Beach State College Student ID number
- course with the reference number
- details of the assistance needed and any error messages
- The **Student Help Desk Hours of Operation** are posted on the web page:

On hours and days that the Help Desk is closed, the student may leave a voice message or an e-mail and the issue will be addressed the next business day.

CLASS POLICIES AND METHODOLOGY

Attendance: Professors are required to take attendance. **Students are expected to access the course web site daily.** Students who are actively involved in their learning are more successful. Students are expected to complete all class work; scheduled tests; and participate in structured class discussions.

ALL students are expected to attend all scheduled tests, classes, and clinical/labs. In the event of an absence due to extenuating circumstances, the student is expected to notify the appropriate faculty member.

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Electronic Device Use: The use of Hand-held devices that are iPod capable are encouraged to facilitate downloadable information as learning strategies and study tools. Cell phones are prohibited in the campus Testing Centers.

Email Policy: All students have access to a college email account. It is the responsibility of the student to activate this account in order to be kept current with college, program and course information. College email should be checked daily. This course has email within the course. Course email should be used for all course-related communications with faculty.

Faculty will contact students via college and course email, so be certain to check these email accounts daily for any updates or changes to coursework.

Equipment & Supplies: Required text books; access to a computer with active Internet service; word processing and printing capabilities are essential to be successful in this class. Students are also required to have a Syllabus; pen; pencil; paper; and a CD/memory stick.

Professor's Expectations: Students will follow these Strategies for Success :

- 1 Read in advance and come to class prepared.
- 2 Attend all Classes
- 3 Utilize resources currently available:
 - a. Media & Instructional Technology Services (MTIS)
 - b. Student Learning Center (SLC), If reading comprehension is a problem for you – explore the resources in TC 210 such as: the video on how to read a textbook, and the bank of computer programs that cover Math, English, Reading, and Study Skills.
 - c. Nursing Skills Lab
- 4 Study groups: form a group for serious study time. Make rules that all students must come prepared. This is not a social gathering.
- 5 Visual learners: Take notes & recopy notes. Take notes as you read your text and then merge the notes together!
- 6 Auditory learners: tape lectures; listen again, and discuss material with your peers.
- 7 Do not procrastinate when it comes to studying and/or reading.
- 8 Explore the reference text: *Test Success* by Nugent & Vitale. This book is an excellent guide on how to read test questions; how to choose the “best” answer; etc. Available in the Palm Beach State College bookstore. There is a copy on the 3rd floor of the LLRC, at the Reference Desk.
- 9 Look at the “big picture.” Answer these questions:
 - Do you have the commitment to succeed?
 - How many hours are you working?
 - What are your other life commitments?
 - Are you neglecting your wellness plan?
 - Have you studied effectively?
 - Have you spent quality time with your loved ones?
- 10 Remember that the faculty is here to assist and support you. Please feel free to come to us for any further direction.
YOU CAN DO IT !!!

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Methods of Instruction:

- | | | | |
|---|-------------------------------------|----|---------------------------------------|
| 1 | Selected reading | 8 | Student group work |
| 2 | Lectures | 9 | Journal Articles |
| 3 | Demonstrations | 10 | Study Guides |
| 4 | Discussions | 11 | Interactive Educational Activities |
| 5 | Audiovisuals | 12 | Internet – Blackboard Learning System |
| 6 | Interactive video software programs | 13 | Student Lead Presentation |
| 7 | Computer-Assisted Instruction | 14 | Critical Thinking Exercises |

Classroom Strategies

- A. Class Discussion
- B. Media Presentations: Video, PowerPoint
- C. Group Presentations/Case Scenarios
- D. Critical Thinking Exercises

Evaluation Methods

- A. Group/Individual Activities
- B. Critical Thinking Assignments
- C. Class Attendance/Participation
- D. Periodic Exams, Final Examination
- E. Critique of a Journal Article/paper

Unique Requirements of the Class: This course has an Internet web component located at: [Online Learning - Blackboard Campus](#)

To pass the course, you must be able to access this web site. The course web site will be available three days prior to the start of the semester. Your password will not work until that time. **It is the student's responsibility to have accessed this site no later than the semester start date.** The web site has a security system which requires a *Sign on* and a *Password*. Only registered students will be able to access the course.

All students enrolled in a Nursing course must maintain compliance with the policies and procedures published in the Nursing Student Handbook in addition to those established for the general college population by Palm Beach State College.

Please refer to the following documents:

- Palm Beach State [College Student Handbook](#):
- Palm Beach State College [Nursing Student Handbook](#):
- [PantherWeb](#) Student Information:

COLLEGE POLICIES AND WEB INFORMATION

Academic Dishonesty

Academic dishonesty includes the following actions, as well as other similar conduct aimed at making false representation with respect to the student's academic performance:

(1) Cheating on an exam, (2) Collaborating with others on work to be presented, if contrary to the stated rules of the course, (3) Submitting, if contrary to the rules of the course, work previously submitted in another course, (4) Knowingly and intentionally assisting another student in any of the above actions, including assistance in an arrangement whereby work, classroom performance, examination, or other activity is submitted or performed by a person other than the student under whose name the work is submitted or performed, (5) Plagiarism.

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Please refer to the **Palm Beach State [College Student Handbook](#)**

Classroom Etiquette and Student Behavior Guidelines

Students will demonstrate respect for professors and fellow students. Behavior that is disruptive to a positive learning environment reported by the professor will result in a warning on the first instance; the second instance might result in expulsion from the course or campus.

Computer Competency Component

Each student will, to the satisfaction of the professor, demonstrate a fundamental understanding of basic computer operations through various professor-determined exercises and/or assignments.

Disability Support Services

Students with disabilities are advised, in compliance with federal and state laws, that accommodations and services are available through the office of [Disability Support Services](#) (DSS). It is the student's responsibility to contact [Disabled Student Services Advisors](#) and to submit appropriate documentation prior to receiving services.

Eating, Drinking and Smoking

Eating and drinking are confined to areas designated on the campus. Smoking is not permitted in any College building and only in areas designated at each campus.

Student Responsibility Policy

When a student attends the College, s/he becomes subject to its jurisdiction. Students are expected to conduct themselves in a responsible manner, in all areas of campus life. By enrolling, they pledge to obey the rules and regulations of the College and are responsible for observing all College policies and procedures as published in the student handbook, the College catalog and other College publications. The student will be responsible for preparing for class, participating in class, and completing assignments on time.

Palm Beach State [College Websites of Interest](#)

Withdrawal Policy for Individual Courses: The last day to withdraw from a College course with a "W" grade in this course is November 4, 2010. It is the responsibility of the student to use the PantherWeb system or visit a campus Registrar's office to withdraw. An official withdrawal entitles the student to a grade of "W" in the class.

DEPARTMENT CONTACT INFORMATION

Kellie Bassell, MSN, EdS, RN
Nursing Program Director
AH 110 (561) 868-3412
Fax (561) 868-3452
[Email](#)

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GETTING STARTED

1. Make sure you have all the computer system requirements as listed in the Computer Requirements section of this syllabus.
2. E-Mail the professor with your name and phone number. The professor will communicate with you through Blackboard or your PALM BEACH STATE COLLEGE-issued email address.
3. Obtain course materials. The textbook(s) can be purchased at the PALM BEACH STATE COLLEGE campus bookstore or [online](#).
4. Log onto the course web site [Online Learning - Blackboard Campus](#). Use your PantherWeb logon information.
5. Once inside the course website, read the "Mandatory Online Orientation" and complete the *Orientation Quiz*.
6. Explore the different parts of the web page. Be sure you print the syllabus, course calendar, and assignment sheet so that you know what is expected of you during the semester.
7. Read the instructor's *Welcome* message on the discussion board and post a reply to it introducing yourself to the class.
8. Print the course worksheets and content outlines that follow this section of the syllabus.
9. Begin completing your assignments as listed on the course calendar and/or class schedule.

Have fun!

Disclaimer

Changes may be made to the syllabus at any time during the term by announcement of the professor. It is the responsibility of the student to make any adjustments as announced.

COURSE CONTENT OUTLINES

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UNIT I: COURSE ORIENTATION

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The student will:</p> <ol style="list-style-type: none"> Describe the purpose of and requirements for NUR 2000L. Describe the transition process into the role of the student. 	<p>A. Orientation to course</p> <ol style="list-style-type: none"> General information Learning Outcomes for course Course requirements <ol style="list-style-type: none"> Written assignments Participation 	<p><u>Required:</u></p> <p>Review NUR 2000L Syllabus</p> <p>Review Nursing Student Handbook</p> <p>Establish Student Portfolio</p> <p>Take Online Tour of Library</p> <p>Review Essential Nursing Resource Page</p> <p>Wellness Activity</p> <p>Class Discussion Topic: Role Transition</p> <p>Write Personal Definition of Nursing</p>

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UNIT II: INTRODUCTION TO PROFESSIONAL NURSING

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The Student will:</p> <ol style="list-style-type: none"> 1. Compare and contrast the nursing profession as an art and as a science. 2. Describe the historical evolution of nursing as a profession. 3. Explain the role of theoretical frameworks as they apply to nursing as a profession. 4. Identify the major concepts of King’s Theory of Goal Attainment. 5. Discuss methods of application for King’s Theory of Goal Attainment for clients across the life span. 6. Identify key concepts of holistic nursing practice methods for application across the life span. 7. Describe trends in nursing education. 8. Explain the basis for conducting research in nursing. 9. Discuss the contributions of formal education and research in the development of nursing practice as a profession. 10. Describe the five (5) concepts of the PALM BEACH STATE COLLEGE Nursing Conceptual Framework from a holistic wellness perspective. 11. Utilize the five (5) concepts of the PALM BEACH STATE COLLEGE Nursing Conceptual Framework while applying the Nursing Process to health promotion, health maintenance, and disease prevention across the life span. 	<ol style="list-style-type: none"> A. Historical Overview <ol style="list-style-type: none"> 1. Societal influences in development of nursing practice 2. Contributors to nursing as a profession. 3. Impact of technological age on advancing nursing as a practice and profession. B. Theoretical Frameworks of Professional Nursing Practice <ol style="list-style-type: none"> 1. Role of theory in the professional practice of nursing. 2. Major contributors to development of nursing theory. <ol style="list-style-type: none"> a. Imogene King’s Theory of Goal Attainment b. Dossey’s Theoretical Approach to Holistic Nursing. 3. Palm Beach State College <ol style="list-style-type: none"> a. Philosophy b. Conceptual Framework c. Overview of the 5 concepts <ol style="list-style-type: none"> (1) The 5 concepts <ol style="list-style-type: none"> (a) Oxygenation (b) Cellular Integrity (c) Regulation (d) Mobility (e) Perceptual/Sensory/Cognition (2) Health Promotion, Health Maintenance, and Disease Prevention and their application to the 5 concepts across the life span. C. Nursing Education and Research <ol style="list-style-type: none"> 1. Role of formal education in the practice of nursing as a profession. <ol style="list-style-type: none"> a. Methods of obtaining current nursing education. 2. Role of Research <ol style="list-style-type: none"> a. Nursing Practice b. Nursing as a Profession 	<p>Required:</p> <p>Read Palm Beach State College Nursing Student Handbook</p> <p style="padding-left: 40px;">A. Review Palm Beach State College Curriculum, Framework</p> <p>Review Website:</p> <p>www.dosseydossey.com/barbara/default.html</p> <p>On Reserve (3rd Floor) Dossey: Core Curriculum for Holistic Nursing Chapters 9 & 10 - pp. 66-80</p> <p>Complete Wellness Activity</p>

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UNIT III: MAINTAINING WELLNESS

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The student will:</p> <ol style="list-style-type: none"> 1. Differentiate health, illness & wellness as they relate to health promotion and disease prevention. 2. Discuss the nurse’s role in Health Promotion 3. Compare various models of health. 4. Identify factors affecting health status, beliefs and practices. 5. Describe factors affecting health care adherence 6. Differentiate illness from disease and acute illness from chronic illness. 7. Describe effects of illness on individuals’ and family members’ roles and functions. 8. Distinguish the various services, which collectively make up the Health Care Delivery System (H.C.D.S.) and the role of the nurse therein. 9. Identify major factors, which influence health care. 10. Discuss current challenges in the H.C.D.S. 11. List current trends & issues, which affect H.C.D.S. 	<ol style="list-style-type: none"> A. Health promotion and disease prevention throughout the life span. <ol style="list-style-type: none"> 1. Healthy people 2010 initiative 2. Nurse’s role 3. Personal Wellness Plan B. Health, Wellness, Illness <ol style="list-style-type: none"> I. Concepts of health and well-being <ol style="list-style-type: none"> 1. Concepts of health and well-being <ol style="list-style-type: none"> a) Health b) Personal definitions of health c) Wellness and well-being 2. Models of health and wellness 3. Variables influencing health status, beliefs, and practices <ol style="list-style-type: none"> a) Internal variables b) External variables 4. Health belief models <ol style="list-style-type: none"> a) Health locus of control model 5. Health care adherence 6. Illness and disease <ol style="list-style-type: none"> a) Illness behaviors b) Effects of illness 	<p>Required:</p> <p>Access Healthy People 2020 website.</p> <p>Complete Personal Wellness Assessment/Plan Paper</p> <p>Complete Discussion Topic: Wellness</p> <p>Complete Wellness Activity</p>

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UNIT IV: CRITICAL THINKING

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The Student will:</p> <ol style="list-style-type: none"> 1. Discuss the skills and attitudes of critical thinking. 2. Discuss the relationships among the nursing process, critical thinking, the problem solving process and the decision-making process. 	<ol style="list-style-type: none"> A. Critical Thinking <ol style="list-style-type: none"> 1. Skills in critical thinking 2. Attitudes that foster critical thinking <ol style="list-style-type: none"> a. Independence of thought b. Fair-mindedness c. Insight into egocentricity and sociocentricity d. Intellectual humility e. Intellectual courage f. Integrity g. Perseverance h. Confidence in reason i. Curiosity 3. Standards of critical thinking 4. Applying critical thinking to nursing practice <ol style="list-style-type: none"> a. Problem solving <ol style="list-style-type: none"> 1) Trial and error 2) Intuition 3) Research process and scientific/modified scientific method b. Decision making 5. Developing critical-thinking attitudes and skills <ol style="list-style-type: none"> a. Self-assessment b. Tolerating dissonance and ambiguity c. Seeking situations where good thinking is practiced d. Creating environments that support critical thinking 	<p><u>Required:</u></p> <p>Define Critical Thinking Complete Discussion Topic: Critical Thinking Example</p>

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UNIT V: NURSING PROCESS

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The student will:</p> <ol style="list-style-type: none"> 1. Describe the nursing process. 2. Differentiate between subjective & objective data during the assessment phase of nursing process. 3. Discuss the unique characteristics of subjective data. 4. Create nursing diagnoses for identified client needs. 5. Describe the process of planning individualized nursing care. 6. Compose correctly worded expected outcomes or goals. 7. Discuss interventions included on a nursing care plan. 8. Describe the implementation of a nursing care plan. 9. Describe the evaluation of a nursing care plan. 10. Utilize the five (5) concepts of the Palm Beach State College Nursing Conceptual Framework while applying the Nursing Process to health promotion, health maintenance and disease prevention across the lifespan. 	<ol style="list-style-type: none"> A. Nursing process <ol style="list-style-type: none"> 1. Definition and purposes 2. Phases of the process 3. Interrelatedness of phases B. The Significance of Nursing Process <ol style="list-style-type: none"> 1. Impact on nursing practice 2. Standard of care – JCAHO, facility review 3. Care plans, Standards of care, Critical pathways C. Assessment phase <ol style="list-style-type: none"> 1. Purpose of Assessment <ol style="list-style-type: none"> a. Establish a database to identify overall state of health 2. Types of Assessment <ol style="list-style-type: none"> a. Comprehensive (admission) b. Focused – limited scope c. Ongoing – recurring assessment for specific problems 3. Data Collection <ol style="list-style-type: none"> a. Subjective – patient self-report b. Objective – can be measured, compared to a norm c. Other Sources – family, staff, medical records, literature 4. Methods of Data Collection <ol style="list-style-type: none"> a. Observation b. Interview c. Health History d. Physical Examination e. Lab and Diagnostic Data 5. Data Organization <ol style="list-style-type: none"> a. Functional Health Patterns b. NANDA 	<p>Required:</p> <ul style="list-style-type: none"> Define Nursing process steps Define Nursing diagnosis Define NANDA Define Outcome Criteria Participate in Group discussion Complete Daily Holistic Assessment Tool (DHAT) Complete Comprehensive Holistic Assessment Tool (CHAT) with an elder Complete Self Directed Attitude Assessment of the Aging Process (SDA AAP). Learning Guide: Nursing Process Learning Guide: Physical Assessment

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UNIT V: NURSING PROCESS (CONTINUED)

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
	<ul style="list-style-type: none"> 6. Assessment activities <ul style="list-style-type: none"> a. Collection of data b. Validation of data D. Subjective data <ul style="list-style-type: none"> 1. Individual characteristics 2. Developmental 3. Personal, interpersonal & social system transactions 4. The interview process E. Nursing diagnosis phase <ul style="list-style-type: none"> 1. Definition & purposes 2. Organization of assessment data <ul style="list-style-type: none"> a. NANDA common language – improves communication and understanding of client problems 3. Analysis of data <ul style="list-style-type: none"> a. (P) Problem b. (E) Etiology c. (S) Signs & symptoms 4. Statement of nursing diagnosis <ul style="list-style-type: none"> a. Actual b. Potential 5. Compare and Contrast Nursing and Medical Diagnoses <ul style="list-style-type: none"> a. Methods of Documentation <ul style="list-style-type: none"> 1. Narrative 2. Problem-Oriented Medical Record 3. Computerized Charting F. Planning phase <ul style="list-style-type: none"> 1. Priority setting 2. Goal-setting <ul style="list-style-type: none"> a. Short term b. Long term 3. Expected outcomes <ul style="list-style-type: none"> a. Realistic & achievable b. Measurable, observable & behavioral c. Client – centered d. Time designated e. Mutually set 4. Planning nursing care 	

Course Syllabus – Hybrid

UNIT V: NURSING PROCESS (CONTINUED)

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
	<ul style="list-style-type: none"> a. Priority setting b. Sources of interventions <ul style="list-style-type: none"> 1. Dependent 2. Independent 3. Interdependent c. Rationale for interventions d. Specificity of interventions G. The implementation phase <ul style="list-style-type: none"> 1. Action Phase – giving the care needed to affect the change in client condition 2. Types of Nursing Care Delivery Systems <ul style="list-style-type: none"> a. Primary b. Functional c. Team 3. Roles within the health care team <ul style="list-style-type: none"> a. Teamwork b. Delegation H The evaluation phase <ul style="list-style-type: none"> 1. Results are compared to outcome criteria from Planning Stage. <ul style="list-style-type: none"> a. Positive – goal attainment b. Partially met goals c. Negative – unmet goals 2. Quality Assurance <ul style="list-style-type: none"> a. Peer Review 3. Revision of Care Plan I Documentation <ul style="list-style-type: none"> 1. Medical Records <ul style="list-style-type: none"> a. Components used by nurse b. Nurse’s Progress Notes 2. Verbal Reporting 	

Course Syllabus – Hybrid

UNIT V: TEACHING/LEARNING PROCESS

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The student will:</p> <ol style="list-style-type: none"> 1. Describe key elements of the teaching-learning process. 2. Compare and contrast teaching-learning environments across the life span. 3. Identify the professional responsibilities of client teaching. 4. Integrate the application of the nursing process to the teaching-learning process. 5. Identify and apply guidelines for effective client teaching. 6. Discuss the implications of culture on the teaching-learning process. 7. Develop a teaching plan utilizing the nursing process. 	<ol style="list-style-type: none"> A. Teaching <ol style="list-style-type: none"> 1. Teaching clients and their families 2. Teaching in the community 3. Teaching health personnel B. Learning <ol style="list-style-type: none"> 1. Learning Theories <ol style="list-style-type: none"> a. Behaviorism b. Cognitivism c. Humanism 2. Using Learning Theories 3. Factors affecting learning <ol style="list-style-type: none"> a. Motivation b. Readiness c. Active involvement d. Relevance e. Feedback f. Nonjudgmental support g. Simple to complex h. Repetition i. Timing j. Environment k. Emotions l. Physiologic events m. Cultural aspects n. Psychomotor ability C. Nurse as Educator 	<p>Required:</p> <p>Teaching Plan on assigned Well Elder.</p> <p>Complete Self Learning Style Assessment</p>

Course Syllabus – Hybrid

UNIT VI: COMMUNICATION

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The Student will:</p> <ol style="list-style-type: none"> 1. Discuss key elements of therapeutic relationship. 2. Discuss key elements of the communication process. 3. Compare and contrast methods of communication. 4. Describe the different types of communication and the impact of utilization. 5. Recognize the professional nurse’s role in and impact of utilizing the communication process. 6. Identify types of crises and describe nurses’ role in crisis intervention. 7. Recognize key elements of psychological responses to physical illness. 8. Identify the elements of assertive communication. 9. Compare and contrast different documentation methods: source-oriented and problem-oriented medical records, PIE, focus charting, charting by exception, computerized records, and the case management model. 10. Identify and discuss guidelines for effective recording that meets legal and ethical standards. 11. Identify essential guidelines for reporting client data. 12. Identify abbreviations and symbols commonly used for charting. 13. Explain how various forms in the client are used to document steps of the nursing process (assessment, diagnosis, planning, implementation, and evaluation). 14. Compare and contrast the documentation needed for clients in acute care, home health care, and long-term care settings. 	<ol style="list-style-type: none"> A. Therapeutic Relationship B. Communication Process <ol style="list-style-type: none"> 1. Components 2. Factors influencing C. Methods of Communication Process <ol style="list-style-type: none"> 1. Verbal 2. Nonverbal D. Types of Communication <ol style="list-style-type: none"> 1. Therapeutic <ol style="list-style-type: none"> A. Elements of B. Barriers to 2. Non-therapeutic E. Professional Responsibility <ol style="list-style-type: none"> A. Patient Interactions B. Interdisciplinary Interactions F. Communication With Special Populations Crisis Intervention Physically Ill G. Medical Records <ol style="list-style-type: none"> 1. Components used by nurse 2. Nurse’s Progress Notes <ol style="list-style-type: none"> a. Methods of Documentation <ol style="list-style-type: none"> (1) Narrative (2) Problem-Oriented Medical Record (3) PIE (4) Focus (5) Charting by exception (6) Computerized Charting H. Verbal Reporting I. Interpersonal Process Recording (I.P.R.) 	<p>Required:</p> <p>Review Therapeutic Communication, Videos (Located under Web links)</p> <ol style="list-style-type: none"> a. Basic Components of Communication b. Opening, Questioning and Using Silence c. Responding and Closing <p>Discussion Topic: Communication</p> <p>Complete Interpersonal Process Recording (IPR) with one client.</p> <p>Learning Guide: Therapeutic Communication</p>

Course Syllabus – Hybrid

UNIT VII: PROFESSIONALISM

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The Student will:</p> <ol style="list-style-type: none"> 1. Identify the role of the professional nurse. 2. Identify the scope of practice between LPN and RN in the Nurse Practice Act. 3. Identify and discuss the responsibilities and accountability of the professional nurse in the practice setting. 4. Discuss the responsibility of teaching by the RN. 5. Describe the characteristics of tasks appropriate to delegate to unlicensed and licensed assistive personnel. 6. List the five rights of delegation. 	<ol style="list-style-type: none"> A. Roles and Responsibilities <ol style="list-style-type: none"> 1. The role of the professional nurse includes application of the nursing process, advocacy for patients, and management of care. B. Legal and Ethical Issues <ol style="list-style-type: none"> 1. Read and discuss the Nurse Practice Act. 2. ANA Standards of Care 3. Legal Responsibilities of Students C. Personal Professional Growth <ol style="list-style-type: none"> 1. Discuss the scope of practice for the RN 2. Differentiate job from profession 3. Profession includes <ol style="list-style-type: none"> a. Education b. Theory c. Service d. Autonomy D. Accountability and Leadership E. Health Team Collaboration F. The Transition Process <ol style="list-style-type: none"> 1. Identifying personal goals 2. Overcoming barriers and fears 3. Strategies for success G. Political Action H. Delegation <ol style="list-style-type: none"> 1. Unlicensed Assistive Personnel 2. Licensed Assistive Personnel I. 5 Rights of Delegation <ol style="list-style-type: none"> 1. Right task 2. Right circumstances 3. Right person 4. Right direction and communication 5. Right supervision and evaluation 	<p>Required:</p> <p>Discussion Topic: Compare definitions of Nursing from ANA and Board of Nursing</p> <p>Review Florida Nurse Practice Act.</p> <p>Wellness Activity</p> <p>Review Ethical Agreement sign and place in student portfolio.</p> <p>Complete Presentation on Professionalism topic.</p>

Course Syllabus – Hybrid

UNIT VIII: ASPECTS OF HOLISTIC CARE

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The Student will:</p> <ol style="list-style-type: none"> 1. Discuss how values, beliefs, culture, spirituality, sexuality, self-concept, and developmental stage affects the nurse/client relationship. 2. Define and provide examples of the following culture, subculture, customs, beliefs, attitudes, and values. 3. Discuss the impact of culture on health beliefs and health behaviors 4. Demonstrate sensitivity to the cultures, values, and practices of others. 5. Identify nursing strategies that offer culturally sensitive care. 	<ol style="list-style-type: none"> A. Cultural: <ol style="list-style-type: none"> 1. Concepts of Culture 2. Influence of Culture on health 3. Application to Nursing Care 4. World Religions & Health Implications 5. Transcultural Nursing 6. Vulnerable populations B. Spiritual: <ol style="list-style-type: none"> 1. Characteristics 2. Application of Nursing Care C. Sexuality: <ol style="list-style-type: none"> 1. Sexual Nature of Individuals 2. Human Sexual Response 3. Attitudes Toward Sexuality 4. Application to Nursing Care D. Self-Concept: <ol style="list-style-type: none"> 1. Identity, Body Image, Self-Esteem & Role Performance 2. Development of Self-Concept 3. Factors Affecting Self-Concept 4. Application to Nursing Care E. Developmental Stage <ol style="list-style-type: none"> 1. Physiological, motor, psycho-social, cognitive, moral, spiritual F. Nursing Implications 	<p>Required:</p> <p>Discussion: Personal cultural heritage and its impact on your life.</p> <p>View Video: Patient Diversity (Found under web links).</p> <p>Wellness Activity:</p> <p>Complete Self-Assessment of Sexual Knowledge and Attitudes - SASKA</p>

Course Syllabus – Hybrid

UNIT IX: TRANSITION PROCESS

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
<p>The Student will:</p> <ol style="list-style-type: none"> 1. Describe the transition process into the role of the professional nurse. 2. Discuss strategies for success. 	<ol style="list-style-type: none"> A. Transition to Role <ol style="list-style-type: none"> 1. Identifying personal goals 2. Overcoming barriers and fears 3. Strategies for Success 4. Time Management 	<p>Required:</p> <p>Located under Web links:</p> <p>Review: Successful Note taking</p> <p>Critical Thinking</p> <p>Test taking with Professor Nightingale</p> <p>Essential Nursing Resources Page</p> <p>Explore Student Learning Center at PALM BEACH STATE COLLEGE website.</p> <p>Discussion Topic: Role Transition</p> <p>Wellness Activity</p> <p>Develop 1 and 5 year professional goals</p>

COURSE LEARNING GUIDES & TOOLS

LEARNING GUIDE: NURSING PROCESS

THE NURSING PROCESS

1980 – American Nurses’ Association (ANA) Definition of Nursing

A profession concerned with the diagnosis and treatment of human responses to actual or potential health problems.

1987 - Revision of definition

“Nursing is the diagnosis and treatment of human responses to health and illness.”

1955 Lydia Hall introduced the term:

“Nursing Process”

1973 - ANA published “Standards of Nursing Practice”

This described: the 5 phases of the Nursing Process:

- Assessment
- Nursing Diagnosis
- Planning
- Intervention
- Evaluation

What is a Process?

1. A continuous development involving many changes
2. A particular method of doing something, generally involving a number of steps or operations.

The Nursing Process is a five-step process:

1. Nursing Assessment
2. Nursing Diagnosis
3. Planning
4. Implementation
5. Evaluation

1995 Doenges, Moorhouse & Burley stated:

The Nursing Process provides an orderly logical problem-solving approach for administering nursing care so that the patient’s needs for such care are met comprehensively and effectively.

THE NURSING PROCESS

Characteristics of the Nursing Process

1. Patient-Centered: Data collection related to the patient
2. Dynamic - Evolving, every changing - not static
3. Interpersonal and Collaborative
4. Universally Applicable - can be used in any health setting
5. Compared to Problem-Solving Approach and Scientific Method
6. Variety of Skills:
 - Interpersonal Skills
 - Technical Skills
 - Intellectual Skills

Assessment involves:

- I. Data Collection
 - a. Subjective data - What the patient verbalizes
 1. Chief complaint, and symptoms
 2. Past history including current tx.
 3. Review of systems
 4. Review of personal, interpersonal, and social systems
 5. Environmental issues
 6. Patient's perceptions about their health problems
 - b. Objective data - Observations or measurements made by data collector – (tested against an accepted standard.)
 1. Lab and diagnostic studies
 2. Physical Assessment
 - c. Sources of Data
 1. Client (Patient)
 2. Family - Significant Others
 3. Health Team Members
 4. Medical Records
 5. Literature Review

The Nursing Diagnosis

Nursing Diagnosis is a statement that describes the client's actual or potential response to a health problem that the nurse is licensed and competent to treat. The definition of the PES Method is:

P - Problem (Client's health problem)

E - Etiology (Cause of problem)

S - Signs and Symptoms (Defining Characteristics or As Evidenced by= **AEBs**)

The Planning Process:

1. Setting priorities
2. Establishing patient goals with expected outcomes
3. Selecting nursing strategies
4. Developing nursing care plans

Goals - (behavioral objectives) are the desired outcome or change in patient behavior, which are written in broad terms.

Goals can be Short term - 1 week / Long term - weeks or months

EX - Nutritional Status will improve.

Course Syllabus – Hybrid

Expected outcomes: (outcome criteria) are more **specific measurable** criteria used to evaluate whether the goal has been met. Using as evidenced by (**AEB**) gives the nurse a guide to writing specific expected outcomes.

EX - Weight gain of 2 lbs. by Sept. 15th

Guidelines for Writing Goals and Expected Outcomes

1. Patient - Centered - The patient will . . .
2. Singular Factors – One problem per goal
3. Observable Factors
4. Measurable Factors
5. Time - Limited Factors
6. Mutual Factors – The nurse and the patient will work on these problems together
7. Realistic Factors

Interventions: 3 Types Of Interventions

Independent - Nurse uses : “Nursing Judgment” to deliver care

Does not require an “ORDER” from M.D. or any other professional

Interdependent - Working in collaboration with other Health Team Members

Dependent - based on directions or orders to deliver specific care including, but not limited to, giving meds, inserting tubes, IV Therapy, wound care, etc.

Evaluation:

This answers the question, “Were the goals met?” If so, are they marked as attained or met?

If goals are **NOT** met, they must be examined to see if the goals were appropriate and realistic.

Then the client must be reassessed and the plan of care modified to meet the client’s needs.

INTERNET RESOURCES FOR NURSING PROFESSIONALS

- Agency for Health Care Research and Quality: <http://www.ahcpr.gov/>
- American Academy of Hospice & Palliative Medicine: <http://www.aahpm.org>
- American Holistic Nursing Association: <http://ahna.org>
- American Journal of Nursing: <http://www.nursingworld.org/ajn/>
- American Medical Association: <http://www.ama-assn.org/>
- American Pain Society: <http://www.ampainsoc.org>
- ANA: <http://www.ana.org>
- Centers for Disease Control: <http://www.cdc.gov/>
- Florida Department of Health – Business and Professional Regulation: <http://fcn.state.fl.us/dbpr/>
- National Institutes of Health: <http://www.health.nih.gov>
- Hospice & Palliative Nurse’s Association: <http://www.HPNA.org>
- Medscape: <http://www.medscape.com/>
- Nursing Center: <http://www.nursingcenter.com/journals>
- United States National Library of Medicine: <http://www.nlm.nih.gov/>
- Oncolink: <http://www.oncolink.upenn.edu/>
- American Association for the History of Nursing: <http://www.aahn.org>

GUIDELINES FOR WRITTEN ASSIGNMENTS

- Wellness Assessment
- DHAT
- CHAT
- IPR
- Presentation

CRITERIA FOR WELLNESS PAPER

Purpose: To deepen your understanding of health patterns as they relate to you and your family. The goals of this paper are to enhance your personal well being and nursing practice.

The paper is to be typed (word processed) and double-spaced, using APA format. Please include a reference page, as well as an Appendix for Internet Resource URL sites. Also include the Evaluation Form For Wellness Paper. There will be 6 parts to the paper. They are as follows:

1. Write a personal statement on “What being healthy means to me.”
2. Describe your family’s health patterns as follows:
 - A. Place of birth
 - B. Cultural background
 - C. State of health
 - D. Health care practices for your family including maternal and paternal grandparents, mother and father, yourself, spouse, children, siblings.
 - E. What patterns emerge from the above?
 - F. Discuss any concerns/issues you may have.
 - G. Have you changed any of your health practices due to your family pattern?
3. Describe your own practices of health promotion/disease prevention (HP/DP) in the following areas:
 - A. Physical activity and fitness.
 - B. Nutrition - include cancer prevention strategies.
 - C. Use of tobacco, alcohol and other drugs.
 - D. Safety in home (abusive toxic substances/drug safety potential, guns secure).
Safety in car (seatbelts, where children sit).
 - E. Environment (lead, radon, allergens).
 - F. Food.
 - G. Stress reduction.
 - H. STD’s.
 - I. Immunizations.
 - J. SBE = Self Breast Exam, mammogram, pap, testicular exam, PSA, rectal.
 - K. Physician (cholesterol, B/P, DM) assessments.
 - L. Alternative Therapies
 - M. Support.
 - N. Other.
4. Develop your own long-term personal wellness plan using the nursing process. (This plan will be an active wellness plan throughout the nursing program.)
5. Do an Internet search to find at least 2 resources that would be valuable for you to use. Include a copy of these in the Appendix of your paper and the reference section of your paper. Be sure to have URL (Uniform Resource Locator) e.g. <http://www.palmbeachstate.edu>.
6. The reference page has to include at least 2 resources from book and/or professional journal along with 2 Internet search resources.
7. Refer to the Evaluation Form For Wellness Paper for specific evaluated criteria.

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	16	<ul style="list-style-type: none"> ▶ occult stool ▶ rectal exam ▶ skin/tongue lesions <p>K. Yearly health care provider visits</p> <ul style="list-style-type: none"> ▶ B/P ▶ H&H ▶ cholesterol ▶ blood sugars <p>L. Use of alternative modalities - herbs, massage, yoga, acupuncture, tai chi, etc.</p> <p>M. Personal support system</p> <p>N. Other</p>
	20	<p>IV. Personal Wellness Plan</p> <ul style="list-style-type: none"> A. One NANDA self-diagnosis B. Two goals (must be specific, measurable, realistic) C. Minimally five interventions D. Evaluation
	6	<p>V. References and Internet Search</p> <ul style="list-style-type: none"> A. Must minimally include 2 books and/or professional journal articles plus 2 Internet resources with copies of the first page identifying the URL site.
Total Actual Points	Total Possible Points 100	<div style="border: 1px solid black; padding: 10px; display: inline-block;"> <p>75 points are required for a passing grade of SATISFACTORY.</p> </div>

Faculty Comments:

**DAILY HOLISTIC ASSESSMENT TOOL
(DHAT)**

GUIDELINES FOR DAILY HOLISTIC ASSESSMENT TOOL (DHAT)

Date of birth: Do not need to fill in

Culture Needs: Identify the ethnic background for your patient.

Admitting Diagnosis: Indicate what your patient was admitted for

Secondary Diagnosis: Underlying health history

Pathophysiology: List and define any medical history. Use a reference to define.

Health Challenges: Subjective - indicate what the patient said to you.
Objective – indicate what you see or can measure

Circumference, birth weight, and gestational age: N/A.

Lifespan: Indicate whether patient is an adolescent, early adulthood, middle adulthood or later adulthood.

Stage of Growth and Development According to Erickson: Indicate the anticipated stage of growth and development.

Actual Stage of Growth and Development: Select one appropriate for the individual and explain why client is in this stage.

Family Role/Issues: Identify roles that this individual takes on within the family and identify any issues that are currently present or created by this hospitalization.

Allergies: List food, drug, chemicals and/or environmental.

SENSORY/PERCEPTION/COGNITION

L.O.C.: Identify whether the patient is awake, alert, lethargic.

Pupils: Assess pupils reaction to light.

Level of Orientation: Check as appropriate for your patient.

Hearing Aid: Check if your patient has a hearing aid, which ear(s). Write no if your patient does not have one.

Hard of Hearing: Check item if patient is hard of hearing, if not, write no.

Glasses/Contacts: Circle item if patient has either one or both. If patient has neither write none.

Mood: Fill in appropriate blank with yes or no.

Course Syllabus – Distance Learning (Online)

Substance Abuse: *Identify how many packs or number of cigarettes per day. If patient does not smoke, write none. "Rx drugs: Write in yes or no. *ETOH: write in yes or no. *Illicit drugs: write in yes or no. *Any yes answer should be followed up on back with further explanation and details.

History of abuse, memory & judgment/anxiety Level: Fill in the appropriate blank with yes or no.

MOBILITY

Activity Tolerance/Limitations: Identify any issues affecting mobility. Indicate how patient is tolerating activity.

Functional Ability: Indicate ability utilizing numbers.

Assistive Needs: Indicate ability utilizing numbers.

Fall Risk: Indicate yes or no.

OXYGENATION

Respirations

Pattern & Rate: Identify the pattern of response and rate. Examples: even, labored, rapid .

Breath Sounds: Identify sounds as well as location of your assessment, i.e., clear bilaterally, rales right base, rhonchi, crackles, wheezing.

Oxygen Therapy: What type of oxygen therapy and how many liters.

Oxygen Saturation: Indicate percent if assessed or state not assessed.

TX's: Respiratory treatments. If your patient is receiving treatment indicate what type and how often, otherwise write no.

CARDIOVASCULAR

Heart Sounds: Check that you heard normal heart sounds.

PMI: If in appropriate location, check yes.

Murmur: Did you hear a murmur? Indicate yes or no.

Pulse Deficit: check yes or no in appropriate space.

Apical Rate: Write in actual rate and circle either regular or irregular.

Fetal Heart Rate: N/A if patient is not pregnant.

Capillary Refill: Circle either brisk or slow and indicate the time in seconds for refill.

Homans: Indicate whether your patient has a positive or negative human sign on the right and left side.

Peripheral Pulses: Check your patients pedal pulses. Indicate whether they are present and the quality of the pulses.

Course Syllabus – Distance Learning (Online)

CELLULAR INTEGRITY

Skin Temperature: Assess your patient and check appropriate area.

Edema: If present circle and indicate location in space. Mark no if not present.

Wound: Indicate whether your patient has a laceration, or abdominal incision.

Drainage/Discharge: Using the REEDA method, assess your patients wound, then answer questions appropriately. Indicate yes or no for drainage. ***Color:** indicate if present and what color. ***Odor:** indicate yes or no.

Site/Wound Care: Indicate what you are doing for the stated wound, i.e.; pericare, topicals, sitz bath.

REGULATION

Nutrition: Mark adequate or poor based on your assessment and the patient's nutritional status.

Therapeutic: Indicate type of diet.

Elimination Pattern: Indicate your patient's pattern and check appropriate box.

LBM: Indicate date of last BM.

Bowel Sounds: Circle presents or absent. Indicate location.

Urinary: Identify patients voiding pattern. State if catheter is present.

Fluid Restriction: Indicate yes or no.

Intake/Output: Record totals for your shift.

Formula/Type: N/A

Intravenous Fluid: Indicate type of fluid infusing and rate. Identify site location and if a Saline Lock or MAP is in place

PRIORITY NURSING DIAGNOSIS

A total of **three nursing diagnoses** will be identified with each DHAT. One should be a psychosocial issue. The student will develop 3 complete nursing plans of care to be submitted the next clinical day.

Course Syllabus – Distance Learning (Online)

Evaluation of Daily Holistic Assessment Tool (DHAT) & Care plan

	<u>% Possible</u>	<u>% Earned</u>
Assessment	10%	_____
Med sheet(s)	15%	_____
Lab sheet(s)	15%	_____
Care Plan #1	20%	_____
Care Plan #2	20%	_____
Care Plan #3	<u>20%</u>	_____
TOTAL	100%	_____

Student Name: _____ Date: _____

Adult Daily Holistic Assessment Tool (DHAT)

Client Initials _____ Age _____ DOB _____ Gender _____ Date _____

WT _____ HT _____ Admission Date: _____ Allergies _____

Admission Diagnosis / Current Diagnosis: _____

Secondary Diagnosis: _____

Pathophysiology (textbook reference): _____

Initial Assessment	Time: _____
Vital Signs	T _____ P _____ RR _____ B/P _____
Sensory / Perception / Cognition:	
LOC / Visual or auditory deficits	<input type="checkbox"/> awake <input type="checkbox"/> alert <input type="checkbox"/> oriented <input type="checkbox"/> asleep <input type="checkbox"/> confused <input type="checkbox"/> obtunded <input type="checkbox"/> none specify: _____
Mood	<input type="checkbox"/> appropriate <input type="checkbox"/> depressed <input type="checkbox"/> anxious <input type="checkbox"/> angry <input type="checkbox"/> euphoric <input type="checkbox"/> labile
Behavior	<input type="checkbox"/> cooperative <input type="checkbox"/> uncooperative <input type="checkbox"/> apprehensive <input type="checkbox"/> agitated <input type="checkbox"/> lethargic
Speech / Primary language	<input type="checkbox"/> clear <input type="checkbox"/> appropriate <input type="checkbox"/> inappropriate <input type="checkbox"/> aphasia <input type="checkbox"/> impaired hearing Primary language: _____
Pupils	(L) _____ mm <input type="checkbox"/> brisk <input type="checkbox"/> sluggish <input type="checkbox"/> nonreactive (R) _____ mm <input type="checkbox"/> brisk <input type="checkbox"/> sluggish <input type="checkbox"/> nonreactive PERRLA
Pain	Score: _____ location: _____ description: _____ medicated Y* N
Growth & Development (Erikson) Stage	(Actual Stage) _____ AEB _____
* Alteration in S/P/C	none present R/T _____
Cellular Integrity:	
Skin temperature / moisture	<input type="checkbox"/> warm <input type="checkbox"/> cool <input type="checkbox"/> cold <input type="checkbox"/> dry <input type="checkbox"/> moist <input type="checkbox"/> diaphoretic
Color / turgor	<input type="checkbox"/> pink <input type="checkbox"/> pale <input type="checkbox"/> cyanotic <input type="checkbox"/> mottled <input type="checkbox"/> jaundiced <input type="checkbox"/> elastic <input type="checkbox"/> tenting
Edema	<input type="checkbox"/> none <input type="checkbox"/> present <input type="checkbox"/> location _____ pitting +1 +2 +3 +4
Mucous membranes	<input type="checkbox"/> pink <input type="checkbox"/> pale <input type="checkbox"/> moist <input type="checkbox"/> dry <input type="checkbox"/> lesions
Rash / lesion / wound	<input type="checkbox"/> none <input type="checkbox"/> present site describe _____ _____ location _____
* Alteration in Skin Integrity	none present R/T _____
Oxygenation:	
--Respiratory: Effort	<input type="checkbox"/> unlabored <input type="checkbox"/> dyspneic <input type="checkbox"/> nasal flaring <input type="checkbox"/> abdominal <input type="checkbox"/> stridor <input type="checkbox"/> grunting <input type="checkbox"/> retractions Regular irregular
Lung sounds	<input type="checkbox"/> RUL _____ <input type="checkbox"/> RML _____ <input type="checkbox"/> RLL _____ <input type="checkbox"/> LUL _____ <input type="checkbox"/> LLL _____ Clear Decreased Absent Rales Rhonchi Wheezes

Student Name: _____

Date: _____

O ₂ therapy / O ₂ saturation	none <input type="checkbox"/> O ₂ therapy _____ lpm / % <input type="checkbox"/> NC <input type="checkbox"/> Mask <input type="checkbox"/> Oxyhood saturation level _____%
Cough / Respiratory Treatments	nonproductive <input type="checkbox"/> productive _____ tx's _____
* Impaired Gas Exchange	none present R/T _____
--Cardiovascular: Apical	regular <input type="checkbox"/> irregular <input type="checkbox"/> S1 <input type="checkbox"/> S2 <input type="checkbox"/> PMI <input type="checkbox"/> Murmur
Extremities: Capillary refill / peripheral pulses	< > _____ seconds {0 – 3} R/L brachial _____ R/L radial _____ R/L dorsal pedalis _____ R/L posterior tibial _____ other _____
Monitors	none specify: _____ <input type="checkbox"/> O ₂ saturation <input type="checkbox"/> cardiorespiratory <input type="checkbox"/> other _____ <input type="checkbox"/> alarm parameters verified and on
*Alteration in tissue perfusion	none present R/T _____
Regulation:	
Abdomen / LBM Diet _____	soft <input type="checkbox"/> firm <input type="checkbox"/> rigid <input type="checkbox"/> distended <input type="checkbox"/> round <input type="checkbox"/> flat <input type="checkbox"/> tenderness / LBM _____ <input type="checkbox"/> continent <input type="checkbox"/> incontinent
Bowel sounds	RLQ ___ RUQ ___ LUQ ___ LLQ ___ + present -absent ++hyperactive +/-hypoactive
NG / GT	none specify _____
*Alteration in nutrition	none present R/T _____ size ___ <input type="checkbox"/> gravity <input type="checkbox"/> suction
GU	no problems <input type="checkbox"/> Foley <input type="checkbox"/> dysuria <input type="checkbox"/> hematuria <input type="checkbox"/> frequency <input type="checkbox"/> continent <input type="checkbox"/> incontinent LMP _____
Intravenous Fluids	none specify/solution & rate _____
* Alteration in elimination	none For shift: total in _____ total out _____ <input type="checkbox"/> present R/T _____
Mobility:	
Muscle tone / strength / Range Of Motion	strength equal bilaterally UE and LE <input type="checkbox"/> weakness (specify) _____ <input type="checkbox"/> Full Range Of Motion <input type="checkbox"/> limitations: _____
Gait / fall risk	steady <input type="checkbox"/> unsteady <input type="checkbox"/> pre-ambulatory <input type="checkbox"/> paralysis /describe _____
Functional ability	independent <input type="checkbox"/> total assistance <input type="checkbox"/> requires assistance (explain) _____
Casts / Assistance devices	none specify _____
*Alteration in Mobility	none present R/T _____
* for abnormal findings, see additional notes	
SN signature:	

STATE AND PRIORITIZE 3 NURSING DIAGNOSES

Course Syllabus – Hybrid

LAB WORK AND DIAGNOSTIC TESTS

TEST	RESULTS	NORMALS	DATES	REASON FOR TEST	NURSING SIGNIFICANCE

Course Syllabus – Hybrid

MEDICATION SHEET

PATIENT ALLERGIES DATE:

STUDENT:

TRADE/GENERIC NAME CLASSIFICATION	SPECIFIC INDICATIONS/ REASON GIVEN TO YOUR CLIENT	MECHANISM OF ACTION	PATIENT DOSE/ROUTE/SAFE DOSAGE RANGE (AGE SPECIFIC)	MAJOR SIDE EFFECTS	DRUG/DRUG OR DRUG/DIET INTERACTIONS AND CONTRAINDICATIONS	CLIENT SPECIFIC NURSING IMPLICATIONS
TRADE: GENERIC: CLASSIFICATION:						
TRADE: GENERIC: CLASSIFICATION:						
TRADE: GENERIC: CLASSIFICATION:						

Course Syllabus – Hybrid

CLIENT INITIALS: __ DATE: __ NURSING DIAGNOSIS: _____ RT: _____ AEB: _____	NURSING CARE PLAN PRIORITY CONCEPT: <input type="checkbox"/> Oxy <input type="checkbox"/> Reg <input type="checkbox"/> Cell Integ <input type="checkbox"/> Mob <input type="checkbox"/> S/P/C	HUMAN PATTERN: <input type="checkbox"/> Exchanging <input type="checkbox"/> Valuing <input type="checkbox"/> Perceiving <input type="checkbox"/> Communicating <input type="checkbox"/> Choosing <input type="checkbox"/> Knowing <input type="checkbox"/> Relating <input type="checkbox"/> Moving <input type="checkbox"/> Feeling
---	--	--

Assessment	Planning Goal Desired Outcome (Specific/Measurable)	Implementation Nursing Interventions	Rationale Reason for Interventions	Evaluation What Happened:	Goal Met?*	
					Yes	No
Pertinent Data:	Patient Will:	Nurse Will:	Why:			
Subjective: (What did client say – use direct quotations)						
Objective: (What did you see/hear/smell/feel – list findings)						

*If the client goal was/was not met briefly describe why and what steps would be taken next:

**LEARNING GUIDE:
PHYSICAL ASSESSMENT**

CRITICAL THINKING EXERCISES – PHYSICAL ASSESSMENT

What would you do if.....	
Your physical assessment differed from the findings of the previous shift’s assessment?	
Your client becomes very anxious in the middle of the physical assessment?	
Visitors were in the room and you needed to perform a head to toe assessment of your client?	
A member of the health care team inquires about your client’s breath sounds and you forgot to listen to them?	
The transporter has come to take your client for a test just as you are entering the room to do a physical assessment. What do you do?	
The mother of your infant client refuses to comply with a physical assessment of her child?	
Your pregnant client asks you why she is spotting blood?	
Delegation: What part of the physical assessment can be delegated to unlicensed assistive personnel or LPN?	

Course Syllabus – Hybrid

LEARNING GUIDE: HEAD TO TOE PHYSICAL ASSESSMENT
USING THE FIVE CONCEPTS OF HUMAN FUNCTIONING

* Indicates assessment skills for the pediatric client

CONCEPT OF NURSING KNOWLEDGE	AREA/ SYSTEM	ASSESSMENT SKILL	DOCUMENTATION DESCRIPTIVE TERMS
Perceptual/Sensory/Cognition	Head & Neck Teach about: 1. The importance of frequent/routine oral care 2. The importance of immunizations	Use a pen light: Pupil reaction Inspect mouth Lips Gums* Teeth* Tongue* Breath Speech LOC (level of consciousness)* Orientation Status Sensory deficit (Right/left/bilateral) Cry* Newborn reflexes* Head circumference* Fontanel* Anterior Posterior Ears* Earaches Check for foreign bodies	Brisk, sluggish, fixed, PERRLA Moist, dry WNL, fruity, musty, ammonia, ETOH Clear, garbled, slurred, inappropriate, aphasic Awake, alert, drowsy, stuporous, arouses to pain only, coma Person, Place, Time X1 X2 X3 Glasses, contacts, hearing aid(s) Lusty, weak Sucking, rooting, gag, moro, startle, Babinski Measured in cm's Flat, bulging, depressed Frequency? Location ((R/L/ Bilateral)?)

Course Syllabus – Hybrid

CONCEPT OF NURSING KNOWLEDGE	AREA/ SYSTEM	ASSESSMENT SKILL	DOCUMENTATION DESCRIPTIVE TERMS
Oxygenation	<p>Thorax/Lungs (Respiratory)</p> <p>Teach about:</p> <ol style="list-style-type: none"> 1. Flu vaccine, elderly 2. Hazards of smoking <p>Heart/Vascular (Cardiovascular)</p> <p>Teach about:</p> <ol style="list-style-type: none"> 1. Knowing baseline BP 2. Regular monitoring of BP 3. Importance of reducing fat in diet 4. Importance of exercise 	<p>Hair & scalp*</p> <p>Breathing Pattern</p> <p>Breath Sounds What? Where?</p> <p>Cardiac Landmarks</p> <p>Auscultate Apical Pulse</p> <p>Auscultate Heart Rhythm (S₁ S₂)</p> <p>Palpate Pulse Points (10)</p> <p>Palpate Capillary Refill</p> <p>Inspect Color of: Buccal mucosa</p> <p>Conjunctiva</p> <p>Inspect for Varicosities Homan's sign</p> <p>*Heart Rhythm (not uncommon to hear S₃ & sinus dysrhythmia in pediatric client)</p>	<p>Scaly, lice, nits, ticks</p> <p>Even, unlabored, labored, apneic, dyspneic, tachypneic, shallow</p> <p>Clear, crackles, rhonchi, wheeze, friction rub, stridor</p> <p>Apical Pulmonic Erb's Tricuspid Mitral Epigastric</p> <p>Beats per minute</p> <p>Regular, irregular</p> <p>Strong, bounding, weak, thready</p> <p>Brisk, sluggish</p> <p>Pink, red, pale, cyanotic</p> <p>Pink, red, pale</p> <p>Absent, Present Absent, Present</p> <p>S₁ S₂ S₃ Sinus dysrhythmia</p>

Course Syllabus – Hybrid

CONCEPT OF NURSING KNOWLEDGE	AREA/SYSTEM	ASSESSMENT SKILL	DOCUMENTATION DESCRIPTIVE TERMS	
Cellular Integrity	Breasts/Axillae	Inspect Breasts	Symmetrical, striae, peau d' orange, asymmetry, nipple deviation, edema, mass (Geriatric-breast tissue shrinks, softens, and becomes pendulous)	
	Teach about: 1. Importance of monthly self breast exam	Newborn*(enlarged)		
		Pregnancy		Breasts enlarge Nipples enlarge
	Integument (Skin)		Inspect: Skin color	
	Teach about: 1. Monthly self skin examination		Skin temp.	Warm, cool, hot
	2. Skin protection with SPF 15 or greater		Skin moisture	Dry, moist, diaphoretic
			Skin turgor	Elastic, tight, loose
			Edema	Absent, general, dependant, localized, pitting 1+, 2+, 3+, 4+.
	FYI: Geriatric population at risk for delayed wound healing		Inspect for: Alteration in Skin Integrity	Lesions, scars, rash, skin tears, blister, abrasion, birthmarks, decubitus
			Newborn skin*	Bright red, pink, cyanotic, yellow, mottled, flaky, dry, edema, downy
			Inspect for: Wound/Incision	Open, closed, approximated, edema
				Staples, sutures, steristrips
			Inspect for: Wound drains	Hemovac, J-Pratt drain (J-P drain)
		Wound drainage	Serous, sero-sanguinous, sanguinous, purulent	

Course Syllabus – Hybrid

CONCEPT OF NURSING KNOWLEDGE	AREA/SYSTEM	ASSESSMENT SKILL	DOCUMENTATION DESCRIPTIVE TERMS
Regulation	Abdomen (gastrointestinal) Teach about: 1. Nutrition-the importance of a well balanced diet. 2. Importance of roughage and fluids for adequate bowel and urinary elimination	Dressings	Wet, dry, intact, changes, reinforced, discontinued
		Inspect Mouth	
		Auscultate Bowel sounds in all 4 quadrants	Present, absent, hyperactive, hypoactive
		Palpate abdomen	Soft, hard, flat, distended, tender, non-tender
		Nutrition Diet	Regular, soft, full, liquid, clear liquid, NPO, aplastic, 1800 calorie ADA
		Formula* Breast or bottle	Enfamil, Enfamil with iron, Similar, Proscobee, breast
		Elimination Stool	Formed, hard, soft, loose Date of last BM? *Newborn - meconium
		Color Quantity Quality	Clear, brown, green, coffee ground, bloody
		Emesis Color Amount	NG, Dobhoff, J-tube, G-tube, PEG tube
		Nausea	Gravity, continuous, intermittent, patent
		Inspect for: Tubes	Clear, brown, green, coffee ground, bloody
		Tubes to suction	NS, H ₂ O
		Tube drainage (measured in ml's)	Colostomy, Ileostomy
Tube irrigation (measured in ml's)			
Ostomy Location			

Course Syllabus – Hybrid

CONCEPT OF NURSING KNOWLEDGE	AREA/SYSTEM	ASSESSMENT SKILL	DOCUMENTATION DESCRIPTIVE TERMS
Mobility	Genitalia/Anus Teach about: 1. Monthly testicular self exam 2. Regular PSP smear, and GYN exam 3. Safe sex/abstinence 4. *Moms-Infant girls: clean from front to back	Inspect: Perineal area Discharge Inspect Urine Color Clarity Voiding pattern Amount Frequency Route *Pediatric Voiding pattern Inspect Anus *do not palpate infant/child's rectal wall	WNL, intact, red, edema, excoriated *circumcised (Geriatric - testes shrink & become more pendulous with age) Yellow, red, amber Clear, cloudy, murky, clots, sediment Continent, incontinent Measured in ml's Times per shift Independent, bedpan, bedside commode, urinal, catheter, BRP Diaper, toilet trained WNL, intact, hemorrhoids, edema
	Musculoskeletal Teach about: 1. Benefits of regular exercise	Strength Mobility/Movement/ROM Gait *Pediatric mobility *Spine	Bilateral, equal, Right sided deficit, left sided deficit (upper/lower), paraplegia, quadraplegia Independent, assisted, limp, shuffle, cane, walker, crutches Rolls over, sits up, crawls, stands, walks Intact, openings, masses, prominent curves

**COMPREHENSIVE HOLISTIC ASSESSMENT TOOL
(CHAT)**

FOCUS: THE WELL ELDER

**STUDENT CLINICAL EXPERIENCE USING THE
COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (CHAT) WITH AN ELDER**

General Guidelines:

1. Follow an individual who is 65 years of age or older.
2. Make a visit(s) lasting 60 minutes utilizing guidelines related to a specified area of focus.
3. Summarize the visit using the “Summary of Visit with Elder” form.
4. Contact faculty for problems that arise or whenever assistance is needed.
5. Develop a teaching plan based on your nursing health history.

Preparation Activities:

1. Review Learning Guide on Head to Toe Physical Assessment for obtaining a nursing health history.
2. Self-assessment on own time.
 - A. How would you describe your health?
 - B. Where do you place yourself on the wellness-illness continuum?
 - C. How do you promote wellness in yourself?
 - D. Is there anything that interferes with you being healthy?

Student Learning Experience:

1. Conduct and record a nursing health history using the Palm Beach State College Nursing Comprehensive Holistic Assessment Tool. (C.H.A.T.) Remember to include completed Daily Holistic Assessment Tool.
2. Complete Nutritional Assessment.
3. Prepare a teaching plan based on the elders learning needs.
4. Develop two nursing care plans.

Learning Guides:

Palm Beach State College Comprehensive Holistic Assessment Tool (C.H.A.T.)
Teaching Care Plan

Discussion Guidelines:

1. How does your elder perceive his/her health?
2. How do you perceive your elder's health?
3. Where do you think your elder is on the wellness-illness continuum?
4. Identify factors that promote wellness in your elder.
5. Identify anything that interferes with your elder's health and well-being.

Course Syllabus – Hybrid

INTERVIEWING FORMAT

Introduce self and purpose of the interview.

Obtain permission from individual to be interviewed.

Be aware of yourself and the interviewee:

- Gestures

- Posture

- Voice tone and rate of speech

- Distance between you and interviewee

- Hearing deficit

- Vision deficit.

Questions concerning what, how, when, and where sustain the interview; those asking “why” may be difficult to answer.

Questions requiring a “yes” or “no” answer may inhibit flow of conversation, e.g., “Are you satisfied with your health care? Instead you might ask, “What has your health care been like?”

Avoid judgment, e.g., “That is good” or “That is bad.” Rather, “Did you feel that was O.K. (or) not O.K.?”

When you feel it is time to bring closure to the interview, state “I have only a few more minutes, is there anything else you would like to talk about?”

Always give feedback about what you have learned in the interview and ask in what way the interview has been useful or helpful to the interviewee.

Thank the person for sharing their time and their views.

Do not share addresses or phone numbers or go to the home of a stranger.

In the event an immediate problem is encountered with the interviewee contact your instructor as soon as possible for assistance.

Course Syllabus – Hybrid

Valerie L. Remnet, R.N., M.S.W.

1. Because the elderly person has decreasing energies to cope with the tasks of everyday living, the visitor may have to invest proportionately more energy into the visit.
2. The visitor needs to pace the visit according to the elderly person's fluctuating energy levels and physical conditions.
3. Sensory decrements have to be considered. Communication can be maximized if the visitor sits 1 ½ to 2 ½ feet from the person and faces him directly. Avoid having the older person facing a window or lamp because such bright light can put an additional strain on weakened eyes.
4. The use of touch can be a meaningful communication bridge.
5. Avoid information overload by: speaking slowly; using short sentences; dealing with one thought at a time; and asking for feedback to be certain meaningful communication has taken place. The elderly person needs 15% more time to respond.
6. Enhance the aged feelings of self-esteem by both encouraging his maximum participation and acknowledge his role of being an authority on aging. He is the product of his total life experiences and he is the only one who knows what these experiences have been. His past plays a significant part in current functioning.
7. Importance of choices - express confidence in the person's ability to make choices and follow through.
8. Motivation to participate in an activity will be increased if:
 - A. an older person is intrigued by a task rather than perceiving it as "just busy work";
 - B. the role or activity conveys the message the "you are important";
 - C. there is a possibility of forming meaningful relationships.
9. The use of reminiscence is an effective tool in linking relevant past events to present situation.
10. Some elderly do not have the strength to cope with the confusion of bureaucracies. So if necessary, be an advocate. Connect the elderly person with appropriate resources in the community.

Course Syllabus – Hybrid

THE AGED FAMILY DEVELOPMENTAL TASKS

The following developmental tasks are to be achieved by the aging couple as a family as well as by the aging person alone:

1. Decide where and how to live out the remaining years.
2. Continue a supportive, close, warm relationship with the spouse or significant other, including a satisfying sexual relationship.
3. Find a satisfactory home or living arrangement and establish a safe, comfortable household routine to fit health and economic status.
4. Adjust living standards to retirement income; supplement retirement income if possible with remunerative activity.
5. Maintain maximum level of health; care of self physically and emotionally by getting regular health examinations and needed medical or dental care, eating an adequate diet, and maintaining personal hygiene.
6. Maintain contact with children, grandchildren, and other living relatives, finding emotional satisfaction with them.
7. Maintain interest in people outside the family, and in social, civic, and political responsibility.
8. Pursue new interests and maintain former activities in order to gain status, recognition, and a feeling of being needed.
9. Find meaning in life after retirement and in facing inevitable illness and death of oneself and spouse as well as other loved ones.
10. Work out a significant philosophy of life, finding comfort in a philosophy or religion.
11. Adjust to the death of spouse and other loved ones.

Course Syllabus – Hybrid

EVALUATION OF COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (CHAT)

	<u>% Possible</u>	<u>% Earned</u>
CHAT form	10%	_____
Nutritional forms	10%	_____
Med sheet(s)	10%	_____
Lab sheet(s)	10%	_____
Care Plan #1	20%	_____
Care Plan #2	20%	_____
Teaching Plan	<u>20%</u>	_____
TOTAL	100%	_____

Student Name: _____ Date: _____

Admission Assessment: Comprehensive Holistic Assessment Tool (CHAT)

Client Initials: _____ DOB: _____ Age: _____ Wt: _____

Diagnosis: _____

**attach daily assessment

Patient Admission Information:

I. PERCEPTUAL / SENSORY / COGNITION

Communicating: *pattern involving sending messages*

Name preferred: _____ Sex: _____ Age: _____ Date: _____

Informant: Patient Parent Spouse Other _____ Admitted from: Home ED OR Other _____

At time of interview patient is: alert appropriate relaxed agitated anxious tearful sleepy other _____

Primary language: _____ Interpreter needed: _____

Relating: *pattern involving established bonds*

Role: *marital status, children, parents, siblings*: _____

Significant others / Primary caregiver: _____

Lives with: _____

Recent changes in family: No if Yes, explain: _____

History of physical / sexual / emotional abuse: _____ Do you feel safe at home? _____

Are you in a relationship in which you or your child have been hurt or threatened? _____

In the past year, has someone close to you hit, kicked, punched, slapped, or shoved you or your child? _____

Occupation / Educational experience: _____

Patient / parent concern related to role responsibilities (school, work, financial, caregiver): _____

Socialization / support systems: _____

Valuing: *pattern involving spiritual growth*

Religious preference: _____ Spiritual needs: _____

Cultural preferences / needs: _____

Knowing: *pattern involving the means associated with information*

Medical History:

Chief complaint: _____

Previous / Ongoing Health problems (symptoms, length of illness, treatment) _____

Previous Hospitalizations / Surgery _____

Immunizations: Up to date Needs _____

Student Name: _____ Date: _____

Infectious Disease Exposure: None Chicken Pox Rubella Measles Mumps TB Hepatitis

List all medications in use (prescription, OTC, herbals) – see attached medication sheet

List all allergies (medications, food, environment and reaction)

Medication / Food / Environment	Reaction

Risk factors: (smoking, family history, etc.): _____

Substance use: Alcohol (*type*) _____ drinks/day Cigarettes: _____ per day

Illicit drug use: _____ Rx drug use: _____

Perception / Knowledge of Health / Illness: _____

Readiness to learn (ready, willing, and able): _____

Comprehension: Ability to grasp concepts and respond to questions: HIGH MEDIUM LOW

Motivational Level: asks questions eager to learn anxious uninterested uncooperative disinterested denies need for education

Memory: No problem Limited short term memory Limited long term memory

Learning Barriers: None Language Cultural / Religious Emotional Hearing Vision Dexterity

Describe: _____

Feeling: *pattern involving the subjective awareness of information*

Comfort / Pain: (*Is patient in pain? Chronic? Acute? What methods relieve pain, provide comfort?*): _____

Emotional Integrity: (lonely, sad, depressed, angry, joy): _____

Perceiving: *pattern involving the reception of information:*

Sensory Perception: (*Able to receive information via all senses? Deficits noted?*): _____

Visual: _____ Contacts: _____ Eyeglasses: _____

Hearing: _____ Earaches: _____ Hearing Aids: _____

Choosing: *pattern involving the selection of alternatives*

Coping / Stress Management Measures: _____

Support systems: _____

II. MOBILITY

Moving: *pattern involving activity*

See daily assessment for physical assessment component

Functional ability: (*independent, if not specify deficits and needs*): _____

Assistive devices required: _____

Orthopedic equipment: _____

Physical Therapy: _____

Age related hazards of mobility: _____

Fall Risk: _____

Recreation / Play: _____

Self care: _____

III. OXYGENATION

See daily assessment for physical assessment component

Home nebulizer / O₂ / CR monitor: _____

IV. CELLULAR INTEGRITY

See daily assessment for physical assessment component

Skin integrity risk factors: none obesity incontinent urine/feces emaciated immobility prematurity altered LOC altered sensation breakdown present Home treatment plan: _____

V. REGULATION

Exchanging: *pattern involving mutual giving and receiving*

See daily assessment for physical assessment component

Recent weight loss or gain: _____

Therapeutic diet: _____ Dietary restrictions: _____

Suck quality: _____ Loose teeth: _____ Dentures: _____ Problems: _____

Sleep patterns: _____

Sexually active: _____ Sexual preference: _____ Birth Control: _____ Problems: _____

LMP: _____ Menarche (age): _____ Menopause (age): _____ BSE: _____ Difficulties: _____

Reproductive History: # of pregnancies: _____ # of births: _____ # of living children: _____ Problems: _____

Testes: _____ TSE: _____ Circumcised: _____ Problems: _____

Additional Comments: _____

Student Name: _____ Date: _____

Discharge Plan: _____

Course Syllabus – Hybrid

SUMMARY OF VISIT WITH ELDER

Due: _____

Your Name: _____

No. of Visits: _____

Place of meeting: _____

Time: _____

Elder's age: _____ Sex: _____

1. How does your elder describe his/her health?

2. How do you perceive your elder's health?

3. Identify factors that promote wellness in your elder.

4. Identify anything that interferes with your elder's health and well-being.

Course Syllabus – Hybrid

NUTRITION SCREENING TOOL

Height: _____ Weight: _____ Ideal Body Weight: _____ Weight 6 mo. ago: _____

How many teeth: _____ Status: _____

Date last dental exam: _____ Dentures: _____ Partial: _____ Complete: _____

Fit: _____

Chewing problems:

Swallowing problems:

Appetite:

Use of Vitamins/Mineral Supp.:

Use of Laxatives:

Use of Alcohol:

Does individual have any health problems that affect his/her ability to eat or drink?

Does individual have any problems that affect his/her ability to prepare food?

How does individual get to the store to buy groceries?

(Identify problems with transportation, mobility, ability to carry grocery bags, etc.)

Does individual have access to:

running water yes _____ no _____

refrigeration yes _____ no _____

cooking facilities yes _____ no _____

Course Syllabus – Hybrid

24-Hour Diet Recall

“I would like you to tell me everything you ate and drank from the time you got up in the morning until you went to bed at night and what you ate during the night. Include snacks and drinks of all kinds.”

(Record amount and type of food or drink and time taken.)

Was the 24-hour nutritional intake unusual in any way?

Yes _____ No ____

If yes, describe how it was unusual.

Course Syllabus – Hybrid

COMMUNITY RESOURCES

NUTRITION

Resource List:

Course Syllabus – Hybrid

TEACHING PLAN

Include at least one problem on the next page.

1. State a knowledge deficit that currently applies to your elder.
2. List an objective related to your elder's knowledge deficit.
3. Describe how you will meet the above objective.
4. Discuss your teaching plan with your clinical group in post conference.

TEACHING CARE PLAN

KNOWLEDGE DEFICIT/ LEARNING NEED	GOAL AND PLAN FOR TEACHING	EVALUATION
	<p>Goal:</p> <p>Plan:</p>	

Course Syllabus – Hybrid

LEARNING GUIDE
SELF-DIRECTED ATTITUDE ASSESSMENT OF THE AGING PROCESS
(SDAAAP)*

1. A person can be considered old when:

2. Words that society uses to describe the elderly are:

3. Growing old means:

4. Seeing an old person make me feel:

5. The best thing about getting old is:

6. The worst thing about getting old is:

7. How many elders do you personally know?

8. What influence have they (see #7) had on you?

9. Why is “getting old” an issue today?

10. Most elderly live in

Course Syllabus – Hybrid

11. Economically, older people are:

12. Socially older people are:

13. Culturally the elderly are:

14. The spiritual needs of the elderly are:

15. Healthwise older people are:

16. Mentally older people are:

17. Sexually older people are:

18. What will your greatest challenge as a health care professional be regarding care of the elderly?

19. What are your own personal goals regarding your aging process?

LEARNING STYLE ASSESSMENT

Course Syllabus – Hybrid

Learning Styles:

1. Auditory Learner

This student learns from hearing words spoken. When reading, this student vocalizes, moves the lips or throat while reading. In essence reads to self as striving to understand new material. This student is better able to understand and remember words or facts by hearing. Lectures will be particularly effective as well as audiotapes, rote oral practice and group discussions.

2. Visual Learner

This student learns well from seeing words in books, on the chalkboard, charts, movies, videotapes, etc. This student may even write down words that are given, orally, in order to learn by seeing them on paper. This learner will remember and use information better if given a chance to read it.

3. Kinesthetic Learner

This student learns best by experience and a combination of stimuli. The manipulation of material along with sight and sound, will make a big difference to this student. He/She will seek to handle, touch, and work with what is to be learned. This student can write fluent essays, care plans and good answers on tests to show what has been learned. He/She may feel less comfortable, perhaps even stupid, when asked to give oral answers. Thoughts are better organized on paper than when given orally. This student will benefit by the opportunity to write reports, keep notebooks and journals for credit, and take written tests for evaluation. This learner will seek to take copious notes and will perform better during evaluations if allowed to write or demonstrate procedures, rather than explain them orally.

Additional Learning Types

Social Learner

This student strives to study with at least one other student and will not get as much accomplished when studying alone. Others' opinions and preferences are valued. Group interaction for this student increases learning and later recognition of facts. This student is very social in class.

Solitary Learner

This student gets more work done alone and thinks best and remembers more when learning alone. This student cares more for his/her own opinions than for the ideas of others. This student should be encouraged to go to the library to study.

Orally Dependent Learner

This student can easily tell you what 95% has been mastered. This student speaks fluently, comfortably, and seems able to say what he/she means. This student may know more than paper/pencil tests show. The student is probably not shy about giving reports or talking to the instructor or classmates. The muscular coordination involved in writing may be difficult for this student. Organizing and putting thoughts on paper may be a slow and tedious task. As a result, written work may appear carelessly done or incomplete.

Course Syllabus – Hybrid

CRITICAL THINKING EXERCISES

What would you do if.....	
The learner was profoundly deaf and used sign language?	
The learner was confused. You are to instruct her on the importance of tapering a medication as part of her discharge-teaching plan?	
The learner spoke only a foreign language?	
The learner was fourteen years old?	
The learner was an infant and the mother spoke broken English?	
The learner had motor aphasia, but his receptive aphasia was intact?	
The learner could not read?	
Delegation: Is there any area of teaching a client that can be delegated to unlicensed assistive personnel?	

**INTERPERSONAL PROCESS RECORDING
(IPR)**

GUIDELINES FOR WRITING AN INTERPERSONAL PROCESS RECORDING

OBJECTIVES:

1. This IPR is to focus on an actual interaction between student nurse and a patient or the patient's significant other during the clinical experience.
2. An IPR is an opportunity for the nurse to evaluate the effectiveness of therapeutic communication skills. This is not a patient teaching or data gathering exercise. Therefore, the focus of this exercise is Therapeutic Communication.

GENERAL INSTRUCTIONS:

1. **The introduction** is to be typed in narrative format. The introduction is an essential part of the IPR in order to acquaint the reader with the setting, and circumstances in which the interaction took place. This should include the client's facial expression, voice quality, appropriateness of dress and grooming and room environment. Refer to Criteria and Evaluation Tool for IPR for content.
2. **The body of the IPR** (client verbatim – nurse verbatim section), is to be written in the 5-column format found in the syllabus or at the Palm Beach State College Nursing website. Make copies of the format as needed. Verbatim statements of the nurse and the client during the interaction should be documented. Time lapses and silences should be noted, as well as the length of the silence. This section is to be written in an objective fashion, without any interpretations on the part of the student. Refer to Criteria and Evaluation Tool for IPR for directions. The body of the IPR must include at least six responses between client and nurse. A "response" is client and student each talk once. Minimally the client and student must each speak six times.
3. **Non-verbal behavior** of nurse and client section is to be used for recording communication and behavior that is not verbalized. Significant gestures, facial expressions, body postures, tones of voice, eye contact, etc., should be noted – both the client's and the nurse's. For example, it should be recorded that the voice dropped to a whisper when he spoke about his mother's death. Examples of behavioral "clues" to anxiety should be included.
4. **Interpretation of interaction** section includes your ideas as to what was going on – in a dynamic sense – during the interaction. How did you perceive the client to feel? How did you feel? You should also note any associative looseness and/or flight of ideas, as well as disorders of thinking that were present and defense mechanisms that were employed by the nurse or client. Any shifts in the conversation made by either the client or the nurse should be noted.

Your interpretations should be supported with theoretical knowledge. You should include the phases of the interaction.

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5. **Alternative responses** section is one of the most important parts of the IPR and is heavily weighted in terms of evaluation. This section provides the student with an opportunity to look back on the interaction and to formulate responses that might have been more effective than the one used. Although the interaction itself may have been ineffective in achieving the stated goal, it can still be a learning experience, and be a guide for future interactions.

Each alternative response should be accompanied by a rationale (either theoretical or your own logic) as to why it might promote more effective communication. **Every student response must have an alternate or it will be returned to be redone.**

6. **The summary** of the IPR is to be typed in narrative form and should relate to the initial goal identified. The student should include the strengths and weaknesses of the interaction as well as writing objectives for client care based on his/her interpretation. The student should include objectives for his or her own improvement. The participation of both the nurse and the client should be evaluated. References should be cited in a bibliography. Refer to Criteria and Evaluation Tool for IPR for content.
7. **Bibliography** - Any references used should be footnoted and a bibliography attached. Correct APA bibliographical form must be used.
8. Credit will be deducted for spelling and grammatical errors. Any paper which does not meet the requirements will be returned to the student to be redone.
9. Criteria and Evaluation tool must be submitted with the paper for the instructor to mark for grading.

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**CRITERIA AND EVALUATION TOOL FOR
INTERPERSONAL PROCESS RECORDING (IPR)**

NAME: _____

Satisfactory	Unsatisfactory	
		1. Introduction includes:
		A. Date of interaction
		B. Duration of interaction
		C. Description of location where interaction took place
		D. Client's initials, age, gender
		E. Client's personal, interpersonal and social strengths and weaknesses.
		F. Admitting diagnosis and other pertinent medical diagnoses
		G. Initial goal of interaction. State any changes as interaction occurred.
		2. Body of IPR includes:
		A. Exact verbal statements of client and nurse. (At least six responses between client and nurse.)
		B. Non-verbal communications of client and nurse include: affect, speech quality, observations of body language, personal space.
		C. All verbal and nonverbal communications of the client and nurse are analyzed (interpreted) using appropriate terminology.
		D. State alternate communication techniques for each of the nurse's actual responses utilizing a variety of communication skills.
		E. State rationale for alternate responses.
		3. Summary statements includes:
		A. Whether objectives were met, if not, why not.
		B. Evaluate your therapeutic communication techniques in this interaction.

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Satisfactory	Unsatisfactory	
		C. Identify what you learned regarding the clients personal, interpersonal and social systems.
		D. Identify therapeutic communication techniques that you perceive will be helpful for you to use in future interactions.
		E. Assess and identify your personal or interpersonal strengths and weaknesses.
		F. State interactions you plan to utilize to address these needs.
		4. Bibliography of at least two resources used to interpret/analyze interaction and to acquire therapeutic communication techniques.
		5. Submitted on time.
		6. Used appropriate format for introduction, body of IPR with five-column format and summary.

Comments:

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BODY OF INTERPERSONAL PROCESS RECORDING (IPR)

Patient Verbatim	Nurse Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

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Patient Verbatim	Nurse Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

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Patient Verbatim	Nurse Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

**LEARNING GUIDE:
THERAPEUTIC COMMUNICATION**

**LEARNING GUIDE
SENSORY/PERCEPTION/COGNITION**

DO'S AND DON'TS OF THERAPEUTIC COMMUNICATIONS

DO'S:

1. Be Honest!
2. Maintain **Confidentiality!**
3. **Listen** to what the client is saying and doing as though you were attending a concert -- that is -- note **variations and themes** or verbal messages, non-verbal gestures, and symbolic messages.
4. **Be aware of your response** to what the client is “saying,” what is your “gut-level” feeling - empathy, sympathy, apathy, defensiveness, identification? How are you behaving?
5. Use **Broad opening** statements: **summarize** at end of interview.
6. Use **Silence** - both you and the client need time to “process” and respond to each other’s messages.
7. **Give Feedback And Validate** the client’s messages - **Do Not Assume!!!**
8. Respond to **feelings, reality and content**.
9. Have a **goal** for every interaction.
10. Use “I” messages – i.e., “I don’t understand”; “this is what I understand you to be saying”; “I do not like to be screamed at”.
11. Deal with **Here** and **Now** Issues.

DON'TS:

1. **Give Advice** – “I think you should”? (must, ought)
2. **Use Cliché’s** – “Everything will be O.K. soon.”
3. **Compare** - the client with others – “Everybody who is depressed comes out of it sooner or later.”
4. **Argue** - or get involved in POWER struggles – “the facts are”; “this is why you are wrong”; “Don’t you realize”.
5. **Use Why!**
6. **Try To Be A “Friend”** - avoid superficial chatter.
7. **Force the Relationship; Time is Essential** for developing **Trust, Intimacy, and Self-Disclosure**.

**LEARNING GUIDE
SENSORY/PERCEPTION/COGNITION**

COMMUNICATIONS SKILLS

UNHELPFUL RESPONSES TO BE AVOIDED

Patronizing responses:

These make the client feel childish, as if the person is not taken seriously, as if you are humoring the person.

Giving advice or quick solutions:

These make you seem cold and uncaring, as if you don't understand.

Clichés, generalities or philosophical statement:

These have the effect of wiping out the client's feelings, trivializing them, and also send the message that you don't want to be bothered.

Judgmental remarks:

These seem to indicate your approval or disapproval. They indicate to the client that you are viewing the person's feelings from your perspective, not the person's.

Inadequate responses:

These offer nothing and avoid the issue. They indicate that either your mind is elsewhere or you couldn't care less.

Irrelevant responses:

These avoid the client's feelings and make you seem uncaring.

Inappropriate warmth or sympathy:

Clients are insulted by flattery, over-friendliness or pity.

Condescending responses and put-downs:

These include sarcasm, ridicule, inappropriate attempts at humor, scolding and authoritarian reminders. They indicate to the helper that you think the person is silly or selfish or wrong to feel as the person does.

Psychological interpretations:

These are unjustified speculations about another's personality or relationships and can be both insulting and harmful to the client.

Inappropriate self-sharing:

These switch the focus to you and your experiences, leaving the client rejected and showing you as more interested in yourself.

Inaccurate empathy:

This occurs when you misperceive the client's feelings by a mile and are way off the beam in your understanding of his reasons for those feelings, or indicate that you are willing to listen or incapable of understanding.

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LEARNING GUIDE SENSORY/PERCEPTION/COGNITION

INTERPERSONAL TECHNIQUES

Therapeutic Techniques	Examples
1. Using Silence	Being present.
2. Accepting	Yes Uh hum I follow what you said Nodding
3. Giving Recognition	Good morning, Mrs. S. You've tooled a leather wallet. I noticed that you've combed your hair.
4. Offering Self	I'll sit with you awhile. I'll stay here with you. I'm interested in your comfort.
5. Giving Broad Openings	Is there something you'd like to talk about? What are you thinking about? Where would you like to begin?
6. Offering General Leads	Go on. And then? Tell me about it.
7. Placing the Event in Time or in Sequence	What seemed to lead up to.....? Was this before or after.....? When did this happen?
8. Making Observations	You appear tense. Are you uncomfortable when you.....? I notice that you're biting your lips. It makes me uncomfortable when you.....
9. Encouraging Description of perceptions	Tell me when you feel anxious. What is happening? What does the voice seem to be saying?
10. Encouraging Comparison	Was this something like.....? Have you had similar experiences?

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Therapeutic Techniques	Examples
11. Reflecting	Patient: Do you think I should tell the doctor? Nurse: Do you think you should? Patient: My brother spends all my money and then has the nerve to ask for more. Nurse: This causes you to feel angry.
12. Focusing clearly.	This point seems worth looking at more
13. Exploring	Tell me more about that? Would you describe it more fully? What kind of work?
14. Giving Information	My name is..... Visiting hours are..... My purpose in being here is..... I'm taking you to the.....
15. Seeking Clarification	I'm not sure that I follow. What would you say is the main point of what you said?
16. Presenting Reality	I see no one else in the room. That sound was a car backfiring. Your mother is not here, I'm a nurse.
17. Voicing Doubts	Isn't that unusual? Really? That's hard to believe.
18. Seeking Consensual Validation	Tell me whether my understanding of it agrees with yours. Are you using this word to convey the idea?
19. Verbalizing the Implied	Patient: I can't talk to you or to anyone. It's a waste of time. Nurse: It's if you're feeling that no one understands? Patient: My wife pushes me around just like my mother and sister did. Nurse: Is it your impression that women are domineering?
20. Encouraging Evaluation	What are your feelings in regard to.....? Does this contribute to your discomfort?

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Therapeutic Techniques

21. Attempting to Translate into Feelings

Examples

Patient: I'm dead.

Nurse: Are you suggesting that you feel lifeless?

or: Is it that life seems without meaning?

Patient: I'm way out in the ocean.

Nurse: It must be lonely.

or: You seem to feel deserted.

22. Suggesting Collaboration

Perhaps you and I can discuss and discover that produces your anxiety.

23. Summarizing

Have I got this straight?

You've said that.....

During the past hour you and I have discussed.....

24. Encouraging Formulation of a Plan of Action

What could you do to let your anger out harmlessly?

Next time this comes up, what might you do to handle it?

PRESENTATION

GUIDELINES FOR PRESENTATION

The Presentation is designed to address professional aspects of nursing.

The presentation is worth a maximum total of 15% of the course grade. Depending upon class size, this may either be done as a group activity or done alone. If there is a group, each student in the group will sign a form (Group Participation Form), which indicates participation and contribution.

The topic should address issues of professional nursing. Some ideas are listed below. By all means, feel free to choose a topic not listed, but have it cleared with the instructor before proceeding with your research.

Professionalism

Membership in professional organizations, ethics in nursing, legal aspects of nursing, professional behavior and presentation in the workplace

Career options

Hospice nursing, travel nursing, advanced practice nursing, trauma nursing, etc.

Diversity in nursing

Men in nursing, ethnic diversity in nursing, generational differences among nurses

Workforce issues

The shortage of nurses, ADN versus BSN as entry level to practice, staffing ratios

Include 5 references from the Internet, and from other sources, which will support your information.

For those in the on-campus class:

Dress in a professional manner, as you are speaking to the group. Don't be nervous, these are your peers who you have become familiar with all semester. Remember to speak to the audience, not the presentation up on the screen.

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EVALUATION FORM

The Presentation is worth a maximum total of 15% of the course grade. Each student who participates in the group will receive the same percentage total.

Criteria:	Possible Percentage	Actual Percentage:
The topic addressed a professional aspect of nursing	10%	_____
The presentation delivery was professional	25%	_____
The presentation used creativity and was interesting.	25%	_____
The presenter(s) demonstrated knowledge of the topic.	25%	_____
There were 5 references using APA format.	10%	_____
A copy of the presentation was submitted to the instructor	5%	_____
Total:	100%	_____

Comments:

**APPENDIX A:
GUIDELINES FOR CHARTING**

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GUIDELINES FOR CHARTING

1. Follow agency policy regarding notes - format, frequency.
2. Must use ink (black).
3. Print or write legibly.
4. Precede each entry with date and time.
5. Do not erase or completely mark out a mistake. Draw a single line through the error and sign it.
6. Always sign your name, on any entry you have made on flow sheets or nurse's notes, according to agency policy.
7. Avoid using the word patient - some facilities chart the patients' name.
8. Chart in chronological order, recording on every line so the order cannot be altered.
9. Do not write between the lines. If you inadvertently omit a note - make a late entry.
10. Record information as close as possible to the time you deliver care. Do not document in advance.
11. Write notes only for patients you have cared for.
12. Never change your documentation to cover up for someone else's mistakes.
13. Eliminate bias from your notes.
14. Do not generalize. Be specific.
15. Indicate in the record that you not only know what complications may occur - but that you are seeking to prevent them.
16. Ensure continuity note problems as they occur - the resolutions used, and any changes in the patient status.
17. Document the safeguards you use to protect your patient.
18. Record your patients' response to medications and treatment.
19. Record any significant symptoms or changes in the patients' conditions.
20. Record physician visits.
21. Document discussion of questionable medical orders, and the directions for confirming, canceling, or changing them.
22. If something goes wrong - document the mistake or accident in the nurse's notes, and on the incident report.
23. Avoid vague words like – "normal", "good", "bad", "adequate".
24. Use proper spelling - keep a dictionary handy.
25. Use abbreviations with care! If in doubt - spell it out!

GUIDELINES FOR DOCUMENTATION BY SYSTEMS

- 1. Skin**
Change in skin pigmentation (color), texture (turgor), temperature, eruptions, rashes, unusual hair growth or loss.
- 2. Neuro**
Headache, nervousness, sleep disturbance, vertigo, syncope, sensory or motor disturbance, paralysis/paresis, paresthesia/hyperesthesia/hypoesthesia, memory loss, nightmares, twitching, convulsions, tremors, dysphagia, handwriting changes, mental status, level of consciousness (ability to follow command), disorientation, pupil size and reaction.
- 3. Cardiovascular**
Dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, hypertension, claudication, varicose veins, thrombophlebitis, raynaud syncope, chest pain, heart rate (palpitations, rhythm changes, heart murmur), edema (pedal, sacral, periorbital), tele (heart sounds), pulses (peripheral, apical, jugular veins), capillary refill.
- 4. Respiratory**
Breath sounds (wheezing, rales, etc.), character of breathing (rate, dyspnea, shallow, etc.), chest movement, cough, expectoration, hemoptysis, night sweats, sneezing, rhinorrhea, oxygen, gases, vents, trachs, suctioning, chest drainage (tubes), sputum specimens, oral hygiene, post-op coughing and deep breathing, incentive spirometry, type of secretions, position of bed, pulse oximeter/apnea monitor.
- 5. Gi/Metabolic**
Dietary habits, appetite, food intolerance, use of antacids, indigestion, nausea, vomiting, distension, abdominal pains, abdominal masses, jaundice, hematemesis, bowel habits, diarrhea, constipation (laxative use), melena stool formation and description, hemorrhoids, incontinence, abdominal surgery, bowel sounds, abdominal tubes/drains, ostomies, hyperalimentation, diabetes/thyroid, vice changes, goiter, polydipsia, polyphagia, polyuria, excessive sweating, inspection and palpation of abdomen.
- 6. Gu/GYN**
Dysuria, polyuria, oliguria, hematuria, pyuria, calculi, force of stream, output (color, amount, etc.), strain urine, retention, bladder distention, frequency, hesitancy, nocturia, incontinence, discharge (type, color, odors), care of tubes (foley, suprapubic), Imp (vaginal discharge/bleeding), rashes, soaks.
- 7. Musculoskeletal**
Muscle weakness, pain, aches, cramps, atrophy, back or joint stiffness, deformities, dislocation, fractures, radicular pain, casts, ambulation, therapy, use of devices, elevation/immobilization of extremities or body parts, traction.
- 8. Psycho-social**
Behavior (anxious, afraid, impatient, angry), emotional response to current treatment/hospitalization, self-concept/body language image changes, grieving, limitations in intellectual capacity, cultural factors (beliefs, response to pain), ineffective family coping.