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NUR 155.01: Meeting Adult Physiological Needs I

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College of Technology Practical Nursing Program
NUR 155 Course Overview
Fall 2004

Course Name and Number:

NUR 155 Meeting Adult Physiological Needs I

Instructor:

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406/243-7864

Credit and Time Allotment:

Credits:	5
Lecture:	45 contact hours 3 hrs/wk – 15 wks
Clinical:	84 contact hours 12 hrs/wk – 7 wks

Prerequisite Courses:

NUR 151, NUR 152, SCN 119N, prerequisite or co-requisite SCN 150N

Course Description:

The focus of this lecture course is the continued application of nursing theories, principles and skills to meet the basic human needs of adult clients experiencing more complex, recurring actual or potential health deviations.

The nursing process provides the framework which enables students to synthesize aspects of communication, ethical/legal issues, cultural diversity, and optimal wellness. Supervised care of the adult client is provided during the clinical experience in the acute care setting. Emphasis is placed on the use of nursing assessment, the nursing process and communication skills to enable the student to assist in identifying needs, planning, providing, and evaluating care for the adult client experiencing more complex health deviations.

Course Objectives: At the completion of NUR 155, the student will:

1. Spell and define medical terminology accurately for each unit in the class.
2. Demonstrate on written examinations an understanding of the nursing assessments to assist in planning care to meet human needs of the adult client.
3. Demonstrate understanding of the nursing process by its application to direct nursing care of adult clients experiencing recurring medical/surgical health deviations.
4. Demonstrate on written examinations theoretical knowledge of the recurring medical/surgical health deviations in adult clients.
5. Describe, on written examinations, ethical and legal implications in the planning, implementing and evaluating of nursing care.
6. Describe, on written examinations, human development and cultural diversity as effectors of basic human needs.
7. Identify, on written examinations, teaching/learning needs of adult clients with common, recurring medical/surgical health deviations.
8. Practice in a professional manner, utilizing the criteria on the evaluation form for the course as a guide.
9. Demonstrate effective verbal and written communication and active listening skills during interactions with clients, families, and health team members, as evidenced by instructor and/or health care staff observations.
10. Demonstrate skill in applying the nursing process to care of adult clients with recurring health deviations, as evidenced by implementation of planned nursing interventions.
11. Demonstrate professional accountability and reliability as evidenced by preparation for clinical, requesting assistance when indicated and reporting errors to the clinical instructor and/or health care staff.
12. Demonstrate ethical behavior as evidenced by implementing care for clients regardless of age, values, development or sociocultural background.
13. Safely and accurately administer medication with supervision of clinical instructor or health care staff upon approval of instructor.
14. Document and report care given, maintaining client confidentiality, on agency forms, with instructor or staff approval.
15. Utilize accepted principles/practices and assistance as required to perform technical nursing procedures.
16. Utilize time and resources effectively in managing his/her assignment, as evidenced by completion of care within the allotted time.
17. Write nursing care plans for assigned clients, utilizing defining characteristics, approved NANDA format and diagnoses, client centered goals, nursing interventions and evaluation criteria as presented in NUR 152.

Methods Of Instruction:

1. Classroom lecture
2. Computer simulations and computer-assisted-instruction
3. Study guides
4. Group discussion
5. Audio-visual materials
6. Clinical instruction
7. Pre- and/or post-conferences
8. Observation and practice in clinical setting
9. Practice individualized physical and emotional assessment in clinical setting
10. Simulated nursing care experiences and feedback demonstrations by students
11. Written nursing care plans on one patient after each clinical week
12. Selected reference reading

Methods Of Evaluation:

1. Unit exams
2. Final Exam.
3. Pop quizzes at instructors discretion.
4. Instructor evaluation of students, utilizing clinical evaluation tool for NUR 155 and instructor observation of supervised clinical practice
5. Written care plans for assigned clients
6. Participation in clinical conferences.

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

ATTENDANCE POLICY: Regular attendance is expected, and will be taken every class period. Lack of attendance will adversely affect final grades. A student may miss up to three class days without penalty, but the fourth absence, and each absence thereafter will result in a loss of one full letter grade to the final course grade. If a student misses a class or lab, it is the student's responsibility to make up for the absence. Absenteeism greater than one day in clinical will result in failure of the clinical portion of the course. Tests are to be taken on the day they are scheduled. Makeup tests will be taken on the first day the student returns to class. All makeup tests will automatically have a 10% reduction in score unless the student has contacted the instructor before the next class period and received approval for the absence.

Disability Statement: Eligible students with disabilities will receive appropriate accommodations in this course when requested in a timely way. Please speak with me after class or in my office. Please be prepared to provide a letter from your DSS Coordinator. For students planning to request testing accommodations, be sure to bring the form to me in advance of the two-day deadline for scheduling in the ASC.

Course Outline:

1. Fluid and Electrolytes and Shock
2. Musculoskeletal Disorders
3. Endocrine Disorders
4. Reproductive Disorders
5. Digestive Disorders
6. Integumentary Disorders

Required Textbooks:

Title: Introduction to Medical-Surgical Nursing (2003) 3rd ed.
Author: Linton and Maebius
Publisher: Saunders
Workbook to accompany: Introduction to Medical-Surgical Nursing (**REQUIRED**)

Title: Virtual Clinical Excursions
Author: Collette Moreno
Publisher: Saunders

Recommended Text Books:

Medical Dictionary of choice
Care Planning/Nursing Diagnosis
Handbook of choice
Laboratory/Diagnostic Studies
Handbook of choice
Nursing Drug Handbook of choice

UNIT 1: Fluid and Electrolytes and Shock

Central Objective: Utilizing the nursing process and the appropriate nursing diagnosis, examine the needs of the individual with compromised fluid, electrolyte, acid/base or tissue perfusion.

Student Objectives:

- A. The student will be able to:
 - 1. Describe the extracellular and intracellular fluid compartments.
 - 2. Describe the composition of the extracellular and intracellular fluid compartments.
 - 3. Discuss the basic regulatory mechanisms for maintaining fluid balance.
 - 4. Discuss common disturbances in fluid balance, including causes, signs and symptoms, treatment and nursing care.
 - 5. Describe the major functions of the following electrolytes: sodium, potassium, magnesium, calcium and chloride.
 - 6. Discuss common disturbances in electrolyte balance including causes, signs and symptoms, treatment and nursing care.
 - 7. List data to be collected in the assessment of fluid and electrolyte status and in fluid or electrolyte imbalances.
 - 8. Explain why the elderly are at increased risk for fluid and electrolyte imbalances, and age appropriate assessment techniques.
 - 9. List the four types of acid-base imbalance.
 - 10. Identify the major causes and signs and symptoms of each acid-base imbalance.
 - 11. Explain the medical management and appropriate nursing interventions of each acid-base imbalance.
 - 12. List the types of shock.
 - 13. Describe the pathophysiology and signs and symptoms of each type of shock.
 - 14. List the signs and symptoms of each stage of shock.
 - 15. Explain the first aid emergency treatment of shock outside the medical facility.
 - 16. Identify general medical and nursing interventions for each type of shock.
 - 17. Explain the rationale for medical/surgical treatment of shock.
 - 18. Assist in developing care plans for patients in each type of shock.
 - 19. Define all key, italicized or unfamiliar terminology.
 - 20. Discuss expected actions of each of the categories of drugs used to treat shock.

- B. Describe the following diagnostic studies; including purpose, procedure and normal values:
1. Urine pH
 2. Urine concentration test (specify gravity)
 3. Urine Osmolality
 4. Creatinine clearance test – urine
 5. Urine sodium and potassium
 6. Serum hematocrit
 7. Serum creatinine
 8. Blood urea nitrogen (BUN)
 9. Serum osmolality
 10. Serum albumin
 11. Serum electrolytes
 12. Arterial blood gas values
- C. Utilize the nursing process (assessment, diagnosis, plan, implementation, evaluation) for the client experiencing fluid volume imbalances:
1. Fluid volume, deficient
 - a. Related to inadequate fluid intake, excessive fluid loss, high blood glucose, inadequate ADH production or effect, high fever
 2. Acute confusion
 - a. Related to decreased cerebral tissue perfusion
 3. Constipation
 - a. Related to excessive reabsorption of water from stool in the colon
 4. Risk for injury
 - a. Related to decreased level of consciousness
 5. Risk for impaired skin integrity
 - a. Related to poor tissue perfusion
 6. Ineffective tissue perfusion
 - a. Related to decreased cardiac output secondary to decreased blood volume.
 7. Excess fluid volume
 - a. Related to fluid retention, excess or hypotonic intravenous fluid administration.
 8. Acute confusion, disturbed thought processes
 - a. Related to cerebral edema

9. Risk for injury
 - a. Related to decreased level of consciousness
 10. Risk for impaired skin integrity
 - a. Related to edema
 11. Impaired tissue perfusion
 - a. Related to reduced cardiac output with heart failure.
- D. Utilize the nursing process for the client experiencing shock
1. Ineffective tissue perfusion
 - a. Related to failing cardiac pump, hypovolemia, or inadequate venous return
 2. Decreased cardiac output
 - a. Related to hypovolemia, peripheral vasodilation, myocardial disorders
 3. Disturbed thought processes
 - a. Related to inadequate cerebral perfusion and metabolic acidosis.
 4. Deficient fluid volume
 - a. Related to hemorrhage, inadequate fluid intake, excessive fluid loss.
 5. Anxiety
 - a. Related to hypoxia, life-threatening situation.
 6. Risk for injury
 - a. Related to confusion, adverse effects of drugs, invasive treatments
 7. Risk for infection
 - a. Related to trauma, invasive therapeutic procedures
 8. Ineffective family coping
 - a. Related to anxiety, uncertainty of patient's outcome.
- E. Learning Objectives
- Read:
- Introduction to Medical-Surgical Nursing, Linton & Maebius, Chs 13 & 18
- Complete and hand in for a grade:
1. Lesson 17 "Fluid and Electrolytes: in Virtual Clinical Excursions
 2. Lesson 6 "Shock" in Virtual Clinical Excursions

UNIT 2: Musculoskeletal Disorders

Central Objective: Utilizing the nursing process and the appropriate diagnoses, examine the needs of the client with a musculoskeletal disorder or injury.

Student Objectives:

- A. Describe the pathophysiology, treatment and nursing implications for the following musculoskeletal disorders:
 - 1. Rheumatoid arthritis
 - 2. Osteoarthritis
 - 3. Gout
 - 4. Osteoporosis
 - 5. Carpal tunnel syndrome
 - 6. Progressive systemic sclerosis
 - 7. Polymyositis
 - 8. Bursitis
 - 9. Ankylosing spondylitis
 - 10. Polymyalgia rheumatica
 - 11. Reiter's syndrome
 - 12. Behcet's syndrome
 - 13. Sjögren's syndrome
- B. Describe the following diagnostic studies and nursing interventions for each:
 - 1. Radiographs, CAT scan, and MRI
 - 2. Arthroscopy
 - 3. Arthrocentesis (joint aspiration)
 - 4. Arthrography
 - 5. Bone scan
 - 6. Laboratory tests:
 - a. antinuclear antibodies (ANA)
 - b. erythrocyte sedimentation rate (ESR)
 - c. Rheumatoid factor (RF)
 - d. C-Reactive Protein
 - e. Creatinine

7. Urine Studies
 - a. 24-hour urine for creatinine
 - b. Urinary uric acid (24 hour collection)
8. Doppler ultrasound
9. Bone biopsy
- C. Describe the following therapeutic regimens and the basic nursing implications for:
 1. Traction
 2. Open reduction; closed reduction
 3. Internal fixation; external fixation
 4. Casts
 5. Crutches
 6. Slings
- D. Describe the basic use, classification, side effects, and nursing implications for the following medications:
 1. Nonsteroidal antiinflammatory drugs (NSAIDs)
 2. Glucocorticoids
 3. Antic gout agents
 4. Second generation nonsteroidal anti-inflammatory drugs: COX₂ inhibitors
 5. Disease-modifying antirheumatic drugs (DMARDs)
 6. Bone resorption inhibitors
- E. Regarding connective tissue disorders, the student will:
 1. Define connective tissue
 2. Describe the function of connective tissue
 3. Describe the characteristics and prevalence of connective tissue diseases
 4. Identify the data to be collected in the nursing assessment of a patient with a connective tissue disorder
 5. Assist in developing a nursing care plan for a patient whose life has been affected by a connective tissue disease
- F. Regarding fractures, the student will:
 1. Identify the types of fractures
 2. Describe the five stages of the healing process
 3. Discuss the major complications of fractures, their signs and symptoms, and their management
 4. Discuss the nursing care of a patient with a fracture
 5. Describe specific types of fractures, including hip fractures, Colles fractures and pelvic fractures

- G. Regarding amputations, the student will:
1. Identify the clinical indications for amputations
 2. Describe the different types of amputations
 3. Discuss the medical and surgical management of the amputation patient.
 4. Identify appropriate nursing interventions during the pre-operative and postoperative phases of care
 5. Assist in developing a nursing care plan for the amputation patient.

H. Learning Objectives:

Read:

Introduction to Medical-Surgical Nursing, Linton and Maebius, Musculoskeletal Disorders: (Chapters 39,40, 41)

Review:

Anatomy and Physiology of the Musculoskeletal System

Complete and hand in for a grade:

Lesson 7, “ORIF/Fractures” in Virtual Clinical Excursions

UNIT 3: Endocrine Disorders

Central Objective: Utilizing the nursing process and the appropriate nursing diagnosis, examine the needs of the individual with compromised endocrine function.

Student Objectives:

- A. Examine:
 - 1. The basic clinical manifestations, pathophysiology, nursing implications and management of the following endocrine disorders.
 - a. Hyperthyroidism and Grave's disease
 - b. Hypothyroidism and Myxedema
 - c. Hyperparathyroidism
 - d. Hypoparathyroidism
 - e. Addison's Disease
 - f. Cushing's Syndrome and Cushing's disease
 - g. Pheochromocytoma
 - h. Diabetes mellitus
 - i. Hypoglycemia
 - j. Hyperglycemia
 - k. Diabetes Insipidus
 - l. Syndrome of Inappropriate Antidiuretic Hormone (SIADH)
 - m. Goiter
 - n. Acromegaly
 - o. Gigantism
 - p. Cretinism
 - q. Hypopituitarism
 - r. Pituitary tumors

- B. Describe the following diagnostic studies and the standard nursing interventions for:
1. Laboratory Studies
 - a. T₃, T₄, TSH and TRH
 - b. Pituitary hormone level
 - c. Fasting blood sugars
 - d. Glucose tolerance test
 - e. Two hour postprandial glucose level
 - f.
 2. Hypertonic saline test
 3. Fluid deprivation test
 4. Radioactive iodine uptake
 5. Thyroid scan
 6. CT scan – cerebral
 7. Cerebral angiogram
 8. Dexamethasone suppression tests
- C. Describe the following therapeutic regimens and the basic pre and postoperative nursing implications for:
1. Thyroidectomy
 2. Adrenalectomy
- D. Describe the basic use, classification, and nursing implications for the following medications:
1. Thyroid hormone replacement drugs
 2. Antithyroid drugs
 3. Calcium salts
 4. Calcitonin
 5. Bisphosphonates
 6. Glucocorticoids
 7. Mineralcorticoids
 8. ADH Hormone preparations
 9. Pituitary hormone suppressants
 10. Antidiabetic medications (Oral Hypoglycemic or Antihyperglycemic)
 11. Insulin

- E. Identify nursing assessment data relevant to the function of:
1. The adrenal glands
 2. The pituitary glands
 3. The thyroid glands
 4. The parathyroid glands
- F. Describe:
1. The role of insulin in the body.
 2. Significant differences in the two major types of diabetes mellitus.
 3. Laboratory tests used in the diagnosis of diabetes mellitus.
 4. Preparation needed to teach a newly diagnosed diabetic patient about the disease, treatment, and self-care.
 5. Early signs and symptoms that might indicate ketoacidosis and describe appropriate nursing care.
 6. Signs and symptoms of an insulin reaction (hypoglycemia) and describe appropriate nursing intervention.
 7. The acute and long-term complications and results of poorly controlled diabetes mellitus.
 8. Signs and symptoms of hypoglycemia and diabetes mellitus.
 9. The pathophysiology of diabetes mellitus and hypoglycemia
 10. Treatment of diabetes mellitus and hypoglycemia.
- G. Assist in the development of nursing care plans for patients with disorders of the adrenal, pituitary, thyroid and parathyroid glands.
- H. Learning Objectives

Read:

Introduction to Medical Surgical Nursing, Linton and Maebius, “Endocrine Disorders” Chapters 42, 43, and 44

Review:

Anatomy and Physiology of the Endocrine System

Complete and turn in for a grade:

Lesson 18 “Diabetes Mellitus and Hypoglycemia” Virtual Clinical Excursions

Unit 4: Reproductive Disorders

Central Objectives: Utilizing the nursing process and the appropriate nursing diagnoses examine needs of the client experiencing compromised sexual function.

Student Objectives:

- A. Examine:
 - 1. The pituitary hormones responsible for ovulation.
 - 2. The effects of estrogen and progesterone on the female breast and uterus.
 - 3. The following problems, their effects on sexuality, pathophysiology, medical care, signs and symptoms and nursing implications
 - a. Sexually transmitted diseases (STD)
 - (1) Chlamydial infections
 - (2) Gonorrhea
 - (3) Syphilis
 - (4) Acquired immunodeficiency (Human immunodeficiency virus infection)
 - (5) Herpes simplex virus
 - (6) Venereal warts (Condylomata acuminata)
 - (7) Trichomoniasis
 - (8) Bacterial vaginosis
 - b. Inflammatory disorders of reproductive structures
 - (1) Vaginitis or vulvitis
 - (2) Pelvic inflammatory disease (PID)
 - (3) Cervicitis
 - (4) Mastitis
 - (5) Prostatitis
 - (6) Epididymitis
 - (7) Orchitis

- c. Disorders of the reproductive structures
 - (1) Vaginal fistulas
 - (2) Rectocele, cystocele , uterine prolapse
 - (3) Hydrocele
 - (4) Varicocele
 - (5) Cryptorchidism
 - (6) Cancers of cervix, ovary, vulva, vagina, breast, prostate, testes
 - (7) Benign prostatic hypertrophy (BPH)
 - (8) Endometriosis
 - (9) Fibrocystic breast disease
 - (10) Fibroid tumors (Leiomyomas, Myomas)
 - (11) Ovarian cysts
 - (12) Infertility-male and female
 - (13) Phimosis
- d. Menstrual dysfunctions
 - (1) Menopause
 - (2) Menorrhagia
 - (3) Metrorrhagia

B. Describe the following diagnostic studies and relevant nursing interventions for:

- 1. Pelvic examination
- 2. Laboratory tests
 - a. Papanicolaou (Pap smear)
 - b. Smears and cultures
 - c. Enzyme - linked immunosorbent assay (ELISA)
 - d. Serum acid phosphatase
 - e. Prostate Specific Antigen (PSA)
 - f. Semen analysis
- 3. Laparoscopy
- 4. Breast examination, including self-examination
- 5. Mammography
- 6. Breast biopsy, prostate biopsy
- 7. Dilation and curettage (D & C)

8. Testicular examination, including self-examination
 9. Digital rectal exam
 10. Endometrial and cervical biopsies
 11. Colposcopy
 12. Culdoscopy
 13. Cystoscopy
- C. Describe the following therapeutic surgical regimens and the basic nursing implications for:
1. Hysterectomy – all types
 2. Salpingo-oophorectomy
 3. Anterior and posterior colporrhaphy
 4. Mastectomy – all types
 5. Prostatectomy – all types
 6. Vasectomy
- D. Describe the basic use, classification, and nursing implications for the following medications:
1. Androgens (testosterone)
 2. Estrogens (Premarin R)
 3. Antibacterial, antifungal or antiprotozoal agents
 4. Estrogen receptor modulators
 5. Antiviral agents
 6. Oral contraceptives
 7. Vaginal treatments
 - a. Douche
 - b. Insertion of creams and suppositories
 - c. Antifungals (Monistat, Mycostatin)
- E. At the completion of this unit the student will:
1. List data to be collected when assessing the female and male reproductive systems.
 2. Identify the nursing interventions associated with douche, cauterization, and heat therapy used to treat disorders of the female reproductive tract.
 3. Describe the nursing interventions for the menopausal patient.

4. Assist in developing a nursing care plan for a female patient with a reproductive system disorder; for a male patient with a reproductive system disorder.
5. Explain the importance of the nurse's approach when dealing with patients who have sexually transmitted diseases.
6. Design a teaching plan on the prevention of sexually transmitted diseases
7. List nursing considerations when a patient is on drug therapy for a sexually transmitted disease.
8. Assist in developing a nursing care plan for a patient with a sexually transmitted disease.

F. Learning Objectives

Read:

Introduction to Medical-Surgical Nursing, Linton & Maebius, Chapters 45, 46, and 47.

Review:

Anatomy and Physiology of the Male and Female Reproductive System

Complete and turn in for a grade:

Lesson 2, "Female Reproductive Disorders" Virtual Clinical Excursions

UNIT 5: Digestive Disorders

Central Objective: Utilizing the nursing process and the appropriate nursing diagnosis, examine the needs of the client with compromised digestive function.

Student Objectives:

- A. Examine:
 - 1. Basic clinical manifestations, treatment and nursing implications for common disorders of the gastrointestinal tract and accessory organs:
 - a. Disorders affecting ingestion
 - (1) Anorexia
 - (2) Stomatitis
 - (3) Oral cancer
 - b. Disorders affecting digestion and absorption
 - (1) Nausea and vomiting
 - (2) Hiatal hernia
 - (3) Gastroesophageal reflux disease (GERD)
 - (4) Gastritis
 - (5) Peptic ulcer
 - (6) Stomach cancer
 - (7) Obesity
 - c. Disorders affecting absorption and elimination
 - (1) Diarrhea
 - (2) Constipation
 - (3) Intestinal obstruction
 - (4) Appendicitis
 - (5) Peritonitis
 - (6) Abdominal hernia
 - (7) Inflammatory bowel disease
 - (8) Diverticular disease
 - (9) Cancer of the colon

- d. Disorders of the liver
 - (1) Hepatitis
 - (2) Cirrhosis
 - (3) Cancer of the liver
- e. Liver transplantation
- f. Disorders of the gall bladder
 - (1) Cholecystitis and cholelithiasis
- g. Disorders of the pancreas
 - (1) Pancreatitis
 - (2) Cancer of the pancreas

B. Describe the following diagnostic studies and the standard nursing implications for each:

1. Radiological exams, including: upper GI, barium swallow, barium enema, cholangiography, liver scan, CT, MRI, ultrasonography
2. Endoscopic exams including: Esophagoscopy, endoscopic retrograde cholangiography, endoscopic retrograde cholangio-pancreatography (ERCP), colonoscopy, esophagogastro-duodenoscopy, proctoscopy and sigmoidoscopy gastroscopy
3. Laboratory tests including: Gastric analysis, stool occult blood, fecal fat, stool ova and parasites, serum bilirubin, serum enzymes (AST, ALT, LDH), prothrombin time and INR, serum amylase, urine amylase.

C. Describe the following therapeutic regimens and the basic nursing implications for:

1. Gastrointestinal intubation and intestinal decompression
2. Surgery: gastric, colon and gall bladder
3. Nutritional replacement and modifications to include TPN, gastrostomy and nasogastric feedings
4. Fecal diversions

D. Describe the basic use, classification, and nursing implications for the following medications:

1. Antidiarrheal agents
2. Stool softeners/laxatives
3. Anticholinergics
4. Antacids
5. H₂ receptor antagonists
6. Mucosal barrier

7. Emetics/Antiemetics
8. Synthetic prostaglandins
9. Prokinetic agent

E. The student will be able to:

1. List the indications for ostomy surgery to divert feces.
2. Describe the nursing interventions to prepare the patient for ostomy surgery.
3. Explain the types of procedures used for fecal diversion.
4. Assist in developing a nursing care plan for the patient with each of the following types of fecal diversions: ileostomy, continent ileostomy, ileoanal reservoir and colostomy.
5. List the data to be included in the nursing assessment of the patient with a digestive disorder; the patient with liver, gall bladder or pancreatic disease.
6. Describe the care of the patient who has an esophageal balloon tube in place.
7. Assist in developing a nursing care plan for patient with digestive, liver, gall bladder or pancreatic dysfunction.

F. Learning Objectives

Read:

Introduction to Medical –Surgical Nursing, Linton & Maebius, Chapters 36 and 37, and Ch 25, pp 347-358.

Review:

Anatomy and Physiology of the Digestive Tract

Complete and turn in for a grade:

Lesson 10, “Digestive Tract Disorders” in Virtual Clinical Excursions

Unit 6: Integumentary Disorders

Central Objective: Utilizing the nursing process and the appropriate nursing diagnosis, examine the needs of the client having compromised skin integrity.

Student Objectives:

- A. Examine:
 - 1. Anatomy and Physiology of skin
 - 2. Components of the nursing assessment of the skin
 - 3. Key terms used in describing the skin and skin lesions
- B. Describe the following diagnostic studies and the standard nursing interventions for:
 - 1. Skin biopsy; shave, punch and excisional
 - 2. Potassium hydroxide (KOH)
 - 3. Tzanck's smear
 - 4. Wood light inspection
 - 5. Patch test for allergy
- C. Describe the following therapeutic regimens and the basic nursing implications for:
 - 1. Dressings
 - 2. Drug therapy: oral and topical
 - 3. Wet compresses and soaks
 - 4. Phototherapy
 - 5. Negative pressure wound therapy
 - 6. Burn therapy, including debridement and skin grafting
 - 7. Acne therapy
 - 8. Plastic surgery; aesthetic and reconstructive
- D. Describe the basic use, classification, and nursing implications for the following medications:
 - 1. Keratolytics
 - 2. Topical antibacterials antivirals and antifungals
 - 3. Topical antiinflammatories
 - 4. Vitamin A derivatives
 - 5. Pediculicides and scabicides
 - 6. Antipsoriatics

E. Examine:

1. The basic clinical manifestations, pathophysiology, management and nursing care of the following integumentary disorders
 - a. Pruritus
 - b. Atopic dermatitis (eczema)
 - c. Seborrheic dermatitis
 - d. Psoriasis
 - e. Intertrigo
 - f. Fungal infections
 - g. Acne
 - h. Herpes Simplex
 - i. Herpes Zoster
 - j. Infestations (scabies, lice)
 - k. Skin cancer
 - l. Burns
 - m. Pressure ulcers

F. At completion of this unit the student will:

1. Describe common problems associated with immobility.
2. Discuss the impact of exercise and positioning on preventing complications related to immobility.
3. Identify the risk factors for pressure ulcers.
4. Describe the stages of pressure ulcers.
5. Describe methods of preventing and treating pressure ulcers.
6. Discuss the effects of immobility on respiratory status, nutrition and elimination.

G. Learning Objectives

Read:

Introduction to Medical-Surgical Nursing, Linton and Maebius, Chs 48 and 20

Review:

Anatomy and Physiology of Skin

**THE UNIVERSITY OF MONTANA-MISSOULA
COLLEGE OF TECHNOLOGY
PRACTICAL NURSING PROGRAM
GENERAL GUIDELINES FOR NUR 155 CLINICAL**



Clinical experiences are planned to provide the student with the opportunity to apply knowledge and skills in the hospital or other assigned setting. I understand what a stressful time this is for students. That is why I want you to remember that my door is always open, my phone number always available and my mind is always ready to listen and understand. During this hectic semester of your student career, it is most important to strive for balance in your student work and your personal life. As stated so nicely by an anonymous Irishman:

Take time for work, it is the price of success.
Take time to think, it is the source of power.
Take time to play, it is the secret of youth.
Take time to read, it is the foundation of wisdom.
Take time to be friendly, it is the road to happiness.
Take time to dream, it's hitching your wagon to a star.
Take time to love, it is the highest joy of life.
Take time to laugh, it is the music of the soul.

GROOMING

1. Immaculate grooming and daily personal hygiene including deodorant are essential because of close proximity to clients and others.
2. Hair must be contained, clean and worn off the face and in a conservative style to provide protection for the client.
3. Facial hair for men must be clean, trimmed and worn in such a manner that will not obstruct nursing activities.
4. Simple make-up and clean, short nails are expected in the clinical setting. Clear or light colored nail polish may be worn.
5. Since odors of any kind may be offensive to client, products with strong odors should be avoided while working in a clinical setting. (i.e., perfumes, tobacco, etc.)
6. Gum is not to be chewed in the clinical area.
7. Jewelry is limited to wedding and engagement rings and a watch. Limit earrings to two small studs per ear. Avoid hoops or dangling styles. Religious symbols are not to be visible if worn. Avoid wearing necklaces.
8. Visible tattoos and/or hickies must be covered unless absolutely impossible to do so. No visible underarms or cleavage at any time (e.g. bending over).
9. Only naturally occurring hair color is allowed. Unacceptable: green, blue, pink, etc.
10. Additional criteria will be defined and enforced by nursing instructors in specified clinical areas. Failure to meet any or the above criteria may result in the student being excused from the clinical area.

UNIFORMS

Uniform regulations are designed to maintain uniformity appropriate to and within a profession. Frivolous, revealing or form-fitting apparel and accessories are not appropriate for professional wear. Students should choose items that portray an image of competence, confidence and professionalism. Therefore, ***strict personal hygiene and clean pressed uniforms***, as well as strict adherence to uniform policy of the institution or assigned unit are requested and expected of College of Technology students.

When picking out patients on Wednesday afternoon, you must be dressed appropriately and have your name tag on. No jeans, shorts, or holes in clothing is allowed. It can be casual, but must look nice and professional.

Questions regarding appropriate apparel should be brought to the Practical Nursing Instructor prior to clinical. Students ***not in compliance*** with the uniform policy will be sent home and the clinical day will be an absence. ***All students while on clinical duty will wear the uniform designated by the nursing program.***

1. Uniforms under the maroon lab coat must be white, professional in appearance, clean and functional allowing for the freedom of movement and modesty. Clean, white shoes and white or flesh-colored hose are to worn. Open-toe shoes or sandals are not permitted. Proper undergarments must be worn at all times, but must not be visible.
2. The official designated name pin is required part of the uniform. Modifications to the pin, except those mentioned above, are unacceptable. ID badges/name pins must be worn in a visible manner.
3. Maroon lab coat and name pins ***must*** be worn in the hospital (or other clinical setting) outside scheduled clinical time when additional patient or medication information is required for assignments.

CLINICAL RULES AND DRESS CODE

HOSPITALS

1. At the clinical site at 0645 a.m.
2. At CMC sign in on the clipboard at the front desk.
3. Park in the far end of the CMC parking lot.
4. Dress code is white pants, white shoes and school jacket with name tag.

ATTENDANCE AND ABSENTEEISM

1. Because of the critical relationship between time and learning, the instructor believes that students cannot miss planned experiences and gain knowledge needed to care for human lives. Students are required to meet all class and clinical requirements. Since the acquisition of knowledge and skills in nursing is cumulative, both in theory and clinical areas, class attendance and participation are ***strongly*** encouraged. This aids in the monitoring and evaluation of the student's progress

through the program of learning. Absenteeism greater than one day in **clinical** is an automatic failure of the clinical portion of class. Absenteeism greater than 3 in the **classroom** is an automatic loss of one final letter grade. For further missed classroom days, each absence reduces the final course grade by one letter (B to C, C to D, etc.)

2. Nursing students must attend each agency clinical experience. Students are expected to be punctual and prepared to begin clinical experience at the designated time. In case of unavoidable absence or tardiness on the assigned day, the student must call the assigned unit at least 30-minutes prior to assigned arrival time. Obtain the name of the person with whom you leave your message. The instructor must be notified personally prior to student scheduled time. Failure of a student to assume this responsibility to assigned patients will result in a student contract being completed by the instructor concerning the clinical performance. Do not come to clinical if you have a fever, diagnosed or contagious rash or diarrhea. Be especially cautious if working with infants or immunosuppressed patients (i.e., no cold sores).
3. Children are not to be brought to class, clinical, or post-clinical conferences, evaluation, examinations or nursing lab at any time. Disruptive behavior is distracting for other students and inconsiderate to those presenting information.
4. Signing in every day upon arrival (where required) is each student's responsibility. Failure to do so will risk your being marked absent or tardy. Grades will reflect overall pattern of attendance. ***Post-clinical conference attendance is mandatory.***
5. Vehicles must be parked in appropriate areas. At Saint Patrick Hospital, vehicles must be parked on the street, at least two blocks away from the hospital. Do not park in the lots or in the Safeway lot. You can park in the designated Saint Patrick Hospital parking lot on Broadway, but must have a note in the front window of your car designating you as a COT nursing student. Parking in the hospital lot will result in dismissal from the program. At Community Medical Center, students are to park in the lots designated for employees.
6. If it is necessary for the instructor to miss clinical either due to illness, personal leave, meeting or conference attendance, in lieu of clinical the student will be required to complete a paper pertaining to the clinical area in which he/she was to be assigned.

POST-CLINICAL CONFERENCES

Post-clinical conferences are an integral part of the curriculum and students will be informally evaluated on participation. The student is expected to meet specific objectives in each clinical assignment.

Post-clinical conference will be at the end of the clinical experience each week and will last approximately 1 hour. The purpose of the conference is to:

1. Analyze clinical experience and share learning experiences with others
2. Correlate theory to clinical practice
3. Provide an opportunity to identify, clarify and explore nursing problems
4. Provide for active participation of each student
5. Assigned case study conferences are informal and spontaneous, discussion is encouraged. Each student is expected to participate by contributing and sharing clinical experiences related to the objectives and focus of the clinical experience.

The Nursing Care Plan is due Thursday at 7:00 a.m. Please clip it to the sign in form at CMC's front desk. Work is to be handed in on the assigned date. No work will be accepted late without prior permission from the instructor. Late assignments will be penalized. If assignments are late three times in one semester, the student may fail the course based on the instructor's discretion.

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

YOUR ROLE AS A STUDENT NURSE

"FEAR LESS, HOPE MORE; EAT LESS, CHEW MORE; WHINE LESS, BREATHE MORE; TALK LESS, SAY MORE; HATE LESS, LOVE MORE AND ALL GOOD THINGS ARE YOURS." *SWEDISH PROVERB*

1. All personal belongings (wallets, purses, books, etc.) should be kept in a locker space, if provided, or left at home. Coats are to be hung in the areas provided for nursing staff on each unit.
2. Gum chewing, tobacco use or coffee breaks are not allowed on the unit. Please avoid crowding staff lounges. Eating and drinking at the nurses' stations is prohibited by OSHA standards. Do not eat or drink stock foods on the nursing units.
3. Students are allowed two 20-minute breaks and a 30 minute lunch hour for each twelve hour shift worked. Breaks are to be taken off the nursing units but on facility grounds in designated eating areas and must first be approved by your primary nurse.

4. Confidentiality is top priority. Never discuss a patient with anyone not directly involved with that patient's care. NEVER discuss patients in cafeteria, elevator, at home or in any public area. Do not write the patient's name on any of your written assignments, job sheets, assignment sheet or other notes. Use patient's initials only. Breach of this confidentiality will result in immediate dismissal from assigned clinical area and completion of a Student Contract. Repeat offenses may result in probation, suspension or dismissal from the program.
5. Patient charts may not be taken off the nursing units. If the nurses' station is crowded, take the chart to the conference room after leaving a note in the chart holder stating where the chart is and who has it. No part of a chart may be copied. Computer copies of lab results, etc. may not be taken off the unit or used in student care plan assignments.
6. Language in all areas (including break areas) will be well-modulated, sensitive and sensible and will not be of a confidential nature. Objectionable language use in any clinical area will not be tolerated. Offenders may be removed from assigned areas and referred to student services. Never discuss your personal problems with patients, visitors or hospital staff. Be cautious about expressing your opinion without thinking. Do not become involved with the family business of patients.
7. When answering the phone, identify the unit and give your title. For example:
"Neuro Unit, Alex Smith, Student Nurse"
8. At the completion of your shift, check to make sure your patient's room is neat and that your patient has fresh water, etc. Remember to pick up after yourself in patient rooms, utility rooms, conference rooms and nurses' stations.
9. On each assigned unit, be familiar with the location of the crash cart and the procedures for a code blue. Be familiar with the phone numbers at both hospitals for reporting code situations:

Saint Patrick Hospital - 5330
Community Medical Center - 2222
10. When leaving the nursing unit for any reason, let your primary nurse know where you are going and why. You may and should attend all tests and therapies with your patient. Please leave a message on the instructor's beeper if you will be accompanying your patient off the unit or leave the unit for any reason. Students will not be responsible for a patient while accompanying them off the unit and will not substitute for hospital personnel for transport. Students may not independently accompany patients outside the institution.

11. Before discharging a patient, make a final check with the primary nurse: all patients must have IV's DC'D, receive needed supplies, medications, prescriptions, personal belongings, discharge instructions and a written discharge order by the physician.
12. Page your instructor for all medications, procedures and approval of charting. After paging instructor, remain by the phone (please tell me the extension you will be by) for the instructor to return your call. Immediately inform your instructor of any mistakes or other incidents.
13. It is your responsibility to seek and find learning experiences such as procedures to perform. Word of warning: **Do not let us find you standing around with your hands in your pockets!!!** Clues to upcoming procedures include noting NPO signs, special sets and equipment brought to the unit and listening carefully during report. Call your instructor for all procedures. Before performing any tasks or procedures, ask yourself "WHY?" You should be prepared to discuss the rationale and underlying principles for all procedures. Never assume anything! Find the needed information!!
14. Document according to agency and unit policy format. Documentation varies from facility to facility and from unit to unit. Have all nurse's notes approved by instructor prior to writing them in the chart until you are comfortable with the format. Start notes on scratch paper promptly after initial patient assessment and update appropriately throughout the shift. Record vital signs, appetite, I and O and medications promptly.
15. Medications are to be set up and administered only in the presence of your instructor until designated otherwise by your instructor. Follow exactly the medication administrations protocol learned in classroom and lab. Page your instructor 30 minutes before each scheduled medication time (unless previously arranged with the instructor). Know the medications (generic and brand names, usual dosage range, action, side effects, route, dosage and any pertinent nursing implications). If unable to reach your instructor, ask your primary nurse to give the medication.
16. Demonstrate an interest in nursing, your patients and others while on duty. Be the first person to smile and say hello to hospital staff members, patients, visitors, etc.
17. When orienting on a nursing unit, be familiar where the policy and procedure manuals are located. You will be expected to follow them to the letter.

18. Each day prior to report, review patient's chart for any changes or new orders. Make appropriate changes on your daily jot sheets and use the information to ask pertinent questions during report. Having thoroughly studied the chart the day before, you need only check the preceding 24-hours of nurses' notes, doctors' orders, vital signs and other flow sheets, doctors' progress, lab and diagnostic reports and medication administration record (MAR). If the chart is unavailable to you the day before, you are responsible for making time to prepare properly PRIOR to report. If your assigned patient has been discharged, it is your responsibility to select an alternate patient to care for.
19. Introduce yourself to your primary nurse before leaving report. Tell him/her what your hours will be and what you will and will not be doing. Know your primary nurse's first name! Complete the contract and obtain primary nurse's signature.
20. On all assigned patients, you will systematically assess LOC, affect, comfort level, integumentary, neuromuscular, respiratory, cardiovascular, GI and GU systems. (Refer to Appendix A "Physical Assessment Guide - Systems Approach"). This includes vital signs, apical pulse, breath sounds, abdomen, bowel sounds, peripheral pulses, neurological assessments, as well as all dressings, IV's, catheters, hemovacs, NGs, oxygen, etc. Take vital signs at least every four hours and keep an I and O on your patient, ordered or not. ***Report questionable or abnormal findings promptly to instructor and primary nurse.*** Complete initial assessment immediately after report and conferring with your primary nurse. If you will have difficulty completing patient care before leaving for the day, let your primary nurse know as soon as possible. The full assessment should be in the chart no later than 0900.
21. If asked to "tape" a report on your patient, write out the information on scratch paper and have it approved by your primary nurse before recording.
22. Books on nursing units may be used for reference but may not be taken home. Many of them belong to staff and managers. You are encouraged to utilize the nursing library at the College of Technology, Saint Patrick Hospital, or the Mansfield Library. They contain a wide variety of excellent nursing references. Check with the librarian for the current hours and policies.

WRITTEN WORK FOR THIRD SEMESTER

1. Pathophysiology – assignment is to be done on standard size paper, written legibly in ink or typed on one side. *Paper torn from a spiral notebook, written in pencil and containing spelling or grammar errors will be unacceptable.* The pathophysiology paper will require you to discuss:

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

Author(s): last name first

Title: first letters capitalized

Journal: underline

Issue: volume, number, pages, date

The pathophysiology paper is due Thursday each week by 7:00 a.m. Work is to be handed in on the assigned date. No work will be accepted late without prior permission from the instructor. Late assignments will be penalized. If assignments (either patho paper or care plans) are late three times in one semester, the student may fail the course based on instructor discretion.

2. Care Plan – A weekly care plan will be turned in for each week rotation unless the student assignment is a case study. Papers are to be turned in on Thursday by 7:00 a.m. of the following week. Plans submitted should meet the format discussed in NUR 155. The care plan should include: (Refer to **Appendices C – F**)

- a. clinical prep form
- b. medication sheet
- c. nursing care plan
- d. clinical log form
- e. pathophysiology

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

CLINICAL OBJECTIVES

CENTRAL OBJECTIVE:

At the completion of this course, the student will have had the opportunity to develop nursing objectives to meet the needs of adult medical/surgical clients. The clinical experience is a coordinated learning experience utilizing the nursing process and relevant theoretical base.

Student Objectives:	Learning Objectives:
<p>I. By the completion of NUR 155, the student will be expected to care for selected clients experiencing the following:</p> <ul style="list-style-type: none"> A. Alterations in respiratory function. B. Alterations in musculoskeletal function. C. Alterations in renal function. D. Alterations in endocrine function. E. Alterations in gastrointestinal function. F. Alterations in skin integrity. G. Alterations in reproductive function. <p>II. By the completion of NUR 155, the student will have satisfactorily completed clinical prep forms, nursing care plans and performed more advanced health assessments, as designated by clinical instructors.</p> <p>III. By the completion of NUR 155, the student will demonstrate competence in the nursing process, communication, cultural diversity situations, human needs, ethical/legal issues, professional role and management as delineated on the clinical instructors.</p>	<p>I. Clinical Settings</p> <ul style="list-style-type: none"> A. CMC <ul style="list-style-type: none"> 1. Medical/Surgical unit 2. Rehab nursing unit 3. Day surgery unit <p>II. Clinical paper formats and focus</p> <ul style="list-style-type: none"> A. Medications Form B. Nursing Care Plan C. Clinical Log Form D. Pathophysiology paper E. Clinical Preparation form F. Care contract with primary nurse. <p>III. NUR 155 Clinical Evaluation</p>

**THE UNIVERSITY OF MONTANA-MISSOULA
COLLEGE OF TECHNOLOGY
NUR 155 CLINICAL EXPERIENCE I -- PRACTICAL NURSING PROGRAM
OUTPATIENT SURGERY DEPARTMENT – MISSOULA COMMUNITY MEDICAL CENTER**

At the end of the clinical week the student will:

1. Prepare the patient for surgery by assisting the staff with initial admitting data such as BP, HR, Height and Weight, and ordered skin preparation.
2. List medication taken and any allergies to meds for all patients.
3. Properly identify the patient and place any wrist identifiers.
4. Observe, assist, and document assessment data pre- and post-op.
5. Record all care given in approved area format.
6. Develop communication skills with patients, their families, and the staff.
7. Discuss pertinent issues of patient-self-esteem and anxiety as well as student concerns in post-conference.
8. Observe pre- and post-op patient teaching in the out-patient setting.

WRITTEN WORK FOR EXPERIENCE:

9. Describe in writing the total peri-operative preparations and care observed for one surgical client during clinical week using own words and references, not typed reports.
10. Write one nursing diagnosis to include nursing interventions, measurable goals, and evaluation criteria for the patient observed in the Out-Patient Department.
11. Complete the pre-op medication sheet and drug calculations.
12. Complete a clinical log form indicating procedures observed and performed.

☺WELCOME TO THE SURGERY DEPARTMENT☺

To help you gain the most from your experience, we have provided this information for reference.

We have students from eight different programs requesting to observe surgery. We will make every effort to accommodate students but only when advance arrangements have been made. For infection control and patient privacy, visitors to the O.R. are limited to two people **IF** the patient consents. Whenever possible, please check your assignments the day before to research that case you will be observing. The O.R. desk is staffed from 0630 to 1830 with someone who will be able to help you plan your assignment. Reference materials are available by the O.R. desk if needed.

Fifteen to thirty minutes before the case, check in at the desk and then change into scrubs, hat and name tag. None of your own clothing should be visible (no turtlenecks). The charge nurse at the desk will introduce you to the nurse you will be assigned with. Any changes in assignments must be made through the O.R. desk. Should you leave the O.R. and plan to return, please wear a cover coat while outside of the department.

When you enter an O.R. suite, please be aware of the patient=s status. During an induction or the patient awakening, every effort should be made to keep noise and conversation to a minimum. The circulating nurse will indicate the best place for you to stand in the O.R. suite, focusing their concerns on sterility, equipment placement and team movement. Please ask prior to moving around the room. There are activities in the O.R. which may place you at risk. Universal precautions are required when handling any potentially contaminated item. Protective eyewear is required when near to the surgical field. Exposure to chemicals and radiation we use may be teratogenic, so please notify the O.R. desk if there is any chance you may be pregnant.

Surgeons may invite you to scrub in so that you are closer to the field. This is acceptable and encouraged but an O.R. employee must coach you through the scrub and gowning.

It is very common for visitors to feel dizzy in the O.R. For your safety, go to the nearest wall and sit down. Do not attempt to leave the O.R. unescorted.

As with all areas you will work in, remember that patient confidentiality must be one of your highest priorities. Things you see or hear in the O.R. can be discussed only in the appropriate clinical or academic setting (that does not include the cafeteria). Please feel free to bring any questions or concerns about your O.R. experience to Jane or myself. We hope you will gain valuable insight into intraoperative patient care management while in the O.R.

Cathy Manis-Craighead
Assistant Director
Surgical Services
Phone ext. 5277

Standard Administration Times for Medications

Frequency:

BID	0900-2100	CD	1200
BIDM	0800-1700	DIGQD	1200
BIDPC	0900-1800	AM	0900
BIDAC	0730-1630	AM & PM	0900-2100
q12h	0900-2100		
q8h	0800-1600-2400		
q6h	0600-1200-1800-2400		
q4h	0400-0800-1200-1600-2000-2400		
q3h	0900-1200-1500-1800-2100-2400-0300-0600		
q24h	0900 or 2100		
q2h	02-04-06-08-10-12-14-16-18-20-22-2400		
q4hWA	0800-1200-1600-2000-2400		
QD	0900		
QID	0900-1300-1800-2100		
TID	0900-1300-1800		
QIDAC	0730-1130-1630-2100		
QIDPC	0900-1300-1800-2100	TIDPC	0900-1300-1800
QIDM	0800-1200-1700-2100	TIDM	0800-1200-1700
TIDAC	0730-1130-1630	INSULIN	0715 and 1615

Standard Administration Times for IV Meds:

QD	0900
Q24H	0900 or 2100
Q12H	0900-2100 or 0600-1800 or 1200-2400
Q8H	0800-1600-2400 or 1200-2000-0400
Q6H	0600-1200-1800-2400
Q4H	0400-0800-1200-1600-2000-2400

ROUTINE DISCHARGE INSTRUCTIONS

MEDICATIONS:

It is necessary for the nurse to explain any/all medications to be taken at home, time interval, etc. Also explain any prescriptions that are being sent home with the patient. Use easily understood lay terminology in explanations.

DRESSING AND/OR INCISION CARE:

Charge out supply of dressings if needed for dressing changes at home. Include type of bath to be taken, type of diet and activity limits. If available, include the day and date of the next Doctor appointment.

PRECAUTIONS TO BE INCLUDED WITH THE DISCHARGE INSTRUCTIONS, AS APPROPRIATE

Instruct the patient to *notify the physician if any of the following occur:*

1. Elevated temperature over 100.4 degrees
2. Incision becomes inflamed, red, swollen, hot, with increased pain, yellow thick drainage
3. Excessive bright red drainage

Specific instructions should be given for various diagnoses, for example: lumbar fusion, vaginal hysterectomy, etc.

POST-OP HIP SURGERY

DO NOT!



Stand with toes turned in.



Bend WAY over

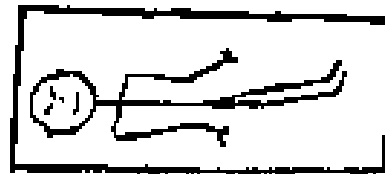


Cross legs

DO NOT!

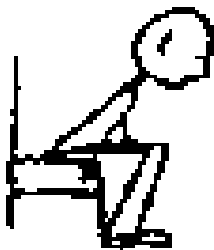


Pull blankets up like this



Lie without pillow between legs

DO NOT!



Get up like this



Sit low on toilet or chair

APPENDIX A

ASSESSING NUTRITIONAL STATUS OF AN INDIVIDUAL

I. General Objective:

Using the nursing process, the student will:

- A. Assess an individual's nutrition for adequate, less than adequate, or more than adequate body requirements.

II. Specific Objectives:

- A. Identify risk factors which may indicate the potential for altered nutritional requirements.
 - 1. Physiological:
 - a. Burns
 - b. Cancer
 - c. Infection
 - d. Trauma
 - e. Dysphagia
 - f. Intestinal disorders
 - 2. Situational:
 - a. Anxiety
 - b. Sedentary life style
 - c. High stress life cycle
 - d. Depression
 - e. Allergies
 - f. Financially low income
 - g. Lack of nutritional knowledge
 - h. Frequent fad diets
 - i. Inability to chew
 - j. Altered dental health
 - k. Activity restrictions
- B. Assess an individuals nutritional patterns through interview.
 - 1. "What is a typical 24- hour pattern of food and fluid intake?" (type and amounts)
 - 2. "How is your appetite?"
 - 3. "Any food allergies?"
 - 4. "Any problems with ability to eat?" (chewing, swallowing, feeding self)

5. “Where do you usually eat?”
 6. “Who usually prepares your food?”
 7. “Are there cultural/religious restrictions?” (other restrictions)
 8. “What are the likes and dislikes in food?”
 9. Related factors
 - a. “What is the occupation?”
 - b. “What type of exercise is performed?” “How often?”
 - c. “What eating habits are good for your health?” (knowledge of nutrition)
- C. Gather objective data to determine nutritional status.
1. Weight
 2. Height
 3. Age
 4. Sex
 5. Integument assessment:
 - a. Skin color, temperature, moisture, turgor
 - b. Hair quality
 - c. Nail quality
 6. Oral cavity assessment
 - a. Condition of teeth (dentures)
 - b. Oral mucous membranes
 - c. Ability to chew, swallow
 7. Ability to feed self
- D. Summarize data and determine if nutritional requirements are adequate, less than or more than body requirements.

**University of Montana – College of Technology
Practical Nursing Program
Clinical Evaluation**

Student _____ **Semester** _____ **Year** _____

Performance in clinical is defined as a pass or fail. Passing is a minimum of 80% of the clinical objectives. A failure in clinical performance of less than 80% will result in a course grade of an F.

Performance is graded on a scale of 1-5.

1. The student fails to be prepared for clinical or meeting the clinical objective. The attitude and/or performance is so inconsistent that the student is considered unsafe.
2. The student continues to have difficulty with commonly or repeated nursing problems in meeting the clinical objective.
3. The student requires a level of instruction supervision that is unusual for the level of the learner in meeting the clinical objective. Requires frequent cues in performing skills.
4. The student occasionally requires supervision that is consistent for the level of the learner in meeting the clinical objectives. requires rare cues in performing skills.
5. The student rarely requires supervision that is consistent for the level of the learner in meeting the clinical objectives. proficient in performing skills without supporting cues.

During the course of the clinical if the student is experiencing difficulty in meeting the objectives, a warning notice will be submitted explaining the areas of difficulty. The student and instructor will meet and set goals to improve the clinical performance.

Failure to be adequately prepared for clinical by determination of the instructor or tardiness may result in removal from the clinical unit for the day, counting as an absence. Two such incidents will constitute a failing grade for the semester.

Clinical assignments submitted consistently late 3 or more times will constitute a failing grade for the semester.

Major infractions deemed to cause issues of patient safety, honesty, or legal concerns will be reviewed by the faculty. Consequences will be based on the faculty consensus.

1. The student will display appropriate physical performance and job safety by:

	5	4	3	2	1
a. Having sufficient upper body muscle coordination and adequate dexterity to handle body fluid specimens, biohazards, chemical hazards and instruments safely in order to prevent harm to self or others.					
b. Being able to perform delicate manipulations on specimens, instruments and equipment sufficient to meet specifications for accuracy in diagnostic testing.					
c. Be able to lift and move objects and people up to 75 pounds in weight.					
d. Having sufficient touch discrimination to feel veins in order to perform phlebotomy and venipuncture procedures.					
e. Being able and willing to work with body fluids and organisms that may be infectious.					
f. Being able to safely work with chemical reagents.					
g. Being able to sit, stand and walk for long periods of time.					
h. Having the visual discrimination to read charts and graphs, read instrument scales, discriminate colors, and visualize objects through a microscope.					
i. Being able to adapt to changing environments and be able to prioritize tasks.					
j. Being able to demonstrate correct aseptic technique.					

Instructor's Comments:

Student's Comments:

2. The student will be able to demonstrate the use of the nursing process and problem solving skills in the delivery of patient care to all ages.

	5	4	3	2	1
a. Gathers appropriate data from chart, tests, client, resource person, taking no client-identifying data out of the facility.					
b. Establishes therapeutic relationship with client and/or family while maintaining respectful manner.					
c. Assesses for developmental and cultural needs of the client and his/her family.					
d. Uses assessment data systematically to assist in the development of accurate nursing diagnoses.					
e. Selects appropriate goals and teaching strategies.					
f. Selects appropriate client outcomes and interventions based on appropriate rationale.					
g. Evaluates nursing interventions and modifies care plan appropriately.					
h. Recognizes discrepancies in techniques, procedures or results.					
i. Suggests a course of action to correct the situation.					
j. Seeks troubleshooting information from written procedures or product reference manuals.					
k. Interacts appropriately and efficiently with other health care professionals.					
l. Completes assigned charting in a timely, professional manner while complying with institutional policies and procedures.					

Instructor's Comments:

Student's Comments:

3. The student will demonstrate correct and safe administration of medications by:

	5	4	3	2	1
a. Being prepared with medication knowledge including generic/trade name, usual and patient dose, action, adverse reactions and nursing considerations, for each patient.					
b. Safely and correctly administering medications specific to patient need and specific nursing implications.					
c. Showing correct documentation reflecting evaluation of therapeutic response for all PRN medications administered.					
d. Recording accurate and concise medication administration according to facility's policy.					

Instructor's Comments:

Student's Comments:

4. The student will display appropriate communication and interpersonal skills by:

	5	4	3	2	1
a. Responding to events, situations and constructive criticism in a positive manner.					
b. Displaying proper telephone usage and etiquette.					
c. Using legible, neat handwriting and correct spelling in recording results and in correspondence with others.					
d. Receiving report at beginning of the shift.					
e. Reporting pertinent data to RN during and at the end of the shift without being prompted.					
f. Collaborating with nursing team in an appropriate and professional manner.					
g. Consulting with members of the health care team, regarding patient care issues when appropriate, organizes shift effectively.					
h. Prioritizing client care needs when providing care, and identifies discharge needs.					
i. Establishing working relationship with health care team, asks appropriate questions, readily accepts responsibility for mistakes and oversights.					
j. Being accessible and prompt in answering client, staff, and faculty requests.					
k. Avoiding inappropriate interruptions.					
l. Demonstrating appropriate sensitivity to other's supplies and work area.					
m. Complying with policies regarding patients' rights.					
n. Treating others with care and compassion.					
o. Offering to help others when his or her assignments are completed.					
p. Demonstrating the ability to perform multiple tasks at the same time.					
q. Keeping work area, including patient rooms, neat and well supplied.					

Instructor's Comments:

Student's Comments:

5. The student will display professional responsibility and accountability by:

a. Preparing for clinical ahead of time (i.e. has reading done, medications reviewed, brings appropriate supplies, etc.)	5	4	3	2	1
b. Completing assignments in a timely manner according to level of training. Reporting to the clinical instructor or the designated teaching personnel at the expected time and place, including after breaks.					
c. Notifying the instructor and facility in a timely manner regarding planned or unexpected absence or tardiness, according to the facility's policy and procedure.					
d. Accepting responsibility for all of client care assignments.					
e. Accepting and seeking out constructive criticism.					
f. Seeking out faculty when needing assistance and/or before performing procedures.					
g. Approaching and performing routine tasks confidently without assistance.					
h. Demonstrating appropriate levels of growing independence within the student role and level of learning.					
i. Contributing in clinical conference according to clinical area expectations.					
j. Presenting to all clinical assignments in uniform which is neat and clean hair appropriately prepared, and shoes unscuffed. (Per student handbook and facility expectations)					

Instructor's comments:

Student's comments:

6. The student will display integrity and ethical standards by:

	5	4	3	2	1
a. Admitting when he or she has made an error.					
b. Not falsifying any information (patient or quality control data)					
c. Demonstrating honesty reporting and sharing information.					
d. Maintaining patient confidentiality, discussing clients only on a need-to-know basis with other health care providers.					
e. Demonstrating the ability to work in the presence of change/new situations without undue confusion or inefficiency.					
f. Demonstrating the ability to work in the presence of interruptions without undue confusion or inefficiency.					
g. Demonstrating patience when interruptions occur.					

Instructor's comments:

Student's comments:

7. The student will, without supervision, and/or independently, safely and accurately perform skills taught in previous courses and apply theoretical knowledge to related skills. (List below the skill performed and evaluation outcome.)

	5	4	3	2	1

Instructor's Comments:

Student's Comments:

8. The student will, with supervision and/or assistance, safely and accurately perform new skills taught and apply theoretical knowledge to related skills. (List below the skill performed and evaluation outcomes.)

	5	4	3	2	1

Instructor's comments:

Student's comments: