

## **Union County College Practical Nursing Program**

<b><u>Course Title</u></b>	Adult Health I
<b><u>Course Number</u></b>	PNU 191
<b><u>Course Credit</u></b>	10 (7 Theory/3 clinical) (105 hours theory/135 hours clinical)
<b><u>Pre-requisites</u></b>	PNU 190, ENG 101 (or ENG 111/112), BIO 102, PSY 101 GPA 2.5
<b><u>Co- requisite</u></b>	Elective

### **Course Description**

In this course, the student will continue to use the nursing process, within the self-care framework, to assist adult clients in meeting their physiological and psychosocial self-care requisites in the long term and acute care setting. Emphasis will be placed on client assessment and an understanding of the common, chronic conditions that alter an individual's state of wellness. Care of clients pre- and postoperatively, and those experiencing fluid and electrolyte imbalances, infectious diseases, and selected cardiovascular, respiratory, musculoskeletal, and endocrine deviations will be discussed. Principles of critical thinking and therapeutic communication will be integrated throughout the course. Content that is presented in the classroom will be reinforced with clinical experiences in the skills laboratory and client care settings where students will apply basic nursing principles and techniques. 10 credit hours, 7 theory, 3 clinical

### **Student Learning Outcomes**

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

1. Apply the nursing process and critical thinking approach to experiences with adult clients from diverse multicultural backgrounds who have commonly occurring/chronic health deviations.
2. Demonstrate the ability to safely perform specified nursing techniques in the simulated and/or actual client care setting.
3. Describe the assessment, medical treatments, and nursing interventions for commonly occurring/chronic health deviations.
4. Incorporate legal standards and ethical guidelines into nursing practice in the acute care, subacute, and/or long term care setting.
5. Use beginning therapeutic communication skills with clients and families from diverse multicultural backgrounds.
6. Share client information appropriately with other members of the health care team.
7. Use members of the health care team appropriately as resources of information for the delivery of client care.
8. Incorporate the client's psychosocial/spiritual (holistic health) needs into the plan of care.

9. Prepare basic teaching plans to assist clients to meet their universal, developmental, and/or health deviation requisites.
10. Obtain library and internet resources and access nursing information to use in classroom and clinical experiences.

### **Method of Evaluation**

To pass the course, the student must satisfactorily complete all of the requirements for the course. The student must attain a minimum overall grade of 75 or C+ for all course work.

1. Unit Tests – 60% (4 exams – 15% each)
2. Comprehensive Examination – 40% This exam will test students' overall knowledge and comprehension of the information assimilated throughout the course.
3. Students will need to complete the scheduled skill lab practice sessions and are required to attend the lab independently. Documentation of attendance with the Nursing Skill Lab Instructor's signature is necessary. Students will demonstrate clinical competency in the learning lab, long term, and/or acute care setting through completion of assigned nursing skills.
4. Submission of all required clinical assignments.
5. Completion of assigned interactive computer programs, including *ATI Learning System* exams and *Software for Nurses* programs.

### **Resources**

Required (newest editions):

Asperheim, M.K. (2009). *Introduction to Pharmacology* (11<sup>th</sup> ed.). St Louis: Saunders/Elsevier

*Mosby's Nursing Drug Reference* (2009) St. Louis: Mosby.

Potter, P. & Perry, A. *Basic Nursing* (6th ed.). St. Louis: Mosby. (text & study guide)

Potter, P. & Perry, A. (2007). *Pocket Guide to Basic Skills and Procedures* (6<sup>th</sup> ed.). St. Louis: Mosby

Williams, L. & Hopper, P. (2007). *Understanding Medical Surgical Nursing* (3<sup>rd</sup> ed.). Philadelphia: F.A. Davis (text & study guide)

Nugent, P. & Vitale, B. (2008). *Fundamentals Success* (2nd ed.). Philadelphia: FA Davis.

Recommended texts:

Colgrove, K. Callicoatt, J. Ray A. Hargrove-Huttel, R. *Med-Surg Success : A Course Review Applying Critical Thinking to Test-Taking* Philadelphia: FA Davis.

Gray-Morris, D. *Calculate with Confidence* (4th ed.). St. Louis: Mosby.

Leonard, P. Quick & Easy Medical Terminology. St. Louis: Mosby.

*Mosby's Dictionary of Medicine, Nursing, and Health Professions*, St Louis: Mosby.  
(newest edition)

Nugent, P. & Vitale, B. *Test Success: Test Taking Techniques for Beginning Nursing Students*. Philadelphia: F.A. Davis

Pagana, K. & Pagana, T. *Diagnostic and Laboratory Tests* St Louis: Mosby (newest edition)

Computer-Assisted Instruction:

The ATI Learning System, Software for Nurses, and FITNE programs will be available for online use from a home computer. Instructions for logging in and use will be provided in class.

Students will also need to go to the Academic Learning Center or Computer lab to obtain a student ID, if they do not already have one.

Examples of Educational Media

Vital Signs, Wound Care, Respiratory Disorders, Cardiac Disorders, "The Natural Process of Aging." All nursing media is found in the Library catalog.

**Course Activities**

Clinical Experiences-with focus on Orem's Self Care Framework

- Direct client care experiences in acute, subacute, and/or long-term care settings
- Simulated client care experiences in the Nursing Skills Laboratory (as available)
- Observation in the Operating Room and Post Anesthesia Care Unit (as available)
- Community care experiences – health screenings (as available)

Written Clinical Requirements

Care Plans as assigned  
Weekly Client Assessment Tool

Medication Information Forms  
2 Journal Articles  
Teaching Plan  
Client Documentation

### Nursing Skills Lab

- Mobility: Review of range of motion, turning/positioning, transfers; use of assistive devices for ambulation & transfers

Read: Potter, P. & A. Perry, *Basic Nursing*  
Chapters 35 pages 1016-1043 (wound care)

Read: Williams & Hopper *Understanding Medical Surgical Nursing* (3<sup>rd</sup> ed.)  
Chapter 53 pages 1208-1211-(wound care)  
Chapter 54 pages 1213-1221(wound care)

- Safety: Use of safety reminder devices (restraints), motion alarms, side rails
- Prevention of Infection: Aseptic technique, sterile dressings, wound care, isolation precautions
- Review of medication administration, IV therapy, and approach to pharmacology
- Physical Assessment: Heart, lung, and abdominal sounds, Geri-Mannequin N/G or enteral tube feedings
- Basic sensory assessment – eye & ear exam, neuro check
- Elimination: Catheter insertion & care, enemas
- Specimen collection:

### Course Policies

Students are referred to the Practical Nursing *Student Handbook* for information on general course policies, including classroom and clinical requirements, absences, uniforms, and grading.

### PNU 191 Clinical Requirements

Students must pass all of the clinical objectives in order to pass the course. Clinical objectives will be met in the Nursing Skills Laboratory and/or in the clinical setting.

Students are expected to demonstrate consistently safe performance throughout the clinical experience.

Satisfactory clinical performance is achieved by:

1. Preparing for client care experiences
2. Assessing, recording, and reporting the client's status correctly.
3. Implementing appropriate nursing interventions and evaluating the client's response.

4. Maintaining client safety, comfort, dignity, and confidentiality.
5. Demonstrating professional behavior with clients, peers, instructors, and staff members.
6. Participating in scheduled clinical experiences. Clinical evaluation conferences are held to review achievement of the clinical objectives. A student may, at any time during the course, receive a clinical warning or a clinical failure for inconsistent, unsafe, or unethical performance. A course withdrawal is not permitted if the student has received a clinical failure.

### Confidentiality

All information that is obtained during client interactions is considered to be of a confidential nature. Important information regarding clients may be shared with agency staff members, instructors, and peers in an appropriate manner and setting. Students are not to disclose information to other individuals who are not directly involved in the client's care. Tape recording of conversations or photographing clients is prohibited without the express written consent of the client. Students are not to photocopy or remove any client records. When completing written assignments following clinical experiences, **DO NOT** use the client's name on any documentation. Only the client's initials or room number may be used. Every effort should be made to maintain the client's confidentiality. Students demonstrate respect for clients by protecting their privacy and only reporting and recording information that is relevant to their care and well-being.

### Infection Control Policy

While participating in clinical experiences, students need to be aware of Standard Precautions and Transmission specific precautions (droplet, airborne, contact). All equipment, linens, utensils, dressings, etc. that come in contact with a client's body fluids are considered contaminated and need to be handled accordingly. The following are some basic guidelines to follow:

1. Wash hands before and after client care.
2. Use barrier protection (eyewear, masks, gloves, gowns) when indicated.
3. Dispose of equipment and other materials appropriately (such as in sharps containers or designated hampers).
4. Report the presence of open lesions or infections to the instructor.

### Clinical Site

Clinical agencies are selected based on the nursing course objectives and the types of experiences that are available. Students are expected to arrange for their own transportation to affiliating agencies. Sufficient time should be allowed between the beginning or end of the clinical time and any other academic or personal obligation.

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>Unit I: Assessment</b></p> <p>A. PATIENT ASSESSMENT attainment of self-care requisite</p> <ol style="list-style-type: none"> <li>1. History</li> <li>2. Cultural sensitivity</li> <li>3. Assessment skills               <ol style="list-style-type: none"> <li>a. Inspection</li> <li>b. Palpation</li> <li>c. Auscultation</li> </ol> </li> </ol> <p>B. PLANNING/IMPLEMENTATION TO IDENTIFY SELF-CARE DEMANDS</p> <ol style="list-style-type: none"> <li>1. Physical assessment</li> <li>2. General appearance and behavior-simple mental status</li> <li>3. Height and weight</li> <li>4. Integument</li> <li>5. Head and neck</li> <li>6. Chest–lung sounds, heart sounds</li> <li>7. Peripheral vascular-peripheral pulses</li> <li>8. Abdomen-bowel sounds</li> <li>9. External genitalia</li> <li>10. Musculoskeletal-ROM gait posture</li> <li>11. Neurological-sensorimotor function</li> </ol> <p>C. EVALUATION</p> <ol style="list-style-type: none"> <li>1. Documentation/reporting               <ol style="list-style-type: none"> <li>a. Alternate nursing process and charting formats</li> </ol> </li> <li>2. Client outcomes</li> </ol>	<p><u>Required readings:</u></p> <p>Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 20 pages 354 &amp; 355 Chapter 29 pages 553 &amp; 555 Chapter 32 page 638-640 Chapter 36 pages 756-760 Chapter 41 page 886 &amp; 895 Chapter 45 page 983 Chapter 47 pages 1045 &amp; 1046</p> <p>Potter &amp; Perry <i>Basic Nursing</i> Chapter 13</p> <p>Gray-Morris <i>Calculate with Confidence</i> Chapter 22</p> <p><u>Skill Lab Practice:</u></p> <p>Review of vital sign measurement Pain assessment Client assessment skills- pupillary response, heart ,lung &amp; bowel sounds, introductory neuro check. Use of MAR, transcribing orders IV calculations Piggybacks</p> <p><u>Computer Lab:</u></p> <p>FITNE Vital Signs Clinical simulation programs (nursing) Software for Nurses</p> <p>Educational Media: Breath sounds, heart sounds</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>Unit II: Growth and Development – Older Adult-Gerontology</b></p> <p>A. ASSESSMENT OF THE HEALTH STATE – attainment of universal and developmental self-care requisites</p> <ol style="list-style-type: none"> <li>1. History <ol style="list-style-type: none"> <li>a. Risk factors</li> <li>b. Medical conditions</li> </ol> </li> <li>2. Physical assessment <ol style="list-style-type: none"> <li>a. General appearance</li> <li>b. Changes associated with the aging process</li> <li>c. Appearance of eyes, ears, nose, oral cavity, &amp; skin</li> </ol> </li> <li>3. Common alterations – sensorimotor deficits <ol style="list-style-type: none"> <li>a. Vision loss</li> <li>b. Hearing Loss</li> <li>c. Nose and sense of smell</li> </ol> </li> </ol> <p>B. PLANNING/IMPLEMENTATION TO MEET THE THERAPEUTIC SELF-CARE DEMAND</p> <ol style="list-style-type: none"> <li>1. Nursing interventions <ol style="list-style-type: none"> <li>a. Health promotion</li> <li>b. Safety measures</li> <li>c. Support &amp; communication</li> <li>d. Medication administration</li> </ol> </li> <li>2. Teaching to meet self-care requisites <ol style="list-style-type: none"> <li>a. Nutrition/fluids</li> <li>b. Exercise</li> <li>c. Medications: self-administration</li> <li>d. Safety/Follow-up measures</li> <li>e. Use of sensory aids</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i></p> <p>Chapter 14 pages 242-258 Chapter 13 pages 233-234 Chapter 52 pages 1169-1171, 1173-1174, 1176-1189 (sensory) Chapter 51 pages 1145-1161 (sensory)</p> <p>Potter &amp; Perry <i>Basic Nursing</i> Chapter 19 pages 543-548 Chapter 36 (sensory)</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chap 33 pages 223-230.</p> <p><u>Skill Lab Practice:</u></p> <p>Assessment of Geri-Mannequin Basic sensory assessment – eye, Ear, &amp; nose exam</p> <p><u>Computer Lab:</u></p> <p>ATI Fundamentals &amp; Medical-Surgical Assessments</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>Unit II: Growth and Development – Older Adult-Gerontology (continued)</b></p> <p>C. PLANNING/IMPLEMENTATION TO MEET THE THERAPEUTIC SELF-CARE DEMAND</p> <ol style="list-style-type: none"> <li>1. Nursing interventions <ol style="list-style-type: none"> <li>a. Health promotion</li> <li>b. Safety measures</li> <li>c. Support &amp; communication</li> </ol> </li> <li>2. Teaching to meet self-care requisites <ol style="list-style-type: none"> <li>a. Nutrition/fluids</li> <li>b. Exercise</li> <li>c. Medications</li> <li>d. Safety/Follow-up</li> </ol> </li> </ol> <p>D. EVALUATION</p> <ol style="list-style-type: none"> <li>1. Documentation/reporting <ol style="list-style-type: none"> <li>a. Client outcomes</li> </ol> </li> </ol>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>Unit III: Mobility &amp; Immobility</b></p> <p>A. ASSESSMENT OF THE HEALTH STATE – attainment of universal self-care requisites</p> <ol style="list-style-type: none"> <li>1. History <ol style="list-style-type: none"> <li>a. Musculoskeletal problems – arthritis</li> <li>b. Neurological problems - weakness</li> <li>c. Risk factors</li> </ol> </li> <li>2. Physical assessment <ol style="list-style-type: none"> <li>a. General appearance</li> <li>b. Age/developmental status</li> <li>c. Body alignment</li> <li>d. Mobility - Function <ol style="list-style-type: none"> <li>1) Range of motion</li> <li>2) Gait</li> <li>3) Exercise</li> <li>4) Activity tolerance</li> </ol> </li> <li>e. Hazards of immobility</li> </ol> </li> </ol> <p>B. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</p> <ol style="list-style-type: none"> <li>1. Medical treatment <ol style="list-style-type: none"> <li>a. Physical therapy</li> <li>b. Pain management</li> <li>c. Wound Care</li> </ol> </li> <li>2. Nursing interventions <ol style="list-style-type: none"> <li>a. Body mechanics</li> <li>b. Comfort measures</li> <li>c. Turning/positioning</li> <li>d. Transfers</li> <li>e. Ambulation – assistive devices: canes, walkers, crutches</li> <li>f. Hoyer Lift</li> </ol> </li> <li>3. Teaching to meet self-care requisites <ol style="list-style-type: none"> <li>a. Exercise &amp; rest</li> <li>b. Use of assistive devices</li> <li>c. Medications</li> </ol> </li> <li>4. Community resources</li> </ol> <p>C. EVALUATION</p> <ol style="list-style-type: none"> <li>1. Documentation/reporting</li> <li>2. Client outcomes</li> </ol>	<p><u>Required readings:</u></p> <p>Potter &amp; Perry <i>Basic Nursing</i>  Chapters 25 &amp; 34  Chapters 35 pages 1016-1043  (wound care)</p> <p>Williams &amp; Hopper  <i>Medical Surgical Nursing</i>  Chapter 53 pages 1208-1211-  (wound care)  Chapter 54 pages 1213-  1221(wound care)</p> <p><u>Skill Lab Practice:</u></p> <p>Review:</p> <p>Range of motion  Turning/positioning  Transfers  Ambulation – use of  assistive devices  Braden Scale</p> <p><u>Computer Lab:</u></p> <p>FITNE Mobility  ATI Fundamentals Assessment</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT IV: Infectious Disease</b></p> <p>A. REVIEW OF SYSTEM</p> <ol style="list-style-type: none"> <li>1. Chain of infection</li> <li>2. Body defenses – immunity</li> </ol> <p>B. DESCRIPTION OF HEALTH DEVIATION</p> <ol style="list-style-type: none"> <li>1. Bacterial infections <ol style="list-style-type: none"> <li>a. Tuberculosis</li> <li>a. Lyme disease</li> <li>b. Food poisoning</li> </ol> </li> <li>2. Viral infections <ol style="list-style-type: none"> <li>a. Herpes zoster</li> <li>b. Influenza</li> <li>c. Hepatitis</li> <li>d. HIV/AIDS</li> <li>e. Sepsis</li> </ol> </li> <li>3. Nosocomial &amp; community – acquired infections  MRSA(methicillin resistant staph aureus)  CDT (Clostridium difficile toxin)  VRE (vancomycin resistant staph aureus)</li> </ol> <p>C. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ol style="list-style-type: none"> <li>1. Health history – <ol style="list-style-type: none"> <li>a. Risk factors</li> <li>b. Medical conditions</li> <li>c. Immunizations</li> <li>d. Presence of signs &amp; symptoms</li> </ol> </li> <li>2. Physical assessment <ol style="list-style-type: none"> <li>a. General appearance</li> <li>b. Age/Developmental status</li> <li>c. Vital signs</li> <li>d. Specific signs and symptoms of local or systemic infection</li> </ol> </li> </ol>	<p><u>Required readings:</u> Review for Skills lab  Williams &amp; Hopper  <i>Medical Surgical Nursing</i>  Chapter 7  Chapter 19  Chapter 30 pages 583-584  Chapter 31 pages 590-596  Chapter 32 page 641  Chapter 35 pages 720-723  Chapter 54 page 1228</p> <p>Potter &amp; Perry <i>Basic Nursing</i>  Chapter 11, pages 210-222.  Chapter 31 page 888</p> <p>Asperheim, <i>Introduction to Pharmacology</i>  Chapter 16 page 53-68</p> <p><u>Skill Lab Practice:</u></p> <p>Use of barrier precautions- eyewear, masks, gloves, and gowns  Aseptic technique  Sterile technique  Medication administration</p> <p><u>Computer Lab:</u></p> <p>ATI Fundamental Concepts and Medical-Surgical Nursing Assessments</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT IV: Infectious Disease (continued)</b></p> <p>C. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ul style="list-style-type: none"> <li>3. Diagnostic tests <ul style="list-style-type: none"> <li>a. Blood counts</li> <li>b. Culture &amp; sensitivity</li> <li>c. Blood titers</li> <li>d. Radiographic imaging</li> </ul> </li> </ul> <p>D. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</p> <ul style="list-style-type: none"> <li>1. Medical Treatment <ul style="list-style-type: none"> <li>a. Medication administration – antibiotics, antivirals, antiinfectives</li> <li>b. Immunizations</li> <li>c. Fluid &amp; nutritional therapy</li> </ul> </li> <li>2. Nursing interventions <ul style="list-style-type: none"> <li>a. Transmission prevention –Standard precautions Transmission specific – airborne, droplet, contact Barrier protection – isolation procedures Personal protection equipment</li> <li>b. Health promotion: Nutrition Stress reduction Rest/exercise</li> </ul> </li> </ul>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT IV: Infectious Disease (continued)</b></p> <ul style="list-style-type: none"> <li>c. Asepsis <ul style="list-style-type: none"> <li>Medical – hand washing</li> <li>Surgical – treatments, wound care</li> </ul> </li> <li>d. Medication administration</li> <li>e. Supportive care</li> </ul> <p>3. Teaching to meet health deviation self-care requisites</p> <ul style="list-style-type: none"> <li>a. Preventive measures in the home</li> <li>b. Specific care measures – medication administration</li> </ul> <p>4. Community Resources - referrals</p> <p><b>E. EVALUATION</b></p> <ul style="list-style-type: none"> <li>1. Documentation/Reporting</li> <li>2. Client outcomes</li> </ul>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT V: Perioperative Care</b></p> <p>A. DESCRIPTION</p> <ol style="list-style-type: none"> <li>1. Perioperative experience               <ol style="list-style-type: none"> <li>a. Types of surgery</li> <li>b. Effects of surgery</li> <li>c. Sites – inpatient, ambulatory or outpatient</li> </ol> </li> </ol> <p>B. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ol style="list-style-type: none"> <li>1. History</li> <li>2. Physical Assessment</li> <li>3. Psychological status</li> <li>4. Learning needs</li> </ol> <p>C. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</p> <ol style="list-style-type: none"> <li>1. Preoperative preparation               <ol style="list-style-type: none"> <li>a. Medical treatment Diagnostic tests Preoperative medications</li> <li>b. Nursing interventions Preoperative teaching Informed consent Preoperative checklist Client preparation: Enemas: Urinary catheterization</li> </ol> </li> <li>2. Intraoperative care               <ol style="list-style-type: none"> <li>a. Surgical asepsis</li> <li>b. Operative team</li> <li>c. Anesthesia General Regional/local Alternative methods</li> <li>d. Complications</li> </ol> </li> </ol>	<p>Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 11</p> <p>Potter &amp; Perry <i>Basic Nursing</i> Chapter 35 pages 1044-1065 (surgical wound care) Chapter 37</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chapter 22 pages 122-130</p> <p><u>Skill Lab Practice:</u> Perioperative assessment skills Surgical wound care Clean, wet to dry &amp; dry sterile dressings Application of bandages and binders</p> <p><u>Computer Lab:</u> FITNE Sterile Technique Clinical simulation programs (nursing folder) ATI: Fundamental Concepts Saunders IRP: Fundamental Skills, Perioperative Nursing Care</p> <p><u>Educational Media:</u> Pre-, Postoperative Care</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT V: Perioperative (continued)</b></p> <p>3. Immediate postoperative care (PACU)</p> <ul style="list-style-type: none"> <li>a. Promotion of oxygenation</li> <li>b. Promotion of circulation</li> <li>c. Surgical wound assessment &amp; care</li> <li>d. JP drains, straight drains</li> <li>e. Medication administration – pain relief</li> <li>f. Discharge to unit/home</li> </ul> <p>4. Inpatient postoperative care</p> <ul style="list-style-type: none"> <li>a. Oxygenation Coughing, deep breathing, incentive spirometry Positioning/turning</li> <li>b. Comfort &amp; safety Pain relief-Patient Controlled Analgesia (PCA) Positioning Hygiene</li> <li>c. Surgical wound care Dressings/drainage collection Binders</li> <li>d. Hydration &amp; nutrition</li> <li>e. Exercise/ambulation</li> <li>f. Elimination</li> <li>g. Complications Hemorrhage/shock Respiratory difficulty –     atelectasis, pneumonia, airway obstruction Wound infection Dehiscence/evisceration Paralytic ileus Urinary retention</li> </ul>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT V: Perioperative (continued)</b></p> <ul style="list-style-type: none"> <li>5. Teaching to meet health deviation self-care requisites <ul style="list-style-type: none"> <li>a. Preoperative teaching – coughing, deep breathing, turning, ROM</li> <li>b. Use of PCA</li> <li>c. Surgical wound care</li> <li>d. Use of assistive devices</li> </ul> </li> <li>6. Community Resources - referrals</li> </ul> <p><b>E. EVALUATION</b></p> <ul style="list-style-type: none"> <li>1. Documentation/Reporting</li> <li>2. Client outcomes</li> </ul>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>Unit VI: Elimination</b></p> <p>A. ASSESSMENT OF THE HEALTH STATE – attainment of self-care requisites</p> <ol style="list-style-type: none"> <li>1. History <ol style="list-style-type: none"> <li>a. Elimination patterns</li> <li>b. Factors influencing elimination</li> <li>c. Specific medical conditions</li> </ol> </li> <li>2. Physical assessment <ol style="list-style-type: none"> <li>a. General appearance</li> <li>b. Age/developmental status</li> <li>c. Signs &amp; symptoms of alterations</li> <li>d. External integrity – urinary meatus and anus</li> </ol> </li> <li>3. Diagnostic tests <ol style="list-style-type: none"> <li>a. Urinary characteristics</li> <li>b. Stool specimens</li> <li>c. Radiographic studies</li> <li>d. Endoscopy</li> </ol> </li> <li>4. Common alterations <ol style="list-style-type: none"> <li>a. Infection-UTI</li> <li>b. Urinary retention</li> <li>c. Constipation</li> <li>d. Diarrhea</li> <li>e. Incontinence</li> <li>f. Irritable Bowel Syndrome</li> <li>g. GERD</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i></p> <p>Chapter 32 Chapter 34 pages 688-691 Chapter 36 Chapter 37 page 778</p> <p>Potter &amp; Perry <i>Basic Nursing</i> Chapters 32 &amp; 33 Chapter 31 pages 887, 889-908 Chapter 33 pages 673-674 Chapter 34 page 700-701</p> <p><u>Skill Lab Practice:</u></p> <p>Catheter care, condom catheter I &amp; O Specimen collection-urinalysis, midstream, sterile specimen, stool specimen, fecal occult blood Enema administration GT/NGT feeding &amp; administration</p> <p><u>Computer Lab:</u></p> <p>Software For Nurses-GI Health Problems Software for Nurses GU Health Problems ATI Learning System: Fundamentals</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>Unit VI: Elimination (continued)</b></p> <p><b>B. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC DEMAND</b></p> <ol style="list-style-type: none"> <li>1. Medical interventions           <ol style="list-style-type: none"> <li>a. Medications               <ol style="list-style-type: none"> <li>1) Antibiotics</li> <li>2) Anticholinergics</li> <li>3) Cholinergics</li> <li>4) Laxatives</li> <li>5) Stool softeners</li> <li>6) Antidiarrheal agents</li> </ol> </li> <li>b. Diet</li> </ol> </li> <li>2. Nursing interventions           <ol style="list-style-type: none"> <li>a. Positioning, privacy, scheduling</li> <li>b. Fluid and nutritional intake</li> <li>c. Medication administration</li> <li>d. I &amp; O, daily weights</li> <li>e. Skin care</li> <li>f. Catheter insertion &amp; care</li> <li>g. Exercise</li> </ol> </li> <li>3. Teaching to meet self-care requisites           <ol style="list-style-type: none"> <li>a. Hygienic care</li> <li>b. Diet &amp; fluids, diet types &amp; rationale</li> <li>c. Medications</li> <li>d. Patterns of elimination</li> </ol> </li> </ol> <p><b>C. EVALUATION</b></p> <ol style="list-style-type: none"> <li>1. Documentation/reporting</li> <li>2. Client outcomes</li> </ol>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>Unit VII: Comfort and Pain Management</b></p> <p>A. ASSESSMENT OF THE HEALTH STATE – attainment of self-care requisite</p> <ol style="list-style-type: none"> <li>1. History           <ol style="list-style-type: none"> <li>a. Patterns</li> <li>b. Influencing factors</li> <li>c. Medical conditions</li> <li>d. Impact of pain or sleep alterations on daily living</li> </ol> </li> <li>2. Physical assessment           <ol style="list-style-type: none"> <li>a. Age/developmental status</li> <li>b. Pain assessment – 5<sup>th</sup> vital sign</li> <li>c. Signs &amp; symptoms of alterations</li> </ol> </li> <li>3. Common alterations           <ol style="list-style-type: none"> <li>a. Pain experience</li> </ol> </li> </ol> <p>B. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</p> <ol style="list-style-type: none"> <li>1. Medical interventions           <ol style="list-style-type: none"> <li>a. Medications               <ol style="list-style-type: none"> <li>1) Hypnotics</li> <li>2) Sedatives</li> <li>3) Analgesics</li> <li>4) PCA</li> <li>5) Opioid Antagonists</li> </ol> </li> <li>b. Surgery</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 9</p> <p>Potter &amp; Perry <i>Basic Nursing</i> Chapter 30</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chapter 22</p> <p><u>Skill Lab Practice:</u> Pain assessment FLACC scale Visual analog scale Faces Scale</p> <p><u>Computer Lab:</u> ATI Learning System: Fundamentals</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>Unit VII: Comfort and Pain Management (continued)</b></p> <ul style="list-style-type: none"> <li>2. Nursing interventions <ul style="list-style-type: none"> <li>a. Environmental control</li> <li>b. Bedtime routines</li> <li>c. Comfort measures</li> <li>d. Activity/exercise</li> <li>e. Relaxation techniques</li> <li>f. Medication administration</li> <li>g. TENS</li> <li>h. Additional measures – distraction, massage, imagery</li> </ul> </li> <li>3. Teaching to meet self-care requisites <ul style="list-style-type: none"> <li>a. Methods to promote sleep</li> <li>b. Pain relief measures</li> </ul> </li> </ul> <p><b>C. EVALUATION</b></p> <ul style="list-style-type: none"> <li>1. Documentation/reporting <ul style="list-style-type: none"> <li>a. Response to pain management</li> </ul> </li> <li>2. Client outcomes</li> </ul>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT VIII: Fluid, Electrolyte, Acid-Base Balance</b></p> <p>A. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ol style="list-style-type: none"> <li>1. Fluid and electrolytes <ol style="list-style-type: none"> <li>a. Body fluids – distribution, function</li> <li>b. Electrolytes – intracellular, extracellular</li> <li>c. Fluid &amp; electrolyte movement – diffusion, filtration, osmosis</li> <li>d. Regulation of fluids &amp; electrolytes</li> </ol> </li> <li>2. Imbalances <ol style="list-style-type: none"> <li>a. Fluid volume – hypervolemia, hypovolemia</li> <li>b. Electrolytes – sodium, potassium, calcium, magnesium, chloride, phosphate, protein</li> <li>c. Acid-Base – metabolic &amp; respiratory acidosis and alkalosis</li> </ol> </li> </ol> <p>B. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</p> <ol style="list-style-type: none"> <li>1. Medical Treatment <ol style="list-style-type: none"> <li>a. Diagnostic tests – blood chemistry</li> <li>b. Medications – fluid, electrolyte, and acid-base balancing agents</li> <li>c. Intravenous therapy</li> <li>d. Nutrition &amp; fluid management</li> <li>e. Supportive care – oxygenation, dialysis</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 5</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chapter 28 pages 179-185</p> <p><u>Skill Lab Practice:</u></p> <p>Client assessment skills Height &amp; Weight I &amp; O Intravenous infusions</p> <p><u>Computer Lab</u></p> <p>FITNE IV Therapy</p> <p>Saunders IRP: Nursing Sciences, Fluid and Electrolytes Acid-Base Balance</p> <p><u>Video:</u></p> <p>Fluid and Electrolyte Balance</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT VIII: Fluid, Electrolyte, Acid-Base Balance (continued)</b></p> <p><b>B. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</b></p> <p>2. Nursing Interventions</p> <ul style="list-style-type: none"> <li>a. Physical assessment – signs &amp; symptoms of imbalances</li> <li>b. Vital Signs</li> <li>c. Intake &amp; output</li> <li>d. Daily weights</li> <li>e. Nutrition &amp; fluid monitoring</li> <li>f. Medication administration</li> <li>g. Supportive care – oxygenation, skin care</li> </ul> <p>3. Teaching to meet health deviation self-care requisites</p> <ul style="list-style-type: none"> <li>a. Patient monitoring of intake &amp; output</li> <li>b. Reporting of signs &amp; symptoms of imbalances</li> <li>c. Medication administration</li> <li>d. Fluid &amp; dietary restrictions</li> </ul> <p>4. Community Resources - referrals</p> <p><b>C. EVALUATION</b></p> <ul style="list-style-type: none"> <li>1. Documentation/Reporting</li> <li>2. Client outcomes</li> </ul>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT IX: Cardiovascular</b></p> <p>A. REVIEW OF SYSTEM Cardiovascular system</p> <p>B. DESCRIPTION OF HEALTH DEVIATIONS</p> <ol style="list-style-type: none"> <li>1. Hypertension</li> <li>2. Coronary artery disease - angina</li> <li>3. Congestive Heart Failure</li> <li>4. Vascular insufficiencies</li> </ol> <p>C. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ol style="list-style-type: none"> <li>1. Health History</li> <li>2. Physical Assessment <ol style="list-style-type: none"> <li>a. General appearance</li> <li>b. Vital signs –heart sounds</li> <li>c. Specific signs and symptoms:</li> <li>d. Chest pain, fatigue, edema, irregularities of heart rate or rhythm, shortness of breath, cyanosis</li> </ol> </li> <li>3. Diagnostic procedures <ol style="list-style-type: none"> <li>a. Laboratory exams – Cardiac enzymes, Cholesterol, lipoproteins, triglycerides</li> <li>b. Electrocardiogram</li> <li>c. Stress tests</li> <li>d. Imaging</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 20 pages 346-369 Chapter 21 Chapter 23 pages 407-418, 430-441 Chapter 26</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chapter 20 pages 91-105</p> <p><u>Skill Lab Practice:</u></p> <p>Assessment of heart sounds</p> <p><u>Computer Lab:</u></p> <p>Software For Nurses- Cardiovascular Health Problems</p> <p>ATI Medical-Surgical Nursing Assessment</p> <p><u>Educational media:</u></p> <p>Assessment of Circulatory System</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT IX: Cardiovascular (continued)</b></p> <p><b>D. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</b></p> <ol style="list-style-type: none"> <li>1. Medical treatment           <ol style="list-style-type: none"> <li>a. Medications –               <ul style="list-style-type: none"> <li>Antihypertensives</li> <li>Antilipemics</li> <li>Anticoagulants</li> <li>Cardiotonics</li> <li>Diuretics</li> </ul> </li> <li>b. Diet/fluid restrictions</li> <li>c. Activity - exercise</li> <li>d. Oxygen</li> </ol> </li> <li>2. Nursing interventions           <ol style="list-style-type: none"> <li>a. Monitoring –               <ul style="list-style-type: none"> <li>Vital signs – heart rate and rhythm</li> <li>Fluid status – I&amp;O</li> </ul> </li> <li>b. Medication administration</li> <li>c. Diet</li> <li>d. Pain management</li> <li>e. Oxygen administration</li> <li>f. Activity and rest</li> <li>g. Emotional support</li> </ol> </li> <li>3. Teaching to meet health deviation self-care requisites           <ol style="list-style-type: none"> <li>a. Preparation for diagnostic tests/surgery</li> <li>b. Self-monitoring of status</li> <li>c. Medications</li> <li>d. Diet</li> <li>e. Exercise</li> <li>f. Medical follow-up</li> </ol> </li> <li>4. Community resources - referrals</li> </ol> <p><b>E. EVALUATION</b></p> <ol style="list-style-type: none"> <li>1. Documentation</li> <li>2. Client outcomes</li> </ol>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT X: Respiratory</b></p> <p>A. REVIEW OF SYSTEM Respiratory system</p> <p>B. DESCRIPTION OF HEALTH DEVIATIONS</p> <ol style="list-style-type: none"> <li>1. Upper and lower respiratory tract infections including: <ol style="list-style-type: none"> <li>a. Asthma</li> <li>b. COPD – Emphysema,</li> <li>c. Bronchitis</li> <li>d. Pneumonia</li> </ol> </li> </ol> <p>C. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ol style="list-style-type: none"> <li>1. Health History <ol style="list-style-type: none"> <li>a. Prior/current health deviations</li> <li>b. Smoking, environmental exposure</li> <li>c. Medications</li> </ol> </li> <li>2. Physical Assessment <ol style="list-style-type: none"> <li>a. General appearance</li> <li>b. Vital signs</li> <li>c. Specific signs and symptoms: Dyspnea, cough, excess sputum, adventitious lung sounds, hemoptysis, chest pain</li> </ol> </li> <li>3. Diagnostic procedures <ol style="list-style-type: none"> <li>a. Blood chemistry</li> <li>b. Arterial Blood Gases</li> <li>c. Sputum examination</li> <li>d. Pulmonary function tests</li> <li>e. Radiographic exams</li> <li>f. Bronchoscopy</li> <li>g. Biopsy</li> <li>h. Pulse oximetry</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 29 pages 548-562 Chapter 31 pages 591-593, 602-611</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chapter19</p> <p><u>Skill Lab Practice:</u></p> <p>Assessment of lung sounds Pulse oximetry Oxygen therapy</p> <p><u>Computer Lab:</u></p> <p>Software For Nurses- Respiratory Health Problems</p> <p>ATI Medical-Surgical Nursing Assessment</p> <p><u>Educational Media:</u></p> <p>Assessment of Respiratory System</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT X: Respiratory (continued)</b></p> <p><b>D. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</b></p> <ol style="list-style-type: none"> <li>1. Medical treatment <ol style="list-style-type: none"> <li>a. Medications – Bronchodilators Expectorants Steroids Antibiotics Aerosol therapy-nebulizer</li> <li>b. Diet/fluids</li> <li>c. Oxygen</li> </ol> </li> <li>2. Nursing interventions <ol style="list-style-type: none"> <li>a. Coughing</li> <li>b. Incentive spirometry &amp; deep breathing</li> <li>c. Chest physiotherapy – postural drainage</li> <li>d. Oxygen administration-cannula, masks</li> <li>e. Airway management</li> <li>f. Fluids</li> <li>g. Emotional support</li> </ol> </li> <li>3. Teaching to meet health deviation self-care requisites <ol style="list-style-type: none"> <li>a. Preparation for diagnostic tests/surgery</li> <li>b. Self-monitoring of status</li> <li>c. Medications</li> <li>d. Oxygen safety</li> <li>e. Airway management</li> <li>f. Medical follow-up</li> </ol> </li> <li>4. Community Resources - referrals</li> </ol> <p><b>E. EVALUATION</b></p> <ol style="list-style-type: none"> <li>1.Documentation/Reporting</li> <li>2.Client outcomes</li> </ol>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT XI: Endocrine</b></p> <p>A. REVIEW OF SYSTEM</p> <ol style="list-style-type: none"> <li>1. Endocrine glands</li> <li>2. Hormones and their functions</li> </ol> <p>B. DESCRIPTION OF HEALTH DEVIATIONS</p> <ol style="list-style-type: none"> <li>1. Disorder of the pancreas Diabetes Mellitus <ol style="list-style-type: none"> <li>a) Type I</li> <li>b) Type II</li> </ol> </li> </ol> <p>C. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ol style="list-style-type: none"> <li>1. History – changes in appearance, weight, appetite, elimination</li> <li>2. Physical Assessment <ol style="list-style-type: none"> <li>a. General appearance</li> <li>b. Vital signs</li> <li>c. Specific signs and symptoms</li> </ol> </li> <li>3. Diagnostic Procedures <ol style="list-style-type: none"> <li>a. Blood Chemistry</li> <li>b. Urinalysis</li> <li>c. 24 hour Urine</li> <li>d. HA1c</li> <li>e. Blood Glucose</li> <li>f. Glucose Tolerance Test</li> </ol> </li> <li>4. Severe Complications <ol style="list-style-type: none"> <li>a. Fluid &amp; electrolyte imbalances</li> <li>b. Hypo/hyperglycemia</li> <li>c. Ketoacidosis</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 38 page 818 Chapter 40</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chapter 27 page 164-177</p> <p><u>Computer Lab:</u></p> <p>Software For Nurses- Endocrine Health Problems ATI Medical-Surgical Assessment</p> <p><u>Skill Lab Practice:</u></p> <p>Drawing up and mixing insulin Use of glucometer</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT XI: Endocrine (continued)</b></p> <p><b>D. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</b></p> <ol style="list-style-type: none"> <li>1. Medical treatment           <ol style="list-style-type: none"> <li>a. Medications – Insulin, hypoglycemics</li> <li>b. Diet/Fluids</li> </ol> </li> <li>2. Nursing Interventions           <ol style="list-style-type: none"> <li>a. Monitor – Vital signs Fluid balance Neurological status Laboratory results Psychological status</li> <li>b. Skin care</li> <li>c. Nutritional &amp; fluid intake</li> <li>d. Activity &amp; Rest</li> <li>e. Psychological support</li> </ol> </li> <li>3. Teaching to meet health deviation self-care requisites           <ol style="list-style-type: none"> <li>a. Preparation for diagnostic tests</li> <li>b. Self-monitoring of status</li> <li>c. Medications</li> <li>d. Skin care</li> <li>e. Activity</li> <li>f. Medic Alert</li> </ol> </li> <li>4. Community Resources</li> </ol> <p><b>E. EVALUATION</b></p> <ol style="list-style-type: none"> <li>1.Documentation/Reporting</li> <li>2.Client outcomes</li> </ol>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT XII: Neurological</b></p> <p>A. REVIEW OF SYSTEM Nervous system</p> <p>B. DESCRIPTION OF HEALTH DEVIATIONS 1. Cerebral Vascular Accident (CVA)</p> <p>C. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ol style="list-style-type: none"> <li>1. Diagnostic procedures <ol style="list-style-type: none"> <li>a. CAT scan</li> <li>b. MRI</li> <li>c. Cerebral angiography</li> <li>d. EEG</li> <li>e. Radiographic studies</li> </ol> </li> <li>2. History</li> <li>3. Physical Assessment <ol style="list-style-type: none"> <li>a. Screening</li> <li>b. General appearance</li> <li>c. Vital signs</li> <li>d. Neuro assessment</li> <li>e. Specific R/L hemisphere signs and symptoms: Changes in level of consciousness or neuromuscular activity (hemiparesis/paralysis), weakness, headache, fatigue, sensory alterations – swallowing, speech changes</li> </ol> </li> <li>4. Complications <ol style="list-style-type: none"> <li>a. Respiratory distress</li> <li>b. Increased intracranial pressure</li> <li>c. Coma</li> <li>d. Paresis/Paralysis</li> <li>e. Communication alterations</li> <li>f. Dysphagia</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 49</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chapter 21, page 107-121</p> <p><u>Computer Lab:</u></p> <p>Software For Nurses- Neurological Health Problems ATI Medical/Surgical Assessment</p> <p><u>Skill Lab Practice:</u></p> <p>Neuro assessment Positioning/transfers Safety measures Communication</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT XII: Neurological (continued)</b></p> <p><b>D. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</b></p> <ol style="list-style-type: none"> <li>1. Medical treatment <ol style="list-style-type: none"> <li>a. Medications – Anticoagulants Clot Busters-t-PA, aspirin, plavix, coumadin, heparin</li> <li>b. Activity – rehabilitation, exercise</li> <li>c. Oxygen</li> </ol> </li> <li>2. Nursing interventions <ol style="list-style-type: none"> <li>a. Monitoring – Vital signs Level of consciousness Fluid status – I &amp; O</li> <li>b. Medication administration</li> <li>c. Safety precautions</li> <li>d. Diet</li> <li>e. Promotion of elimination</li> <li>f. Oxygen administration</li> <li>g. Activity and rest – positioning/transfers, exercise, rehabilitation</li> <li>h. Emotional support</li> </ol> </li> <li>3. Teaching to meet health deviation self-care requisites <ol style="list-style-type: none"> <li>a. Preparation for diagnostic tests</li> <li>b. Self-monitoring of status</li> <li>c. Medications</li> <li>d. ADLs</li> <li>e. Diet</li> <li>f. Rehabilitation - Exercise</li> <li>g. Medical follow-up</li> </ol> </li> <li>4. Community Resources – referrals, support groups, medical supplies</li> </ol> <p><b>E. EVALUATION</b></p> <ol style="list-style-type: none"> <li>1.Documentation/Reporting</li> <li>2.Client outcomes</li> </ol>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT XIII: Oncology</b></p> <p>A. DESCRIPTION OF HEALTH DEVIATION</p> <ol style="list-style-type: none"> <li>1. Pathophysiology</li> <li>2. Causes</li> <li>3. Prevention/control</li> </ol> <p>B. ASSESSMENT OF HEALTH STATE – Attainment of Self Care Requisites</p> <ol style="list-style-type: none"> <li>1. Health History <ol style="list-style-type: none"> <li>a. Risk factors</li> <li>b. Warning signals</li> </ol> </li> <li>2. Physical Assessment <ol style="list-style-type: none"> <li>a. General appearance</li> <li>b. Vital signs</li> <li>c. Specific signs and symptoms:</li> </ol> </li> <li>3. Diagnostic procedures <ol style="list-style-type: none"> <li>a. Tissue sampling –Cytology, Biopsy</li> <li>b. Direct Imaging – Fiberoptic, Endoscopy</li> <li>c. Indirect imaging – radiographic tests, mammograms, GI series, radioisotopes, CAT scans, MRI, ultrasound</li> <li>d. Laboratory studies – CEA, CA-125, acid phosphatase, PSA, CBC</li> </ol> </li> </ol>	<p><u>Required readings:</u> Williams &amp; Hopper <i>Medical Surgical Nursing</i> Chapter 10</p> <p>Asperheim, <i>Introduction to Pharmacology</i> Chapter 29 pages 187-199</p> <p><u>Computer Lab:</u></p> <p>ATI Medical/Surgical Assessment</p>

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT XIII: Oncology (continued)</b></p> <p>C. PLANNING/IMPLEMENTATION TO MEET THERAPEUTIC SELF-CARE DEMAND</p> <ol style="list-style-type: none"> <li>1. Medical treatment           <ol style="list-style-type: none"> <li>a. Medications –</li> <li>b. Chemotherapy</li> <li>c. Biological response modifiers</li> <li>d. Antibiotics</li> <li>e. Hematopoietic growth factors</li> <li>f. Surgery</li> <li>g. Radiotherapy – external &amp; internal radiation</li> <li>h. Bone marrow transplants</li> <li>i. Diet/fluid-TPN, NGT</li> <li>j. Activity – exercise</li> </ol> </li>   <li>2. Nursing interventions           <ol style="list-style-type: none"> <li>a. Monitoring – pain, vital signs, fluid status, lab values</li> <li>b. Hygienic care – oral care, skin care</li> <li>c. Medication administration – response to chemotherapy, PCA use</li> <li>d. Radiation safety</li> <li>e. Diet</li> <li>f. Pain management</li> <li>g. Supportive care –oxygen, elimination, prevention of complications</li> <li>h. Activity and rest</li> <li>i. Emotional support</li> </ol> </li> </ol>	

COURSE CONTENT	READINGS/STUDENT ACTIVITIES
<p><b>UNIT XIII: Oncology (continued)</b></p> <p>3. Teaching to meet health deviation self-care requisites</p> <ul style="list-style-type: none"> <li>a. Preparation for diagnostic tests, surgery, and treatments</li> <li>b. Infection prevention</li> <li>c. Radiation therapy – skin care &amp; safety measures</li> <li>d. Self-monitoring of status</li> <li>e. Medications – Chemotherapy</li> <li>f. Diet</li> <li>g. Exercise</li> <li>h. Medical follow-up</li> <li>i. Screening guidelines</li> </ul> <p>4. Community resources - referrals</p> <ul style="list-style-type: none"> <li>a. Support groups</li> <li>b. Visiting nurse</li> <li>c. Hospice</li> <li>d. Outpatient rehabilitation</li> </ul> <p>D. EVALUATION</p> <ul style="list-style-type: none"> <li>1. Documentation</li> <li>2. Client outcomes</li> </ul>	

**PNU-191  
ADULT HEALTH I  
CLINICAL EVALUATION TOOL**

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

CLINICAL FACULTY: \_\_\_\_\_ CLINICAL SITE: \_\_\_\_\_

OBJECTIVE	EVALUATION	
<b>1. Assume responsibility for own learning by active participation in the care of adults.</b>	PASS	FAIL
a. Comes prepared for clinical experiences	PASS	FAIL
b. Seeks new learning activities to increase strengths and improve limitations	PASS	FAIL
c. Identifies the need for guidance and seeks it appropriately.	PASS	FAIL
d. Applies all previously learned knowledge.	PASS	FAIL
e. Identifies strengths and areas requiring improvement.	PASS	FAIL
f. Completes all clinical requirements in the time specified.	PASS	FAIL
g. Arrives on time for all clinical experiences and provides appropriate notification of emergency absence.	PASS	FAIL
h. Participates in pre- and post-care conferences.	PASS	FAIL
i. Responds appropriately to recommendations for improvement.	PASS	FAIL
<b>2. Utilize legal and ethical standards in adult health nursing practice.</b>	EVALUATION	
a. Implements nursing care for the adult client in a manner reflecting professional and agency standards of practice.	PASS	FAIL
b. Maintains clients' rights and dignity when implementing nursing care.	PASS	FAIL
c. Demonstrates accountability for own actions.	PASS	FAIL
d. Maintains confidentiality of client interactions and documentation.	PASS	FAIL
e. Acts appropriately in interactions with peers, instructors, staff members, and clients.	PASS	FAIL
f. Presents a professional demeanor and appearance during clinical experiences.	PASS	FAIL

OBJECTIVE		
<b>3. Apply interpersonal verbal and nonverbal communication skills in the clinical care of adults.</b>	EVALUATION	
a. Employs appropriate verbal and non-verbal communication with clients, families, and health care team members.	PASS	FAIL
b. Demonstrates a nonjudgmental attitude in nurse-client interactions.	PASS	FAIL
c. Demonstrates caring behaviors in nurse-client interactions.	PASS	FAIL
d. Reports and records essential data, with instructor guidance, in an effective manner.	PASS	FAIL
e. Collaborates with other members of the health care team, with instructor supervision, to assist the client to meet self-care requisites.	PASS	FAIL
<b>4. Identify the physiological, psychological, sociological, and spiritual impact of illness on the adult client.</b>	EVALUATION	
a. Applies pathophysiological and psychosocial principles to nurse-client interactions.	PASS	FAIL
b. Develops a plan of care that is appropriate to the client's self-care requisites.	PASS	FAIL
c. Uses appropriate resources to obtain accurate information to incorporate into the plan of care.	PASS	FAIL
d. Provides health promotion information to the client, with instructor guidance.	PASS	FAIL
<b>5. Apply nursing competencies in the care of clients in the acute, long term, and/or subacute care settings.</b>	EVALUATION	
a. Provides and maintains a safe and comfortable environment for the client.	PASS	FAIL
b. Implements all previously learned skills in a safe and effective manner: basic assessment, vital signs, safety measures, positioning, transfers, ambulation, dosage calculation.	PASS	FAIL
c. Implements required procedures/skills appropriately: <ul style="list-style-type: none"> <li>i. Client assessment: Heart, lung, &amp; abdominal sounds, sensorimotor function (neuro check), peripheral pulses, pain/comfort level</li> <li>ii. Provides hygienic care</li> </ul>	PASS	FAIL

OBJECTIVE	EVALUATION	
<ul style="list-style-type: none"> <li>iii. Monitors client's oxygenation, pulse oximetry</li> <li>iv. Administers oral, topical, and parenteral medications.</li> <li>v. Monitors IV fluid therapy.</li> <li>vi. Promotes urinary and bowel elimination: Offers bedpan/urinal, catheter care, catheterization, enema administration.</li> <li>vii. Monitors nutritional and fluid intake.</li> <li>viii. Provides enteral nutrition – tube feedings</li> <li>ix. Maintains medical and surgical asepsis.</li> <li>x. Performs wound care and dressing changes.</li> </ul>	PASS	FAIL
<ul style="list-style-type: none"> <li>d. Applies principles of standard precautions in all clinical experiences – uses appropriate protective equipment and isolation procedures.</li> </ul>	PASS	FAIL
<b>6. Apply critical thinking skills in the application of the nursing process in the care of adult clients.</b>	EVALUATION	
<ul style="list-style-type: none"> <li>a. Completes client assessment in an effective manner.</li> </ul>	PASS	FAIL
<ul style="list-style-type: none"> <li>b. Identifies nursing diagnoses based on clients' universal and health deviation self-care requisites.</li> </ul>	PASS	FAIL
<ul style="list-style-type: none"> <li>c. Formulates client-centered goals/outcomes consistent with the nursing diagnoses.</li> </ul>	PASS	FAIL
<ul style="list-style-type: none"> <li>d. Plans fundamental nursing care for adult clients based on assessment data and goals/outcomes.</li> </ul>	PASS	FAIL
<ul style="list-style-type: none"> <li>e. Identifies rationales and principles underlying nursing interventions.</li> </ul>	PASS	FAIL
<ul style="list-style-type: none"> <li>f. Evaluates client responses to nursing interventions.</li> </ul>	PASS	FAIL

**STUDENT COMMENTS**

**Midterm**

**Final**

**STUDENT SIGNATURE** \_\_\_\_\_

**FACULTY COMMENTS**

**Midterm**

**Final**

**FACULTY SIGNATURE** \_\_\_\_\_

UNION COUNTY COLLEGE  
PRACTICAL NURSING

**INTERIM ASSESSMENT ANECDOTAL**

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

Clinical Faculty \_\_\_\_\_ Clinical Faculty \_\_\_\_\_

\_\_\_\_\_ Student is making satisfactory progress in meeting the clinical objectives for the course.

\_\_\_\_\_ Student is not making satisfactory progress in meeting the clinical objectives for the course.

Clinical Strengths:

Clinical Difficulties:

Refer to clinical objective #

Plan for remediation:

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

Faculty \_\_\_\_\_ Date \_\_\_\_\_