REGISTERED NURSING PROGRAM

NURSING EDUCATION 135

NURSING I: FUNDAMENTALS OF NURSING

ACADEMIC YEAR 2007-2008
REGISTERED NURSING

NE 135

NURSING I: FUNDAMENTALS OF NURSING

FALL 2007

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Carmen Carrouche-Rivers, RN, MSN and
Sara Lefkowitz, RN, BSN, MPA
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<th>WEEK OF STUDY</th>
<th>Monday: 9:10 AM to 12 PM NE 135 TOPICS/ Potter &amp; Perry CHAPTERS</th>
<th>Wong’s Essentials of Pediatric Nursing</th>
<th>Potter &amp; Perry Virtual Clinical Excursions For Fundamentals of Nursing (Due Friday)</th>
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<td><strong>September 3:</strong> Labor Day Holiday-</td>
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<td><strong>September 6:</strong> Chapter 17 Planning Nursing Care: 317-338 Chapter18 Implementing Care: pp. 339-253 Chapter 19 Evaluation: pp. 354-369</td>
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| 4    | September 10:  
Chapter 36-Activity and Exercise: pp. 929-958.  
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pp. 79-103 | Virtual Clinical Excursion (VCE): Lesson 8 & Lesson 2 | | | September 13:  
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<td>Virtual Clinical Excursion (VCE): Lesson 11 Chap. 9: Sleep Assessment Chap. 15: Ears and the Auditory System Chap. 16: Eyes and the Visual system</td>
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<td>Chapter 44: Urinary Elimination, pp. 1322-1372 Chapter 45: Bowel elimination: pp. 1373-1419</td>
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<td><strong>Care of the Surgical Patient</strong></td>
<td>Chapter 49: Care of the surgical Client, pp. 1593-1644 Pediatric signed consent form due.</td>
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<td><strong>Client Education</strong> (Teaching the surgical patient)</td>
<td>Chapter 24: Client Education: pp. 448-475 Community Based nursing Chapter 3: Community Based Nursing: pp. 46-59 Pediatric Home Health History and a Safety Home Checklist due</td>
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<td>November 26</td>
<td>Nursing Theory and Research</td>
<td>Chapter 4: Nursing Theory, pp. 60-72 Chapter 5: Nursing Research, pp. 73-88 Nursing Care Management: Chapter 20-managing Client Care: pp. 370-387 Pediatric Project due</td>
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Course Description:

NE 135 - Nursing I: Fundamentals of Nursing is a 4-student unit course. The prerequisites, advisory, and co-requisites for this course are: English 120 or ESL 120; Biology 120, 224, 240; Chemistry 110; Nursing Education 90; CIS 116; and NE 135L, NE 138. There are five to three lecture hours weekly for 16 weeks, for a total of 64 hours.

This is a foundation course for nursing practice. The course presents concepts related to clients within the context of their environments, including growth and development, culture, and health-illness, and to the health care delivery system and the political, economic, and social factors that affect it. The course introduces caring in nursing, critical thinking in applying the nursing process and managing client care, communication, client education, and legal and ethical practice.

Students learn how to perform an age-specific health assessment and basic physical examination, to recognize alterations in these assessments, and to engage in therapeutic interventions that promote and maintain clients’ health. Students learn fundamental nursing concepts related to care of immobilized clients, surgical clients, clients with alterations in skin/tissue integrity, and clients with sensory alterations.

Student Units:

4 units

Expected Outcomes for Students:
Upon completion of this course, the student will be able to:

1. Describe the following aspects of the current health care delivery system: health care regulation and cost control methods, levels of health care and services, and key issues in health care delivery.

2. Discuss current nursing practice, including legal parameters, professional responsibilities and roles, theoretical foundations, and nursing research as a basis for practice.

3. Discuss how understanding the client in an environmental context (stage of growth and development, culture and ethnicity, family, level of health/wellness and presence of illness) will influence the quality of care.

4. Define caring in nursing practice, including theoretical views of caring and ways to convey caring.

5. Discuss critical thinking in nursing, including levels of critical thinking, critical thinking competencies, and the components of a critical thinking model (knowledge, experience, attitudes, and standards).

6. Explain the steps of the nursing process, and utilize the nursing process to develop a nursing care plan for a client, focusing on the client’s actual nursing diagnoses.

7. Describe nursing responsibilities in the management of client care, including major concepts in effective management, communication/collaboration strategies with health care team, and methods of creating a safe care environment.

8. Describe the following areas related to professional standards in nursing practice: ethical problems and dilemmas occurring in health care; policy and legal principles that regulate nursing practice; principles of effective verbal communication and written documentation; and client education.

9. Identify information from the nursing history, a basic physical examination, and laboratory and diagnostic tests to assess the following systems: integumentary, musculoskeletal, cardio-pulmonary, immune, gastro-intestinal, endocrine, reproductive, urinary and neurological. Differentiate normal and abnormal findings in infants, children, adults, and older adults.
10. From analysis of data collected, describe actual nursing diagnoses, and plan interventions to meet basic human needs for activity/exercise, safety, hygiene, oxygenation, fluid/electrolytes/acid/base balance, sleep, comfort, nutrition, and elimination; and to maintain wellness.

11. Discuss psychosocial aspects of client health – self-concept and self-esteem, sexuality, spirituality, and coping –, the assessments made in these areas, factors influencing psychosocial integrity, and nursing interventions to promote psychosocial health.

12. Discuss changes in physiological and psychosocial function associated with surgery, and develop a generic nursing care plan for a client during the preoperative, intraoperative, and postoperative periods.

13. Develop a generic nursing care plan for a client at risk for or with an alteration in skin/tissue integrity.

14. Develop a generic nursing care plan for a client with a sensory alteration that provides sensory stimulation, a safe environment, and promotion of communication and self-care.

**Methods of Instruction:**

- Lecture/PowerPoint Presentations
- Discussion of Case Studies
- Focused Small Group In-Class Activities
- Virtual and On-line Assignments

**Course Content:**

I. Health Care Delivery System
   A. Health Care Regulation (e.g., JCAHO, Professional Standards Review, Utilization Review) and Cost Control (Perspective Payment Systems, Managed Care Organization, Capitation, and Health Care Plans)
   B. Levels of Health Care and Services
   C. Key Issues in Health Care Delivery – Quality Health Care and Cost Reduction, Competency, Evidence-Based Practice, Use of Assistive Personnel

II. Nursing Practice
   A. Legal Parameters – Nurse Practice Act, Licensure & Certification
   B. Professional Responsibilities & Roles – Autonomy/Accountability, Caregiver, Advocate, Educator, Communicator, Manager
   C. Theoretical Basis for Practice – Nursing links Person, Health, & Environment; Nursing Theory generates Nursing Knowledge for use in Practice
   D. Nursing Research as a Basis for Practice

III. The Client
   A. Developmental Theories/Principles & Implications for Client Care
   B. Culture and Ethnicity & Implications for Client Care
C. Family – Concept of Family, Implementing Family-Centered Care
D. Health-Wellness and Illness – Health Promotion & Illness Prevention, Impact of Illness on Client & Family

IV. Caring in Nursing Practice
A. Theoretical Views on Caring & Ethic of Care
B. Caring in Nursing Practice

V. Critical Thinking in Nursing Practice; Nursing Process
A. Definition & Levels of Critical Thinking, General Critical Thinking Competencies, & Specific Critical Thinking Competencies for Nursing
B. Critical Thinking Model – Specific Knowledge Base & Experience in Nursing, General & Specific Critical Thinking Competencies, Attitudes or Dispositions, Intellectual & Professional Standards
C. Nursing Process - Nursing Assessment, Nursing Diagnosis, Planning/Implementing/Evaluating Nursing Care
D. Managing Client Care – Nursing Care Delivery Models, Clinical Care Coordination, Use of Resources, & Quality Management

VI. Professional Standards in Nursing Practice
A. Ethics and Values – Professional Nursing Values, Bioethics, & Processing an Ethical Dilemma; Legal Implications in Nursing - Legal Limits of Nursing, Federal & State Statutory Issues in Nursing Practice, Civil & Common Law Issues in Nursing Practice, & Risk Management
B. Communication/Documentation
   1. Levels/Basic Elements/Forms of Communication
   2. Therapeutic versus Non-Therapeutic Communication; Confidentiality
   3. Developmental Aspects of Communication
   4. Multidisciplinary Communication; Guidelines for Quality Documentation and Reporting
   5. Client Education – Purposes, Teaching-Learning Principles, Role of the Nurse in Teaching & Learning, Teaching Tools for Instruction

VII. Psychosocial Basis for Nursing Practice
A. Self-Concept – Stressors Affecting Self-Concept, the Nursing Process & Self-Concept
B. Sexuality – Alterations in Sexual Health; Sexuality and the Nursing Process
C. Spiritual Health – Concepts of Spiritual Health, Spiritual Problems/Distress,
Spiritual Health & the Nursing Process

D. Stress and Coping – Factors Affecting Coping, the Nursing Process & Coping with Stress

VIII. Health Assessment and Basic Physical Examination

A. Basic Physical Examination - Cultural & Developmental Sensitivity, Skill of Physical Assessment, Preparation for & Organization of the Examination, General Survey

B. Relevant Information from Nursing History, Basic Laboratory and Diagnostic Tests, & Physical Examinations for the Integument, Musculo-Skeletal, Cardio-Pulmonary, Immune, Gastro-Intestinal, Endocrine, Reproductive, and Neurological Systems.

C. Normal and Abnormal Findings in Basic Laboratory & Diagnostic Tests & Physical Examination for each System for Infants, Children, Adolescents, Adults, and Older Adults.

IX. Basic Human Needs; Clients with Special Needs

A. Types of Needs – Activity & Exercise, Safety, Hygiene, Oxygenation, Fluid/Electrolyte/Acid-Base Balance, Sleep, Comfort, Nutrition, & Urinary & Bowel Elimination

B. Factors affecting Systems Function to meet Basic Human Needs – Physiological, Developmental, Lifestyle, & Environmental

C. Methods for Meeting Basic Human Needs and Maintaining Wellness in Infants, Children, Adolescents, Adults, and Older Adults

D. Care of the Immobilized Client

E. Care of the Surgical Client during the preoperative, intraoperative, & postoperative surgical phases

F. Care of the Client with an Alteration in Skin/Tissue Integrity

G. Care of the Client with a Sensory Alteration

Critical Thinking:

Students learn to:

- Recognize components of a critical thinking model for nursing
- Use critical thinking in applying the nursing process to assist clients to promote and maintain optimal wellness
- Conduct a nursing assessment and health history & perform a basic physical examination to determine causalities and establish a database about an individual’s perceived needs, health problems, & responses to these problems
• Set specific & expected outcomes of care, select nursing interventions based on the causalities & desired outcomes, & evaluate whether nursing actions are effective to meet the expected outcomes
• Apply the nursing process to case studies and develop nursing care plans or concept maps (in class)
• Find solutions to clinical problems through discussion of clinical case studies in class and to be open-minded & inquisitive (critical thinking dispositions)

Assignments and Methods of Evaluation:

• On-line Assignments; Chapter Review Quizzes, Internet searches, and Critical Thinking Exercises
• Pediatric Home Health Project
• Virtual Hospital Assignments
• In-Class Examinations – Multiple Choice Questions, Alternate Item Questions, and Essay Questions about Case Studies
• Final Examination– Multiple Choice Questions, Alternate Item Questions, Essay Questions about Case Studies

Course Evaluation:

The results of unit examinations, the Pediatric Home Health Project, and a final examination will determine the theory grade. Please refer to the College of Marin Registered Nursing Program Registered Nursing Student Handbook for policies, procedures, and regulations that students are held accountable to while enrolled in the RN Program. Please review ones pertaining to Academic Integrity, Grading Regulation, and Attendance Policy that are entitled: Student Conduct-Board Policy 4.002, Letter from the Program Director Regarding Cheating, Methods and Tools for Measurement of Student Achievement in Nursing Courses-Theory Course Evaluation, and Attendance Regulation.

The unit examinations and Pediatric Home Health Project will be worth sixty percent (60%) of the final course grade, and the final examination will comprise forty percent (40%) of the final course grade. **The final course grade must be seventy –two percent (72%) or better to pass this course.** Students who receive a grade lower than a "C" in any nursing course may not progress to the next course in the COM's RN Program.

Final grades for this course will be determined by the following method: **"The average of all exams in the course must equal 72% or higher for the student to pass this course.**" Any points from additional course assignments will not be included into the course's examination average unless the examination average is at 72% or higher. The course instructor(s) determines the weighting of additional papers and projects for the final grade. The instructor determines the weighting of additional papers and projects for the final grade. For this class the weighting of additional assignments is Virtual Assignments (6%) and Pediatric Home Health Project (10%). The unit examinations are scheduled for September 17th (11%), October 15th (11%), November 12th (11%), and December 4th (11%); and the final exam TBA (40%).

The student must contact the course instructor(s) in advance of any absence from an examination. At that time, a different version of the examination and a new test date will be arranged e.g. in the testing center within one week of the missed examination. Failure to notify the instructor prior to the beginning of an examination or to make up the missed examination will result in a no credit (0 points) for the missed examination.

Theory courses are graded on an A, B, C, D, and F basis with a 91%-100% range for an A, an 81%-90% for a B, and 72%-80% range for a C, a 62%-71% for a D, and 61% and below for a F. This grade rating system is based on a COM RN Program policy to maintain consistency among nursing education courses.
Pediatric Home Health Project:

Students are assigned a community project – the Pediatric Home Health Project. They select a family with a child, identify specific learning needs for health maintenance, and plan and implement a single-focused teaching plan. Students also do a home safety check to determine potential areas of risk for child safety. This project provides opportunities for students to gain skills in communicating with children and their families and in applying teaching-learning principles in teaching and evaluating learning in children and their parents and/or caregivers.

Each student is to select a family (with a child or children) who is willing to have the student make three separate visits over the course of 2 months. The student will get a signed consent form from the family. This part of the project is due on October 29, 2007. During the first visit, you will complete a Pediatric Home Health History on one child and a Safety Home Checklist. This part of the project is due on November 5, 2007. During the second visit, you will teach the parent(s) basic practices to promote or protect health and prevent illness in their child. Your teaching will be on learning needs identified during your first visit and should focus on one area only, such as safety or nutrition. During your third visit, you will evaluate the effectiveness of your teaching. This part of the project is due November 26, 2007. Objectives and readings for the Pediatric Home Health Project, along with an interview/home visit permission form and an Outline of a Pediatric Health History are included in Appendix I at the back of this syllabus. **Grading is based on the criteria noted for this project in Appendix II.**

All written assignments are to be turned in per instructor's directions in order to receive full credit in the course. It is expected that all written assignments will 1) be turned in on time, 2) be neat, legible, and written in ink or typed per instructions, and 3) contain proper grammar, punctuation, and spelling. It is advisable for students to keep a copy of written assignments for their records. The COM's policy on Student Conduct will be upheld, as well as other policies, procedures, and regulations that are noted in the Student Handbook.

Required Texts:


First Mosby Book Package: obtained at the College of Marin Book Store after July 24, 2007

Second Mosby Book Package: obtained at the College of Marin Book Store after October 5, 2007

*Registered Nursing Program Student Handbook*, 2007-2008

Special Student Materials:

Access to a computer with Intranet

Course Instructions:

Consult the NE 135 course schedule for the topics for each class date and **always** bring this syllabus and the Fundamentals of Nursing textbook with you to class. **Before each class**, review the class learning objectives, complete the required readings, complete all class assignments, and define the terms in the vocabulary lists. **Be prepared for class**; there will be in-class learning activities to reinforce the class learning objectives; such as small groups, classroom discussions, critical thinking exercises, and case
studies. A student, whom comes to class unprepared, by not doing the assigned work prior to class, may feel lost when they are in class with the other students who are being asked to put the knowledge/information that they attained by preparing for class to use in classroom learning activities. Please refer to the Nursing Program's Philosophy on learning in the Registered Nursing Program Student Handbook, 2007-2008.

**ATI:**

All first year students will receive the Nursing Care of Children Review Module (for now- no cost to the student) to utilize throughout the four semesters of the nursing program. In the COM's curriculum, the Pediatric content is integrated with the adult and geriatric content. Review Modules are soft-covered booklets (also will be online) which are unit-based, teaching guides covering nursing topics via concise summaries and key concepts in the format of: critical thinking exercises using a case study approach, open-ended questions with rationales for clinical decisions, and clinical application scenarios. Unsecured Assessments/Tests are online multiple-choice questions designed to assess the effectiveness of students' self-remediation. To help strengthen the students' understanding of the material, rationales for each response-option are provided in an interactive style. Unsecured or non-proctored assessments are available to students at anytime on an internet-connected computer. Currently, the non-proctored test for Nursing Care of Children will be available to students during the Spring 2008 semester.

At various times during the course of the nursing program students will be tested to make an assessment of their mastery of nursing content areas, nursing process, critical thinking, therapeutic intervention, communication skills, and cognitive levels. These secured assessments/tests are provided in a proctored, timed-setting. The current Proctored Assessment includes the RN Comprehensive (NCLEX) Predictor at the end of the nursing program. The nursing faculty is currently investigating the components of ATI that would be suited for our nursing students and to support the program's nursing curriculum. A decision will be made concerning the further use of the ATI program during the 2007-2008 academic year.

**Simulation:**

Students may be scheduled to learn NE 135 and/or NE 135L content in the simulation laboratory. If a simulation is scheduled on the course calendar, then the student is expected to attend that learning activity(s). If the student is absent from this experience refer to the attendance policy and regulation in the RN Student Handbook. Students will be given rules of the simulation lab to read and sign prior to a simulation case scenario. Simulation as a teaching methodology will be conducted in a learning environment, and it is not intended to be a graded learning activity. However, students are asked to prepare prior to the simulation case scenario, just as if they were getting ready to attend clinical. On the day of the scheduled simulation case study the student is expected to wear their College of Marin nursing uniform and come prepared for clinical (drug handbook, watch with a second hand, hair off of the collar, follow the dress code for clinical, and be prepared by researching the case scenario and answering the questions on the learner handout).
WEEK ONE: August 20th

Chapter 1: Nursing Today

Key Terms
Autonomy, client, cultural diversity, health, holistic care, interdisciplinary, licensed vocational nurse (LVN)/licensed practical nurse (LPN), National Council Licensure Examination for Registered Nurses (NCLEX-RN), nursing, profession, registered nurse (RN)

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe various historical influences that impacted today’s nurse.
- Describe how trends in society have directed nursing practice.
- Compare the different educational programs in nursing.
- Describe how professional nursing practice is influenced by standards of professional nursing, professional organizations, and professional nursing roles.

Worldwide Nurse, a resource for nurses with links to professional nursing organizations, boards of nursing, and information about nursing history and other topics of interest to nurses, has a website at http://www.wwnurse.com.
The American Nurses’ Association, the professional organization for nurses, has a website at http://www.nursingworld.com.

Chapter 6: Health and Wellness

Key Terms
Disease, etiology, health goals, health-illness continuum, health perception, health promotion, health within illness, illness, population health, preventive health care, primary health care, primary prevention, secondary prevention, tertiary prevention, well-being, wellness

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe the perception of health for individuals, families, and communities.
- Compare factors that affect health for individuals, families, and communities.
- Understand the focus of assessment of health in the individual, family, and community.
- Identify health goals and expected outcomes in planning for individuals, families, and communities.
- Discuss the use of the nursing diagnosis Health-seeking behaviors.
- Identify methodologies of intervention for improving the health of individuals, families, and communities.
- Evaluate health outcomes in individuals, families, and communities.
Chapter 33: Infection Control

Key Terms
Antibacterial, antibiotic, antibody, antimicrobial, bacterium, differential cell count, Gram stain, iatrogenic infection, immunization, immunocompromised, immunosuppression, infection, infection control, inflammatory response, isolation, medical asepsis, nosocomial infection, pathogen, quarantine, septicemia, standard precautions, surgical asepsis, virulence, virus

Learning Objectives
After studying this chapter, the student should be able to do the following:

- Discuss the course of an infection, the physiological defenses against infection, and the chain of infection in relationship to infection control.
- Describe the assessment of a client who is at risk for infection, an actual infection, and the responses to infection.
- Identify appropriate nursing diagnoses for a client with either an active infection or an increased risk for infection.
- Plan for goal-directed interventions to prevent infection or control the spread of infection.
- Identify specific interventions needed to prevent transmission of infection, manage a client with a compromised immune system, and reduce the personal risk for infection.
- Evaluate the outcomes that describe progress toward the goals of health protection nursing care.
- Identify work restriction guidelines for client and care provider protection.
- Identify cultural beliefs that may influence care.

Mosby’s Nursing Skills Videos. Have students view the following video(s) and complete the related exercises found in the Instructor’s section of the Evolve website:

- Basic Principles
- Wound Care

The Centers for Disease Control and Prevention (CDC), an agency of the U.S. Department of Health and Human Services, provide a vast amount of information related to specific diseases and infection control for health care personnel.

Chapter 7: Caring in Nursing

Key Terms
acting-out behaviors, active listening, attending behaviors, body language, context, decoder (receiver), empathy, encoder (sender), feedback, language, message, nonverbal communication, paralanguage, personal space, sensory channel, therapeutic rapport, therapeutic relationship, unconditional positive regard, verbal communication

Learning Objectives
After studying this chapter, the student should be able to do the following:

- Understand the nature of a therapeutic relationship based on the phases of the relationship, elements of the relationship, theories about the relationship, and elements of the communication process.
- Describe verbal and nonverbal behaviors that affect communication.
- Identify and give examples of therapeutic communication techniques.
- Identify and give examples of non-therapeutic communication techniques.
Chapter 2: The Health Care Delivery System

Key Terms
Access, biomedical model, capitation payment system, diagnosis-related group (DRG), exclusive provider organization, health maintenance organization (HMO), health promotion, illness prevention, managed care, Medicaid, Medicare, preferred provider organization (PPO), prospective payment system, rehabilitation, retrospective payment system, supportive care

Learning Objectives
After studying this chapter, the student should be able to do the following:

• Identify the characteristics of health care as a system of delivery of services.
• Compare the four types of health care services.
• Identify health care personnel and describe their training, roles, and responsibilities.
• Discuss inpatient, outpatient, and community settings for the delivery of health care.
• Compare the types of health care financing
• Discuss current issues and opportunities in health care delivery.

An Internet search using the term health policy can produce more than a million results. Have students pick a topic of interest to them in the area of health care delivery and do their own searches. Here are a few suggestions:
The American Hospital Association offers information about development health care legislation (some information restricted to members only). The AHA site is available at http://www.aha.org
The Center for Reproductive Law and Policy, a nonprofit legal organization dedicated to promoting women’s health and rights, provides access to information about women’s reproductive health at http://www.crlp.org.
The National Alliance for the Mentally Ill, an advocacy organization that works for treatment and research into brain disorders and a better quality of life for those who suffer from them, offers a wealth of information at http://www.nami.org.
Chapter 7: Assessing Vital Signs

Key Terms
apical pulse, auscultatory gap, basal metabolic rate (BMR), bradycardia, bradypnea, diastolic blood pressure, eupnea, Korotkoff’s sounds, orthostatic hypotension, oxygen saturation, peripheral vascular resistance, pulse deficit, pulse oximeter, pulse pressure, systolic blood pressure, tachycardia, tachypnea, thermogenesis, thermolysis, tidal volume (TV)

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Identify the rationale for the assessment of vital signs.
- Interpret deviations from the normal ranges of each vital sign according to the client’s age.
- Describe the normal physiological features of each vital sign.
- List factors that influence temperature, pulse, respirations, oxygen saturation, and blood pressure.
- Safely and accurately measure axillary, oral, rectal, and tympanic temperatures; apical and radial pulses; respirations; oxygen saturations; and blood pressure.
- Measure vital signs in an organized, accurate manner.

Document and report vital sign measurements correctly.

Student Learning Activities:

Read Potter & Perry Chapter 32; pages 671 to 687 up to Skin, Hair, and Nails

Read Health Assessment for Nursing Practice, 3rd edition, Chapter 4, Interviewing to Obtain a Health History and Chapter 5, Techniques and Equipment for Physical Assessment

Read Wong's Essentials of Pediatric Nursing, 7th edition, Chapter, 6, Communication and Health Assessment of the Child and Family and Chapter 7, Physical and Developmental Assessment of the Child

Mosby’s Nursing Skills Videos. Have students view the following video(s) and complete the related exercises found in the Instructor’s section of the Evolve website:
- Measurements

The Hypertension Network, a website founded by a professor of medicine at the hypertension center of the New York Presbyterian Hospital in Manhattan, presents basic facts, lifestyle issues, information on home monitoring, risk factors, and hypertension treatment information for patients. The network is available at http://www.BloodPressure.com


Chapter 32: Physical Assessment

Key Terms
Accommodation, auscultation, bronchial, bronchovesicular, ecchymosis, inspection, lesion, ophthalmoscope, otoscope, palpation, percussion, point of maximal impulse, precordium, respiratory excursion, tactile fremitus, turgor, vesicular
Learning Objectives

After studying this chapter, the student should be able to do the following:

- Describe the four techniques used in physical examination: inspection, palpation, percussion, and auscultation.
- Identify the purpose of the primary instruments used in physical assessment.
- Acquire nonthreatening techniques for physical examination to ensure client comfort and prepare the client for each regionally focused area of a complete physical examination.
- Perform a complete physical examination on a client using a head-to-toe approach.
- Recognize normal physical findings.
- Recognize when physical findings deviate from normal.

Mosby’s Nursing Skills Videos. Have students view the following video and complete the related exercises found in the Instructor’s section of the Evolve website:

- Measurements

The Family Visits the Doctor is an advertisement website for an educational children’s coloring book that explains each step of a physical examination and why a checkup each year helps families stay healthy. It provides excerpts from the book.

MammaCare presents information about, and ordering information on, a system for teaching physical examination of the breast. The system was originally developed under a grant from the National Cancer Institute. The website can be found at http://www.MammaCare.com.

Health Assessment & Physical Examination—Case Study is a discussion forum provided by Delmar Publishers. These discussions focus on case study topics introduced each month. Previous topics are listed separately and their accompanying discussions, when available, are stored within this forum.

The Children’s Virtual Hospital, which is maintained by The Children’s Hospital of Iowa, includes articles pertaining to physical examination and other subjects. One article of particular interest on this website is “Electric Airway: Upper Airway Problems in Children: Summary of Physical Examination in Epiglottitis.”

Chapter 14: Critical Thinking

Key Terms

Abstract, Benner’s stages of skill acquisition, caring, clinical judgment, concept, critical thinking, decision making, diagnostic reasoning, empirical, nursing process, problem solving, theory

Learning Objectives

After studying this chapter, the student should be able to do the following:

- Discuss the importance of theory in nursing practice.
- Compare and contrast nursing theories about caring.
- Differentiate between critical thinking, problem solving, decision making, diagnostic reasoning, and clinical judgment.
- Describe the elements of a critical thinking model.
- Discuss critical thinking skills used in nursing practice.
- Recognize obstacles to critical thinking.
- Describe the five interwoven phases of the nursing process.
Chapter 15: Nursing Assessment

Key Terms
active listening, active processing, assessment, biographical data, cardinal signs and symptoms, chief complaint, closed question, cue, data, database, demographic data, functional health patterns, inference, interview, intuition, leading question, minimum data set, nursing history, objective data, open-ended question, orientation phase, signs, subjective data, symptoms, termination, validation, working phase

Learning Objectives
After studying this chapter, the student should be able to do the following:

• Make preliminary decisions in preparation for data collection.
• Understand data collection as a critical thinking process.
• Employ interviewing techniques in taking a health history.
• Develop a systematic framework for organizing data.
• Document the assessment in the client’s health record.

Health Status allows you to take a free health risk assessment online. You can get an online report of the results, link to additional resources, create a personal health page, and periodically receive additional information. The website can be found at http://www.healthstatus.com

Real Age: The Leader in Age Reduction provides information about risk factors and prevention of aging. Some of the information appears helpful; however, be aware the website is trying to sell products. This site can be found at http://www.realage.com

You First offers a health risk assessment, pointers on staying healthy, and health links. The website is sponsored by Greenstone Healthcare Solutions, a wholly owned subsidiary of the Pharmacia-Upjohn Company. This site can be found at http://www.youfirst.com/

Chapter 16: Making a Nursing Diagnosis

Key Terms
clinical judgment, collaborative problem, cue, defining characteristic, descriptor, diagnostic label, diagnostic reasoning, differential diagnosis, nursing diagnosis, related factors, risk factors, “risk for” nursing diagnosis, taxonomy, wellness nursing diagnosis

Learning Objectives
After studying this chapter, the student should be able to do the following:

• Discuss the classification of nursing diagnoses.
• Describe the five components of a NANDA nursing diagnosis.
• Compare and contrast four types of nursing diagnoses.
• Describe the process of diagnostic reasoning.
• Discuss several sources of diagnostic error and how to avoid them.

Information about the Nursing Diagnosis and Extension Classification, a research effort designed to refine, extend, validate, and classify nursing diagnoses, can be found at http://www.nursing.uiowa.edu/ndec/index.htm
WEEK THREE: September 3rd

Chapter 17, 18, 18: Planning, Implementing and Evaluating Care

Key Terms

care plan conference, case management, clinical pathway, collaboration, computerized care plan, consultation, discharge planning, evaluation, expected outcome, goals, individualized care plan, long-term goal, nursing care plan, nurse-initiated intervention, nursing intervention, Nursing Intervention Classification, Nursing Outcomes Classification, nursing-sensitive client outcome, physician-initiated intervention, short-term goal, standardized care plan, standards of care

Learning Objectives

After studying this chapter, the student should be able to do the following:

- Describe types of planning for individual clients.
- Describe the process of planning for individual client care, including nursing diagnoses, priorities, expected outcomes, and interventions.
- Discuss the skills and types of interventions to individualize care for each client.
- Describe the process of evaluating expected outcomes and nursing interventions.

World Wide Nurse, subtitled The Internet’s Nursing Resource, provides a free discussion forum. You can follow the interesting discussions or add your own topic. This website can be found at http://www.wwnurse.com

The Health Care Professionals Network offers information on policies for health care agencies. Developed as a networking medium for health care professionals, this website is meant to provide health care professionals in all types of facilities with information that will be helpful in developing processes to enhance the quality of care and services while meeting the requirements of external review agencies.

HealthLinks.net is a free worldwide directory/portal service for health care professionals and consumers. Its main focus is on assisting users in the task of locating medical and health care information, products, resources, services, and practitioners on the Internet. It also provides a series of forums for health care discussions, a free classified ads area, a chat area divided into discipline-specific rooms, and a monthly newsletter containing articles about health care, and computer- and Internet-related subjects. This site can be found at http://www.healthlinks.net.

No specific websites have been identified that focus on the evaluation phase of the nursing process. Information about the American Nurses Association Standards of Care can be found by visiting the ANA website at http://www.nursingworld.org.
WEEK FOUR: September 10th

Chapter 36: Activity and Exercise

Key Terms
Atrophy, bed rest, contracture, deep vein thrombosis, disuse, excoriation, footdrop, friction injury, hypomotility, hypostatic pneumonia, immobility, inactivity, interface pressure, maceration, orthostatic hypotension, osteoporosis, pressure ulcer, pulmonary embolus, renal calculi, shear, trochanter roll, Valsalva maneuver, wrist drop

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe the physiological concepts underlying the diagnosis of Risk for disuse syndrome.
- Discuss the factors that may lead to immobility and disuse.
- Assess a client who is at risk for complications from disuse.
- Diagnose the client at risk for disuse complications.
- Plan goal-directed interventions to prevent complications of disuse.
- Describe interventions needed to prevent complications of disuse.
- Evaluate outcomes that describe progress toward managing immobility and preventing disuse.

Mosby’s Nursing Skills Videos. Have students view the following video(s) and complete the related exercises found in the Instructor’s section of the Evolve website:
- Oxygenation
- Suctioning

The Arthritis Foundation website is available at http://www.arthritis.org/
The National Association of Orthopaedic Nurses (NAON) website is available at http://naon.inurse.com/

Chapter 37: Client Safety

Key Terms
Asphyxiation, aspiration, burn, choking, injury, poisoning, restraint, strangulation, trauma

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Discuss the epidemiology of common injuries from falls, asphyxiation, and poisoning.
- Discuss the epidemiology of trauma from burns, electricity, motor vehicle accidents, and radiation.
- Identify the behavioral, environmental, socioeconomic, developmental, cognitive, and physiological factors that affect safety.
- Assess the client’s risk for injury.
- Distinguish between related nursing diagnoses for the client at risk for injury
- Plan interventions to prevent injury and promote safety in the acute care setting, the client’s home, and the community.
- Evaluate client outcomes and nursing interventions used to help the client reduce the risk for injury.
Chapter 38: Hygiene

Key Terms
Alopecia, caries, cerumen, dentures, gingivitis, perineum, plaque, tartar

Learning Objectives
After studying this chapter, the student should be able to do the following:

- Describe the structure and function of the skin, hair, nails, and oral cavity.
- Discuss problems associated with personal hygiene.
- Discuss the life span and physiological, cultural, and lifestyle factors that influence hygiene practices.
- Assess the client who is at risk for or has an actual self-care deficit in managing personal hygiene, feeding, toileting, or dressing related to physical, psychological, or cognitive impairment.
- Choose appropriate nursing diagnoses related to the client’s ability to engage in self-care.
- Plan client-centered outcomes to help the client meet self-care deficits.
- Describe nursing interventions to promote hygiene of the skin, mouth, and hair, as well as feeding, toileting, and dressing/grooming.
- Evaluate outcomes of nursing care in helping the client meet self-care needs.

Chapter 46: Mobility and Immobility

Key Terms
Flaccid, hemiparesis, hemiplegia, isometric exercise, isotonic exercise, kyphosis, paraparesis, paraplegia, PQRST model, proprioception, quadriparesis, quadriplegia, range-of-motion exercises, spastic, synovium

Learning Objectives
After studying this chapter, the student should be able to do the following:

- Describe the concepts of the structure and function of the musculoskeletal system pertaining to mobility.
- Discuss factors affecting mobility.
- Describe the assessment of a client with impaired mobility.
- Identify appropriate nursing diagnoses for clients with mobility problems.
- Identify expected outcomes for permanent and temporary mobility problems.
- Intervene to help a client restore or improve mobility.
• Evaluate nursing care for the nursing diagnoses Impaired physical mobility and Activity intolerance.

Mosby’s Nursing Skills Videos. Have students view the following video(s) and complete the related exercises found in the Instructor’s section of the Evolve website:
• Body Mechanics and Exercise
• Preventing and Treating Pressure Ulcers
• Wound Care

The National Association of Orthopaedic Nurses (NAON) website is available at http://naon.inurse.com/
Physical Therapist Online is available at http://physicaltherapist.com/
Physiotherapy Web Services is available at http://www.physiotherapy.net.au/

CASE STUDY
Activity and Rest

Rosemary Yee, a 38 year old Chinese-American woman, is married to Pat Yee. They have a 6 week old infant named Marcus. She has come to the office of Dr. Carlino, an internist, where you work as the Registered Nurse. Rosemary complains of difficulties sleeping and generalized joint “achiness” that occurs when she awakens. The nurse reviewed Rosemary’s sleep questionnaire that revealed she did not have any sleep difficulties prior to her son’s birth. She wrote that it is very difficult for her to fall asleep, that she sleeps for only 3 to 4 hours, and that she is very unsatisfied with her last night’s sleep. When she wakens, she feels tired and still drowsy, and states she has no energy for her usual daily activities. Yoko, a 72 year-old paternal grandmother lives with this family and her primary role is to care for Marcus. Both Rosemary and Pat work in the city during different hours so that one of them can be at home most of the time.

1. Identify what type of health history the client needs for this office visit and what type for her return visit? Describe the major differences between these two types of health histories and the documentation the RN will need to perform for each health history. During which visit would the RN assess Rosemary’s osteoporosis risk factors, explain your rationale?

2. Conduct a health interview that demonstrates how to acquire pertinent information using the PQRSTU mnemonic to investigate the client’s chief complaint.

3. Describe what causative factors or stimuli (label as M=maturational, S=situational, P=physiological, T=treatment) from the above case study and the health interview (that is supported by data collected from the client) which gives the nurse valuable information to formulate the “related to” (R/T) part of the nursing diagnoses.

Chapter 9: Caring for Families

Key Terms
Attachment, cephalocaudal, concrete operations, conservation, constitutional delay of puberty, critical periods, development, differentiated development, egocentrism, formal operations, growth, object permanence, proximodistal, sensory stimulation, symbolic play

Learning Objectives
After studying this chapter, the student should be able to do the following:
1. Examine current trends in the American family.
2. Explain how the relationship between family structure and patterns of functioning affect the health of individuals within the family and the family as a whole.
3. Compare the client within the context of family to the family as client and explain the way the theses perspectives influence nursing practice.
4. Describe how the nursing process can be used to provide for the health care needs of the family.
   • Compare and contrast significant theories of growth and development.
   • Identify developmental milestones from infancy through school age.
   • Describe environmental, socioeconomic, nutritional, and physiological factors affecting growth and development for the child from infancy through school age.
   • Describe the assessment of growth and development and health maintenance from infancy through school age.
   • Discuss assessment strategies to detect altered growth and development and to promote health maintenance.
   • Select an appropriate related nursing diagnosis for the well infant, toddler, and school-age child with problems in growth and development and health maintenance.
   • Plan interventions to promote growth and development and health maintenance from infancy through school-age.
   • Evaluate outcomes from infancy through school-age children, for Delayed growth and development and for Ineffective health maintenance.
   • Assess, plan for, and intervene with parents who exhibit alterations in parenting.

Chapter 12: Young to Middle Adult

Key Terms
constitutional delay of puberty, egocentrism, formal operations, gynecomastia, menarche, nocturnal emission, sandwich generation, young adulthood

Learning Objectives
After studying this chapter, the student should be able to do the following:
   • Discuss the developmental tasks of adolescence and young adulthood.
   • Identify a variety of factors affecting adult development.
   • Describe the assessment of the adolescence and young well adult for normal function and risk factors.
   • Differentiate among the variety of nursing diagnoses appropriate for adults seeking knowledge or health care related to development or health maintenance.
   • Plan nursing interventions for health maintenance and risk factor reduction as appropriate to the adult’s developmental level.
   • Evaluate the outcomes that describe progress toward the goals of health maintenance.

Chapter 13: The Older Adult

Key Terms
Ageism, menopause, middle adulthood, midlife crisis, older adult, retirement, sandwich generation

Learning Objectives
After studying this chapter, the student should be able to do the following:
   • Discuss the aging and the developmental tasks of middle and older adulthood.
   • Identify factors affecting the health and well-being of middle and older adults.
• Describe the assessment of a well middle or older adult for normal function and risk factors.
• Describe modifications of the health history and physical examination for the older adult.
• Differentiate among the variety of nursing diagnoses appropriate for adults seeking knowledge or health care practices to increase the likelihood of successful aging.
• Plan nursing interventions for health maintenance and reduction of risk factors as appropriate to the adult’s developmental level.
• Evaluate the outcomes that describe progress toward the goals of health maintenance.

The Novartis Foundation for Gerontology, an educational web center for the promotion of education on healthy aging and interaction between the public and health care professionals, has specified areas or links for “physicians and researchers,” “other health care professionals,” and “patients.” This site is available at http://www.healthandage.com/.
The U.S. Department of Health and Human Services website is available at http://www.hhs.gov/
Chapter 39: Oxygenation

Key Terms
Bronchospasm, chest percussion, chest physiotherapy, cough, cyanosis, diaphragmatic (abdominal) breathing, dyspnea, endotracheal tube, hemoptysis, hypercapnia, hyperventilation, hypoventilation, hypoxemia, hypoxia, incentive spirometer, postural drainage, pulse oximetry, pursed-lip breathing Respiration, sputum, ventilation, vibration, afterload, antidiuretic hormone, atherosclerosis, baroreceptors, bradycardia, cardiac output, claudication, , diastole, dysrhythmia, edema, inotropic agent, ischemia, necrosis, preload, stroke volume, systole, tachycardia, viscosity

Learning Objectives
After studying this chapter, the student should be able to do the following:

- Describe the anatomic and physiological concepts underlying the three tissue perfusion diagnoses.
- Discuss some common problems of cardiovascular function.
- Identify the life span, physiological, and cultural/lifestyle factors affecting tissue perfusion and cardiac function.
- Explain how to assess the client at risk for problems of tissue perfusion or cardiac function, how to detect the manifestations of an actual problem, and how to recognize the client’s responses to problems.
- Differentiate among nursing diagnoses used for clients with cardiovascular problems amenable to nursing care.
- Plan for goal-directed interventions to prevent or correct problems of tissue perfusion and cardiac function.
- Evaluate the outcomes of nursing care to promote cardiac function and tissue perfusion.
- Describe the physiological concepts underlying the respiratory nursing diagnoses.
- Discuss the most common lifestyle, environmental, developmental, and physiological factors affecting respiration, as well as contributing pathologies.
- Assess the client who has risk for experiencing a respiratory problem and the client’s responses to the respiratory problem.
- Diagnose the client’s respiratory needs that are amenable to nursing care
- Plan goal-directed interventions to prevent or correct the respiratory diagnoses.
- Describe and practice key interventions for respiratory care, including positioning, suctioning, providing supplemental oxygen, and maintaining a patent (open) airway.
- Evaluate the outcomes that describe progress toward the goals of respiratory nursing care.

The American Lung Association website provides a wealth of information about lung disease, research, and the work of the American Lung Association. This site can be found on the Internet at http://www.lungusa.org.

The American College of Chest Physicians website provides information on respiratory disease and allows users to search the journal Chest for abstracts. This site can be found at http://www.chestnet.org

The American Association of Respiratory Care website provides information about respiratory care, meetings, and educational programs. The IQ tests for patients are fun to take and informative. This site can be found at http://www.aarc.org.
The Mayo Clinic Heart Resource Center, providing information about heart disease, high blood pressure, and circulatory problems, and the latest information on the prevention of heart disease, has a website at http://www.mayohealth.org/mayo/common/htm/heartpg.htm

About.com, a website providing information about and links to other sites for topics related to heart disease, is available at http://heartdisease.about.com/

The American Heart Association website, providing information about a variety of cardiovascular diseases, including myocardial infarction, stroke, and others, is available at http://www.americanheart.org/

CASE STUDY
Oxygenation: Ventilation

Mary Mott is the 60-year-old wife of Joseph (see Protection: Skin Integrity case study), and she has a past medical history of COPD, MI and CHF. COPD are initials for chronic obstructive lung disease, which often results from a long history of asthma, bronchitis, or other chronic pulmonary disorder. Mary has been a smoker since age 20, and was smoking 2-3 packs per day until recently. CHF or congestive heart failure is the result of the heart muscle becoming too weak and ineffective to function as a strong pump. This is a probable result of her long-standing history of several heart attacks. She is now being seen in the Emergency Department of Marin Valley Hospital with complaints of increasing shortness of breath and fatigue with even minimal activity that has steadily worsened over the last 3-4 days.

As the RN in the ER, you are assigned to assess Mrs. Mott. She tells you that she has been very active all her life and until recently, spending much time with her 6 children, their families, and her 5 grandchildren. She says she suddenly feels very old and can’t do her usual activities anymore. She says that she now has to rest, even after such easy tasks as making her bed, and this is a new change. She seems very despondent and sad.

1. Obtain the health history data that you would collect relevant to the present problem.

2. Describe what causative factors or stimuli (label as M=maturational, S=situational, P=physiological, T=treatment) from the above case study and the health interview (that is supported by data collected from the client) which gives the nurse valuable information to formulate the “related to” (R/T) part of the nursing diagnoses. Underline in red all of the stimuli noted for this client.

CASE STUDY
Oxygenation: Circulation

John Smith is a 46 year-old male, married to 42 year-old Jane Smith. He has worked at the local automobile manufacturing plant since graduation from college 21 years ago. Sales for the autos have been decreasing for the last several years and the company is now in the midst of major organizational changes. As a top manger for his company, John has considerable responsibility for the impending reorganization and down-sizing, and is extremely concerned about the effects these major changes will have on the company and community. He now comes to your medical office, complaining of feeling tired, having no energy, and noticing a strange sensation in his chest. John is overweight, sedentary, and smokes. As the RN in the medical office, you are to perform an initial assessment of John.

1. Demonstrate an initial assessment, in order to determine if John’s signs and symptoms are at an emergency, urgent care, or medical provider level of care (triage).

2. Describe what causative factors or stimuli (label as M=maturational, S=situational, P=physiological, T=treatment) from the above case study and the health interview (that is supported by data collected from the client) which gives the nurse valuable information to formulate the “related to” (R/T) part of the nursing diagnoses. Underline in red all of the stimuli noted for this client.
3. Perform a physical examination of the circulatory system showing how to obtain the following information: and identify whether the data collected is adaptive or maladaptive behaviors. Underline in blue all of the maladaptive behaviors.
   a. carotid arteries; data collected are 2+ bilateral, no bruit noted bilateral
   b. point of maximal impulse; datum collected is PMI at Lt MCL at 5th ICS and is 1/2 inch in diameter
   c. heart sounds; data collected are AP (apical pulse) 92 bpm and regular, S1 and S2 strong and regular, no S3, S4, murmurs, rubs, or clicks noted
   d. peripheral pulses; data collected are 2+ radial, ulnar, brachial, femoral, popliteal, dorsalis pedis, and posterior tibial pulses
   e. blood pressure; data collected are Lt arm 164/98 and 154/96 Rt arm

4. Categorize the maladaptive behaviors noted in #3 into groups under the stimuli noted in #2. Select, define and write the nursing diagnosis for each problem. (clue: put data into groups labeled physiological, psychosocial and health maintenance from the list provided below select one nursing diagnosis from a, b and c).
   a. physiological nursing diagnosis could be Acute Pain or Comfort, Altered
   b. psychosocial nursing diagnosis could be Coping, Ineffective Individual or Potential risk for Role Performance, Altered
   c. health maintenance nursing diagnosis could be Health Seeking Behaviors or Management of Therapeutic Regimen, Effective: Individual

Chapter 8: Cultural and Ethnicity

Key Terms
cultural competence, culture, diversity, ethnic, ethnicity, ethnocentrism, humanistic care, multicultural, society, stereotyping, transcultural nursing, universality

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Discuss culture and ethnicity as they relate to the delivery of nursing care.
- Define humanistic care.
- Outline the elements and objectives of transcultural nursing.
- Describe the dangers of stereotyping.
- List and explain the six concepts included in transcultural assessment.
- Understand basic aspects of the African American community, Mexican American community, Hispanic American community, and Native American community.
- Anticipate the effects of cultural characteristics on the successful delivery of health care.

The Transcultural Nursing Society, with information about transcultural nursing and links to related information, can be found on the Internet at http://www.tcns.org/.
The SUNY Institute of Technology library is the home for CulturedMed, a resource center for print materials, electronic databases, and a website dealing with culturally competent health care for refugees and immigrants. The Internet address is http://www.sunyit.edu/library/html/culturedmed/
WEEK SIX: September 24th

Chapter 40: Fluid and Electrolytes

Key Terms
active transport, anion, cation, colloid, colloid osmotic pressure, diffusion, electrolyte, filtration, hydrostatic pressure, hypertonic, hypotonic, isotonic, metabolic acidosis, metabolic alkalosis, milliequivalent, milliosmole, nonelectrolyte, osmolality, osmolarity, osmosis, respiratory acidosis, respiratory alkalosis, third spacing

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe the normal physiology of fluid balance, including fluid compartments, functions of body fluids, and types of electrolytes.
- Identify mechanisms that contribute to the regulation of fluid and electrolyte balance.
- Discuss five common problems related to fluid balance.
- Identify the factors affecting fluid balance, including physiological problems and medical and nursing therapies.
- Describe the general assessment of a client’s fluid balance.
- Describe the focused assessment of clients at risk for fluid problems, the manifestations of actual fluid problems, and client responses to fluid problems.
- Diagnose the problems of clients with fluid imbalances that are within the domain of nursing.
- Plan and carry out goal-directed interventions to prevent or correct fluid and electrolyte imbalances.
- Evaluate outcomes in terms of progress or lack of progress toward the goals of fluid balance with revision of the care plan as appropriate.

The website of the Intravenous Nurses Society provides standards of practice for IV therapy. This is a copyrighted site from which users cannot download. However, users can read standards online and order copies if desired.

INSERT is a website aimed at facilitating good clinical practice via the dissemination of information through a Web-based network group dedicated to intravenous therapy and care. It can be found at http://www.insert.co.uk/

Chapter 42: Comfort

Key Terms
acute pain, adjuvant analgesic, agonist analgesic, analgesia, antagonist, atypical analgesic, breakthrough pain, chronic pain, endorphin, epidural analgesia, equianalgesia, first pass effect, gate control theory, intrathecal analgesia, mixed agonist–antagonist analgesic, modulation, neuropathic pain, nociception, nociceptive pain, nociceptor, nonopioid analgesic, opioid analgesic, opioid naïve, opioid receptor, pain, pain behavior, patient-controlled analgesia, physical dependence, pseudoaddiction, psychological dependence, referred pain, rescue dose, somatic pain, suffering, tolerance, visceral pain

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe the physiological concepts supporting pain-related nursing diagnoses.
• Describe the life span, physiological, and cultural or lifestyle factors that affect the pain experience.
• Assess the client at risk for or experiencing pain and the client’s responses to the experience.
• Diagnose the client’s pain management needs that will respond to nursing care.
• Plan goal-directed interventions to prevent or correct the pain diagnoses.
• Describe and practice key nonpharmacological and pharmacological interventions for pain management.
• Evaluate outcomes that indicate progress in providing effective pain management.

The Agency for Healthcare Research and Quality (AHRQ) website is available at http://www.ahcpr.gov/
The American Academy of Pain Medicine website is available at http://www.painmed.org/
The American Chronic Pain Association website is available at http://www.theacpa.org/
The American Pain Society (APS) website is available at http://www.ampainsoc.org/

CASE STUDY
Senses: Pain

Theresa Jones is a 16 year-old girl admitted to Marin Valley Hospital yesterday with a diagnosis of appendicitis. As the RN on the Surgical unit, you have been assigned to provide care for Theresa over the day. The Night Charge Nurse has reported that Theresa underwent an appendectomy the day before at 10 PM, and her surgery was complicated by perforation of the appendix with peritonitis. She has been awake for most of the night, requesting medication for abdominal pain at frequent intervals. You note that her medical orders state she may receive pain medicine every 3 hours but she has been asking for this medication every 1 to 1 1/2 hours. You decide that you will begin your shift with Theresa by doing a thorough assessment of her and her pain. Her mother, Judy is at the bedside.

1. As you begin your assessment, Theresa is crying out that she is having a lot of pain and Judy is requesting to get her some pain medication. You state, “I need to get some information and to check you out so that I can best relieve your discomfort.” Describe what limited information on a pain assessment and physical examination would you perform at this time, until Theresa’s pain level is reduced to an expectable level for her, when you can complete a full assessment.

2. Name a body position that you could put Theresa in during your initial assessment that could give her some immediate relief from post-operative abdominal pain. State your rationale for this non-pharmacological nursing measure.

3. Identify the variables that are possibly influencing Theresa’s response to pain. How would you incorporate this information into your patient teaching about pain perception and pain response to Theresa and Judy? (TIP: Theresa is a teenager)

4. Discuss what characteristic of pain (superficial or cutaneous, deep visceral, referred, radiating) that you suspect that Theresa could be having. How would you be able to validate your assumption during a pain assessment and physical examination?

5. It has been 15 minutes since you gave Theresa 4 mg Morphine Sulfate IV bolus, how would you determine if this pain medication had a positive effect in reducing her pain? Demonstrate a pain assessment and interpret the following data that were collected:
   a. Onset and Duration: sudden and since 8:00 PM yesterday
   b. Location: pinpoint to the RLQ with radiation across the abdomen
   c. Severity: 3/10 on the numerical rating scale
   d. Quality: sharp at RLQ and a dull ache across the abdomen
   e. Precipitating and Aggravating factors: increased with movement in bed, getting out of bed to ambulate,
and turn, cough and deep breathing

f. Relief measures: decreased with MS, positioning in bed, and patient teaching about pain response and the disease process

g. Associated Symptoms: mild itchiness that increases after MS administration

h. Effects of Pain on the Client; limited mobility, taking sips of clear liquids, T=100.2, P=100, R=24, B/P=132/80, O2 Sat=95%, ICS=550, UO=30cc/hr
WEEK SEVEN: October 1st

Chapter 43: Nutrition

Key Terms
amino acids, anthropometric measurements, calorie, carbohydrate, disaccharide, fiber, glycogen, metabolism, minerals, monosaccharide, nutrient, nutrition, nutritional status, polysaccharide, protein, recommended dietary allowance (RDA), starch, triglyceride, vitamin, anorexia, catabolism, deglutition, dysphagia, enteral nutrition, malnutrition, parenteral nutrition

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe the physiology of malnutrition and starvation.
- Discuss factors affecting nutritional deficits.
- Assess clients who are experiencing severe nutritional deficits.
- Formulate nursing diagnoses for nutritional deficits.
- Plan goal-directed interventions for clients with nutritional deficits.
- Employ a variety of interventions to facilitate optimal nutrition for clients.
- Evaluate the achievement of measurable outcomes for clients with nutritional deficits.
- Describe the elements of a nutritious diet and how the body uses nutrients.
- Distinguish among various guidelines for normal nutrition.
- Discuss the factors that affect nutritional status, such as lifestyle, culture, life span, pregnancy and lactation, and psychological and physiological states
- Describe the assessment of a client’s nutritional status.
- Identify nursing diagnoses applicable to the client with a normal nutritional balance.
- Plan for goal-directed interventions to promote optimal nutrition and reduce nutritional risk factors.
- Describe specific interventions and strategies to promote optimal nutrition and reduce nutritional risk factors throughout the life span.
- Evaluate the outcomes of nutritional interventions.

The U.S. Food and Drug Administration’s Center for Food Safety and Applied Nutrition website is available at http://vm.cfsan.fda.gov/list.html
The Mayo Clinic Nutrition Center’s website is available at http://www.mayohealth.org/mayo/common/htm/dietpage.htm

CASE STUDY
Nutrition

Mrs. Karen Adams brings her daughter Kirsten, age 6 months, to the urgent care clinic. Kirsten is listless, refuses food and fluid, and appears pale. As the RN in the urgent care clinic, you weigh Kirsten and find that she is 11 lb. You notice that she sucks weakly on a pacifier. You take her vital signs: T-98.8, P-116 bpm & regular, R-40 & regular.

1. How would you record the following information related to your nursing assessment of Kirsten?
   (from the above case study information)
   a. history (subjective) assessment data
b. physical (**objective**) assessment data

2. Discuss your approach to obtain Kirsten’s health history information which will vary from that used for an adult. Describe one of the three types of dietary intake tools that would be appropriate to use to identify Kirsten’s current nutrition status.

3. Outline the major categories of information that the nurse should include during the nutritional health interview with Kirsten’s mother, Karen.

4. Describe your approach to obtain Kirsten’s anthropometric measurements (height and head circumference) which will vary from that used for an adult. Use a growth chart to compare your findings with the norm.  
   a. height; datum collected is- 61.8 cm or 24 1/4 inches  
   b. head circumference; datum collected is- 40 cm

5. Identify what assessment techniques (inspection, palpation, percussion, auscultation) are used to determine a client’s nutritional status during the physical examination. Correlate the assessment techniques with the body systems involved.  
   a. skin, hair, and nails  
   b. posture, muscles, and extremities  
   c. oral structures, eyes, and thyroid gland  
   d. liver  
   e. spleen

6. Explain what information the following laboratory tests can provide for this case study.  
   a. hemoglobin and hematocrit  
   b. ferritin and total iron binding capacity  
   c. serum albumin

7. Determine the client’s nutritional status risk as either low, moderate or high and explain the rationale for your decision.

8. Select, define and write two appropriate nursing diagnoses based on your data collection.

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View Video: **Basic Clinical Skills: Feeding the Patient (#11)**

**Chapter 21: Ethics and Values**

Ethics and Values – **Ethic of Care in** Nursing Practice

**Class Learning Objectives:**

*After studying this unit, you should be able to do the following:*

1. Define **morals**, **ethics**, **bioethics**, and **nursing ethics**.
2. Differentiate personal values and morality from professional values.
3. Discuss how to apply ethical principles to clarify values and make decisions in nursing.
4. Identify the common types of ethical problems and dilemmas occurring in health care and examine personal biases.
5. Describe a systematic approach for resolving ethical dilemmas.
6. Describe the nurse's obligations in ethical decisions.
7. Discuss the role of the nurse as client advocate in the delivery of ethical nursing care.
WEEK EIGHT: October 8th

Chapter 47: Skin Integrity and Wound Care

Key Terms
Abrasion, debridement, dehiscence, eschar, epithelialization, evisceration, exudates, fistula, friction, injury, granulation tissue, hematoma, hemorrhage, laceration, maceration, primary lesion, pressure ulcer, secondary lesion, slough, wound

Learning Objectives
After studying this chapter, the student should be able to do the following:

• Describe skin disruptions, wound healing, and problems of wound healing.
• Discuss the staging of pressure ulcers.
• Explain the effect of lifestyle, age, and illness on skin integrity and wound healing.
• Assess the client who is at risk for or has an actual impairment of skin integrity.
• Distinguish among the various nursing diagnoses for clients with alterations in skin integrity.
• Plan for goal-directed interventions to prevent Impaired skin integrity or promote wound healing.
• Evaluate the outcomes of interventions for Impaired skin integrity.

The American Academy of Dermatology website is available at http://www.aad.org/
The Dermatology Nurses’ Association website is available at http://dna.inurse.com/
The Wound, Ostomy and Continence Nurses’ Society (WOCN) website is available at http://www.wocn.org/

CASE STUDY
Protection: Skin Integrity

Joseph Mott, a Caucasian male of Northern European decent, is 66 years old. He is being admitted to the acute medical unit at Marin Valley Hospital. His diagnoses at the time of admission were “Dehydration and Coccyx Decubitus Ulcer.” Joseph has a past medical history of Diabetes, diagnosed when he was 56 years old. He has been living at home in Larkspur with his wife Mary. They own a two-story older home, high up in the hills above the town. He has 6 adult children; with a son and a daughter living nearby.

1. Identify which type of Health History (complete, episodic, interval or emergency) the Registered Nurse performs on admission? What type of Health History does the nurse need to perform when the patient is stabilized?

2. Obtain the Chief Complaint (C/O or CC) from the patient. The chief complaint is the symptom (subjective finding) and/or sign (objective finding) that caused the patient to seek health care. Record the chief complaint in the patient’s own words.

3. Conduct a health interview that demonstrates how to acquire pertinent information using the PQRSTU mnemonic to investigate the chief complaint.
P = Provokes or Palliative
  “What makes it worse and what makes it better?”

Q= Quality or Quantity
  “How does it feel? and How often does it occur?”

R= Region and Radiation
  “Where is it? and Does it go into another area?”

S= Severity
  “On a scale of 1 to 10 with 10 being the greatest-how would you rate it?”

T= Timing
  “When did it begin?, Was the onset sudden or gradual?, and How long does it last?”

U= Understanding
  “What do you think these signs and symptoms mean?”

View:
Video: Lifting and Moving the Patient. #22 (View, if not already viewed)

Read *Health Assessment for Nursing Practice*, 3rd edition, Chapter 10, Nutritional Assessment

Read William's Basic Nutrition & Diet Therapy, appropriated sections

Chapter 22: Legal Implications in Nursing Practice

Key Terms
Accreditation, administrative law, advance directive, assault, autonomy, battery, beneficence, certification, civil law, common law, confidentiality, contract, credentialing, criminal law, defamation, defendant, durable power of attorney for health care, ethics, false imprisonment, fidelity, fraud, informed consent, invasion of privacy, justice, law, liability, license, living will, malpractice, morals, negligence, nonmaleficence, plaintiff, procedural law, professional misconduct, public law, registration, statutory law, substantive law, tort, values, values clarification, veracity

Learning Objectives
*After studying this chapter, the student should be able to do the following:*
- Describe examples of the sources and types of law in nursing practice.
- Describe the professional sources of regulation of nursing practice.
- Describe the legal sources of regulation of nursing practice.
- Apply ethical principles to clarify values and make decisions in nursing.
- Discuss selected client rights and their influence on nursing practice.
- Describe two initiatives to improve the quality of nursing care delivered to clients.
- Summarize actions that one can take to safeguard one’s own nursing practice.

Mosby’s Nursing Skills Videos. Have students view the following video and complete the related exercises found in the Instructor’s section of the Evolve website:
- Basic Principles

Brownson Nursing Notes has a website at http://members.tripod.com/~DianneBrownson/
The Hastings Center has a website at http://www.thehastingscenter.org/
National Institutes of Health Bioethics Resources on the Web is available at
http://www.nih.gov/sigs/bioethics/
The “Virtual” Medical Law Center, in Martindale’s Health Science Guide, has a website at http://www-sci.lib.uci.edu/HSG/Legal.html
Quiz #2

Chapter 36: Sleep

Key Terms
Bruxism, circadian rhythm, dyssomnia, hypersomnia, hypnotic, insomnia, multiple sleep latency test, narcolepsy, nightmare disorder, nocturnal enuresis, non–rapid eye movement (NREM) sleep, obstructive sleep apnea, parasomnia, polysomnography, rapid eye movement (REM) sleep, rest, restless legs syndrome, sleep, sleep deprivation, sleep terrors disorder, slow-wave sleep, sundowning, zeitgeber

Learning Objectives
After studying this chapter, the student should be able to do the following:
• Define the key terms listed.
• Describe the physiological concepts underlying sleep.
• Discuss the developmental and lifestyle factors that affect rest and sleep.
• Discuss the various sleep disorders.
• Describe the general assessment of rest and sleep.
• Assess clients for risk for sleep problems.
• Distinguish among related diagnoses for problems of rest and sleep.
• Plan goal-directed interventions that address sleep pattern disturbances and meet rest needs.
• Evaluate outcomes of nursing care for clients with sleep pattern disturbances.

The National Sleep Foundation, a nonprofit organization that promotes public understanding of sleep and sleep disorders and supports sleep-related education, research, and advocacy to improve public health and safety, has a website at http://www.sleepfoundation.org/.

Chapter 48: Sensory Alteration

Key Terms
Auditory, gustatory, kinesthetic, olfactory, ototoxic, perception, presbycusis, presbyopia, reticular activating system, sensation, sensory deficit, sensory overload, tactile, visual

Learning Objectives
After studying this chapter, the student should be able to do the following:
• Describe the normal physiology of sensation and perception.
• Differentiate among sensory deficit, sensory deprivation, and sensory overload
• Discuss a variety of factors affecting sensory/perceptual function.
• Describe techniques for assessing a client at risk for Disturbed sensory perception, the manifestations of disturbed sensory perception, and the client’s responses to altered sensory perception.
• Identify the related nursing diagnoses for the problems of disturbed sensory perception for vision, hearing, movement, taste, smell, and perception.
• Plan goal-directed nursing interventions to manage disturbed sensory perception.
• Evaluate outcomes for disturbed sensory perception.
CASE STUDY

Basic Neurological Assessment

Randall Stevenson, 46 year-old, was diagnosed as HIV positive approximately 6 years ago. He has enjoyed good health until recently when he began to experience changes in his usually excellent memory, with episodes of dizziness, and periods of unsteady gait. He has been admitted to your medical unit at Marin Valley Hospital for evaluation of these distressing symptoms. When you meet Randall, he tells you he is very fearful of having full blown AIDS; and he has had a number of acquaintances who have become very ill, and several have died. Randall is currently getting medical insurance through his employer. He states that he’ll need to change to another job at his company; because his doctor told him that he will not be able to continue lifting heavy loads and driving a truck.

1. Obtain a health history include questions regarding health and illness patterns, Health promotion and protection patterns and role and relationship patterns.
   a. health and illness patterns- refer to the health History section on pg. 212
   b. health promotion and protection patterns- Do you have difficulty following conversations or television programs?, Do you need to rest during the day?, Do you use alcohol or other mood-altering drugs?
   c. role and relationship patterns- How has your disability affected you?, How has your illness or disability affected members of your family emotionally and financially?, Have you noticed any change in your sexuality?

2. Perform a physical assessment of the nervous system showing how to obtain the following information; and identify if the behaviors are adaptive or maladaptive.
   a. baseline vital signs; data collected include- T 98.8 degrees F, P 84, R 20, B/P 122/80
   b. level of consciousness; data collected include alert and oriented x 4
   c. Glasgow Coma Scale; data collected are- pupils equal, round 3 mm, reactive to light; eyes open-spontaneously; best motor response-obey commands; best verbal response-oriented; limb movement/arms and legs-voluntary motor
   d. pupil consensual response; datum collected is- positive bilaterally
   e. pupil accommodation response; datum collected is- positive bilaterally
   f. speech; data collected are- speech is appropriate and clear
   g. memory; data collected are- immediate recall (memory) able to repeat a series of 5 digits forwards and 4 digits backwards; recent memory able to recalls 3 unrelated words after 5 minutes; remote memory able to recall his mother’s maiden name, USA president’s name, and date of his birthday
   h. circulation; data collected include- 2+ radial and pedal PT/DP pulses bilateral
   i. motor system; data collected are- muscle strength 5/5 neck & shoulders, 4/5 forearms and hands and 3/5 legs and feet bilaterally; grips weak bil
   j. sensory system; data collected are- superficial pain-loss of sharp sensation in legs temperature and light touch sensations intact in all extremities
   k. balance (cerebellar function/coordination); data collected are- positive Romberg test (unstable within 3 seconds with eyes open and closed); gait board based and uncoordinated by swaying and staggering during ambulation (Cerebellar ataxia); uncoordinated and unbalanced with Tandem walk
   l. coordination; data collected are- uncoordinated fine motor function, rapid, rhythmical, alternating movements and lower extremity coordination

3. Write 2 physiological and 1 psychosocial nursing diagnoses for this client.
Chapter 44: Urinary Elimination

Key Terms
Anuria, bacteriuria, diuresis, dysuria, enuresis, functional incontinence, hematuria, Kegel exercises, micturition, nocturia, oliguria, polyuria, reflex incontinence, residual urine, stress incontinence, total incontinence, urge incontinence, urinalysis, urinary frequency, urinary hesitancy, urinary incontinence, urinary retention, urinary urgency, urination, void

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe the normal structure and function of the urinary system.
- Identify common problems of urinary elimination.
- Discuss factors affecting urinary elimination.
- Assess urinary function and identify a client experiencing urinary elimination problems.
- Diagnose problems of urinary elimination that can be managed with nursing care.
- Plan expected outcomes for goal-directed nursing interventions for managing problems in urinary elimination.
- Implement basic nursing care for a client experiencing problems with urinary elimination.
- Evaluate care for a person experiencing problems with urinary elimination.

Wellness Health Care Information Resources website provides links to sites with information for patients, families, and professionals, including links for ostomates. This site can be found at http://www-hsl.mcmaster.ca/tomflem/ostomates.html.

The Interstitial Cystitis Network is a website developed by patients with interstitial cystitis for other patients with this condition; it can be found at http://www.ic-network.com.

The Urology Channel, a website for urologists and their patients, can be found at http://www.urologychannel.com.

Diagnology is a website provided by a global team of professionals—drawn from both the pharmaceutical and the diagnostic industries—that presents ideas for improving health care. The stated purpose of the site is to provide information on conditions for which rapid, accurate diagnostics have never been possible; to facilitate development of high-quality, scientifically validated tools; and to provide immediate answers.

CASE STUDY
Elimination: Bladder

Emily Augello, age 75, is being admitted to the Medical unit at Marin Valley Hospital. As the RN on duty, you have been assigned to admit Emily into room 4305-A. Her admitting diagnosis is R/O (rule out) Urosepsis and UTI (urinary tract infection). A review of her paperwork sent over from the outpatient clinic notes that Emily was complaining of pain and burning on urination, a fever of 100 degrees F, and pain in her right lower back. Emily was brought to the clinic and hospital by her eldest daughter, Maimi. An urinalysis (UA) was done at the Doctor’s office and the following report was sent with Dr.’s orders.

Augello, Emily DOB 07/04/27
Clean Catch UA per dipstick
Color: yellow
Turbidity: hazy
pH: 7
Protein: 2+
Ketones: negative
Blood: 1+
Specific gravity: 1.025
Glucose: negative
Nitrate: positive
Leukocyte esterase: positive

1. Obtain a health history; include a review of the client’s elimination patterns, symptoms of urinary alterations, and factors affecting urination such as age, environmental factors, and medication history. What stimuli predispose the elderly to UTI’s?

2. A doctor’s order for Emily is to obtain a urine sample for UA (urinalysis) and C & S (culture and sensitivity) if indicated. Identify what type of urine sample you would send to the laboratory (clean catch, mini-cath, or straight/foley cath) and state the rationale for your decision. Interpret the above UA report from the clinic.

3. Perform a physical assessment of the urinary system showing how to obtain the following information; and identify if the finding are normal or abnormal.
   a. skin and mucosal membranes; data collected are- turgor > 3 sec, oral mucosa dry
   b. kidneys; datum collected is- positive tenderness at Rt CVA(costovertebral angle)
   c. bladder: data collected include- lower abdominal bulge above the symphysis pubis with light palpation smooth and rounded & Emily complains of discomfort with percussion a dull percussion note is heard
   d. urethral meatus; datum collected is- red, inflamed, and a malodorous yellow DC

4. Use the SOAP method to document your admission health assessment.

   S = subjective
   O = objective
   A = analysis (nursing diagnosis)
   P = nursing interventions (plan)

Adapted from: Jarvis, C. Physical Examination and Health Assessment, 3rd Ed., 2000, W. B. Saunders

Chapter 45: Bowel Elimination

Key Terms
bowel incontinence, cathartic, colostomy, constipation, diarrhea, fecal impaction, feces, flatus, flatulence, guaiac, ileostomy, laxative, occult blood, ostomy, paralytic ileus, peristalsis, steatorrhea, stoma
Learning Objectives

After studying this chapter, the student should be able to do the following:

- Describe the structure and function of the lower gastrointestinal tract.
- Discuss problems of bowel elimination, including constipation, diarrhea, and bowel incontinence.
- Explain the effect on bowel elimination of the client’s diet and exercise, personal habits, cultural background, age, and physiological and psychosocial factors.
- Assess the client for manifestations of and responses to problems of bowel elimination.
- Distinguish among the variety of nursing diagnoses for problems of bowel elimination.
- Plan for goal-directed interventions to prevent or correct problems of bowel elimination.
- Evaluate the outcomes that describe progress toward the goals of bowel elimination.

The National Institute of Diabetes and Digestive and Kidney Diseases, part of the National Institutes of Health in Bethesda, Maryland, provides information about a variety of bowel elimination problems at http://www.niddk.nih.gov/health/digest/digest.htm

The United Ostomy Association, a volunteer-based health organization dedicated to providing education, information, support, and advocacy for people who have had or will have intestinal or urinary diversion, has a website at http://www.uoa.org/.

CASE STUDY

Elimination: Bowel

Elizabeth Jackson is a 72 year old widow of African-American descent. She has been admitted to the medical unit at Marin Valley Hospital with a diagnosis of fecal impaction. Mrs. Jackson underwent a gall bladder operation that was performed 3 weeks ago. At present, Mrs. Jackson weighs 98 pounds and is 5 feet 5 inches tall. Her usual adult weight has been between 140 and 150 lb. Mrs. Jackson has a large extended family consisting of 3 living children 5 grandchildren and 2 great grandchildren. She is the primary caregiver for one of her sons, J. T., who is a 48 year-old Vietnam Veteran, diagnosed with Post-Traumatic Stress Disorder. He resides with his mother but has had multiple, short-term admissions to the psychiatric unit at Marin Valley Hospital.

1. Obtain a health history; include a review of the client’s usual bowel patterns and habits. The nursing history can be organized around the factors that affect elimination:
   a. Determination of the usual elimination pattern
   b. Identification of routines followed to promote normal elimination
   c. Description of any recent change in elimination pattern
   d. Client’s description of usual characteristics of stool
   e. Diet history and description of daily fluid intake
   f. History of exercise
   g. Assessment of the use of artificial aids (laxatives) at home
   h. History of surgery or illnesses affecting the GI tract
   i. Medication history
   j. Social history and emotional state
   l. Mobility and dexterity

2. Calculate Mrs. Jackson’s IBW (Ideal Body Weight). She has medium-sized bones.
   Determine the percentage of weight loss Mrs. Jackson has sustained since her surgery 3 weeks ago.
   How would you identify her current caloric dietary intake?

3. Perform a physical assessment of the gastrointestinal system showing how to obtain
the following information; and identify if the findings are normal or abnormal.

a. **mouth**; data collected include- pink, moist, and intact; dentition present and clean
b. **abdomen**; data collected are- distention, hyperactive bowel sounds in all quadrants, taut, abdomen non-tender, C/O of generalized abdominal cramping
c. **rectum**; data collected include- C/O of rectal pain, impacted stool per palpation
d. **stool**; data collected are- light brown liquid moderate amount; guaiac neg x 3

4. Describe what cultural aspects of care you would incorporate into your patient education regarding Prevention Measures and Screening for Colon Cancer, prior to her discharge to home.

5. Select 2 physiological, 1 psychological, and 1 teaching nursing diagnoses for this patient and state your rationale for each selection.

**VIEW: Basic Clinical Skills Videos: Required**

1. Basic Clinical Skills: Urinary Care (#40) view, if not already viewed
2. Basic Clinical Skills: Cleansing Enema (#32)
3. Physical assessment: The Abdomen (#37)
Chapter 49: The Surgical Client

Key Terms
ambulatory surgery, anesthesia, anesthesiologist, certified registered nurse anesthetist, circulating nurse, general anesthesia, intraoperative phase, local anesthesia, malignant hyperthermia, perioperative, perioperative nursing, postanesthesia care unit, postoperative phase, preoperative phase, regional anesthesia, registered nurse first assistant, scrub nurse

Learning Objectives
After studying this chapter, the student should be able to do the following:

• Describe the surgical experience using the perioperative phases as a framework.
• Identify factors that may affect the surgical outcome of a perioperative client.
• Conduct a preoperative nursing history and physical assessment to identify client strengths and factors that increase risks for perioperative complications.
• Describe the nursing role in the psychological and educational preparation of the surgical client.
• Differentiate among general, regional, and local forms of anesthesia.
• Discuss the role of the perioperative nurse when managing the intraoperative care of the surgical client.
• Identify priority intraoperative nursing diagnoses.
• Design an intraoperative nursing care plan.
• List factors that may affect a postoperative client in the immediate recovery period.
• Explain the nursing management of potential complications the client faces postoperatively.

AORN Online, the homepage of the American Association of periOperative Registered Nurses, provides resource links, an online library, and other information at http://www.aorn.org/.
The Operating Room Nurses Association of Canada, dedicated to the promotion and advancement of excellence in perioperative patient care, has a website at http://www.ornac.ca/.
WEEK TWELVE: November 5th

Chapter 24: Client Education

Key Terms
affective learning domain, cognitive learning domain, learning, learning contract, learning objectives, psychomotor learning domain, teaching, teaching plan

Learning Objectives
After studying this chapter, the student should be able to do the following:

• Discuss the rationale for client teaching, including its purpose and benefits.
• Describe the teaching and learning process, including domains of learning and principles of effective teaching.
• Describe factors that affect client teaching.
• Discuss the nursing diagnosis Deficient knowledge.
• Develop a teaching plan for a client.
• Discuss strategies for effective client teaching.
• Discuss methods for evaluating teaching and learning.

The Comprehensive Health Enhancement Support System (CHESS) website includes a demo and is an award-winning system for health education. It is available at http://chess.chsra.wisc.edu/Chess/.

New York University Health Education Professional Resources’ website offers information about health education but mainly provides links to health education journals and other sites. It includes links to CDC health education information. This site is available at http://www.nyu.edu/education/hepr/resources/software.

The Daily Apple is a site for health education founded by a PhD in physiology and backed by an advisory panel.

Chapter 3: Community Based Nursing

Key Terms
Community, community diagnosis, community forum, community health nursing, epidemiology, focus group, health status, human capital, key informant, opinion survey, participant observation, parish nurse, population, public health nursing, relative risk, resource availability, social integration, social status, vulnerable population, windshield survey

Learning Objectives
After studying this chapter, the student should be able to do the following:

• Describe a variety of vulnerable populations.
• Identify other factors affecting vulnerable populations.
• Understand the concept of the community as client.
• Assess both the individual and groups for factors affecting vulnerability.
• Write nursing diagnoses for vulnerable individuals and populations.
• Plan goal-directed interventions for vulnerable individuals, groups, and communities.
• Evaluate the impact of nursing care on vulnerable populations.
• Describe a conceptual model for understanding the needs of vulnerable populations.
Differentiate community health nursing from community-based nursing.
Discuss the role of the nurse in community-based practice and the competencies needed.
Define and give examples of vulnerable populations.
Discuss the elements of a community assessment.

The Administration on Aging is available on the Internet at http://www.aoa.dhhs.gov/
The National Coalition for the Homeless website is available at http://www.nationalhomeless.org/
The Institute for Research on Poverty at the University of Wisconsin-Madison has a website at http://www.ssc.wisc.edu/irp/
WEEK THIRTEEN: November 12th
 Quiz #3

Chapter 27: Sexuality

Key Terms
Androgyny, arousal, bisexual, gender, gender identity, gender role, heterosexual, homophobia, homosexual, libido, orgasm, sexual desire, sexual dysfunction, sexual identity, sexual orientation, sexual patterns, sexual response cycle, sexuality

Learning Objectives
After studying this chapter, the student should be able to do the following:

- Describe the biological, psychological, social, and cultural influences in the development of sexuality.
- Discuss concepts related to sexual development.
- Assess the client who is at risk for or is experiencing alterations in sexuality patterns or sexual dysfunction.
- Identify nursing diagnoses for sexual problems that are amenable to nursing care.
- Use a standard model of care to provide goal-directed interventions to prevent or correct sexuality diagnoses.
- Evaluate the outcomes that describe progress toward the goals of nursing care for sexuality issues.
- Discuss sexual health promotion across the life span.
- Describe issues in the health care of gay men and lesbians.

The American Psychiatric Nurses Association website is available at http://www.apna.org/
The American Psychological Association website is available at http://www.apa.org/.
Online psychiatric journals are available at http://www.psychwatch.com/journalpage.htm

Chapter 28: Spiritual Health

Key Terms
Agnostic, atheist, faith, hope, monotheism, polytheism, religion, spiritual distress, spiritual health, spiritual well-being, spirituality

Learning Objectives
After studying this chapter, the student should be able to do the following:

- Relate the concepts of spirituality, religion, and faith with the concept of providing spiritual care in nursing.
- Discuss the factors affecting a client’s spiritual and religious needs.
- Assess a client for spiritual well-being.
- Write nursing diagnoses for clients with spiritual distress or impaired religiosity.
- Plan individualized care for clients experiencing spiritual distress or impaired religiosity.
- Evaluate interventions for relieving spiritual distress or impaired religiosity.
- Discuss nursing care for enhancing spiritual well-being or religiosity.

The American Holistic Nurses’ Association website is available at http://ahna.org/
The Carter Center of the Interfaith Health Program website is available at http://www.ihpnet.org/4health.html
Chapter 26: Self Concept

Key Terms
body image, personal identity, role, role performance, self-concept, self-esteem

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Differentiate among self-concept, self-esteem, personal identity, role performance, and body image.
- Discuss factors affecting self-concept.
- Assess responses of clients who may be at risk for changes in self-esteem or body image.
- Write a nursing diagnosis and develop a care plan for a client experiencing an alteration in the components of self-concept.
- Plan goal-directed interventions that address the identified nursing diagnosis
- Describe key interventions for clients who are experiencing alterations in self-esteem and body image.
- Evaluate the client’s progress toward expected outcomes for alterations in self-esteem and body image.

Chapter 29: Grief and Loss

Anger, anticipatory grief, bereavement, code status, denial, disenfranchised grief, dysfunctional/complicated grief, grief, grief attack, grief work, hospice, loss, mourning, normal grief, palliative care, searching, selective attention, sense of presence, thanatology

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Define the concepts of loss, grief, mourning and bereavement, death, and thanatology.
- Compare and contrast the types of loss and grieving.
- Identify a variety of factors affecting the grief response.
- Describe the assessment of a client or family member who is experiencing grief.
- Describe the focused assessment of a dying client.
- Differentiate among nursing diagnoses that describe problems associated with loss.
- Plan nursing interventions used in caring for the dying patient.
- Plan interventions to help the client and family feel understood and to facilitate grief work.
- Evaluate the outcomes of caring for a person experiencing grief.

The American Association of Retired Persons maintains a website called the AARP Webplace, which includes resources for coping with grief and loss. It is available at http://www.aarp.org/.
The Association for Death Education & Counseling website is available at http://www.adec.org/
The Hospice Foundation of America has website at http://www.hospicefoundation.org/.

Chapter 30: Stress and Coping
Key Terms
Adaptation, adaptive coping, anxiety, coping, crisis, defense mechanism, developmental crisis, homeostasis, maladaptive coping, psychoneuroimmunology, resilience, situational crisis, stress, stressor

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe physiological and psychological concepts of stress.
- Describe the three stages of the general adaptation syndrome.
- Discuss factors affecting stress tolerance.
- Assess anxious clients to determine the level of anxiety.
- Differentiate stress-related nursing diagnoses from other related nursing diagnoses.
- Plan goal-directed interventions to prevent, reduce, or manage stress.
- Evaluate achievement of the expected outcomes for client’s progress toward stress tolerance and coping.

The American Psychological Association’s Internet Help Center, giving people “mouse-click” access to resources that can help them cope with the stresses of modern life, is available at http://www.apa.org/
WEEK FIFTEEN: November 26th

Chapter 4: Nursing Theory

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe the relationship between theory, nursing process and client needs.
- Compare and contrast nursing theory to theory in other disciplines
- Discuss the value of theory in nursing practice.
- Discuss the relationship between theory and knowledge development in nursing.

Chapter 5: Nursing Research

Key Terms
Abstract, data, data collection, dependent variable, experimental research, hypothesis, independent variable, informed consent, institutional review board, instruments, nonexperimental research, operational definition, qualitative research, quantitative research, quasi-experimental research, research design, research problem, sampling, theoretical framework

Learning Objectives
After studying this chapter, the student should be able to do the following:
- Describe the importance of nursing research.
- Identify the types of ethical dilemmas in nursing research and the mechanisms for the protection of human subjects.
- Describe the types of research personnel, the types of studies, and the parts of a typical research study.
- Explain the steps of the research process.
- Describe how evidence-based practice uses the results of nursing research to improve client care.

The website of the National Institute of Nursing Research provides information about the Institute, news and information, legislative activities, research programs, scientific advances, and links to other resources. This site can be found at http://www.nih.gov/ninr

The website of the Center for Research on Chronic Illnesses of the University of North Carolina at Chapel Hill is funded by the National Institute of Health (NIH) to promote nationwide excellence in nursing research. The site offers an online newsletter, information about research, and links to other sites.

Chapter 20-managing Client Care

Key Terms
Accountability, authority, change-of-shift report, concurrent audit, continuous quality improvement, delegation, for-profit, leadership, management, nonprofit, not-for-profit, nurse manager, peer review, performance appraisal, policy, primary nursing, procedure, protocol, quality assurance, responsibility, retrospective audit, risk management, Standards of Practice, Standards of Professional Performance, team nursing, total client care, transactional leadership, transformational leadership

Learning Objectives
After studying this chapter, the student should be able to do the following:

- Describe the impact of organizational philosophy, structure, and methods of communication on nursing practice in a complex health care agency.
- Distinguish between nursing as a leadership role and as a management role in a health care agency.
- Describe the organization of nursing service as a means to provide quality client care.
- Describe the impact of change management, risk management, and conflict management on client care.
- Identify the role of the nurse in a collaborative health care team.

SpringNet’s Nursing Management page offers a nurse manager’s forum, web links for nurse managers, a listserv for nurse managers, and other resources. This site can be found at http://www.nursingmanagement.com.

**CASE STUDY**

**Basic Neurological Assessment**

Randall Stevenson, 46 year-old, was diagnosed as HIV positive approximately 6 years ago. He has enjoyed good health until recently when he began to experience changes in his usually excellent memory, with episodes of dizziness, and periods of unsteady gait. He has been admitted to your medical unit at Marin Valley Hospital for evaluation of these distressing symptoms. When you meet Randall, he tells you he is very fearful of having full blown AIDS; and he has had a number of acquaintances who have become very ill, and several have died. Randall is currently getting medical insurance through his employer. He states that he’ll need to change to another job at his company; because his doctor told him that he will not be able to continue lifting heavy loads and driving a truck.

1. Obtain a health history include questions regarding health and illness patterns, Health promotion and protection patterns and role and relationship patterns.
   a. health and illness patterns- refer to the health History section on pg. 212
   b. health promotion and protection patterns- Do you have difficulty following conversations or television programs?, Do you need to rest during the day?, Do you use alcohol or other mood-altering drugs?
   c. role and relationship patterns- How has your disability affected you?, How has your illness or disability affected members of your family emotionally and financially?, Have you noticed any change in your sexuality?

2. Perform a physical assessment of the nervous system showing how to obtain the following information; and identify if the behaviors are adaptive or maladaptive.
   a. baseline vital signs; data collected include- T 98.8 degrees F, P 84, R 20, B/P 122/80
   b. level of consciousness; data collected include alert and oriented x 4
   c. Glasgow Coma Scale; data collected are- pupils equal, round 3 mm, reactive to light; eyes open-spontaneously; best motor response-obeys commands; best verbal response-oriented; limb movement/arms and legs-voluntary motor
   d. pupil consensual response; datum collected is- positive bilaterally
   e. pupil accommodation response; datum collected is- positive bilaterally
   f. speech; data collected are- speech is appropriate and clear
   g. memory; data collected are- immediate recall (memory) able to repeat a series of 5 digits forwards and 4 digits backwards; recent memory able to recalls 3 unrelated words after 5 minutes; remote memory able to recall his mother’s maiden name, USA president’s name, and date of his birthday
   h. circulation; data collected include- 2+ radial and pedal PT/DP pulses bilateral
   i. motor system; data collected are- muscle strength 5/5 neck & shoulders, 4/5 forearms and hands and 3/5 legs and feet bilaterally; grips weak bil
   j. sensory system; data collected are- superficial pain-loss of sharp sensation in legs temperature and light touch sensations intact in all extremities
   k. balance (cerebellar function/coordination); data collected are- positive Romberg test (unstable within 3
seconds with eyes open and closed); gait board based and uncoordinated by swaying and staggering during ambulation (Cerebellar ataxia); uncoordinated and unbalanced with Tandem walk

1. **coordination**: data collected are- uncoordinated fine motor function, rapid, rhythmical, alternating movements and lower extremity coordination

3. Write 2 physiological and 1 psychosocial nursing diagnoses for this client.

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**WEEK SIXTEEN: December 3rd**

**Quiz #4**

**FINALS WEEK**

**FINAL TBA**
APPENDIX I
Gerontology Project

On completion of these learning activities, you will be able to:
1. Discuss current demographic trends, pertinent statistics and health care issues related to the aged in the United States society.
2. Explain biological, sociological, and psychological theories of aging.
3. Define adaptation processes necessary for healthy aging.
4. Delineate life events that are common to the older adult, which may precipitate disruptions in the integrity of the psychosocial modes.
5. Outline theories of stress and coping as related to the older adult.
6. Describe factors that influence coping in the older adult.
7. Delineate age-related changes that affect safety and mobility.
8. Explain a method for assessment of mobility and safety of the environment.
9. Discuss barriers to communication as well as techniques that enhance communication with an older adult.
10. Discuss communication interventions that enhance self-esteem in the older adult.

CLINICAL OBJECTIVES:
On completion of these clinical learning activities, you will:
1. Using interview guidelines, visit with a well elder and discuss:
   a. adaptation to healthy aging
   b. effects of life experiences, stress & coping
   c. safety in the environment and mobility
2. Complete a summary report for each interview and analyze:
   a. important concepts that were gleaned related to the assigned focus.
   b. identify communication techniques that enhanced or created barriers.

CBZ
Appendix 1

Project Assignments:

Read: Potter and Perry: Chapter 13- Older Adult, Chapter 23 - Communication

Contract:
Contact an elder who is 70 years or older. If you have access to several relatively independent individuals in this age group, please share the person's name and number as a potential contact for another student.
You may not use your relative (Grandparent) for your interview.
It is up to you to find an individual to participate in these Well Elder interviews. Look in the phone book for potential resources or agencies who can put you in touch with a potential participant for your interviews, such as Senior Access, Whistle Stop, Guardian Smith Ranch -independent resident, The Redwoods-independent resident, or YMCA Cardiac Rehab . . .
Complete two copies of the "Interview Permission" form with a well elder, and turn one copy in to your clinical instructor. Leave the other copy with the elder.

Summaries:
Within two weeks of the scheduled Post-clinical conference days reserved for the discussion of your interviews arrange to meet with your elder, complete "Guideline for Interview", and summarize your meeting on "Summary of Visit with Well Elder".

These completed summaries will be discussed & collected as the calendar indicates on discussion dates.

Grading:
Each summary write-up with clinical conference participation is worth 10 points for a total of 30 points.
Guidelines for Interview # 1

Focus: Adaptation to Healthy Aging: Defining Healthy Aging/Creating a Healthy Environment

Learning Objectives:
- Review Gerontology Project Learning Activities: 1,2,3,9, & 10.

Preparation for Interview:
1. Review principles of communication
2. Review communication techniques that enhance self-esteem of the older adult.

Suggested Questions, points of interest:
1. Describe your typical day.
2. How would you describe your health?
3. What causes you to feel this way?
4. Tell me about your home, neighborhood, community, and/or living arrangements and what they mean to you.

Complete a "Summary of Visit with Well Elder" form.
Points will be given in the following areas based on the clarity, relevance, and completeness of your responses.
1. _____ Description of reactions (+1)
2. _____ Description of therapeutic techniques + examples (+2)
3. _____ Description of communication that created barriers (+2)
4. _____ Description of “healthy aging” (+2)
5. _____ Description of “healthy life-style” (+1)
6. _____ Description of factors influencing independence (+1)
7. _____ Permission Form included (+1)

__________ Total Score (10 possible)
Guidelines for Interview #2
Focus: effects of life experiences including ethno-cultural background and national/international events.
Learning Objectives:
   Review Gerontology Project Learning Activities: 1, 2, 4, 9, and 10.
Preparation for Interview:
   1. Read materials related to ethno-cultural background of the individual you are interviewing.
   2. Think about world events that have occurred over the last 50 years.

Suggested Questions/points of interest:
   1. Describe how your heritage has influenced your life?
      e.g. any problems with racism, sexism, cultural diversity, positive cultural traits...
   2. Please share what important personal/historical events in your life had a profound effect on you.
      e.g. children, divorce, marriage, memorable times-good or bad . . .
   3. Tell me about any historical national/international events that influenced your life.
      e.g. war, depression . . .
   4. As a result of your life experiences, what do you feel has been the most Positive and Negative effects on you?

Complete a "Summary of Visit with Well Elder" form. Points will be given in the following areas based on the clarity, relevance, and completeness of your responses.
   1. ______ Description of reactions (+1)
   2. ______ Description of elder’s reaction (+1)
   3. ______ Description of ethno-cultural background (+2)
   4. ______ Description of ethno-cultural background’s influence (+2)
   5. ______ Description of significant life events (+2)
   6. ______ Description of effect of experiences on perception of self (+2)

__________ Total Score (10 possible)
Guidelines for Interview #3
Focus: Stress/Coping Management in the Well Elderly
Environmental safety and mobility

Learning Objectives:
Review Gerontology Project Learning Activities: 1,2,5,6,7,8,9, & 10.

Preparation for Interview:
Review readings related to how elders cope and adapt--either effectively or ineffectively to stressful situations.
Also review Safety concepts related to elders.

Suggested Questions:
1. What events in your life create stress for you?
2. Describe how you are feeling about your life situation.
3. What resources do you use to help you cope with life events?
5. Describe what extra safety precautions you practice to prevent injury to yourself.
6. Describe how you see yourself in terms of physical activity.
7. Complete the "Guideline for Assessment of Safety and Mobility"

Complete a "Summary of Visit with a Well Elder" and Guideline for Environmental Safety.
Points will be given in the following areas based on the clarity, relevance and completeness of your responses.
1. ______ Description of main stressors (+1)
2. ______ Description of coping mechanisms (+.5)
3. ______ Description of support systems (+.5)
4. ______ Description of possible resources or referrals (+1)
5. ______ Outline of usual day and balance of activity and rest (+1)
6. ______ Description of the termination of the relationship, your feelings about the relationship, and your perception of the elder’s feelings about the relationship (+2)
7. ______ Description of pros and cons of the Gerontology Project (+1)
8. ______ Completion of assessment of safety and mobility (+3)

__________ Total Score (10 possible)
#1 Summary of Visit with Well Elder

Student's Name ___________________________________________  Date ____________
Age of Well Elder ____________  Sex _______________

Describe living environment
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

1. Discuss your general reaction to the interview.

2. Describe how you utilized therapeutic techniques to enhance communication (provide examples).

3. Describe communication that created barriers.

4. Outline how this well elder defined/described "healthy aging."

5. Explain what this well elder felt was necessary for a healthy life-style.

6. Describe what factors enabled this well elder to remain independent.

Adapted from Waters, Verle, Teaching Gerontology, 1992.
Summary of Visit with Well Elder - 2nd Interview

Student's Name _____________________________________                Date _______________
Age of Well Elder ________________                                                      Sex ________________
Place of Residence ______________________________________________________________

1. Discuss the general reaction to the interview.

2. How did the well elder respond to the interview?

3. What is the ethno-cultural background of the elder?

4. Describe how the well elder's ethno-cultural background influenced his/her life.

5. Outline what the well elder identified as significant event(s) that influenced his/her life?

6. What seems to be the overall effect of life's experiences on the well elder's perception of self?
Summary of Visit With Well Elder - 3rd interview

Student's Name _____________________________________                     Date _____________
Age of Well Elder ________________                                                          Sex ______________
Place of Residence _____________________________________________________________

1. What were described as the main stressors in the elder's life?

2. What does the elder do to cope or adapt to the stressors?

3. What/who are the support systems available to the elder?

4. What resources or referrals would probably be beneficial to the well elder?

5. Outline, briefly, this elder's usual day in terms of activity. Indicate how the person balances activity and rest.

Summary of Visit With Well Elder - 3rd interview (continued)
6. Describe the termination of the relationship. How do you feel about your relationship with the elder? Describe your perception of how the elder felt about the relationship you have developed with him/her.

7. Share the pros and cons of this Gerontology Project.

*8. Complete the following page:

Guidelines for Assessment of Safety and Mobility (next 2 pages)

Rev.TAG
GUIDELINES FOR ASSESSMENT OF SAFETY AND MOBILITY

While healthy old people in a familiar environment are no more accident prone than younger people, the consequences of accidents are more serious. Accidents are a leading cause of death in persons over 65 years of age, with falls accounting for most of these deaths -- second only to motor-vehicle deaths. It is therefore imperative for the nurse to assess risk factors as they relate to client safety and mobility.

Assessing the elderly client for safety needs and mobility deficits involves looking at the following areas:

Directions: CIRCLE OR UNDERLINE THE BEHAVIORS THAT YOU IDENTIFY IN YOUR CLIENT.

1. Physical Status
   - Age related changes:
     - Impaired vision and hearing
     - Cataracts; glaucoma; macular degeneration
     - Osteoporosis
     - Menopause/hormone replacement therapy?
     - Slowed reaction time; decrease in speed of movement
     - Altered gait, increased sway; diminished muscle strength
     - Fear of falling?
     - Postural hypotension
     - Complaints of dizziness upon arising?
     - Use of assistive devices
     - Cane; walker; crutches?

   Common medical problems:
   - Dementia, confusion
   - Diminished alertness; impaired cognition?
   - Cardiovascular diseases
   - Dysrhythmias?
   - Neurological disorders
   - Parkinsonism; tremors; hemiparesis?
   - Metabolic disturbances
   - Electrolyte imbalance; hypothyroidism?
   - Musculoskeletal problems; muscle weakness
   - Osteoarthritis?
   - Transient ischemic attack; vertigo; syncope
GUIDELINES FOR ASSESSMENT OF SAFETY AND MOBILITY – (continued)

2. Mental Status

   Disorientation
   Depression; grief
   Multiple losses?
   Anxiety
   Expressed Fears?
   Hazardous behavior?

3. Medications

   Anticholinergics
   Antianxiety and hypnotic agents
   Antipsychotics
   Antidepressants
   Antihypertensives
   Alcohol
   Vasodilators
   Nonsteroidal anti-inflammatory drugs

4. Environment

   Poor lighting
   Is lighting adequate; are there night lights?
   Lack of handrails
   Are there grab bars for the tub, toilet? Handrails for stairs?
   Slippery floors; clutter?
   Throw rugs; highly polished floors; skid-proofing for shower/tub?
   Unfamiliar environments
   Relocation?
   Improper height of beds, chairs, toilets
   Workable smoke detector?
   Emergency call system?
   Impaired home maintenance management

5. Combinations of any of the above factors

Directions: As you collect data with regard to safety and mobility from your geriatric interview, select appropriate nursing diagnoses that reflect actual and potential health problems. Refer to your text, Nursing Diagnosis: Application to Clinical Practice, by Lynda Juall Carpenito, for assistance. Include a list of these diagnoses with your interview summary.

* LIST THREE TO FIVE NURSING DIAGNOSES BASED ON YOUR ASSESSMENT DATA.
I, ______________________________________________, have on this date, ______________________________________________ agreed to allow a College of Marin Nursing Student ____________________________________________________ to interview me three times during the fall semester for the purpose of his/her learning related to the development of more effective communication skills and enhanced understanding of developmental processes including healthy aging, factors that influence life processes, stress and coping management, and safety in the environment and mobility. The information obtained will be confidential (my name anonymous to peers) and discussed only with the instructor and a small group of peers engaged in similar interviews.

Adapted from Waters, Verle, Teaching Gerontology, 1992.
I, ____________________________________________________________, have on this date ____________________________ agreed to allow a College of Marin Nursing Student ____________________________ to interview me three times during the fall semester for the purpose of his/her learning related to the development of more effective communication skills and enhanced understanding of developmental processes including healthy aging, factors that influence life processes, stress and coping management, and safety in the environment and mobility. The information obtained will be confidential (my name anonymous to peers) and discussed only with the instructor and a small group of peers engaged in similar interviews.

Adapted from Waters, Verle, Teaching Gerontology, 1992
APPENDIX II
Pediatric Home Health Case Study

Overview:
The purpose of the Pediatric Home Health Case Study is to provide the student nurse the opportunity to work with a single family with a child (or children) in the home/community setting on three consecutive visits. Emphasis will be on the application of the nursing process using basic knowledge and skills related to growth and development, environmental safety, family dynamics, sociocultural concepts, physical and psychosocial assessment, and patient teaching.

Learning Objectives:
1. Apply the assessment step of the nursing process to a child and family in a home setting.
2. Analyze the assessment data, considering the following selected areas of adaptation related to health promotion, health protection, and preventive services:
   a. nutrition, b. sleep and activity, c. play, d. home safety/injury prevention,
   e. immunizations, f. child rearing practices, and g. use of community resources for care needs.
3. Demonstrate in the assessment an understanding of social, cultural, religious, family and developmental influences on child health promotion.
4. Describe two nursing diagnoses in the selected areas of adaptation related to health promotion and protection identified in objective #2.
5. Develop a single-focused teaching plan in one of the areas identified above, utilizing the preprinted educational materials provided in the syllabus.
6. Implement the teaching plan, utilizing teaching-learning principles and considering the home/community setting.
7. Evaluate the effectiveness of the teaching plan in facilitating learning, utilizing the specific expected outcomes.
8. Discuss principles and techniques of communication and interviewing with children of various ages and with parents.
9. Compare and contrast the nursing assessment process in the home/community with the nursing assessment in a hospital setting.

Learning Activities:
1. **Read:** Hockenberry, Willson and Winkelstein, "Family Influences on Child Health Promotion," pp. 31-53; "Communication and Health Assessment of the Child and Family," pp. 105-130; and "Family-Centered Home Care," pp. 622-635 in Wong’s Essentials of Pediatric Nursing. Focusing on social, cultural, religious, and developmental influences on health, and on the nursing process. Reading assignments for NE 135 will be focusing on basic pediatric physical and psychosocial (developmental) assessments and home assessment. Reading assignments will be given in NE 135, focusing on communication and interviewing with children and parents and health promotion and injury prevention in the child and adolescent.

3. **Complete:** a Pediatric Health History\(^1\) and Child Safety Home Checklist\(^2\) during your home visit. Refer to the Outline of a Pediatric Health History, and the Child Safety Home checklist for details on the areas of assessment and suggested assessment questions. Prior to the home visit, review the assessment content for risk for injury on the particular age group of the child you are assessing. For example, if you are interviewing the parent(s) of a 4-year old, review growth and development during preschool years (e.g., physical, gross motor, fine motor, language, socialization, cognition, and family relationships). In addition, review content from NE 130 on health promotion of a child in that particular age group. For example, if you are focusing on a 4-year old, review health promotion of the preschooler and family (e.g., nutrition, sleep and activity, and injury prevention).

4. **Analyze:** the assessment data and describe areas of concern with nutrition, sleep and activity, play, home safety or injury prevention, immunization, child rearing practices, or use of community resources. Describe these concerns in the form of nursing diagnoses. For example: **Injury, Risk** for related to household/environmental hazards (e.g., unsafe tricycle, broken and uneven sidewalk, house near heavily trafficked street) and maturational factors (e.g., increased motor activity, more aggressive behavior, and resistance to parental authority often seen in 4-year olds).

5. **Review:** the analysis of the assessment data and the descriptions of nursing diagnoses with your instructor.

6. **Develop:** a single focused teaching plan in one of the areas related to health promotion and protection of the child, based on the feedback from your instructor. For example, you decide to develop a single-focused teaching plan for parents of a 4 year old on how to prevent injury from motor vehicles, drowning, burns, and bodily harm from dangerous objects. Include in your teaching plan your goal(s) for teaching, the expected outcomes for your teaching, the content to be covered, and how you plan to present the material, along with supporting teaching-learning principles. For example, see NE 135, Appendices I. Contact the family to arrange a time for the home visit.

7. **Describe:** the actual teaching session with the parent(s) and/or the child. Did you implement your teaching plan as proposed? What factors influenced the implementation? What factors influenced learning?

8. **Evaluate:** whether the expected outcomes were achieved.

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\(^1\)A Pediatric Health History includes: identifying information (e.g., birth date, race/ethnic group, gender), past history (e.g., previous illnesses or injuries, allergies, immunizations, growth and development), family medical history (e.g., diseases with familial tendencies), psychosocial history, family history (include in family assessment), and nutritional assessment. For complete description, check Outline of a Pediatric Health History in Appendix I with accompanying readings from Wong.

\(^2\)The Child Safety Home Checklist is described in Wong, Essentials of Pediatric Nursing, P. 379.
Clinical (Home/Community Setting) Experience

1. Each student is to select a family (with a child or children) who is willing to have the student make three separate visits over the course of two months. Agencies with potential families for the clinical experience will be identified for students in NE 135 early in the semester. An agreement form must be signed, in duplicate, by the family for them to participate (Permission Form is included). One copy is given to the family and one returned to the instructor.

2. After October 17th, the student should plan to make the first home visit and complete a Pediatric Health History and a Child Safety Home Checklist. Based on the data gathered, the student will identify areas of concern in which the student would like to intervene. Describe these concerns in the form of nursing diagnoses. A list of selected nursing diagnoses will be given to you for consideration. After discussing the nursing diagnoses with the instructor, you should follow-up with developing a single-focused teaching plan for the family based on the instructor’s recommendations, and plan for the next visit. Your first contact with the family may be in the clinic setting. You should do as much of the assessment as possible there.

3. Your second visit must take place in the home. You will implement your teaching plan there.

4. Your last, or third, contact with the family can be either by telephone or another home visit. During this time, you can evaluate the effectiveness of your teaching.

Evaluation: The Pediatric Home Health Case Study will be evaluated by a paper. The paper must include the following:

- Pediatric Health History (20 points)
- Child safety Home Check List (5 points)
- Description of two Nursing Diagnoses based on Analysis of Data (5 points)
- Teaching goals and Expected Outcomes for a Single-Focused Teaching Plan (5 points)
- Content for a Single-Focused Teaching Plan (20 points)
- Plans for Teaching, including Teaching-Learning Principles (15 points)
- Description of Implementation (20 points)
- Evaluation of Effectiveness of Teaching in Facilitating Learning (10 points)

Points will be given the Pediatric Health History and the Safety Check List based on how complete, comprehensive, and accurate they are. Points will be given to your descriptions of nursing diagnoses based on how relevant they are to the pediatric client, how complete the statements, and whether the diagnoses reflect a focus on health promotion, health protection or preventive services. Points will be given to the various aspects of the teaching plan based on how clear, accurate, relevant and specific the descriptions. If the paper is not handed in on time, 5 points will be deducted from the total points. If the paper contains numerous errors in grammar, spelling, or terminology, 5 points will be deducted from the total points. The complete Pediatric Home Health Case Study is due November 26, 2007.
OUTLINE OF A PEDIATRIC HEALTH HISTORY

I. Identifying Information
   1. Name
   2. Address
   3. Telephone
   4. Birth date and place
   5. Race/ethnic group
   6. Sex
   7. Religion
   8. Date of Interview
   9. Informant

II. Past History – to elicit a profile of the child’s previous illnesses, injuries, or operations.
   1. Birth history (pregnancy, labor, and delivery, perinatal)
   2. Previous illnesses, injuries, or operations
   3. Allergies
   4. Current medications
   5. Immunizations
   6. Growth and development
   7. Habits

III. Family Medical History – to identify the presence of genetic traits or diseases that have familial
tendencies and to as exposure to a communicable disease in a family member and family habits
that may affect the child’s health, such as smoking and other chemical use.
   1. Family composition
   2. Home and community environment
   3. Occupation and education of family members
   4. Cultural and religious traditions
   5. Family function and relationship

IV. Psychosocial History – to elicit information about the child’s self-concept.

V. Family History – to develop an understanding of the child as an individual and as a member of a
family and a community.

VI. Nutritional Assessment – to elicit information on the adequacy of the child’s nutritional intake
and need: Dietary intake.

Thank you for agreeing to allow a College of Marin nursing student into your home as part of the course requirement. The student's goal is to assess a child and family, develop and implement a teaching plan to support health promotion, and to evaluate the effectiveness of their teaching. There will be two or three visits extended over two months. During the first visit, they will be asking questions to determine health care needs. They will not be providing any direct health care. A follow-up phone call will be made by the student to discuss with you areas of health promotion that can be offered. On the second visit, the student will share with you the results of a home safety assessment and discuss health promotion. On the third visit or during a telephone call, the student will review the goals that were developed and determine the effectiveness of the teaching.

The student will be giving the nursing faculty reports on the visits. Based on feedback from the instructor, follow-up teaching will be done with the family and a report given to the agency of the activities. If you have any questions, please do not hesitate to call us. Both the instructor number and nursing department number have voicemail on which you can leave a message. If it is necessary to reach someone immediately, please call the nursing department office number, 485-9319.

Again, thank you for your contribution to this student's nursing education. Please sign below and return this form for our files. The student will give you a copy of this form.

I agree to participate in the pediatric home health case study pilot project as outlined above.

__________________________________________  ________________
Name                                              Date

____________________________________________
COLLEGE OF MARIN

__________________________________________  ________________
Nursing Student                                  Telephone Number

__________________________________________  ________________
Instructor                                       Instructor