REGISTERED NURSING PROGRAM
NURSING EDUCATION 135L

NURSING I: FUNDAMENTALS OF NURSING

CLINICAL LABORATORY

ACADEMIC YEAR 2007-2008

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Course Information

Course Description and Expected Outcomes

Book Requirement

Course Evaluation
Course Number and Title:

NE 135L Nursing I: Clinical Laboratory

Student Units:

Clinical 2.5 Units

Course Description:

This course is the clinical laboratory for NE 135. Students learn to perform an age-specific health assessment and a basic physical examination, to recognize alterations in these assessments, and engage in activities that promote and maintain clients’ health. Students apply the nursing process to the care of the immobilized client, the surgical client, and the client with an alteration in skin/tissue integrity.

Expected Outcomes for Students:

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

1. Perform an age-specific health assessment and a basic physical examination, analyze basic laboratory and diagnostic results, and determine alterations in these assessments.

2. Determine from an analysis of data actual nursing diagnoses, then plan and implement nursing interventions to meet basic human needs for activity/exercise, safety, hygiene, oxygenation, fluid/electrolytes balance, sleep, comfort, nutrition, and elimination; and to maintain wellness.

3. Assess psychosocial aspects of client health -- self-concept/self-esteem, sexuality, spirituality, and coping -- and the factors influencing psychosocial integrity, and plan and implement nursing interventions to promote psychosocial health.

4. Consider the client’s stage of growth and development, culture and ethnicity, family, level of health/wellness and presence of illness in planning and implementing care.

5. Demonstrate caring in nursing practice by initiating a nurse-client relationship and providing comfort measures that are age appropriate and culturally sensitive.

6. Perform technical skills to meet basic human needs with an understanding of the scientific principle base. Implement age-specific nursing interventions for obtaining vital signs, maintaining infection control, and administering medications.

7. Assess learning needs of client and implement teaching, focusing on specific content areas to promote or maintain health and on select teaching/learning principles. Utilize opportunities for informal teaching of clients.

8. Use interviewing skills to perform a nursing health history, therapeutic communication techniques in interactions with clients, and clear communication with members of the nursing care team.

9. Document assessments and client care accurately on appropriate form or by electronic means with validation from instructor.

10. Apply principles of organization and resource management (human, material, personal, stress, and time) to safely and effectively manage the care of one client in the clinical setting.

11. Adhere to HIPPA guidelines, providing for client privacy and maintaining confidentiality in all professional situation, and the legal parameters for nursing practice.
12. Plan, implement, and evaluate a nursing care plan for a client with impaired body alignment and mobility, considering the effects of immobility on all body systems.

13. Plan, implement, and evaluate a nursing care plan for a client undergoing surgery, focusing on preparation and documentation during the preoperative period, safety during the intraoperative, and managing pain and preventing complications during the postoperative period.

Book Requirements:

- College of Marin Registered Nursing Program Student Handbook, 2007-2008
- Syllabus: NE 101, 2007-2008
- Syllabus: NE 135L Clinical Agency
- Syllabus: NE138 Pharmacology

Course Evaluation:

You will receive a formal written and verbal clinical evaluation at designated times during the semester. A Credit/No Credit (Pass/Fail) system is used and based on Clinical Performance Objectives that are listed in each unit of the course. In order to continue in this nursing program you will be expected to achieve a grade of Credit or Pass in the clinical area. Your instructor, based on your achievement of the clinical performance objectives, will arrive at this grade. See the Clinical Evaluation Tool - Level I at the end of the syllabus.

Written Assignments:

Written assignments include:

NURSING ASSESSMENTS: Nursing Assessments may be assigned using NE 135 Assessment Guidelines. These exercises are designed to assist you in applying assessment theory from NE 135 to your clinical experiences in NE 135L. They will be evaluated by your clinical instructor and used in your clinical evaluation for NE 135L.

WRITTEN NURSING CARE PLANS: Nursing care plans are the nursing process in action and are the tool by which the student learns to think like a nurse. Nursing care plans are part of the American Nurses
Association Standards of Nursing Practice and are legally required by the California Nurse Practice Act. Your clinical instructor will require you to come to each clinical day with a written care plan. There are nursing care plan forms included in the syllabus. Your clinical instructor will explain the forms and care plan expectations.

**GERONTOLOGY PROJECT:** Three Elder Interviews.
You will need to find a well, relatively independent, 70 year or older person to interview. Objectives and readings for the Gerontology Project, along with an interview permission form, interview guidelines, and interview summaries are included in Appendix I. Each interview summary will be worth 10 points for a total of 30 points for the project. The interview summaries will be evaluated by your clinical instructor and discussed in post conference. The interview summary due dates are listed on the calendar. You must receive 22 points or more to successfully complete the project. See Appendix I.
Section II

Weekly Clinical Objectives

1. Orientation to the College of Marin Student Nurse Handbook, HIPPA, OSHA and Infection Control
2. Vital Sign Lab
3. Communication in Nursing and Nursing Documentation
4. Hygiene Lab and Mobility Lab
5. Orientation to Clinical Facility
6. Vital signs, Health History Assessment and Patient Safety
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8. Skin Assessment and Hygiene
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15. Care of the Surgical Client and Patient Teaching
16. Psychosocial Assessment and Sleep Assessment
The first four weeks of clinical will consist of on campus skills labs. These labs teach the student fundamental nursing skills to prepare the student for hospital based care. The labs are participatory and will require the student to learn and demonstrate nursing skills. Dress comfortably. Prepare for each lab by completing the reading and viewing assignments.

**August 21 or August 22 On Campus Clinical Course Week 1**

**Focus: Orientation to the College of Marin Student Nurse Handbook**

**HIPPA OSHA and Infection Control**

**Reading:**
- College of Marin Registered Nursing Student Handbook
- OSHA Syllabus

The Student Nurse Handbook contains the philosophy of the COM Registered Nursing Program and gives an overview of the program. This book contains important information and resources that will help the student succeed in nursing school. It also contains the contract between nursing faculty and students. Keep this book handy and refer to it frequently.

**Clinical Learning Objectives:**

At the end of this clinical learning experience, the student will be able to:

1. Describe the major content areas of the Registered Nursing Student Handbook.
2. Describe OSHA and how it affects your practice as a student nurse.
3. Explain the rationale for universal precautions.
4. Demonstrate the application of universal precautions and prevention of sharps related exposures.
5. Explain how and why infection control measures may differ from the hospital and home.
6. Describe the differences between sterile techniques and aseptic techniques.
7. Compare and contrast nursing care for patients on respiratory precautions, contact precautions, respiratory isolation, enteric precautions and droplet precautions.
8. Describe the purpose of personal protective equipment used by the nurse during patient care procedures.
9. Demonstrate how to don and remove personal protective equipment to minimize exposure to pathogens.
10. Describe HIPPA and how it affects your practice as a student nurse.
August 28 or August 29 On Campus Clinical Course Week 2

Focus: Vital Sign Lab

Reading:

- Potter and Perry: Chapter 31. Vital Signs

Clinical Learning Objectives:

At the end of this clinical learning experience, the student will be able to:

1. Identify normal ranges for temperature, pulse, respirations, blood pressure, and oxygen saturation.
2. Identify age-related variations in vital signs.
3. Demonstrate methods to take axillary, rectal and oral temperatures.
4. Verbalize aseptic principles related to temperature.
5. Convert temperature reading between Fahrenheit and Celsius.
6. Demonstrate the ability to auscultate the apical pulse to identify rate, presence of S1, S2 heart sounds, regular and irregular rhythms.
7. Use the manikin to auscultate cardiac murmurs and S3 sounds.
8. Demonstrate the ability to palpate and determine the radial pulse rate.
9. Locate and palpate the major peripheral pulses.
10. Use a Doppler to assess peripheral pulses.
11. Demonstrate auscultation of blood pressure manually and using an automated blood pressure machine (e.g., Dynamap).
12. Describe importance of choosing correct blood pressure cuff size
13. Demonstrate orthostatic blood pressures (lying, sitting and standing).
14. Demonstrate the correct use of the pulse oximeter.
15. Demonstrate correct documentation of the five vital signs and O2 saturation.
16. Utilize case studies to apply critical thinking skills to vital sign findings.
17. Differentiate between bronchial, bronchovesicular and vesicular breath sounds when auscultating breath sounds.
18. Use the manikin to identify crackles, rhonchi, wheezes, stridor.
19. Demonstrate deep breathing and coughing techniques.
20. Demonstrate diaphragmatic breathing, pursed lip breathing.
21. Demonstrate use of incentive spirometer and a peak flow meter.
September 4 or 5 On Campus Clinical Course Week 3

Focus: Communication in Nursing and Nursing Documentation
Principles of effective verbal communication and documentation

Reading:

- Potter and Perry: Chapter 23. Communication;
- Potter and Perry: Chapter 25. Documentation

Clinical Learning Objectives:

At the end of this clinical learning experience, the student will be able to:

1. Discuss the value of competency in communication for nursing practice.
2. Describe the basic elements of the communication process; including what motivates communication, the means of conveying and receiving messages, interpersonal variables and the environment for the interaction.
3. Discuss the following aspects of verbal communication: vocabulary, denotative and connotative meanings, pacing, intonation, clarity and brevity, timing and relevance.
4. Discuss the following forms of non-verbal communication: personal appearance, posture, and gait, facial expression, eye contact, gestures, and personal space.
5. Compare and contrast therapeutic and social communications.
6. Describe how the nurse maintains confidentiality in communications about the client.
7. Explain and give examples of the following therapeutic communication techniques: active listening, showing empathy, sharing observation, making broad opening statement, using touch, using silence, providing information, reflecting, restating, clarifying, focusing, and summarizing.
8. Explain and give examples of the following non-therapeutic communication techniques: asking personal questions/probing, giving personal opinions/advising, offering false reassurance, changing the subject, offering sympathy, asking for explanations, defensive or aggressive responses, belittling, stereotyping, and judging.
9. Describe how the following influence communication: physical and emotional factors, developmental factors, socio-cultural considerations, and gender.
10. Discuss techniques for effective communication with children of varying ages and older adults.
11. Describe the developmental phases and characteristics of a therapeutic (helping) relationship with primary focus on the demonstration of caring in the relationship.
12. Discuss the following elements of professional communication: courtesy, privacy/confidentiality, trustworthiness, autonomy/responsibility, and assertiveness.
13. Discuss how caring communication is used to build relationships with colleagues and coworkers and how communication is used in collegial relationships to accomplish work.
14. Discuss how to use interview skills to perform a nursing health history in order to collect information for client assessments, adapt communication and approaches to clients, considering level of growth and development, gender, language/culture, education, and physical and cognitive impairments.
15. Document assessments and client care accurately on appropriate forms or by electronic means with validation from instructor.
Utilizing Communication in
The Nurse-Client Relationship

Clinical Learning Objectives:

At the end of this clinical learning experience, the student will be able to:

1. Facilitate a client's expression of thoughts and feelings in response to illness and hospitalization, attempting to promote self-awareness.
2. Design communication strategies appropriate to the pediatric client and caregiver.
3. Demonstrate caring behaviors in providing nursing care.
4. Adapt approaches to clients by utilizing principles from growth and development.
5. Recognize your own anxiety and coping mechanisms. Utilize knowledge of self to objectively assess and respond to individuals therapeutically, rather than automatically.
6. Analyze your communication skills by reflecting on your client care. Demonstrate an awareness of personal communication patterns that enhance or block communication.
7. Demonstrate effective communication in collegial relationships, focusing on being open, clear, and respectful, and keeping team members informed.
September 11 or 12 On Campus Clinical Course Week 4

Focus: Hygiene Lab and Mobility Lab

Reading:

- Potter and Perry: Chapter 36. Activity and Exercise;
- Potter and Perry: Chapter 38. Hygiene

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. Verbalize knowledge of physician’s activity orders and importance of knowing activity restrictions and precautions before moving patients.
2. Utilize the nursing diagnosis, Impaired physical mobility and describe nursing interventions to promote optimal physical mobility and to prevent complications of immobility
3. Describe techniques to prevent injury to the nurse when moving patients
4. Utilize the nursing diagnosis, Risk for Injury: Falls and describe nursing interventions to prevent falls and fall precautions.
5. Demonstrate moving patients in bed using a pull sheet.
6. Describe techniques to prevent skin shear during moving.
7. Demonstrate turning and positioning patients in bed to maintain proper alignment, prevent pressure ulcers and provide comfort.
8. Demonstrate methods to get the patient out of bed to a chair.
9. Demonstrate methods to teach patient active range of motion
10. Demonstrate methods to perform passive range of motion on patients with limited mobility.
11. Demonstrate exercises to prevent DVT in post op patients including ankle circles and ankle pumps
12. Demonstrate use of weight belt, canes, crutches and walker
13. Modify use of assistive equipment for patient activity restrictions such as full weight bearing, partial weight bearing, toe touch weight bearing and non weight bearing
14. Describe methods to enhance patient safety during ambulation.
15. Describe first aide, nursing care and procedures if patient has a fall.
16. Utilize the nursing diagnosis, self care deficit and describe nursing interventions to promote independence, hygiene and self esteem.
17. Describe techniques and rationales for giving a complete and partial bed bath.
18. Describe techniques for giving perineal care.
19. Describe techniques for performing foot and nail care.
20. Describe techniques for performing oral hygiene.
22. Demonstrate techniques for making an occupied and unoccupied bed.
September 18 or 19 Hospital Clinical Course Week 5

Focus: Orientation to Clinical Facility

Dear Student,

Welcome to your first clinical day! This day is for you to get oriented to the clinical facility and understand what the instructor’s expectations are. Think about what is your role as a 1st year, 1st semester student nurse. Patient safety is our number one priority. Learning is our number two priority.

Reading:

• NE135L Clinical Syllabus
• Your NE 135L clinical agency manual
• Clinical facility orientation manual
• Selected agency nursing policies and procedures
• Medical record

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. Demonstrate responsibility by coming to clinical with dress and grooming appropriate to the clinical setting.
2. Demonstrate responsibility by being able to discuss key points of the clinical agency manual including the role of the NE135L student nurse in the clinical setting and the clinical instructor’s expectations.
3. Locate the clinical agency and park in an area designated for student parking.
4. Locate the assigned nursing unit and describe the room numbering and bed numbering system.
5. Locate select clinical agency departments (e.g., ED, admitting, nursing education and staffing office, cafeteria, lab, x-ray, nuclear medicine, pharmacy, central supply)
6. Locate select emergency references and equipment on the nursing unit (e.g., emergency codes and instructions, Crash Cart, RT supplies, resuscitation equipment/ambu bags, fire alarms, fire extinguishers, emergency exits, staircases).
7. Locate and describe the importance of the Nursing Policy and Procedure Manual.
8. Demonstrate appropriate communication skills by greeting and introducing yourself to members of the health care team.
9. Identify and locate select equipment and supplies (e.g., Crash cart, RT supplies, lab supplies, vital sign equipment, weighing scales and lifts, glucometers, linens, personal care items, commodes, IV polices and pumps, medications IV supplies, dressing supplies, dirty utility room, patient charts, Kardexes, staff and patient assignments)
10. Identify and demonstrate the use of equipment and features in a patient room and bathroom (lights, nurse call light, call light cancel, oxygen, suction, air, emergency outlets, intercom, phone, TV, bed siderails, head and foot positioning, wheel locks, IV poles, emergency call lights in bathroom).
11. Describe the organization of the Kardex and the medical record and how to utilize it to collect patient data.
12. Demonstrate how to organize patient data into a nursing care plan.
September 25 or 26 Hospital Clinical Course Week 6

Focus: Vital signs, Health History Assessment and Patient Safety

This will probably be your first day doing patient care. Start by introducing yourself to the nurse and patient care assistant. Work on establishing a therapeutic relationship with the patient and the patient’s significant others. Today you will take vital signs, do a **Health History Assessment** and document care. Health history form is located in forms section of syllabus. Patient safety is our number one priority. Identify methods utilized by the clinical facility to meet patient safety goals and ensure safety of patient and environment.

Reading:

- Potter and Perry: Chapter 4. Interviewing to Obtain a Health History;

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. Demonstrate responsibility by coming to clinical with dress and grooming appropriate to the clinical setting
2. Demonstrate responsibility by arriving on time to the assigned nursing unit with completed pre-lab and care plan and references (including the assigned Clinical Agency Manual).
3. Demonstrate appropriate communication skills by introducing self to staff RN and other health care team members and describing responsibilities and limitations.
4. Establish a caring nurse – patient relationship.
5. Identify methods utilized by the clinical facility to meet patient safety goals and ensure safety of patient and environment.
6. Provide comfort measures that are age appropriate and culturally sensitive.
7. Accurately take vital signs, document, and interpret the data.
8. Report abnormal vital signs to instructor or staff RN in a timely manner.
9. Identify the client’s self care abilities
10. Provide client hygiene that is appropriate to self care abilities and is age appropriate and culturally sensitive.
11. Document care according to agency and instructor guidelines.
12. Accurately complete a **Health History Assessment** form.

Learning Activities:

- Complete the **Health History Assessment** form.
October 2 or 3 Hospital Clinical Course Week 7

Focus: Mobility and Patient Safety

The student continues to work on creating a safe and therapeutic patient care environment. The Clinical Skill focus is on vital signs, physical assessment, communication, and documentation. Today you will complete the Activity Assessment form

Reading:

- Wilson, Health Assessment for Nursing Practice: Chapter 24. Musculoskeletal System

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. Verbalize knowledge of MD orders regarding patient’s activity level.
2. Plan and implement appropriate patient activity related to MD mobility orders.
3. Demonstrate theoretical understanding of reasons for mobilizing the hospitalized client.
4. Turn and position clients to prevent skin breakdown, maintain body alignment, and prevention deformities.
5. Use assistive equipment such as pillows, abduction splint and trochanter rolls to maintain alignment.
6. Demonstrate and implement methods of safe patient transfer from bed to chair and to bathroom.
7. Implement appropriate client safety measures when the patient is out of bed.
8. Instruct the client in appropriate active range of motion exercises.
9. Assess the need for passive range of motion exercises and performs appropriately.
10. Accurately completes the Activity Assessment Form
11. Utilize the nursing diagnosis, “Risk for Falls” and implement nursing interventions to prevent falls.
12. Utilize the nursing diagnosis, “Impaired Physical Mobility” and implement nursing interventions to promote physical mobility.

Learning Activities:

- Complete the Activity Assessment Form
October 9 or 10 Hospital Clinical Course Week 8

Focus: Skin Assessment and Hygiene

The focus this week is on skin assessment and hygiene. If possible, assist with a complete bed bath, give oral hygiene, peri care, skin care, and foot care. Hygienic care is one area of nursing care where we touch and are present with clients in a way that is outside established social norms. It is important to bath patients in a way that preserves their privacy and protects their dignity. Bathing is an optimal time to do a skin assessment, establish therapeutic communication, develop a caring nurse-client relationship and work on providing care that is age appropriate and culturally sensitive. Complete the **Physical Assessment Form: Skin, Mucous Membranes, Hair, and Nails**.

Reading:

- Wilson, *Health Assessment for Nursing Practice*: Chapter 11. Skin, Hair and Nails. (Pay particular attention to material on staging of pressure ulcers.)
- Wilson, *Health Assessment for Nursing Practice*: Chapter 14. Nose, Paranasal Sinuses, Mouth and Oropharynx. (Pay particular attention to assessing the mouth and oropharynx. Observe a case of oral Candidiasis/thrush which is commonly seen in hospitalized patients.)

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. Assist or give complete hygienic care to a client including mouth care, skin care, peri care and foot care.
2. Maintain principles of therapeutic communication and caring during bathing.
3. Demonstrate knowledge of universal precautions during bathing.
4. Demonstrate making an occupied and unoccupied bed.
5. Accurately complete the **Physical Assessment Form: Skin, Mucous Membranes, Hair, and Nails**.
6. Accurately document a skin assessment.
7. Demonstrate an understanding of the staging and documentation of pressure ulcers.
8. Utilize the nursing diagnoses, “Skin Integrity, Impaired” and implement nursing interventions to prevent skin breakdown.

Learning Activities:

- Complete the **Physical Assessment Form: Skin, Mucous Membranes, Hair, and Nails**.
- Observe pressure ulcers, **stage pressure ulcers** and document pressure ulcers.
October 16 or 17 Head Start Lab On Campus Clinical Course Week 9

Focus: Pediatric Communication, Health History and Assessment

Reading:


Clinical Learning Objectives:

1. At the end of this clinical experience, the student will be able to:
2. Describe the mission and history of the Head Start program.
3. Observe appropriate precautions to protect children’s safety and comfort, and take appropriate action to prevent situations that may lead to misinterpretation and mistrust.
4. Describe normal vital signs ranges for pediatric and adult clients.
5. Utilize height weight charts to determine growth and development patterns of pediatric clients.
6. Utilize age-appropriate communication skills and nursing techniques to complete a basic physical assessments on a pediatric client.
7. Recognize normal and abnormal variations in growth and development.
8. Appropriately utilize play in the performance of nursing interventions.
9. Utilize appropriate interview techniques that recognize both the parent and child as the nursing client.
10. Provide appropriate safety teaching to parents and children.

Learning Activities:

- Complete **Head Start Assessment** forms for 2 or more children.
- Participate in role plays
October 23 or 24 Hospital Clinical Course Week 10

1. Focus: Respiratory and Cardiac Assessment

   The focus this week is on oxygenation, ventilation and circulation. The student will continue to integrate past weeks concepts. Cardiopulmonary assessment ranges from the simple to the complex. Get out your stethoscope and listen! Compare your assessment with other students and health care practitioners. Go for it! The main nursing diagnoses for respiratory function are Ineffective airway clearance, ineffective breathing patterns and impaired gas exchange. Lynda Carpenito in her book *Nursing Diagnosis: Applications to Clinical Practice* uses an umbrella diagnosis she calls, Respiratory Function, Risk for Ineffective. Complete Oxygenation: Ventilation Assessment and Oxygenation: Circulation Cardiac Assessment Forms.

Reading:

- Wilson, *Health Assessment for Nursing Practice*: Chapter 17. Lungs and Respiratory System
- Wilson, *Health Assessment for Nursing Practice*: Chapter 18. Heart and Peripheral Vascular System

Clinical Learning Objectives:

At the end of this clinical learning experience, the student will be able to:

1. Perform and document a respiratory assessment
2. Identify abnormal respiratory sounds: wheezes, rhonchi, and crackles.
3. Identify alterations in respiratory function such as hypoventilation, hyperventilation, dyspnea, tachypnea, bradypnea, apnea, irregular respiratory patterns and cyanosis.
4. Utilize the nursing diagnosis, “Ineffective airway clearance” and implement nursing interventions to assure a patent airway.
5. Utilize the nursing diagnosis, “Ineffective breathing pattern” and implement nursing interventions to restore optimal breathing patterns.
6. Utilize the nursing diagnosis, “Impaired gas exchange” and implement nursing interventions to improve gas exchange.
7. Demonstrate the ability to correctly use and adjust the flow rate for the following oxygen delivery systems: nasal prongs, face mask, partial rebreather, and non rebreather.
8. Demonstrate the appropriate use of a portable oxygen tank when a patient is transported off the floor.
9. Demonstrate and perform patient teaching on the correct use of the incentive spirometer.
10. Perform and document a fundamental cardiac assessment including assessing including identification of S1, S2 heart sounds, heart rhythm regular or irregular, quality of peripheral pulses and presence of edema.
11. Perform a peripheral vascular assessment including color, sensation, mobility and temperature of extremities.
12. Utilize the nursing diagnosis “Risk for peripheral neurovascular dysfunction” and implement nursing interventions to maintain or restore optimal peripheral neurovascular function.
Learning Activities:

- Complete Oxygenation: Ventilation Assessment and Oxygenation: Circulation Cardiac Assessment Forms.
October 30 or 31 Hospital Clinical Course Week 11

Focus: Fluid Volume Status and Laboratory Values

The focus for this week is fluid and electrolytes. Patients with nausea, vomiting and diarrhea or patients who lose blood during surgery may be diagnosed with Fluid Volume Deficits. The most common electrolyte imbalances are potassium and sodium. Fluid and electrolyte problems are best interpreted by looking at trends over several days. This week pay particular attention to 24 hour intake and outputs, weight loss or gain and interpreting laboratory results. Electrolyte imbalances are considered Collaborative Problems because the nurse must work with the physician to develop treatment plans.

Reading:

- Potter and Perry: Chapter 40. Fluid, Electrolyte and Acid–Base Balance

Clinical Learning Objectives:

At the end of this clinical learning experience, the student will be able to:

1. Demonstrate the ability to correctly measure a client’s intake of oral fluids using the hospital container volume chart.
2. Demonstrate the ability to accurately convert ounces to mls/ccs
3. Demonstrate the correct use of measurement equipment (e.g., graduated containers, urinals, and urine hats) to measure output.
4. Demonstrate the correct method for emptying a Foley catheter.
5. Accurately calculate a client’s intake and output.
6. Review a client’s intake and output for 8, 12 and 24 hours. Analyze the adequacy of fluid intake.
7. Review a client’s lab values and note abnormal values and potential problems.
8. Utilize the nursing diagnosis “Fluid volume deficit” and implement nursing measures to improve intake.
9. Identify a client on the nursing unit with a potassium imbalance. Describe the imbalance signs and symptoms and collaborative treatment plans.
10. Identify assessment findings for patients who have fluid volume excess.
11. Identify assessment findings for patients who have fluid volume overload.

Learning Activity:

- Fill out laboratory results worksheet. Utilize Fischbach, F.T., Manual of Laboratory and Diagnostic Tests. Discuss the interpretation of lab values and the implications for patient care.
November 6 or 7 Hospital Clinical Course Week 12

Focus: Nutritional Assessment and Nursing Diagnosis: Imbalanced Nutrition: Less than Body Requirements

Many disease processes, medical and surgical treatments may affect the patient’s ability to chew, swallow, digest food and properly eliminate waste products. Poor nutritional status in turn affects skin integrity, wound healing and the immune system. Fluid and electrolyte imbalances may accompany nutritional problems. **Assess your patient’s nutritional status.** Look for connections between nutrition, lab values, skin integrity and wound healing.

Reading:

- Potter & Perry: Chapter 43. Nutrition and

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. Describe how the client’s nutritional status is affected by their disease process, and their medical and surgical treatment plan.
2. Describe the different types of diets that are provided in the clinical facility.
3. Describe the diet that your patient is ordered by the physician. What foods are allowed and prohibited? Does the patient like this diet?
4. Assess a client’s nutritional intake over 8, 12, 24 and 48 hours. Analyze the adequacy of this nutritional intake.
5. Utilize the nursing diagnosis, “Imbalanced nutrition less than body requirements” and plan therapeutic nursing interventions to restore optimal nutrition.
6. Correlate the following client data with nutritional status: daily intake, calorie count, daily weights, albumin levels, and hemoglobin and hematocrit levels.
7. Describe therapeutic nursing interventions to promote nutrition in the post-operative patient.

Learning Activities:

- Fill out *Comprehensive Nutritional Assessment and Nutritional Health Interview.*
Focus Medication Administration and Neurological Assessment

The focus this week is on medication administration. Medication administration is an important nursing responsibility. The College of Marin maintains the highest standards of patient safety during medication administration. The student is expected to know the Six Rights of Medication Administration and identify the patient using two patient identifiers. Each student is expected to research all of the prescribed Routine and PRN medications that their assigned patient is receiving. Adequate medication preparation includes an understanding of why the patient is getting the medication, what the therapeutic effect of the medication is, common side effects, life threatening effects, and nursing implications.

A change in neurological status is a frequent occurrence in hospitalized patients. These changes may be subtle and can be caused by many factors including medications, pain, sleep deprivation, fluid and electrolyte imbalances. An astute nurse will notice these changes early and use the nursing process to intervene for the benefit of the client.

Medication Administration:

During the last 4 weeks of the clinical rotation, students may begin administering oral, topical, and SQ medications with the instructor’s or an RN’s direct supervision if they have:

1. Passed (score of 90% or higher) the NE 138 Medication Dosage Calculation Exam, and
2. Been checked off on the appropriate medication administration competency in the NE 101 Skills Lab. (Students will not be administering IV push or IVPB medications during this rotation), and
3. Developed a patient care plan that includes the appropriate research on the patient’s medications.

Medication administration requires critical thinking and a synthesis of knowledge, clinical skills and the patient’s current clinical presentation. Medication administration requires careful direct supervision, by the clinical instructor or Registered Nurse; therefore not every student who has met the criteria will be able to pass medications during each clinical day. However, the instructor will endeavor to provide at least one opportunity for all students who have met the criteria to pass medications sometime during the last 4 weeks of the NE 135L clinical rotation.

Reading:

- Potter and Perry: Chapter 34. Medication Administration
- Wilson, Health Assessment for Nursing Practice: Chapter 25. Neurological System

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. State the actions, routes of administration, dosages, side effects, toxicity and nursing implications of medications that will be administered.
2. Perform patient assessments and reports to patient’s RN and/or nursing instructor prior to administering medications.
3. Follow the facility policy and procedure for preparing, documenting, and administering medications.
4. Prepare medications utilizing aseptic technique.
5. Pass pharmacology course medication calculation exam with a score of 90% or above.
6. Pass medication administration skills check-off prior to administering medications in the clinical setting by that route.
7. Accurately calculate medication dosages in the clinical setting.
8. Utilize the 6 Rights of Medication Administration.
9. Utilize two patient identifiers when administering medications.
10. Demonstrate knowledge of client allergies when administering medications.
11. With guidance and supervision, administer medications using appropriate medication administration techniques.
12. Prepare and administer medications in presence of instructor or RN.
13. Identify clinical situations which can lead to medication or other medical errors and works with instructor and staff to correct them.
14. Provide appropriate client teaching when administering medications.
15. Assess the patient for changes in neurological status.
16. Utilize the nursing diagnosis “Disturbed sensory perception cognitive, auditory, kinesthetic, tactile” (choose one) and develop appropriate therapeutic nursing interventions.

Learning Activities:

- Complete the Neurological Assessment Form
November 20 or 21 Hospital Clinical Week 14  
Focus: Urinary Elimination and Bowel Elimination

This week we will continue to work on medication administration skills. The clinical skill focus will be on the gastrointestinal system. Illness, hospitalization and surgery cause changes in usual eating patterns resulting in problems with the GI tract. Opioid pain medications, antibiotic and bed rest are other factors interfering with normal GI function. Problems in GI function can be embarrassing for the patient and a challenge for the nurse to effectively manage.

Reading:

- Wilson, Health Assessment for Nursing Practice: Chapter 20. Abdomen and Gastrointestinal System

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. Demonstrate patient teaching for a clean catch urine sample
2. Demonstrate nursing skills for the patient with a Foley catheter care including hygiene, urine sampling, insertion, removal and urine measurement.
3. Perform an assessment to check for bladder distension.
4. Describe signs and symptoms of bladder distention.
5. Demonstrate the use of a Bladder Scan.
6. Discuss medical and surgical causes of urinary retention.
7. Assess a client for signs and symptoms of a urinary tract infection and correlate your assessment with a urinalysis.
8. Utilize the nursing diagnosis “Urinary incontinence” and develop therapeutic nursing interventions to promote continence.
9. Determine the correct method of toileting a client (e.g., fracture bedpan, regular bedpan, bedside commode, bathroom toilet, elevated toilet seat).
10. Do a bowel elimination assessment and determine the patient’s stool patterns.
11. Describe and demonstrate how to assess for abnormal stool patterns including constipation, fecal impaction, and diarrhea.
12. Utilize the nursing diagnosis “Constipation” and develop a therapeutic nursing interventions to promote improved bowel movements.

Learning Activities:

- Fill out Urinary Elimination and Bladder Elimination Assessment Forms
November 27 or 28 Hospital Clinical Week 15

Focus: Care of the Surgical Client and Patient Teaching

The care of the surgical patient gives the student an opportunity to synthesize all the knowledge in NE135 course. Utilize nursing skills to predict and prevent possible surgical complications.

Reading:

- Potter and Perry: Chapter 49. Care of Surgical Patients

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

1. Describe common post surgical complications.
2. Implement therapeutic nursing interventions to prevent post operative complications.
3. Develop and implement a post-operative teaching plan for a select client.

Learning Activity:

- Prepare and present a post operative teaching plan for a client.
December 4 or 5 Hospital Clinical Week 16

Focus: Psychosocial Assessment, Pain Assessment and Sleep Assessment

Pain is the 5th vital sign. Always remember to do a thorough pain assessment and never assume that the patient is complaining of pain from what seems like the most obvious source.

Reading:

Wilson, Health Assessment for Nursing Practice: Chapter 8. Pain Assessment and

Wilson, Health Assessment for Nursing Practice: Chapter 9. Sleep Assessment

Clinical Learning Objectives:

At the end of this clinical experience, the student will be able to:

Perform a complete pain assessment.

Utilize the nursing diagnosis “Acute pain” and implement therapeutic nursing interventions to give satisfactory pain relief.

For a given client, assess the types of pain medications ordered, the amount of pain medication given over 8, 12, 24 hours. and draw conclusions as to the effectiveness of the pain medication regime.

Utilize the nursing diagnosis “Fear and Anxiety” and implement therapeutic nursing interventions to help promote increased psychological and physiological comfort.

Learning Activity:

Complete Sleep Assessment Form
Section III

Gerontology Project
Gerontology Project

On completion of these learning activities, the student 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, the student will be able to:

1. Using interview guidelines, visit with a well elder and discuss:
   a. Adaptation to healthy aging
   b. Effects of life experiences, stress and coping
   c. Mobility and safety in the environment
2. Complete a summary report for each interview and identify:
   a. Important concepts that were gleaned related to the assigned focus.
   b. Communication techniques that enhanced or created barriers.
Project Assignments:

Reading:

- Potter and Perry: Chapter 13. The Older Adult

Learning Contact:

- 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. 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 . . .
- You may not use your relative (grandparent, etc.) for your interview.
- 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 Well Elder" form 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.
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 and attach the Guidelines for Assessment of Safety and Mobility (next 2 pages) and based on your findings select three (3) to five (5) appropriate nursing diagnoses that reflect actual and potential health problems for your client. (Refer to your text, Nursing Diagnosis: Application to Clinical Practice, by Lynda Carpenito for assistance.) List these diagnoses (with appropriate Related To and Manifested By descriptors) below:

1. 

2. 

3. 

4. 

5. 
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 areas listed below.

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 (e.g., 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 (TIA); vertigo; syncope
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? Are there handrails for stairs?)
Slippery floors, clutter (Throw rugs highly polished floors; skid-proofing for shower/tub?)
Unfamiliar environment (Recent 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

Nursing Diagnoses

• List 3 to 5 nursing diagnoses based on the above assessment data.

SAF&MOB.130, 7/93, JLC
Instructor Copy
Interview Permission Form

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

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(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
SECTION III

NE 135L Nursing Fundamentals
HEALTH ASSESSMENT WORKSHEETS

• Health History Assessment Form
• Example of Head to Toe Assessment
• Age-Specific Approaches to Physical Examination
• Integumentary System Assessment
• Activity Assessment
• Sleep Assessment
• Oxygenation: Ventilation Assessment
• Cardiac Assessment
• Comprehensive Nutritional Assessment
• Nutritional Health Interview
• Basic Neurology Assessment
• Elimination: Bladder Assessment
• Elimination: Bowel Assessment
• Psychosocial Assessment
• Sample Questions for an Endocrine Health History Interview
**HEATH HISTORY ASSESSMENT**

Student Name____________________________________Date____________________

**Biographical Data**
Client’s Initials:___________________ Age:_________ Date:____________________
Birthdate:_________ Sex:_________ Marital Status:__________ Race:_______________
Occupation:________________________ Health Insurance:________________________

**Source of History**
_________________________________________________________

**Reason for Seeking Care** (in client’s own words)
________________________________________________________________________

<table>
<thead>
<tr>
<th>Present Health or History of Present Health (investigate the reason for seeking care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P.</strong> Provocative or palliative</td>
</tr>
<tr>
<td><strong>Q.</strong> Quality or quantity</td>
</tr>
<tr>
<td><strong>R.</strong> Region or radiation</td>
</tr>
<tr>
<td><strong>S.</strong> Severity scale</td>
</tr>
<tr>
<td><strong>T.</strong> Timing</td>
</tr>
<tr>
<td><strong>U.</strong> Understand</td>
</tr>
</tbody>
</table>

**Past Health**

<table>
<thead>
<tr>
<th>Childhood Illnesses</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Accidents or Injuries</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chronic Medical Conditions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Operations</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Obstetric History</th>
<th>Immunizations</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last Exam Date</th>
<th>Allergies</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Current Medications</th>
</tr>
</thead>
</table>

---
Dietary Preferences and Restrictions

Family History
Specify
Heart disease_________ Arthritis_________
High blood pressure_______ Allergies_________
Stroke_________________ Obesity_________
Diabetes________________ Alcoholism_________
Blood disorders_________ Mental Illness_________
Breast cancer____________ Seizure disorder_________
Cancer(other)____________ Kidney disease_________
Sickle cell________________ Tuberculosis_________

Construct genogram here
Age/ Live/ Deceased/ Medical Problems/ Occupation/ Country of origin
Genogram( circle-female, square-male, blue-alive, red or line out-deceased)

Review of Systems(Note History of any diseases or surgeries under system)
General Overall Health
Integumentary-
Skin- amount of sun exposure, skin care
Hair
Nails
Head- headache, dizziness, vertigo,
Eyes- vision, glaucoma test, pain, discharge,
Ears- hearing, exposure to loud noises, infections, tinnitus,
Nose and Sinuses- sinusitis, frequent URIs, nasal obstruction,
Mouth- lesions, dental care, dysphagia, altered taste,
Throat- strep, hoarseness or voice change,
Neck- pain, limited motion, lumps,
Breast- self breast exam, last mammogram, pain, nipple drainage,
Axilla- pain
Respiratory System- cough (how much and color), SOB, last x-ray
Cardiovascular System- chest pain, palpitations,
date last EKG or other heart tests cholesterol level
Peripheral Vascular System- coldness, numbness, calf pain, on feet all day, edema, lesions,
Gastrointestinal System- indigestion, change in bowels, laxative use, pain,
bleeding, weight change
Urinary System- nocturia x/night, infections, discharge, pain,

Genital System/Male- testicular self exam
Female- last menstrual period__________, vaginal infections, kegel exercises, last pap exam,

Sexual Health- contraceptive type,

Musculoskeletal System- joint pain, back pain,
range of motion,

Neurologic System- change in consciousness, dizziness,
Mental Status- nervousness, mood change, depression

Hematologic System- bleeding tendency,

Endocrine System- history of DM or thyroid disease

Functional Assessment (Activities of Daily Living)
Self-Esteem/Self-Concept- Education, Financial status, Value-belief system (religious and perception of personal strengths)

Activity/Exercise- Profile of a typical day, Independent or needs assistance with ADL (feeding, bathing, hygiene, dressing, toileting, transfers: bed/chair/stairs/standing/walking)

Leisure activities, Exercise pattern (type, amount per day/week, warm-up, monitor pulse)

Sleep/ Rest- Sleep patterns, daytime naps, use of sleep aids

Nutrition/Elimination- How many meals a day do you eat? Who does the shopping and cooking, who is present for meals, finances adequate for food

Interpersonal Relationships/Resources- Describe own role in family Gets support with a problem from, How much spent alone(is this isolating or pleasurable)

Coping and Stress Management- Describe stresses in life now, Changes in the past year, methods used to relieve stress, are these methods helpful,

Personal Habits
Alcohol
Smoking
Recreational Drugs
Seat belt use
Firearms in house
Environment/Hazards-Housing and neighborhood, adequate heat, access to transportation, involvement in community services, travel, smoke detectors, firearms

Occupational Health-Describe your job, work with any health hazards, use of equipment and monitoring systems to limit health related problems

Perception of Health-How do you define your health, view own health now, health goals, your expectations of nurses, MD, what do you expect will happen to your health in future

Adapted from: Jarvis, C. Physical Examination and Health Assessment, 3rd Ed., 2000, W. B. Saunders
# HEAD TO TOE NURSING ASSESSMENT

<table>
<thead>
<tr>
<th>System</th>
<th>Normal Findings</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vital Signs</strong></td>
<td>Adult: T- 96.8 to 100.4/101 F AP-60 to 100 RR-14 to 24 SBP-90 to 140 DBP-40 to 90</td>
<td>Report any abnormal finding to your clinical instructor and/or primary RN before documenting, to validate the finding.</td>
</tr>
<tr>
<td><strong>Pain- Location/Severity</strong></td>
<td>&lt; 3/10 or patient's goal</td>
<td>&gt;3/10</td>
</tr>
<tr>
<td><strong>Psychosocial</strong></td>
<td>Coping appropriately Communications needs Adequate Support System</td>
<td>Fearful, angry, anxious, tearful, withdrawn, agitated, combative; low/no support</td>
</tr>
<tr>
<td><strong>Neurological</strong></td>
<td>Level Of Consciousness (LOC) and orientation Alert &amp; oriented X 3 or 4 (time, place, person, and purpose)</td>
<td>Lethargic, Stuporous, Somnolent, Comatose Disoriented</td>
</tr>
<tr>
<td><strong>Pupils</strong></td>
<td>3 to 4 mm PERRLA (pupils equal round and reactive to light and accommodation)</td>
<td>Pinpoint or dilated pupils Fixed pupils</td>
</tr>
<tr>
<td><strong>Memory</strong></td>
<td>Intact</td>
<td>Loss of short &amp;/or long-term memory deficit</td>
</tr>
<tr>
<td><strong>Speech</strong></td>
<td>Clear, appropriate</td>
<td>Aphasia, Slurred or Garbled</td>
</tr>
<tr>
<td><strong>Neurological Record (GCS)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>Apical pulse S1 &amp; S2 Regular, strong</td>
<td>Irregular (maybe normal for Pt), weak; note pulse deficit Extra heart sound; murmur</td>
</tr>
<tr>
<td><strong>Peripheral pulses</strong></td>
<td>Pulpable 2+and equal Radial bilaterally Pedal X 4 (DP &amp; PT/Lt &amp; Rt)</td>
<td>Present by Doppler, Absent 1+ (diminished), 3+(full), 4+(bounding); unequal</td>
</tr>
<tr>
<td><strong>Edema</strong></td>
<td>None</td>
<td>1 to 4+ note location</td>
</tr>
<tr>
<td><strong>Chest Pain</strong></td>
<td>None</td>
<td>Report of pain, Notify Instructor</td>
</tr>
<tr>
<td><strong>Postural Orthostatic BP</strong></td>
<td>None</td>
<td>20 mmHg drop SBP &amp; increase Heart Rate when sits/stands</td>
</tr>
<tr>
<td><strong>Capillary Refill</strong></td>
<td>Less than 2 seconds Trunk &amp; Peripheral</td>
<td>Greater than 2 seconds Pediatrics check on all kids</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>Resprations Regular, Non-Labored</td>
<td>Irregular, Labored</td>
</tr>
<tr>
<td><strong>Breath Sounds</strong></td>
<td>Clear all lung fields</td>
<td>Crackles, Rhonchi, Wheezes, Diminished, Absent; note location; I or E</td>
</tr>
<tr>
<td><strong>Dyspnea</strong></td>
<td>None or at Baseline for Pt.</td>
<td>Note at Rest &amp;/or Exertion</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Cough</strong></td>
<td>Nonproductive</td>
<td>Note color &amp; amt sputum</td>
</tr>
<tr>
<td><strong>Oxygen Saturation/O2 Flow</strong></td>
<td>&gt; 90-92% on RA (Room Air)</td>
<td>Note value/O2 Flow Nasal Canula, Mask, Non-Rebreather Mask</td>
</tr>
<tr>
<td><strong>Incentive Spirometer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bowel Sounds</strong></td>
<td>Active X 4 quadrants</td>
<td>Absent, hypoactive, hyperactive</td>
</tr>
<tr>
<td><strong>Flatus (passing gas)</strong></td>
<td>Present</td>
<td>Absent</td>
</tr>
<tr>
<td><strong>Abdomen</strong></td>
<td>Soft and nontender</td>
<td>Distended, firm; c/o tenderness note location</td>
</tr>
<tr>
<td><strong>Bowel movement</strong></td>
<td>Regular pattern w/in 3 days; Brown, soft and formed</td>
<td>Irregular pattern; diarrhea constipation, incontinent</td>
</tr>
<tr>
<td><strong>Note Date of last BM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nausea/Vomiting (N/V)</strong></td>
<td>None</td>
<td>Present</td>
</tr>
<tr>
<td><strong>Guaiac</strong></td>
<td>Negative</td>
<td>Positive</td>
</tr>
<tr>
<td><strong>Diet/% of meal eaten</strong></td>
<td>Varies; 75% or greater</td>
<td>NPO, Clear or Full Liquid, Soft, Regular, Puree, CCU, ADA, Metabolic, Snack</td>
</tr>
<tr>
<td><strong>Nasogastric Tube (NG)</strong></td>
<td>Patent, Note type of tube &amp; Note type of suction or if clamped/closed</td>
<td>Note drainage color/guaiac Note residual amount, Note tube feeding amount</td>
</tr>
<tr>
<td><strong>Genitourinary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Elimination: Voiding or Foley Cath, Condom Cath, Suprapubic Cath, Urostomy</strong></td>
<td>Nondistended; Urine output is in adequate amounts: <em>25 to 30 ml per hour for adequate renal perfusion</em> <em>100 to 150 ml per void for adequate bladder emptying</em></td>
<td>Less than 25 ml per hour report promptly during shift Less than 100 to 150 ml per void indicates retention; Incontinent</td>
</tr>
<tr>
<td><strong>Urine</strong></td>
<td>Clear, yellow to Amber</td>
<td>Cloudy, bloody, sediment</td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Movement of Extremities</strong></td>
<td>MAE (movement all extremities) Equal &amp; strong</td>
<td>Unilateral movement Weak</td>
</tr>
<tr>
<td><strong>CMS (Circulation, Motor, and Sensation)</strong></td>
<td>Intact</td>
<td>Note CMS deficit</td>
</tr>
<tr>
<td><strong>Ambulation</strong></td>
<td>Balanced, coordinated Independent Note times OOB and distance for progressive ambulation</td>
<td>Needs minimal to maximal assistance out of bed (OOB) Note devise: cane, walker, crutches, wheelchair, weight bearing or non WB</td>
</tr>
<tr>
<td><strong>Note risk for fall</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Teds/Sequential Stockings</strong></td>
<td>Note periods of on or off</td>
<td>Too tight could restrict flow</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Wound and Skin</strong></td>
<td><strong>Note Pressure Score Risk on Gosnell/Braden Scale</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Skin</strong></td>
<td>Warm, dry and intact, color is WNL</td>
<td>Pallor, Ruddy, Cyanotic, Jaundice, Diaphoretic, Clammy, Cool; non-intact</td>
</tr>
<tr>
<td><strong>Turgor</strong></td>
<td>Readily recoils</td>
<td>Delayed recoil; &gt;2 seconds</td>
</tr>
<tr>
<td><strong>Wound Note Type of Wound and Location (surgical incision, pressure ulcer, drainage tubes)</strong></td>
<td>Surgical incision edges are well proximated without redness, drainage or edema Clean, Dry, &amp; Intact Granular tissue present</td>
<td>Note dehiscence, evisceration, exudate or drainage, fistulas, sinus tracts, eschar, gangrene, necrosis, edema present</td>
</tr>
</tbody>
</table>
AGE-SPECIFIC APPROACHES TO PHYSICAL EXAMINATION

Age Groups

- Infant: Birth to 12 months
- Toddler: 1 to 3 years
- Preschool: 3 to 5 years
- School-Age: 6 to 12 years
- Adolescence: 12 to 18 years


Infant (Birth to 1 year):

Developmental Indicators:

- Stranger anxiety begins at 7 months; peaks at 9 months.
- Resists being restrained;
- Responds to simple commands by age 9 months;
- Separations anxiety peaks at 13 months

Positioning:

- Supine or prone, before 4 to 6 months: can place on examining table;
- After 6 months sits alone: use this position whenever possible in parent’s lap;
- If on table, place with parent in full view;

NEVER TURN YOUR BACK WITH INFANT ON TABLE, High Risk for Injury;

Fall Sequence:

- If quiet, auscultate heart, lungs, abdomen;
- Palpate and percuss same areas;
- Proceed in usual head-toe direction;
- Perform traumatic procedure last (eye, ears, mouth, (while crying), rectal temperature (if taken);
- Elicit reflexes as body part examined, elicit generalized primitive reflexes last

Preparation:

- Completely undress if room temperature permits;
- Leave diaper in place;
- Gain cooperation with distraction, bright objects, rattles, talking; Smile at infant:
- use soft, high-
  - pitched voice;
- Pacify with pacifier (if parents allow) or sugar water or feeding;
- Enlist parents’ aid for restraining to examine ears, mouth;
- Avoid abrupt, jerky movements
Toddler (1 to 3 years-old):

Developmental Indications:
- Autonomy important;
- Egocentric;
- Stranger anxiety decreases at 18 months;
- Speech begins;
- Negativism present;
- Knows several external body parts;
- Separation anxiety decreases at 2 years

Positioning:
- Sitting on or standing by parent;
- Prone or supine in parent’s lap

Sequence:
- Inspect body areas through play: “count fingers,” “tickle toes”;
- **Minimize physical contact initially**;
- Introduce equipment slowly;
- Auscultate, percuss, palpate whenever quiet;
- Perform traumatic procedures last (same as for infant)

Preparation:
- Have parent remove outer clothing;
- Remove underwear as body part examined;
- Allow to inspect equipment: demonstrating use of equipment is usually ineffective;
- If uncooperative, perform procedures quickly;
- Use restraint when appropriate: request parent’s assistance;
- Talk about examination if cooperative; use short phrases;
- Praise for cooperative behavior

Preschool Child (3 to 5 years-old):

Developmental Indicators:
- Likes to “help”;
- More cooperative, follows simple instructions;
- Knows most external body parts, 3-5 internal parts;
- **Fears bodily harm**

Positioning:
- Prefer standing or sitting;
- Usually cooperative;
- Prefer parent’s closeness

Sequence:
- In cooperative, proceed in head to toe direction;
- If uncooperative, proceed as with toddler

Preparation:
- Request self-undressing;
Allow to wear underpants if shy;  
Offer equipment for inspection, briefly demonstrate use;  
Make up “story” about procedures;  
Use paper doll technique;  
**Give choices when possible;**  
Expect cooperation, use positive statements

**School-Aged Child (6 to 12 years-old):**

**Developmental Indicators:**
- Industrious;  
- Cause & effect develops;  
- Increasing self-control;  
- Understands simple scientific explanations;  
- Knows 5 to 10 internal body parts

**Positioning:**
- Prefers sitting;  
- Cooperative in most positions;  
- Younger age prefer parent’s presence;  
- Older age may prefer privacy

**Sequence:**
- Proceed in head-toe direction;  
- Examine genitalia last

**Preparation:**
- Request self-undressing;  
- Allow to wear underpants;  
- Give gown to wear;  
- Explain purpose of equipment and significance of procedure;  
- **Teach about body functioning and care**

**Adolescent (12 to 18 years-old):**

**Developmental Indicators:**
- Increasing independence;  
- Separates readily from parents;  
- Future-oriented;  
- Knows basic anatomy and physiology

**Positioning:**
- Generally prefer privacy;  
- Offer option of parent’s presence

**Sequence:**
- Proceed in head-toe direction;  
- Examine genitalia last

**Preparation:**
- Allow to undress in private;  
- Give gown;
Expose only area to be examined;
Explain findings during examination;
Matter-of-factly comment about sexual development;
Emphasize normalcy of development
INTEGUMENTARY SYSTEM ASSESSMENT

Student’s Name:______________________________________ Date:_____________________

Biographical Data:
Client’s Initials:___________________ Age:___________ Date:____________________

General Appearance:

Health History:
Past Medical History/Current Medical Problems:
Previous skin problems:
Allergic reactions to food, medication, chemicals, environment:
Personal or family history of skin allergies:
Personal or family history of skin cancer:

History of current skin problem(s): (investigate the reason for seeking care)
Signs or symptoms including onset, location, pain, itching, burning, heat, swelling, or other discomfort, lesions/rashes, distribution-symmetric/linear/circular:
P:______________________________________________________________________
Q:______________________________________________________________________
R:______________________________________________________________________
S:______________________________________________________________________
T:______________________________________________________________________
U:______________________________________________________________________

Occupation:
Environmental influences(plants; animals; use of /presence of chemicals):
Use of cleansers, soaps or detergents:
Use of skin care products or cosmetics:
Presence of external devices(artificial limb, BS fingersticks):
Secretion/excretions on the skin(draining wound, incontinence, sweat):

Risk Factors for Developing Pressure Ulcers
MentationContinencyMobilityNutrition
Sensation Tone Movement Forces: Friction Shearing
Dehibilating disease(s)Infection

Physical Assessment: Skin, Mucous Membranes, hair, and Nails:
Skin and Mucous Membranes(oral mucosa, lips, gums, sclera, conjunctiva):

INSPECTION:
Color(pink/deep brown; cyanosis, pallor, jaundice):
Pigmentation(uniform; hypo/hyperpigmentation):
Vascularity(visible blood vessels; vasodilation, erythema, cords):
bruisingpettechiae telangietases
angiomas venous stars varicosities
Lesions(note location on body drawing body anterior and posterior views below):
Look for macules, papule, nodule, tumor, wheal, urticaria, vesicle, pustule,
cyst, ulcer, excoriation, scar, atrophic scar, lichenification, keloid, crust, scale, fissure, erosion, bullea, scars, lacerations, injuries, atrophy, maceration

1. color_________________________________________________________
2. elevation____________________________________________________
3. pattern or shape______________________________________________
4. size___________________________________________________________
5. location and distribution_______________________________________
6. any exudate? note color and odor

**Stage I-IV pressure ulcer:** Document on body chart and nursing notes in detail. Identify risk factors for pressure ulcers: use Gosnell Scale: Pressure Sore Risk Assessment

**Treatment causalities** (IV, cath, cast ect.): _______________________

**PALPATION:**

Lesions (erytherma, non-blanching at pressure points, borders): __________
Moisture: ____________________________________________
mucous membranes: __________________________
Temperature (warm, hot, cool): ________________________________
Texture (smooth, soft, even): ________________________________
Thickness: ___________________________________________________
Turgor (readily returns back to place): _________________________
Edema (noted as- 1+/2mm, 2+/4mm, 3+/6mm, 4+/8mm): ________________
unilateral________ symmetrical________ generalized________

**Hair:**

INSPECTION & PALPATION:

Color ____________________ Texture ____________________ Thickness __________
Distribution (patchy loss, male pattern baldness, alopecia, hisuitism):

Head __________________________ Facial ___________________________
Extremities _____________________ Pubic area _______________________

Lesions _____________________________

**Infection/Infestation** (lice, mites) __________________________________________

**Nails:**

INSPECTION & PALPATION:

Curvature (160 degrees, clubbing > 180 degrees): _______________________
Configuration (Beau’s lines, pitting, spoon, paronychia, onycholysis) __________
Consistency (soft/hard/crumbling, brittle, thickened) _________________________
Capillary refill (< 2 to 3 seconds) ________________ Color ____________________

Draw all lesions on the corresponding location of the anterior/posterior body:
Nursing Diagnosis:

Document Client Teaching and Client Response to Teaching:
Skin Self-examination: _______________________________________________________

_____________________________________________________________

Use of sunscreen

Client Teaching During Hair, Nail and Skin Assessment: _______________________

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

Student’s Name: __________________________________ Date: __________

**Biographical Data:**
Client’s Initials: ____________________ Age: ________ Sex: ________ Date: ________

**General Appearance:**
______________________________________________________

**Health History:**
Determine if client is experiencing joint- pain, stiffness, swelling, heat, contracture, or limited movement ________________.
Determine if client is experiencing muscle- pain (cramps) or weakness ________________.
Determine if client is experiencing bone- pain, deformity or trauma ________________.
Determine if client is involved in competitive sports, warms up adequately ________________.
Review history for osteoporosis risk factors (circle): heavy alcohol use, cigarette smoking, caffeine intake, constant dieting, calcium intake less than 500 mg daily, thin and light body frame, family history of osteoporosis, postmenopause, nulliparous, or is Asian, Caucasian or Native American, reported height loss, other ________________.
Determine ability to perform activities of daily living (ADL)/Functional Assessment: Any self-care deficit(s) in bathing______, toileting______, dressing______, grooming______, eating______, communicating______, mobility______, or use of mobility aids________________________?

Determine risk factors from self-care behaviors: Occupational hazards from heavy lifting ________________ and repetitive motion to joints ________________; Nature of exercise program ________________; & Recent weight gain______.

**Physical Assessment: Muscles, Joints, Ligaments, Tendons, and Bones:**

**INSPECTION:**
Ambulation/gait: ____________________ Posture: ____________________

**Bones:** from front to back to side
scapulae are even_______ chest A:P diameter(1:2 to 1:3)________________________
upper and lower extremities bony prominence(no evidence of redness)________
arms and legs of equal length________ pelvis is level(hip brims)________

**Spine** (straight spine with normal curvature seen from the side)________________________

**Muscles:** neck(aligned with shoulders, symmetry of skin folds)________________________

**Respiration** (12-20 breaths per minutes) _______ use of accessory muscles _______ breathing
effort(no ICS retractions or visible signs of respiratory distress)________

**Joints:** **Range of Motion**(full, active, without pain, swelling, or redness)____________
contractures________ crepitus with ROM________

**PALPATION**
Bones: shoulders, scapulae, iliac crests, arms, legs(symmetrical bilaterally)________
deformity __________ protrusions _______ masses________________________

**Muscles:** tenderness________ knots________ lesions_______ masses________

**Joints:** tenderness_______ swelling_______ warmth_______ redness________

**ROM** (moves freely, no crepitus)________ resistance to pressure________
Test ROM- ask the person to follow these motions:

  **Cervical Spine**(head and neck)
  ______ touch chin to chest(flexion 45 degrees)
  ______ lift the chin toward the ceiling(hyperextension of 55 degrees)
  ______ touch each ear toward the corresponding shoulder(lateral bending of 40 degrees) do not lift shoulder upward
  ______ turn the chin toward each shoulder(rotation of 70 degrees)________
**Upper Extremity**

(shoulder)
- With arms at sides and elbows extended, move both arms forward and up in wide vertical arcs (forward flexion of 180)
- Then move them back (hyperextension up to 50 degrees)
- Rotate arms internally behind back, place back of hands as high as possible toward the scapulae (internal rotation of 90)
- With arms at sides and elbows extended, raise both arms in wide arcs in the coronal plane (abduction of 180 degrees)
- Touch palms together above head (adduction of 50 degrees)
- Touch both hands behind the head, with elbows flexed and rotated posteriorly (external rotation of 90 degrees)

(elbows)
- Bend elbows (flexion of 150-160 degrees)
- Straighten elbows (extension of 0 degree + or - 5 to 10)
- Hold the hand midway, touch the front of hand to table (pronation 90)
- Then touch the back of hand to table (supination of 90)

(wrist and hand)
- Bend the hand up at the wrist (hyperextension of 70 degrees)
- Bend hand down at the wrist (palmar flexion of 90 degrees)
- Bend the fingers up and down at the metacarpophalangeal joints (hyperextension of 30 degrees)
- With palms flat on table, turn them outward (ulnar deviation of 50-60)
- Then turn palms inward (radial deviation of 20 degrees)
- Spread fingers apart (abduction of 20 degrees)
- Make a fist (fist tight and equal bilaterally)
- Touch the thumb to each finger and to the base of little finger (equal bil)

**Lower Extremity**

(hip)
- Raise each leg with knee extended (hip flexion of 90 degrees)
- Bend each knee up to the chest while keeping the other leg straight (hip flexion of 120 degrees)
- Flex knee and hip to 90 degrees, stabilize by holding the thigh with one hand and the ankle with the other hand, swing the foot outward (internal rotation of 40 degrees)
- Then swing the foot inwards (external rotation of 45 degrees)
- With the knee straight and stabilize pelvis by pushing down on the opposite anterior superior iliac spine, swing leg laterally (abduction 40)
- Then wing leg medially (adduction of 20-30 degrees)
- When standing, swing straight leg back behind body, stabilize pelvis to eliminate exaggerated lumbar lordosis (hyperextension of 15 degrees)

(knee)
- Bend each knee (flexion of 130-150 degrees)
- Extend each knee (a straight line of 0 degrees, some hyperextension of 15)

(ankle and foot)
- Point toes toward the floor (plantar flexion of 45 degrees)
- Point toes toward your nose (dorsiflexion of 20 degrees)
- Turn soles of feet out (eversion of 20 degrees)
- Turn soles of feet in (inversion of 30 degrees)
- Flex and straighten toes

(spine)
- Stabilize the pelvis with your hands, bend sideways (lateral bending 35)
- Bend backward (hyperextension of 30 degrees)
- Twist shoulders to one side, then the other (rotation of 30 bilaterally)
To Test Muscle Strength and Tone ask the person to perform the following maneuvers and grade each muscle according to Table 32-36 “Grading Muscle Strength”:

**Muscle Strength (Grade 1/5, 2/5, 3/5, 4/5 or 5/5)**

- **neck** (sternocleidomastoid)
  - place hand firmly against client’s upper jaw, ask client to turn head laterally against resistance
- **shoulder** (trapezius)
  - place hand over midline of client’s shoulder, exerting firm pressure, have client raise shoulders against resistance-shoulder shrug
- **elbow** (biceps)
  - pull down on forearm as client attempts to flex arm
- **elbow** (triceps)
  - as client’s arm is flexed, apply pressure against forearm, ask client to straighten arm
- **hip** (quadriceps)
  - when client is sitting, apply downward pressure to thigh, ask client to raise leg up from table
- **hip** (gastrocnemius)
  - client sits, holding shin of flexed leg, ask client to straighten leg against resistance

**Muscle Tone** (normal, hypertonicity or hypotonicity) ______________________

**Nursing Diagnosis:**

---

**Document Client Teaching and Client Response to Teaching:**

Follow measures to prevent or minimize osteoporosis: ______________________________

Follow measures to prevent injury from falls: _______________________________________

Client teaching to perform self-care measures: ________________________________

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

Health History:
Description of client’s sleep problem
Prior usual sleep pattern
Recent changes in sleep pattern
Bedtime routines and sleeping environment
Use of sleep and other prescription medications and OTC drugs

Pattern of dietary intake and amount of substances that influence sleep e.g. alcohol and/or caffeine
Symptoms experienced during waking hours
Concurrent physical illness
Recent life events
Current emotional and mental status

Questions to Ask to assess for Sleep Disorders:

Insomnia:
How easily do you fall asleep?______ How often do you have trouble sleeping?______
Do you fall asleep and have difficulty staying asleep?____ Do you awaken from sleep?____

Sleep Apnea:
Do you snore loudly?______ Do you experience headaches after awakening?______

Narcolepsy:
Do you fall asleep at inopportune times (reported by friends or relatives?)____
Are you tired during the day?____ Do you have episodes of losing muscle control?____

THE SMH SLEEP QUESTIONNAIRE

At what time did you:
1. Settle down for the night?
2. Fall asleep last night?
3. Finally wake this morning?
4. Get up this morning?
5. Was your sleep:
   light___
   average___
   deep___
6. How many times did you wake up?____
7. Last night?
8. During the day, yesterday?
9. How well did you sleep last night?
   bad____
   fair____
   well____
If not well what was the trouble?
10. How clear-headed did you feel getting up this AM?
    still drowsy____
    fairly clear-headed____
    alert____
11. How satisfied very you with last night’s sleep?
    very unsatisfied___
    fairly satisfied___
    very satisfied___
12. Were you troubled by waking early and being unable to get to sleep?
    yes___
    no___
13. How much difficulty did you have in getting to sleep last night?
    none___
    some___
    alot___
14. How long did it take to fall asleep last night?

Nursing Diagnosis

Documentation of Client Teaching
OXYGENATION: VENTILATION ASSESSMENT

Student’s Name: ___________________________ Date: __________________

Biographical Data:
Client’s Initials: ___________________ Age: ________ Sex: ________ Date: ________

General Appearance:

Health History: No Yes, explain
Do you have a cough?
What is the color of sputum, how much sputum?
Any shortness of breath, with exertion?
How many pillows to sleep, chair?
Any chest pain with breathing?
Any past history of lung disease?
Do you smoke? How many per day?
How many years?
Do any living or work conditions effect your breathing?
When was your last TB skin test, CXR, flu and pneumovax vaccine?
Do you have frequent colds, sinus problems?
Do you experience chronic hoarseness?
Review history for TB risk factors and for TB sign & symptoms
Review family history for Lung Cancer, TB, allergies, or COPD

Physical Examination: Thorax and Lungs

Inspection:
Thorax cage(A:P diameter, costal angle, trachea)_________________________
sternal and/or ICS bulging or retractions___________visible distress_____
Respiratory rate and pattern_________________________posture____________
Skin, mucous membranes(color)___________________________
Client’s position_______________________nails(color, angle)______________
Client’s facial expression_________________level of consciousness_________

Palpation:
Skin(temperature, moisture)_________________nails(capillary refill)____________
Respiratory Excursion(confirm symmetrical chest expansion)________________
Tactile fremitus____________________________crepitus__________lumps or masses__________tenderness
Trachea(midline)_________________________confirm Resp rate and pattern________

Percussion:
Determine percussion note that predominates over lung fields____________
Diaphragmatic excursion________________________

Auscultation: Use the Diagram on the next page to document your findings
Listen: posterior, lateral, anterior
Any adventitious sounds?_______________If so, perform bronchophony_____
egophony________________________and whisper pectoriloquy________
Diagnosis:

Document Client Teaching and Client Response to Teaching:
Describe warning signs of lung disease.
Recognize their need to receive influenza vaccine annually________when________, and pneumovax vaccine(1 time every 7 to 10 years)_________________________.
Identify when their next TB skin test is due/CXR________________________________.
Discusses measures to reduce or eliminate smoking.______________________________
Recalls ways to reduce risk factors for chronic lung disease and lung cancer.
Lists health prevention actions currently or will perform to reduce colds & sinus problems.

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

Student’s Name: ___________________________________ Date: __________________

Biographical Data:
Client’s Initials: ___________________ Age: ________ Sex: _______ Date: ________

General Appearance: _______________________________________________________

Health History:

Do you have any chest pain or tightness? Yes No
Do you experience any shortness of breath? Yes No
Do you use more than one pillow to sleep? Yes No
Do you have a cough? Yes No
Do you seem to tire easily? Yes No
How is your appetite? ______________________

Do you notice any changes in skin/nail color? Yes No
Any swelling in your feet or legs? Yes No
Do you awaken at night to urinate? Yes No
Assess for past history of heart disease.
Assess for family history of heart disease.
Determine cardiac risk factors:
Note Lipid panel: Total Cholesterol: ______ HDL: ______ LDL: ______ Glucose: ______

Physical Examination: Heart, Carotid, Blood Pressure, and Pulses

A. Carotid Arteries- Inspect and Palpate; note Grade Rt______ & Lt________ (0 = absent, 1+ = weak, 2+ = normal, 3+ = increased, 4+ = bounding)
   Auscultate carotid artery for a bruit; Rt______ & Lt________

B. Heart- Inspect and Palpate; note the location of the PMI________________
   Auscultation; note anatomic areas where you will listen.
   Note the Apical Pulse; Rate________ bpm Rhythm________
   Identify the S2 at the Aortic area, 2nd ICS Rt sternal border______
   Identify the S1 at the Mitral area, 5th ICS MCL________________
   Identify any extra sounds; S3________ or S4________
   Listen for murmurs in systole________ and diastole________________
   Listen for rubs________________ and for clicks________________

C. Peripheral Pulses- Palpate; note Grade for each artery
   Rt __________ Lt __________
   1. radial pulse
   2. ulnar pulse
   3. brachial pulse
   4. femoral pulse
   5. popliteal pulse
   6. dorsalis pedis pulse (DP)
   7. posterior tibial pulse (PT)

D. Pulse Deficit- Palpate the apical rate______, and then the radial rate______

E. Blood Pressure- Auscultate and note the blood pressure in each arm.
   Rt_____________________ and Lt_____________________
Heart Diagram- Identify S1 and S2 in diagram and note any variations at each area:

Nursing Diagnoses:

Document Client Teaching and client Response to Teaching:
Explain the risk factors for heart disease: high dietary intake of saturated fat & cholesterol, lack of regular aerobic exercise, smoking, excess weight, stressful lifestyle, hypertension, diabetes, past history of cardiac disease, or family history of cardiac disease.

Refer client (if appropriate) to resources to reduce or eliminate preventable risk factors.

Encourage client to continue to do the positive lifestyle habits that they are doing and to obtain regular check ups and Lipid panels.
Provide teaching about signs and symptoms of cardiac disease, current diagnostic testing and treatment regime (baby Aspirin every day) in collaboration with the client’s medical provider.

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

Student’s Name:_______________________________________ Date:_______________

Biographical Data:

Client’s Initials:_______________________ Age:__________ Sex:_______ Date:_______

General Appearance:

Health History: See Nutritional Health History, complete a copy of form & attach copy.

Food Intake- As compared to my normal, I would rate my food intake during the past month as either (check one):

unchanged____, more than usual____ or less than usual____.

Symptoms- During the past two weeks, I have had the following problems that kept me from eating enough (check all that apply):

no problem eating___, no appetite, just did not feel like eating ___, nausea___,
vomiting___, constipation___, mouth sores___, dry mouth___, diarrhea___,
pain___ (explain)__________________________,
things taste funny or have not taste___, smells bother me___, other___.

Functional Capacity- Over the past month, I would rate my activity as generally (check one):

normal with no limitations, not my normal; but able to be up & about__
not feeling up to most things, in bed less than half the day___, able to do little activity and spend most of the day in bed or chair___, bedridden__.

Diet Recall- Have the client write down every thing that they ate or drank in the last day.

(Attach a copy and calculate the number of servings in each food group)

Physical Examination: Mouth, Throat, and Metabolic System

1. Weight________ Height________ Body Mass Index (BMI)______________ How much did you weigh six months ago?________, two weeks ago?________
2. Vital Signs: Temperature________ HR________ RR________ BP____________
3. Quick P.E.: mouth________, gums________, teeth________, lips________, Loss of subcutaneous fat(triceps, chest)________, muscle wasting________, ankle/leg edema________, Eyes________, Hair_______, Nails_____

Determine Client’s Nutritional Status: Risk- Low____, Moderate___, or High____

and well nourished______, suspected malnourished______, or overnourished______

Ideal Body Weight(IBW)____________ For a child growth %______ wt/_______ ht

Nursing Diagnosis:

Documentation of Teaching and Client’s Response:

Adapted from Nutrition Screening Initiative in Jarvis, C., Physical Examination and Health Assessment Lab Manual, 2000, W.B. Saunders
NUTRITIONAL HEALTH INTERVIEW

I. Economics
   A. Income - frequency and steadiness of employment
   B. Amount of money for each week or month and individual’s perception of its adequacy for meeting food needs.
   C. Eligibility for food stamps and cost of stamps
   D. Public aid recipient? e.g. WIC Program (Woman, Infant, & Children)

II. Physical activity
   A. Occupation
   B. Exercise
   C. Sleep
   D. Disabilities

III. Ethnic or Cultural background
   A. Influence on eating habits
   B. Religion
   C. Education

IV. Home life and meal patterns
   A. Number in household
   B. Person who does shopping/cooking
   C. Food storage and cooking facilities
   D. Type of housing

V. Appetite
   A. Good, poor, recent changes
   B. Factors that affect appetite
   C. Taste and smell perception - recent changes

VI. Allergies or intolerance or food avoidance
   A. Foods avoided and reasons
   B. Length of time of avoidance
   C. Description of problems caused by foods

VII. Dental and oral health
   A. Problems with eating
   B. Foods that cannot be eaten
   C. Problems with salivation, swallowing, food sticking to mouth

VIII. Gastrointestinal Disease
   A. Problems with heartburn, bloating, gas, diarrhea, vomiting, constipation, distention
   B. Home remedies
   C. Antacids, laxatives, and other drugs

IX. Chronic disease
   A. Treatment - length of time
   B. Dietary modification e.g. low sodium - determine compliance

X. Medications
   A. Vitamins - type and frequency
   B. Prescribed Medications

XI. Recent weight change

XII. Dietary or nutritional problem as perceived by client
BASIC NEUROLOGY ASSESSMENT

Student’s Name: ___________________________________ Date: ____________________

Biographical Data:
Client’s Initials: ___________________________ Age: _______ Sex: _______ Date: _______

General Appearance:
________________________________________________________________________

Health History:

Do you have unusually severe headaches? No Yes, explain

How frequent do you have them?

Have you ever had an head injury? No Yes, explain

Do you ever feel dizziness? No Yes, explain

Have you ever experienced any seizures? No Yes, explain

Do you have any tremors in your hands or face? No Yes, explain

Have you ever had any weakness in a body part? No Yes, explain

Any problem with coordination? No Yes, explain

Do you have any numbness or tingling? No Yes, explain

Any problem with swallowing? No Yes, explain

Any problem with speaking? No Yes, explain

Past history of stroke, spinal cord injury, alcoholism, meningitis, congenital defect?

Any environmental/occupational hazards? No Yes, explain

Physical Examination:

T___________ P____________ R__________ BP____________

Orientation-time_________ , place__________ , person_________ , purpose______________

Level of Consciousness-Glasgow Coma Scale:

Pupils; size/reaction; Left_________ , Right_________

Eyes Open; spontaneously_____, to speech______, to pain______, none______

Motor Response; obeys commands_____, localize pain_____, flexion withdrawal_____,

flexion abnormal_____, extension______, none______

Response to AV; oriented_____, confused_____, inappropriate words______,

incomprehensible works______, none______, endotracheal tube or T______

Speech-_____________________________________________________________________

Circulation-pulses: radial___________ bil; pedal PT/DP___________ bil

Motor system-
muscles: size, strength, tone__________________________________________________

facial symmetry________________ hand grips________________

involuntary movements________________

cerebellar function(coordination)
gait ______________________ Romberg’s test____________________

Sensory system-spinothalamic tract:

superficial pain_________ temperature_________ light touch________________

Nursing Diagnosis(if applicable):

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

Student’s Name: ___________________________ Date: _______________

Biographical Data:
Client’s Initials: _________________________ Age: ________ Sex: _______ Date: ________

General Appearance: ______________________

Health History: __________________________ No Yes, explain
Have you experienced any frequency, urgency, or waking during the night to urinate?
Do you have pain, burning, or itching with urination?
Is your urine color cloudy or foul-smelling?
Do you have any problems controlling your urine?
Male client-Any difficulty starting urine stream?
Do you have any pain or sores on your genitals?
Are you having any penile or vaginal discharge?
Male client-Any lump in testicular self-exam?
    Do you perform regular testicular self-exam?
Female client-Any lump/changes in breast self-exam?
    Do you perform regular self breast examinations?
Are you in a relationship involving intercourse?
    Use a contraceptive(s)? Which one(s)?
Any contact with partner who has a sexually transmitted disease(STD)? History of STD?
Are you experiencing any flank pain?

Physical Examination:
Inspection:(normal bladder is not visible); urine __________ I/O: 8hr _____ 24 hr ______
Lower abdominal contour(flat, bulging) ________________________________
Light Palpation:(normally the bladder can not be palpated unless it is distended)
Lower abdominal above the symphysis pubis(any tenderness or pain; urge to void)_______
Percussion:(normally the bladder can not be percussed unless it is distended)
Lower abdominal above the symphysis pubis(any dull notes to percussion)______________
Indirect or direct percussion over the posterior chest below the scapular line for kidneys
Costovertebral(CVA) tenderness bilaterally(normal is no tenderness noted on percussion)

Client Teaching:
Male client-Teach testicular self-examination____________________________________
During Male Genitalia and Reproductive Tract Assessment_________________________
Female client-Teach breast self-examination_____________________________________
During Female Genitalia and Reproductive Tract Assessment________________________

Nursing Diagnosis:
ELIMINATION: BOWEL ASSESSMENT

Student’s Name: ____________________________________________ Date: __________

Biographical Data:
Client’s Initials: __________________________ Age: __________ Sex: ________ Date: __________

General Appearance:

Health History:

Do you have a change in your appetite? ____________
Has your weight changed recently? Last year? ____________
Are you experiencing difficulty swallowing? ____________
Are there any foods you can’t tolerate? ____________
Do you have any abdominal pain? ____________
Do you have nausea or vomiting? ____________
How often are your bowel movements? ____________
    Usual color? Hard or soft? ____________
Have you ever had black or bloody stools? ____________
Have you experienced any rectal itching, pain or hemorrhoids? ____________
How much high fiber foods do you eat? ____________
Do you eat a high saturated fat diet? ____________
What medications, vitamin, herbs do you take? ____________
Have you received all 3 Hepatitis B vaccines? ____________
Do you have any past history of GI disease? ____________
Have any family members had colon/rectal cancer or polyps? History of GI disease? ____________
When appropriate post-operative or GI illness Are you experiencing flatus? ____________

Physical Examination:

Inspection: Contour of abdomen ___________________ General symmetry ___________________
Skin color & condition ___________________ Pulsation/movement ___________________
Umbilicus ___________________ State of hydration and nutrition ___________________
Person’s facial expression and position in bed ___________________

Auscultation: (order RLQ, RUQ, LUQ, LLQ) ___________________
Bowel sounds in all four quadrants ___________________

Palpation: (note: watch client’s face and not your hands) ___________________
Abdomen wall soft, taut, distended, hard or board-like stiff ___________________
Light palpation of all four quadrants for tenderness ___________________
Rebound tenderness ___________________ If ascites suspected fluid wave ___________________

Client Teaching: Reduction of risk factors for colon/rectal cancer ___________________
During Abdomen Assessment ___________________
During Rectal and Anal Assessment ___________________

Nursing Diagnosis:

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

I. Self-Concept (This pattern pertains to the client’s view of self, including identity, body image, role performance and self-esteem).

   Note Stage of Erikson’s Psychosocial Theory of Development

A. Self-concept Components

   1. Identity
      How does the person describe personal characteristics?
      “How would you describe yourself?”
      a. Self-consistency
         How I’m doing, View of self in relation to actual performance or response to situations?
         Does the client’s description of self match their “Ideal self”
      b. Sexuality (This pattern pertains to the client’s sexuality patterns and activities and reproductive patterns.)
         Assess client’s perception of sexuality and reproductive history
         How does one verbalize sexual desire?

   2. Body Image
      “What aspects of your appearance do you like?”
      “Are there any aspects of your appearance that you would like to change?” Client states, “I need to lose weight.
      Note if client’s description is distorted, positive, or negative

   3. Role Performance (This pattern pertains to the client’s roles in life, and relationships with family members, peers, and the community).
      “Tell me about your primary roles.”
      “How effective are you at carrying out each of these role?”
      a. Role Function
         1. Primary Role- age, sex, developmental level
         2. Secondary Role-work, sick role, assumed roles
         3. Instrumental and Expressive Behaviors-is the client able to perform goal-oriented behaviors associated with his or her roles?
      b. Interdependence
         1. Significant Others
            Who is most concerned about you?
            Does the client have close relationship with others
         2. Support System
            Who do you turn to for support?
            Does the person verbalize feeling of being alone!

   4. Self-esteem (This pattern pertains to the client’s overall sense of self-worth or the emotional appraisal of self-concept).
      “Tell me about the things you do that make you feel good about yourself.”
      “How do you feel about yourself?”

B. Self-concept Stressors (is any real or perceived change that threatens identity, body image, or role performance).
1. Identity confusion—results when a person does not maintain a clear, consistent, and conscious awareness of personal identity.

2. Body Image—changes in appearance, structure, or function of a body part requires an adjustment in body image.

3. Role conflict—results when a person is required to simultaneously assume two or more roles that are inconsistent, contradictory, or mutually exclusive.
   a. sick role
   b. Role ambiguity
   c. Role strain
   d. Role overload

II. Stress and Coping (This pattern pertains to the level of stress in a client’s life and the ability to cope with that stress.)

A. Stress
   1. “What stressful events or changes have occurred in your life in the past year?”
   2. “What causes your stress everyday?”
   3. “How does your body respond to stress?” (e.g. headaches, stomach problems, anxiety, skin changes.)

B. Coping Patterns
   1. How does the client cope with major stress?
   2. How did they cope with past stress?
   3. How does the client cope with everyday stress
      a. problem solving
      b. support
      c. stress management techniques (e.g. relaxation, self-talk, etc.)
      d. use of medications, drugs (including nicotine, caffeine, and alcohol—type, amount, frequency/pattern, length of use and past history)
      e. Other (e.g. avoid, anger, counseling, etc.)

C. Does the client have a history of current or past mental illness/psychiatric history
   1. suicidal thoughts
   2. depression
   3. hallucinations/altered thought
SAMPLE QUESTIONS FOR AN ENDOCRINE HEALTH HISTORY INTERVIEW

Do you feel tired, lethargic, or weak?
Have you noticed any muscle twitching?
Do you feel any numbness or tingling in your arms or legs?
Have you recently unintentionally, gained or lost weight?
Have you recently experienced changes in your moods?
Have you noticed an increase in your urine output?
Have you noticed an unusual or increase in your thirst?
Do you often feel hot or cold when others in the same environment are comfortable?
Have you ever had radiation treatments?
Have you ever had a brain disorder?
What was your growth pattern; were you considered tall or short for your age?
Have you ever been diagnosed with a “glandular” problem?
Does anyone in your family have diabetes?
Does anyone in your family have thyroid disease?
Do you bruise more easily than you used to?
Have you noticed any change in the amount and distribution of your body hair?
Have you noticed an increase in the size of your hands or feet?
Has your voice deepened or otherwise changed lately?
Are you experiencing any visual problems?
Have you ever felt as though your heart was racing, even when you hadn’t been exerting yourself?
Do you often experience constipation or diarrhea?
Has your appetite increased or decreased recently?
Do you every feel depressed for no particular reason?
Section V

Nursing Care Plan Forms

1. Clinical Data Collection Sheet
2. Nursing Care Plan Cover Sheet
3. Nursing Process
4. Medication List
5. Laboratory and Diagnostic Test Results
6. Patient Care Worksheet
7. Student Organization
Clinical Date_________________ Student Name__________________________________________
Facility_________ Unit_________ Room_______ Patient’s Initals______ M/F__________ Age______
Admission Date____________ Language____________________ Occupation________________
Code Status___________ Allergies_______________________ Height________ Weight_______
Medical Diagnosis_______________________________________________________________
Surgery: Date_____ Procedure_____________________________________________________
Past Medical History_____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
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Vital Signs Frequency___________ Vital Signs MD Parameters___________________________
Vital Signs Frequency___________ Vital Signs MD Parameters___________________________

*Preprinted Orders*

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<td>Procedures/Treatments</td>
<td>Labs/tests</td>
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Nursing Care Plan Cover Sheet

Student Name ___________________ Clinical Date ___________ Patient’s Initials __________ Facility ________ Unit ________ Room ________

Medical Diagnosis: __________________________________________________________________________________________________________________________________________

Description of Main Medical Problem and/or Surgical Procedure (include definition of disease process, usual signs and symptoms, laboratory and diagnostic tests, usual medical and/or surgical treatment). ____________________________________________________________________________________________________________________________________________________________

Past Medical History __________________________________________________________________________________________________________________________________________

Nursing Diagnosis

1. ____________________________________________________________________________________________
2. ____________________________________________________________________________________________
3. ____________________________________________________________________________________________

Potential Complication/Collaborative Problems (problems requiring collaboration with an MD or MD’s orders):

1. ____________________________________________________________________________________________
2. ____________________________________________________________________________________________
3. ____________________________________________________________________________________________

Patient Teaching Needs

1. ____________________________________________________________________________________________
2. ____________________________________________________________________________________________
3. ____________________________________________________________________________________________

Student Learning Focus

1. ____________________________________________________________________________________________
2. ____________________________________________________________________________________________
3. ____________________________________________________________________________________________
Nursing Care Plan Cover Sheet

Student Name_________________ Clinical Date___________ Patient’s Initials__________ Facility________ Unit ______ Room________

Medical Diagnosis:_______________________________________________________________________________________

Description of Main Medical Problem and/or Surgical Procedure (include definition of disease process, usual signs and symptoms, laboratory and diagnostic tests, usual medical and/or surgical treatment). ______________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Past Medical History________________________________________________________________________________________
____________________________________________________________________________________________________________

Nursing Diagnosis
1.____________________________________________________________________________________________________ ...

Potential Complication/Collaborative Problems (problems requiring collaboration with an MD or MD’s orders):
1.____________________________________________________________________________________________________
2.____________________________________________________________________________________________________
3.____________________________________________________________________________________________________

Patient Teaching Needs
1.____________________________________________________________________________________________________
2.____________________________________________________________________________________________________
3.____________________________________________________________________________________________________

Student Learning Focus
1.____________________________________________________________________________________________________
2.____________________________________________________________________________________________________
3.____________________________________________________________________________________________________
Nursing Diagnosis

R/T (cause(s) including pathophysiological, maturational, situational, treatment related):

M/B (signs and symptoms of the problem, not signs and symptoms of the cause of the problem):

Goals or Outcomes: Criteria for Evaluating Success of Intervention and Patient’s Progress:

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<th>Interventions</th>
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Nursing Diagnosis ____________________________________________________________

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__________________________________________________________________________
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M/B (signs and symptoms of the problem, not signs and symptoms of the cause of the problem):
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Goals or Outcomes: Criteria for Evaluating Success of Intervention and Patient's Progress:
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NE 135 L Patient Care Worksheet

Room #__________

Patient Name (first initial and 3-4 letters of last name): _________________________________

Admitting Dx: _________________________________________________________________________

Diagnosis Today: _______________________________________________________________________

Hx: __________________________________________________________________________________

Code Status: ______________________________

Allergies: ________________________________

Precautions: Fall, Skin; Contact, Airborne, Droplet

FSBS 0700: ______________________________ FSBS 1200: ________________________________

VS/Pain/O2 Sat 0700: _____________________ VS/Pain/O2 Sat 1200: _________________________

Tubes/Drains: _______________________________________________________________________

Intake: ____________________________________ Output: _____________________________

Diet Type: __________________ % Eaten Bkfst ________ %e Eaten Lunch: ________

IV Solution(s) and rate: ______________________

IV Site(s)/Gauge: ________________________ IV Dressing or Site Change Due: ____________

O2: ______________________________________ Resp Tx/Frequency: _______________________

Activity: __________________________________________________________

Treatments/Dressing Changes: ________________________________________________________

Diagnostic/Laboratory Tests: ____________________________________________________________________
### Laboratory and Diagnostic Test Results

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## Laboratory and Diagnostic Test Results

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Section VI

Clinical Evaluation Form
Level I Clinical Evaluation Tool
NE 135L

Student’s Name: ________________________  Instructor’s Name: ________________________

Clinical Agency: ________________________  Date: _____  Semester: _____  Year: _______

Absences: _______________________________  Tardies: _________________________________

Pediatric Hours: Practical________________   Observed______________________________

Grade (Pass/Fail):____________

Instructor’s Comments

Student’s Comments

Student’s Signature          Date

Instructor’s Signature         Date

Rating Scale

S = Satisfactory  Meets clinical performance objectives at a level commensurate with theory and experience with the program. Functions adequately with moderate direction and guidance. Consistently meets all clinical performance objectives. Seeks assistance when needed and benefits from constructive criticism.

N = Needs Improvement  Is displaying difficulty in meeting clinical performance objectives level commensurate with theory and experience in the program. Needs guidance and detailed instruction. Is unable to consistently apply theory to practice.

U = Unsatisfactory  Exhibits behavior which endangers self, the patient or others. Is deficient in meeting clinical objectives at a level that is commensurate with theory and experience with the program. Is unable to demonstrate improvement with constant guidance and detailed instruction. Is unable to consistently apply theory to clinical practice.

N/R = Not Rated

In order to receive a grade of Credit for this course, all grades must be satisfactory or Needs Improvement. Any grade of Unsatisfactory will result in a grade of Fail of the course.
### Behaviors

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<th>U</th>
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<td>2. Notifies instructor prior to clinical assignment when unable to attend.</td>
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<td>3. Dress and grooming are appropriate to clinical setting.</td>
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<td>4. Exhibits responsibility for attendance and participation in the clinical conference.</td>
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<td>5. Arrives to clinical having completed pre-lab and written care plan</td>
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<td>B. Demonstrates behaviors which reflect accountability.</td>
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<td>1. Reports and introduces self to appropriate person upon arrival and departure from the clinical unit.</td>
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<td>2. Informs the instructor and appropriate staff member when unable to complete care.</td>
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<td>3. Recognizes limitations in knowledge and skills by seeking appropriate guidance from RN or instructor.</td>
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<td>4. Seeks learning experiences to meet course objectives utilizing instructor, staff, and other resources.</td>
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<td>5. Evaluates own performance using the clinical objectives and clinical evaluation tool.</td>
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<td>Caring</td>
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<td>A. Demonstrates caring behaviors appropriate to the role of the RN.</td>
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<td>1. Establishes and maintains therapeutic relationships with clients and families.</td>
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<td>2. Offers emotional support based on the developmental level of the client and is inclusive of significant others.</td>
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<td>3. Demonstrates caring by providing comfort measures that are age appropriate and culturally sensitive.</td>
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<tr>
<td>A. Assesses the physiological, psychological, psychosocial, cultural, and spiritual needs of the individual.</td>
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<tr>
<td>2. Updates the care plan in response to the patient’s changing condition.</td>
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<tr>
<td>3. Conducts a nursing assessment and health history and performs a basic examination to determine causalities and establish a database about and individual’s perceived needs, health problems, and responses.</td>
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<td>4. Assesses age-appropriate growth and development needs of assigned patients.</td>
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<td>5. Completes comprehensive written care plan assignments on time.</td>
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<td>B. Identifies defining characteristics to confirm or rule out a nursing diagnosis.</td>
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<tr>
<td>1. Lists, discusses, and prioritizes appropriate nursing diagnoses, causes, and signs and symptoms</td>
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<tr>
<td>C. Determines expected outcomes appropriate to the nursing diagnoses for patients and families.</td>
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<tr>
<td>1. Sets specific and individualized client goals and expected outcomes of care.</td>
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<td>D. Plans nursing interventions based on assessment, nursing diagnoses, and plan of care.</td>
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<tr>
<td>1. Utilizes fundamental nursing knowledge.</td>
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<td>E. Evaluates the effectiveness of nursing interventions.</td>
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<td>1. Identifies the client’s ability to implement self-care.</td>
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<td>2. Describes and documents the effectiveness of nursing interventions.</td>
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<tr>
<td>3. Discusses evaluation measures used to determine a client’s progress toward goals of care and outcome criteria.</td>
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<td>4. Documents evaluations related to patient care goals and expected outcomes.</td>
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<tr>
<td>Therapeutic Nursing Interventions and Comprehensive Nursing Care</td>
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<tr>
<td>A. Thoroughly prepares for clinical assignment</td>
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<tr>
<td>1. Demonstrates application of learned theoretical principles to patient care assignment.</td>
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<tr>
<td>2. Explains client’s medical diagnosis and treatment plan.</td>
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<td>3. Explains purpose of common laboratory and diagnostic procedures utilized in treatment plan.</td>
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<td>4. Discusses relevant patient data with RN and/or instructor prior to beginning care.</td>
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<td>5. Explains indications for and common side effects of patient’s medications.</td>
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<td>6. Adapts to changes in assignment.</td>
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B. Gives complete nursing care in a systematic and organized manner.

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<td>1.</td>
<td>Identifies priorities in the care of at least one patient.</td>
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<td>2.</td>
<td>Provides total nursing care for assigned patient including stating rationale for nursing interventions based upon scientific principles.</td>
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<td>3.</td>
<td>Ensures the safety of the patient and the care environment.</td>
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<td>4.</td>
<td>Ensures that treatments, procedures, and equipment that are ordered and/or needed for patient are being provided.</td>
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<td>5.</td>
<td>Accurately assesses and reports/documents VS, including pain, at appropriate times, and initiates appropriate follow-up.</td>
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<td>6.</td>
<td>Accurately performs FSBS, documents/reports findings, and initiates follow-up.</td>
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<td>7.</td>
<td>Provides patient with appropriate hygiene and toileting.</td>
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<td>9.</td>
<td>Ensures that patients receive correct diet and required assistance with feeding, and maintains patient swallowing and safety precautions.</td>
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<td>10.</td>
<td>Utilizes safe ambulating/transferring techniques, and observes prescribed patient activity precautions.</td>
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<td>11.</td>
<td>Accurately monitors, reports, and documents intake and output.</td>
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<td>12.</td>
<td>Implements appropriate measures to protect skin.</td>
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<td>13.</td>
<td>Provides prescribed wound care utilizing appropriate clean or sterile technique.</td>
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<td>C. Demonstrates clinical competency.</td>
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<td>1.</td>
<td>Maintains patient safety at all times.</td>
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<td>2.</td>
<td>Identifies and applies theoretical nursing principles in performing nursing procedures.</td>
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<td>3.</td>
<td>Develops the knowledge and technical skills needed to safely, efficiently, and effectively perform nursing procedures.</td>
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<td>D. Prepares and administers pharmacological agents in a knowledgeable, methodical, competent manner.</td>
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<td>1.</td>
<td>Passes nursing program pharmacology course (NE 138) medication dosage calculation exam with a score of 90% or above.</td>
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<td>2.</td>
<td>Passes appropriate medication administration skills check-off prior to administering medications by that route in the clinical setting.</td>
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<tr>
<td>3.</td>
<td>Accurately calculates medication dosages in the clinical setting.</td>
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<td>4.</td>
<td>Researches the actions, routes of administration, dosages, side effects, toxicity, and nursing implications of medications prior to administration.</td>
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<td>5.</td>
<td>Follows the facility policy and procedure for preparing, administering, and documenting medications.</td>
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<td>6.</td>
<td>Utilizes the “6 Rights ” of medication administration.</td>
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<td>7.</td>
<td>Prepares and administers medications utilizing precautions for infection control and maintenance of asepsis and sterility.</td>
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<td>8.</td>
<td>Prepares and administers medications in the presence of the instructor or an RN.</td>
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<td>9.</td>
<td>Performs patient assessments and reports findings to patient’s RN and/or nursing instructor prior to administering medications.</td>
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<td>10.</td>
<td>Utilizes two appropriate patient identifiers when administering medications.</td>
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<tr>
<td>11.</td>
<td>Administers medications utilizing the appropriate medication administration techniques.</td>
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Patient Teaching

A. Provides informal health teaching to patient/family/significant others while providing care (e.g., while assessing vital signs or performing other physical assessments, or administering medications or other treatments).

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<td>1.</td>
<td>Accurately explains medications, treatments, and procedures to patients at a level they can understand prior to administering them.</td>
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<td>2.</td>
<td>Provides timely, accurate response to patient’s/family’s/significant others’ questions, seeking additional reliable resources and references as necessary.</td>
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<td>3.</td>
<td>Participates in discharge teaching.</td>
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B. Provides formal health teaching to patients and family/significant others

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<td>1.</td>
<td>Utilizes the nursing process when engaging in patient teaching.</td>
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<td>2.</td>
<td>Applies teaching/learning principles in teaching and evaluating learning with patients, families/significant others, and members of the health care team.</td>
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3. Initiates health teaching referencing appropriate teaching plans.

**Communication**
A. Communicates in a professional manner with members of the health care team.

1. Introduces self to RN and other nursing team members at the beginning of the shift.
2. Initiates communication with appropriate health care team members and communications are understood by staff and peers.
3. Communicates ideas and information precisely, utilizing appropriate medical terminology.
4. Demonstrates characteristics of a team player, offering help to staff and fellow students.

B. Receives and reports necessary information related to assigned patients.

1. Meets with appropriate persons and gets pertinent information at beginning of shift. Clarifies information regarding patient care when necessary.
2. Reports changes in patient’s condition to patient’s RN and nursing instructor.
3. Updates instructor periodically regarding patient assignment.
4. Gives complete report to appropriate staff member prior to the end of the shift.

C. Utilizes therapeutic communication with patients and families.

1. Utilizes therapeutic communication skills to promote the nurse-client and nurse-family relationship.
2. Utilizes therapeutic communication that is age appropriate and culturally sensitive.

D. Provides accurate, complete, timely documentation.

1. Documents according to agency’s and instructor’s guidelines.
2. Charts vital signs and nursing care within prescribed time frame.
3. Updates and/or completes all charting before leaving nursing unit.
4. Documents all medications given on the MAR.

**Leadership/Management**
A. Demonstrates understanding and utilization of hospital and nursing unit informational and care delivery systems and routines.

1. Describes the roles and functions of members of the health care team.
2. Establishes appropriate working relationships with members of the health care team.
3. Manages care for clients, prioritizing and coordinating aspects of care with instructor and staff.
4. Develops a basic time management system for providing care within time frame allowed.

B. Demonstrates qualities of leadership and life-long learning.

1. Advocates for patient’s comfort and safety.
2. Demonstrates inquisitiveness and truth-seeking, independently and systematically going beyond minimum requirements to increase breadth and depth of knowledge and continually update practice.
3. Identifies clinical situations which can lead to problems with patient safety or medical errors and works with instructor and staff to correct them.

**Ethical/Legal Scope of Practice**
A. Practices in a manner consistent with legal and ethical guidelines.

1. Follows Code of Student Conduct for the College of Marin
2. Follows the policies and procedures of the College of Marin RN program
3. References and works within the policies and procedures of the clinical agency
5. Exhibits honest communication with instructor, staff, and peers.
6. Demonstrates concern and respect for patient and families whose culture, values, and/or behaviors differ from those of the student.
7. Recognizes and reports to instructor quality of care client issues/problems and unsafe practices.