



CENTRAL OREGON COMMUNITY COLLEGE

2015-2016 Nursing Program

NURSING FACULTY

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NUR 106

Course Syllabus

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COURSE TITLE: Nursing I
COURSE NUMBER: NUR 106, CRN: 40633
COURSE DATE: Fall Term, 2015
COURSE LOCATION: HCB 330 or as indicated on the course calendar

INSTRUCTORS:

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COURSE DESCRIPTION:

This course introduces fundamental concepts of nursing practice including nursing process, critical thinking, therapeutic communication, grief, loss, and cultural considerations. Students will have opportunity to begin learning about clients with altered states of health. Students will become familiar with the major drug classifications and develop a working knowledge of pharmacological principles. The clinical skills lab focuses on a core set of beginning level nursing skills. The clinical practicum provides students with the opportunity to apply knowledge and clinical skills to the adult client with basic nursing care needs. First term of the practical nurse sequence and of the nursing program.

Credits: 11 Lecture: 6 Clinical and Lab Practicum 5

PRE-REQUISITE/PROGRAM:

Admission to the Nursing Program. Nursing students are required to provide photocopies to the Nursing Department with documentation of the required immunization, tests, and Healthcare Provider CPR. (*See Nursing Program Acceptance Letter*) Documentation must be received by the department secretary by the date in the admission letter. **Any student not turning in the required documentation on time will forfeit his/her seat in the program to a student on the waiting list. NO EXCEPTIONS.** Strongly recommended: Computer and reliable internet access.

COURSE OUTCOMES:

As Provider of Care:

Apply assessment step of nursing process and meet basic care needs for one patient.

As Manager of Care:

Organize and deliver basic nursing care to one patient

As Communicator:

Communicate therapeutically with individual patients and families

As Teacher:

Reinforce medication teaching to all assigned patients from established standards

As Member within the Discipline of Nursing:

Identify ethical and legal principles for nursing practice.

INSTRUCTIONAL METHODS:

This course is taught using a variety of instructional methods including lecture, class discussions, small group work, Blackboard learning activities, and practicum experiences.

TEXTBOOK & MATERIALS

Required Textbooks:

- Adams, M. P., Holland, L. N., & Urban, C.Q. (2014) *Pharmacology for Nurses a Pathophysiologic Approach* (4th ed.). Boston, MA: Pearson.
- Drug Calculations Online (1st ed.). St. Louis, MO: Mosby Elsevier. *[This is an instructor led course. Must order through the COCC bookstore **only**. Please wait to register until after Advanced Orientation]*
- Ignatavicius, D. D. & Workman, M. L. (2013). *Medical-Surgical Nursing: Patient Centered Collaborative Care*. (7th ed.). St. Louis MO. Elsevier Saunders
- Perry, S.E., Hockenberry, M.J., Lowdermilk, D.L., and Wilson, D. (2014) *Maternal Child Nursing Care*, (5th ed.). St. Louis, MO: Mosby Elsevier.
- Perry, A. G., Potter, P. A. W. (2014). *Nursing Skills On-line Version 3.0 (User Guide and Access Code*, (8th ed.). St. Louis, MO: Mosby Elsevier. ISBN: 978-0-323-28791-3 *[This is an instructor led course. Must order through the COCC bookstore **only**. Please wait to register until after Advanced Orientation.]*
- Potter, P. A., Perry, A. G., Stockert, P. A., and Hall, A. (2015). *Essentials for Nursing Practice*, (8th ed.). St. Louis, MO: Mosby Elsevier.

Required Supplies:

- Stethoscope, pen light, bandage scissors
- COCC Course pack: Syllabus for NUR 106 Theory and Clinical, Syllabus for NUR 106 LRC, LRC Student Manual, Nursing Program Student Handbook, Nursing Program Technical Standards and Progression Policies
- LRC Lab Coat: white. Needed by **October 1st**. Available at the COCC Bookstore. Special sizes can be ordered and obtained within 4 days. Before you buy, check with Siobhan for one from the used rack in LRC at a reduced cost.
- LRC Nursing Student Supplies, *see LRC Coordinator*
- Nursing Student Uniform: green top & pants needed by **October 20th available** at the COCC Book store. Special sizes can be ordered and obtained within 4 days. ***Uniform color must match COCC bookstore shade of green.***

Recommended:

- NCLEX-PN or RN review book
- Medical Dictionary

COURSE CONTENT AND HOURS

COURSE LECTURE TOPICS: 60 CONTACT HOURS

Exams: *8 hours*

As Provider of Care: *30 hours*

- Holistic Approach to Care: Self-Concept, Sexuality, and Spirituality- *2 hours*
- Holistic Approach to Care: Growth and Development- *2 hours*
- Foundations of Nursing Practice: Pain Management- *2 hours*
- Nursing Care of the Patient with Cardiovascular Alterations- *4 hours*
- Holistic Approach to Care: Stress and Coping- *2 hours*
- Foundations of Nursing Practice: Care of the Older Adult- *2 hours*
- Nursing Care of the Patient with Peripheral Vascular Disease- *4 hours*
- Nursing Care of the Patient with Musculoskeletal Disorders- *4 hours*
- Holistic Approach to Care: Cultural Considerations- *2 hours*
- Foundations of Nursing Practice: Cancer Principles- *2 hours*
- Holistic Approach to Care: Grief and Loss- *2 hours*
- Foundations of Nursing Practice: The Surgical Patient- *2 hours*

Pediatric Module: *2 hours*

- Nursing Care of the Pediatric Patient: Child Abuse -*2 hours*

As Provider of Care/Pharmacology: *10 hours*

- Introduction to Pharmacology Concepts- *2 hours*
- Nursing Management for Pharmacology Related to:
 - Pharmacology Across the Lifespan- *1 hour*
 - Lipid Disorders- *1 hour*
 - Cardiovascular Disorders- *1 hour*
 - Hypertension- *1 hour*
 - Bone and Joint Disorders- *1 hour*
 - Coagulation Disorders- *1 hour*
 - Pain Control, Migraines and Anesthesia- *2 hours*

As Communicator: *2 hours*

- Foundations of Nursing Practice: Therapeutic Communication- *2 hours*

As Member within the Discipline of Nursing: *8 hours*

- Introduction to Nursing Practice- *2 hours*
- The Nursing Process- *4 hours*
- Professional Concepts: Ethics and Legal Considerations- *1 hour*
- Professional Concepts: Scope of Practice- *1 hour*

COURSE LEARNING RESOURCE CENTER TOPICS: 60 CONTACT HOURS

Course Orientation: *2 hours*

Open Supervised Practice Lab: *12 hours*

- **Week One:** *2.5 hours*
- **Week Two:** *3.5 hours*
- **Week Three:** *2 hours*
- **Week Eight:** *2 hours*
- **Week Ten:** *2 hours*

As Provider of Care:

Physical Assessment Module

- **Instruction:** *8 hours*
- **Coaching:** *5 hours*
 - Respiratory System
 - *Instruction- 2 hours*
 - *Coaching- 1.25 hours*
 - Cardiovascular System
 - *Instruction- 2 hours*
 - *Coaching- 1.25 hours*
 - Neurological and Gastrointestinal Systems
 - *Instruction- 2 hours*
 - *Coaching- 1.25 hours*
 - Assessments: Putting it all together
 - *Instruction- 2 hours*
 - *Coaching- 1.25 hour*

Nursing Interventions-

- **Instruction-** *3 hours*
- **Coaching-** *12.75 hours*
 - Safe Lifting Module:
 - *Instruction- 1 hour*
 - *Coaching- 2 hours*
 - Medication Module:
 - Safe Medication Administration
 - *Instruction- 1 hours*
 - *Coaching- 1.25 hours*
 - Drawing Up Medications from a Vial/Ampule
 - *Coaching- 1.25 hour*
 - Administering Oral Medications
 - *Instruction- ½ hour*
 - *Coaching- 1.25 hour*
 - Administering Subcutaneous Injections- Single Dose Insulin/Flexipens
 - *Coaching- 1.5 hours*
 - Administering Non-parenteral Medications
 - *Coaching- 1.25 hour*
 - Testing for Occult Blood and Testing for Capillary Blood Glucose Levels
 - *Coaching – 1.25 hours*
 - Wound Module:
 - *Instruction- ½ hour*
 - *Coaching- 3 hours*

Nursing Math: 10 hours

- Orientation to on-line Math program: 0.75 *hours*
- Instruction: 1.25 *hours*
- Practice: 6 *hours*
- Medication Math Competency Exams:- 2 *hours*

Online Nursing Skills: 5.25 hours

- Orientation: 0.5 *hours*
- On-line Modules: 4.75 *hours*

Library Resources: Life beyond Google

- Instruction: 1 *hour*

Surgical Orientation – 1 hour

COURSE CLINICAL EXPERIENCES: 90 CONTACT HOURS

As Provider of Care:

- **Orientation- 8 hours**
 - Clinical Preparation and Reflections- 2 *hours*
 - Electronic medical records- 2*hours*
 - Hospital setting- 2 *hours*
 - SCHS Mandatory Education – 2 *hours*
- **Clinical Communication Concepts- 2 hours**
 - Professional Boundaries- 1 *hour*
 - Safe Clinical Environment- 1 *hour*
- **Clinical Competency: Physical Assessment Module: Initial and Ongoing Focused Assessments – 1 hour**
- **Patient Care- 71.5 hours** 4 – 8 hour days
5 – 6 hour days
1—3 hour School Vision Testing Training
1—3.5 hour Darkness to Light Training
3 hours patient research
- **Simulation- 7.5 hours**
 - Orientation- 1 *hour*
 - Preparation – 1 *hour*
 - Coaching Session- 1.5 *hours*
 - Open Supervised Practice Lab- 1 *hour*
 - SIMULATION Experience- 3 *hours*

ASSESSMENT

Determination of the Course Grade

The course grade is determined by the student's performance in the theory, assignments, clinical practicum, and lab practicum components of the course. If a single component of the course is failed the entire course is failed. Specifically, if the theory; or combined theory and assignments; or clinical practicum; or lab practicum component of the course is failed; or a specific identified assignment is failed (E.g. ProCalc), the whole nursing course is failed. The course will need to be retaken in its entirety upon re-admission into the Nursing Program.

Nursing Course Grades are computed as follows:

92.55 - 100%	= A
89.55 - 92.54%	= A-
86.55 - 89.54%	= B+
81.55 - 86.54%	= B
79.55 - 81.54%	= B-
76.55 - 79.54%	= C+
≤76.54%	= D

Weighting of the Course Grade

Theory Grade: (worth 70% of overall course grade)

	<u>Weight</u>
• Five midterm exams	75%
• Final Exam	<u>25%</u>
	100%

Assignment Score: (worth 30% of overall course grade)

	<u>Weight</u>
• Professional Issues Assignment	10%
• Ethics Assignment	20%
• Wellness Log	10%
• Communication Assignment	20%
• Patient Care Preparation and Clinical Reflection	<u>40%</u>
	100%

Practicum Grades:

	Pass / No Pass
• Clinical: Pass/No Pass	
• Learning Resource Center: Pass/No Pass	
• Medication Math Competency Exam: Pass/No Pass	

Overall Course Grade:

	<u>Weight</u>
Theory Score	70%
Assignment Score	30%
Practicum	Pass/No Pass

COURSE GRADE REQUIREMENTS

Theory:

The theory score is generated from student performance on exams relating to the lectures and independent learning activities for the theory component of the course; and standardized tests. Theory must be passed at $\geq 76.55\%$ in order to pass the nursing course. The combined grade of theory and assignments will be calculated after it has been determined that the student has passed theory. The theory portion is worth 70% and the assignments are worth 30% of the combined grade.

Please note:

Students must pass theory at $\geq 76.55\%$ or 77% to pass the nursing course. If theory is failed, the score received in theory will be assigned as the overall course grade. No other scored assignments will be factored into the calculation of the final grade.

Assignments:

The assignment score is generated from student performance on course assignments related to theory and/or practicum. All assignments must be completed and turned in order to pass the nursing course. For late work, please see the *Nursing Program Student Handbook: Submission of Written Work Policy*.

Please note:

Student must achieve an overall assignment score of $\geq 76.55\%$ to pass the nursing course.

The following individual written assignment must be passed at 77% in order to pass NUR 106:

- *Patient Care Preparation and Clinical Reflection Assignment*

If the student receives a No Pass on this assignment or the overall assignment score, the student will fail the course and receive a D grade = 76.54%, and will not progress to the next nursing course.

Medication Math Competency Exam:

Purpose: Demonstrate competency in medication math skills necessary for safe patient care at the NUR 106 level.

Requirements:

- The medication math competency exam must be passed at a $\geq 90\%$.
- Medication math competency exam is graded as pass/no pass for the course and is part of the overall course grade.
- The medication math competency exam will be proctored in a computer lab (see course calendar for date.)
- If a student fails to pass the first attempt, there will be one additional attempt to pass.
- Upon a second failure, the student's progression in the Nursing Program will be reviewed by the First Year Nursing Team, and as necessary, by the Program Director and Department Chair.
- For students without a first attempt passing grade, activities in the LRC or clinical setting may be restricted.

Please note:

Students must pass the medication math competency exam at $\geq 90\%$ to pass the nursing course. If a student receives a No Pass, the student will fail the course and receive a D grade = 76.54%, and will not progress to the next nursing course.

Lab and Clinical Practicum Performance:

Learning Resource Center (LRC) and clinical practicum are graded as pass/no pass. The clinical grade is generated from student performance in the clinical setting as measured by the Clinical Assessment Tool. The lab grade is generated from student performance in the LRC as measured by the outcomes identified on the Skills Performance Checklists.

Please note:

Students must receive a 'passing' grade in both the lab and clinical practicum to pass the nursing course. If a student receives a No Pass, the student will fail the course and receive a D grade= 76.54%, and will not progress to the next nursing course.

ASSIGNMENT REQUIREMENTS

Clinical Preparation and Reflection Assignment for Medical/Surgical Clinical:

- Written clinical preparation must be completed and ready for instructor review by the beginning of the first clinical day each week. *(See assignment directions for detailed instructions.)* Arrangements will be made with students when patients are discharged prior to care.
- Students must satisfactorily pass one complete Clinical Preparation and Reflection assignment at $\geq 76.55\%$ or 77% in order to pass the nursing course. This assignment will be due week 3 of the clinical experience.
- Students will present required sections of the clinical preparation each week in post conference for feedback and group discussion.
- Once the assignment is passed, students are expected to continue with the abbreviated preparation assignment, and be ready to verbalize the information to his/her instructor. Inadequate preparation or inability to verbalize the nursing process as it applies to the patient will result in progression of the student by the First Year Nursing Team and may require additional written assignments.
- Students failing the assignment will be progressed by the First Year Nursing Team, Nursing Program Director, and Nursing Department Chair.

Therapeutic Communication Assignment:

- Students must complete one Therapeutic Communication Assignment in order to pass the nursing course. This assignment will be due by week 5 of the clinical experience. *(See assignment directions for detailed instructions and calendar for due date.)*

Wellness Log:

- Students must complete the Wellness Log assignment in order to pass the nursing course. *(See assignment directions for detailed instructions and calendar for due date.)*

Professional Issues:

- Students must complete the Professional Issues assignment in order to pass the nursing course. *(See assignment directions on BlackBoard for detailed instructions and calendar for due date.)*

Ethical Assignment:

- Students must complete the Ethical assignment in order to pass the nursing course. *(See assignment directions for detailed instructions and calendar for due date.)*

Grade Sheet NUR 106 Theory Score

Please note: Students must pass theory at $\geq 76.55\%$ or 77% to pass NUR 106. Students must pass theory exams before assignment grade will be calculated into the overall course score. If theory is failed, the score received in theory will be assigned as the overall course grade. No other scored assignments will be factored into the calculation of the final grade.

Calculating Theory Exam Score:

Exams	Points Achieved	Points Possible
#1	_____ / _____	
#2	_____ / _____	
#3	_____ / _____	
#4	_____ / _____	
#5	_____ / _____	

Total: _____ / _____ = _____ X 100 = _____ % X 0.75 = _____
Exam Achieved Possible 2 decimal places **Weighted exam score**

Final: _____ / _____ = _____ X 100 = _____ % X 0.25 = _____
Exam Achieved Possible 2 decimal places **Weighted final exam score**

Theory Exam Score: _____ + _____ = _____ %
Weighted Exam Score **Weighted Final Exam Score** **Overall Theory Exam Score**
Round to nearest hundredth

Theory Score:

If theory score is $\geq 76.55\%$, then to determine theory component for the overall NUR 106 course grade:

_____ % X 0.70 = _____
Overall Theory Score **Weighted Theory Score**
Round to nearest hundredth

Grade Sheet NUR 106 Assignment Scores

Calculating Assignment Scores:

Professional: _____ / 10 = _____ X 100 = _____ % X 0.10 = _____
Issues Achieved Possible 2 decimal places **Weighted score**

Ethical: _____ / 24 = _____ X 100 = _____ % X 0.20 = _____
Assignment Achieved Possible 2 decimal places **Weighted score**

Wellness: _____ / 10 = _____ X 100 = _____ % X 0.10 = _____
Log Achieved Possible 2 decimal places **Weighted score**

Communication: _____ / 20 = _____ X 100 = _____ % X 0.20 = _____
Assignment Achieved Possible 2 decimal places **Weighted score**

Patient Care Preparation and Clinical Reflection Score:

_____ / 50 = _____ X 100 = _____ % X 0.40 = _____
 Achieved Possible 2 decimal places **Weighted score**

Overall Assignment Score:

Assignment:

- Professional Issues
- Ethical Assignment
- Wellness Log
- Therapeutic Communication
- Clinical Preparation and Reflection

Weighted Scores:

Total Score Achieved:

Please note: Students must achieve overall assignment grade of >76.55% to pass NUR 106.

Weighted Overall Assignment Score:

_____ % X 0.30% = _____
 Overall Assignment Assignment **Weighted**
 Score Weight **Assignment Score**

Overall Course Grade Sheet NUR 106

Practicum Grades

- **Clinical Grade:** Pass / No pass
- **Learning Resource Center Grade:** Pass / No Pass
- **Medication Math Competency Exam:** Pass / No Pass

Please note:

- *Students must receive a 'passing' grade in clinical to pass the nursing course.*
 - *Students must receive a 'passing' grade in the LRC to pass the nursing course.*
 - *Students must receive a 'passing' grade of 90% on the medication math competency exam to pass the nursing course.*
 - *If a student receives a No Pass in any of the above areas, the student will fail the course and receive a D grade= 76.54%.*
-

Overall NUR 106 Score: (If passing all course components)

_____ + _____ = _____ %
Weighted Theory Score Weighted Assignment Score Overall Course Percentage Grade

NUR 106 Letter Grade: _____

NURSING PROGRAM POLICIES

PROGRAM POLICIES: See *Nursing Program Student Handbook, Nursing Program Entrance and Technical Standards Polices, Nursing Program Progression Policies and Nursing Program Readmission, Advanced Placement, and Transfer Student Policies.*

College Policies

STUDENT RIGHTS AND RESPONSIBILITIES:

Please read http://www.cocc.edu/Student-Life/Rights_and_Responsibilities/

AMERICANS WITH DISABILITIES STATEMENT:

Students with documented disabilities who may need accommodations, who have any emergency medical information the instructor should know of, or who need special arrangements in the event of evacuation, should make an appointment with the instructor as early as possible, no later than the first week of the term. Students may also wish to contact the COCC Disabilities Services Office in the Boyle Education Center, 541-383-7583.

COCC NON-DISCRIMINATION STATEMENT:

Central Oregon Community College is an affirmative action, equal opportunity institution. It is the policy of the Central Oregon Community College Board of Directors that there will be no discrimination or harassment on the basis of age, disability, gender, marital status, national origin, race, religion, sexual orientation, or veteran status in any educational program, activities or employment. Persons having questions about equal opportunity and non-discrimination, please contact Human Resources for referral to the appropriate personnel, 541-383-7236.

STUDENT INSURANCE:

Students are not covered by medical insurance while on campus or involved in college classes and activities. Students are responsible for their own medical and dental insurance coverage.

WORKERS COMPENSATION:

The nursing program does have a worker's compensation policy. If you are injured while in clinical please contact your instructor immediately. A claim must be filed within 48 hours of the injury.

FINAL EXAM:

A final examination schedule is prepared by the Records Office, approved by the Vice President for Instruction, and published in the schedule of credit classes. On an individual basis, for emergencies and other special circumstances, a student may take a final examination at a time other than that scheduled, providing the student has received prior approval by petition signed by the instructor and the department chair. Approved petitions are returned to instructors, with copies sent to the Vice President for Instruction.

NUR 106

Fall



Theory

Outcomes

Learning Objectives

Learning Activities

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

**As Member Within the Discipline of Nursing
Introduction to Nursing Practice**

Mara Kerr RNC, MS

Outcome

Upon completion of this learning unit, the students will recognize the importance of historical events in the development of nursing as a profession and the current scope of nursing practice.

Learning Objectives

1. Discuss definitions of nursing from Nightingale to the present.
2. Define the concepts of health, wellness, and health promotion.
3. Examine the Institute of Medicines five core competencies for health professions education.
4. Define health within the context of the current health care delivery system.
5. Describe factors that are causing significant changes in the health care delivery system including managed care, case management, and complementary and alternative therapies.
6. Discuss the changes in the health care system that has increased the need for nurses to practice in community-based settings. Give examples of some of these settings.
7. Describe the purposes of health education and the role of nurses.

Learning Activities

Lecture with classroom learning activities [2 hours]

- View DVD *History of Nursing: The Development of a Profession*
- **Required Readings:**
 - **Ignatavicius:** pages 1-7
 - **Potter, Essentials for Nursing Practice:** Chapters 1, 2

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

**As Provider of Care
Holistic Approach to Care
Self-Concept, Sexuality, and Spirituality**

Mara Kerr RNC, MS

Outcome

Upon completion of the learning unit, students will identify components that influence self-concept, sexuality, and spirituality.

Learning Objectives

1. Identify factors that influence the following components of self-concept: body image, self-esteem, roles and identity.
2. Identify nursing problems, goals, and actions concerning altered self-concept.
3. Identify factors and health states that impact an individual's sexuality.
4. Describe how to handle inappropriate sexual behavior in the health care setting.
5. Discuss the relationship of spirituality to an individual's total being.
6. Discuss nursing interventions designed to promote spiritual health.

Learning Activities

Lecture with classroom learning activities [2 hours]

Required Reading

- **Potter:** Spiritual health - Chapter 21, pages 547-554
Self-concept, Sexuality - Chapter 23, pages 596-604

Learning Resources

- Sumner, C. H. (1998). Recognizing and responding to spiritual distress. AJN, 98(1), 26.
- Zook, R. (1997). Handling inappropriate sexual behavior with confidence. Nursing97, 27(4), 65.

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CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

As Provider of Care:
Introduction to Pharmacology Concepts
Jane Morrow RN, MN

Outcome

Upon completion of this learning unit, the student will be able to recognize, describe and discuss principle concepts related to pharmacology.

Learning Objectives

1. Define the terms: protein-bound drugs, half-life, therapeutic index, therapeutic drug range, side effects, adverse reaction, drug toxicity peak and trough levels, loading dose and placebo effect.
2. Explain the applications of pharmacokinetics to clinical practice.
3. Explain the metabolism of drugs and its applications to pharmacotherapy.
4. Apply principles of pharmacodynamics to clinical practice.
5. Distinguish between a drug's generic name and trade name.
6. Compare and contrast the advantages and disadvantages of each route of drug administration
7. Explain the Controlled substance act and give an example of each of the schedule categories.
8. Discuss how a drug's therapeutic index is related to its margin of safety.

Learning Activities

Lecture with group learning activities. [2 hours]

Required Readings:

- **Adams:** Chapters 1, 2, 3, 4, and 5

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

FALL

**As Provider of Care
Holistic Approach to Care
Growth and Development**
Mara Kerr RNC, MS

Outcome

Upon completion of this learning unit, the student will be able to apply principles of growth and development in the planning and delivery of patient care.

Learning Objectives

1. Describe major theories of growth and development.
2. Use knowledge of growth and development to enhance use of the nursing process for individuals across the lifespan.
3. List Erikson's eight stages of ego development that encompass the life span, and state the distinct psychological conflict that characterizes each stage.
4. Assess patient's developmental levels by applying Erikson's psychosocial developmental levels.
5. List pediatric development milestones.
6. Plan nursing interventions that are appropriate for the patient's developmental state, based on Erikson's theory.

Learning Activities

Lecture with classroom learning activities [2 hours]

Required Readings:

- o **Potter:** Chapter 22, pages 568-587

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

**As Provider of Care:
Nursing Care of the Pediatric Patient: Child Abuse**

Mara Kerr RNC, MS

Outcome: Upon completion of this learning unit, the student will be able to identify nursing care concepts for care of the pediatric patient related to child abuse and neglect.

Learning Objectives:

1. Discuss statistics of child abuse in Oregon compared to national trends.
2. Discuss the concept of “threat of harm” for the pediatric patient.
3. Define the types of abuse and most common clinical manifestations.
 - Physical abuse
 - Neglect
 - Emotional abuse
 - Sexual abuse
4. Describe known etiology/pathology/characteristics of perpetrators.
5. Explain Oregon Child Abuse Reporting Law
 - Concept of mandatory reporters
 - How to report
 - What to report
 - Process after a report is made
 - Consequence for *not* making a report
6. Describe components of effective documentation in suspected abuse cases.

Learning Activities:

- Classroom Lecture with PowerPoint *-2 hours*

Learning Resources:

- Potter & Perry, Essentials for Nursing Practice (8th ed.), pp. 323
- www.darknesstolight.org
- <http://www.dhs.state.or.us> > children’s services > child abuse and neglect

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

As Provider of Care:
Nursing Management for Pharmacology Across the Lifespan
Jane Morrow RN, MN

Outcome

Upon completion of this unit the student will be able to apply the principles of pharmacokinetics to both pediatric and elderly patients.

Learning Objectives

1. Apply knowledge about pediatric medications safety and administration to current or potential nursing practice.
2. Identify physiological changes during pregnancy that affect pharmacotherapy.
3. Discuss the nursing interventions specific to pediatric medication dosing, monitoring and administration for infants, toddlers, school-age children and adolescents.
4. Identify the terms: chronologic age, developmental age and first-pass effect.
5. Explain the physiologic changes of the aging process that have a major effect on drug therapy.
6. Explain the pharmacokinetics and pharmacodynamics of the older adult that relate to drug dosing.
7. Discuss reason for noncompliance to drug regimen by the older adult.

Learning Activities

On-line learning activity – located on Blackboard [1 hour]

Required Readings:

- **Adams:** Chapter 8

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

**As Provider of Care
Foundations of Nursing Practice
Pain Management
Mara Kerr RNC, MS**

Outcome

Upon the completion of this learning unit, the student will identify the nursing needs for the patient in pain.

Learning Objectives

1. Review definitions of pain.
2. Describe the theoretical bases for pain and the 3 major categories of pain.
3. Identify variables that influence pain perception.
4. Compare and contrast the characteristics of the major types of pain.
5. Describe the components of a comprehensive pain assessment.
6. Differentiate commonly used drugs for acute and chronic pain.
7. Discuss pain considerations for the older adult and the pediatric patient
8. Discuss complementary and alternative therapies for clients experiencing pain.

Learning Activities

Lecture with classroom activities [2 hours]

Required Readings:

- **Ignatavicius:** 39-63
- **Potter:** Chapter 32, pages 869-902

Learning Resources

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

As Communicator
Foundations of Nursing Practice
Therapeutic Communication

Kiri Simning RN, MSN

Outcome

Upon Completion of this learning unit, students will be able to use basic therapeutic communication techniques in delivery of patient care.

Learning Objectives

1. List the goals of therapeutic communication.
2. Discuss the characteristics, goals, and phases of a therapeutic relationship.
3. Distinguish between therapeutic and social relationships.
4. Summarize components of attentive listening: SOLER.
5. Describe methods of nonverbal communication.
6. Apply therapeutic communication techniques in clinical situations.
7. Recognize ineffective communication techniques that hinder therapeutic conversations.
8. Explore the role of self-awareness in developing therapeutic relationships.

Learning Activities

Lecture with classroom learning activities [2 hours]

Required Readings:

- **Potter & Perry:** Chapter 11, 181-201

Learning Resource

- DVD *Professional Behavior in Healthcare Professions: Effective Communication with Patients*
- Read the article "To Make a Difference: Nursing Presence"
- Worksheets on Communication Techniques
- Complete Therapeutic Communication Assignment in clinical.

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

As Member Within the Discipline of Nursing

The Nursing Process

Michele Decker RN, MSN, MED

Outcome

Upon completion of this learning unit, the student will be able to integrate the steps of the nursing process into delivery of patient care.

Learning Objectives

1. Identify the components of the nursing process.
2. Describe the nursing process and its relationship to high quality patient care.
3. Recognize the benefits of a nursing holistic model in the collection and organization of patient health data.
4. Integrate the functional health approach to the nursing process.
5. Apply clinical judgment and decision-making in the clinical setting at the beginning level.
6. Apply components of the nursing process with every patient contact.

Learning Activities

- **Lecture** with classroom learning activities [4 hours]
- **Required Readings:** Potter & Perry: 104-141
- **Clinical Resources:** Holistic Data Collection Tool, NANDA Nursing Diagnosis List
- **Study Guide for Examination**
 1. How would you describe critical thinking?
 2. How are diagnostic labels, etiologies, and signs/symptoms written in a Nursing Diagnostic Statement?
 3. Based on the ANA definition of nursing, what are appropriate functions for a nurse to perform?
 4. Given a clinical situation, be prepared to determine which phase of the nursing process the nurse is utilizing.
 5. What is the correct way to write expected outcomes?
 6. Identify appropriate nursing clinical functions within the definition of nursing and nursing process.
 7. Describe the steps of the nursing process.
 8. Compare and contrast subjective and objective data.

NUR 106

Fall

**As Provider of Care
Nursing Care of the Patient with
Cardiovascular Alterations**

Kiri Simning RN, MSN

Outcome

Upon completion of this learning unit, the students will be able to identify nursing care needs for clients with heart disease caused by atherosclerosis.

Learning Objectives

1. Learn components of safe and effective care of the cardiac patient by investigating pathology, diagnostic tests and management interventions.
2. Explore health promotion and maintenance strategies for cardiac health.
3. Explain basic care and comfort measures for the cardiac patient.
4. Apply pharmacological therapies to care of the cardiac patient.
5. Apply clinical judgment and decision-making in the clinical setting at the beginning level.
6. Outline interventions that reduce potential complications of cardiac disease.

Learning Activities

Lecture with classroom activities [4 hours]

- ❑ Review sample prep sheet for cardiac patient

Learning Resources

- ❑ **Ignatavicius:** Chapter 35 Assessment, Chapter 37 Heart Failure, Chapter 38 Atherosclerosis, Chapter 40 Coronary heart disease
- ❑ DVD *Cardiac Disorders: Coronary Artery Disease*
- ❑ DVD *Cardiac Disorders: Heart Failure*

Study Guide Learning Objectives

1. Review normal cardiac structure and function.

Resource: any A & P text

2. Identify changes in the cardiovascular system associated with aging.

3. Define the following terms:

Arrhythmia	pulse pressure	cardiac output (CO)
Orthopnea	stroke volume	paroxysmal nocturnal dyspnea (PND)
Chronotropic	inotropic	dyspnea on exertion (DOE)

Resource: any medical dictionary or physical exam text

4. Diagnostic tests: discuss the procedure, purpose, and any nursing responsibilities.

Cardiac catheterization	electrocardiogram (EKG)	holter monitor
Coronary angiography	echocardiogram	stress test
Creatine phosphokinase (CPK)	troponin	Lactic Dehydrogenase (LDH)

5. Describe the pathology, diagnosis, risk factors, clinical presentation, the medical and surgical management, and the nursing care for the following cardiac disorders:

- Coronary artery disease (CAD)
- Myocardial Infarction (MI)
- Heart Failure (previously known as Congestive Heart Failure or CHF)
- Mitral and Aortic Stenosis
- Mitral and Aortic Regurgitation

As Provider of Care
Nursing Management for Pharmacology Related to
Lipid Disorders
Jane Morrow RN, MN

Outcome

Upon completion of this learning unit, the student will be able to recognize, describe and safely prepare, monitor and administer medications for lipid disorders.

Learning Objectives

1. Categorize drugs used in the treatment of lipid disorders based on their classification and mechanism of action.
2. Describe the synergistic effects of anti-hyperlipidemics and non-pharmacological therapies.
3. Describe the nursing process including patient teaching for antihyperlipidemics.
4. For each of the drug classes listed in "Drugs at a glance" (page 286), know representative drug examples, and explain their mechanisms of drug action, primary actions, and important adverse effects.
5. Explain the nurses role in the pharmacologic management of lipid disorders.

Learning Activities

Lecture with group learning activities [1 hour]

Required Readings: Adams: Chapter 22



Nursing Management for Pharmacology Related to Cardiovascular Disorders

Jane Morrow RN, MN

Outcome

Upon completion of this learning unit, the student will be able to recognize, describe and safely prepare, monitor and administer medications for cardiovascular disorders.

Learning Objectives

1. Differentiate the actions of cardiac glycosides, antianginal drugs, and antidysrhythmic drugs.
2. List the classes of medication used for the patient in heart failure and describe their action:
 - o Beta blockers
 - o Angiotensin-converting enzyme inhibitors (ACE inhibitors) and Angiotensin II receptor blockers (ARB's)
 - o Diuretics
 - o Nesiritide (Natreacor)
 - o Phosphodiesterase inhibitor milrinone (Primacor)
3. List the classes of medication used to treat angina and myocardial infarction
 - o Organic nitrates, Beta-adrenergic blockers and Calcium channel blockers
4. Describe the signs and symptoms of digitalis toxicity.
5. Compare the side effects and adverse reactions of nitrate, beta-blockers, calcium channel blockers, quinidine and procainamide.
6. List the classes of medication used to treat dysrhythmias:
 - o Sodium Channel blockers, Beta-adrenergic blockers, Potassium channel blockers, Calcium channel blockers
7. Apply the nursing process including client teaching related to cardiac glycosides, antianginal drugs and antidysrhythmic drugs.
8. For each of the drug classes listed in Drugs at a glance, know representative drug examples, and explain their mechanisms of action, primary action and important adverse effects. Please note: we will not cover thrombolytics.

Learning Activities

Lecture with group learning activities [1 hour]

Required Readings:

- **Adams:** Chapter 26, 27 pp: 362-370 (no thrombolytics), 29 and pages 304-307 (yes, diuretics)

Holistic Approach to Care Stress and Coping

Kiri Simning, RN MS

Outcome

Upon completion of this learning unit, the students will be able to identify how stress and anxiety interfere with client health and learning.

Learning Objectives

1. Describe stress and identify the indicators.
2. Identify how stress and coping relate to health.
3. Examine the concepts of physiologic, psychosocial, developmental, and situational stressors.
4. Describe coping and ego-defense mechanisms.
5. Investigate the components of a focused patient assessment for stress.
6. Summarize methods to reduce stress.
7. Apply nursing interventions to the care of the patient experiencing stress.

Learning Activities

Lecture with classroom learning activities [2 hours]

Required Readings:

- **Potter:** 637-653

Learning Resources

- Read article on Blackboard: [Stop the disruption of anxiety](#)
- Read the online article:
http://www.emedicinehealth.com/sleep_understanding_the_basics/article_em.htm

As Provider of Care
Foundations of Nursing Practice
Care of the Older Adult
Jane Morrow, RN MN

Outcome

Upon completion of this learning unit the student will be able to apply information on developmental changes to care of the older adult.

Learning Objectives

1. Identify and describe the psychosocial and cognitive aspects of aging.
2. Discuss the developmental tasks of the older adult as described by Erikson.
3. Describe the normal biologic aging and age-related body system changes.
4. Describe common myths and stereotypes that perpetuate ageism.
5. Describe how aging can be a surgical risk factor (See Ignatavicius & Workman Chart 16-1, pg. 245).
6. Identify the important mental health problems of aging and their impact upon the functioning of older persons and their families.
7. Identify major legal and ethical issues that are of consideration in the care of older persons.
8. Identify health promotion strategies for the elderly.

Learning Activities

Lecture with classroom learning activities [2 hours]

Required Readings:

- **Ignatavicius:** 15-29
- **Potter:** Chapter 21
 - Table 21-3 Common Physical Changes of Aging p. 586

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

As Member Within the Discipline of Nursing Ethical and Legal Considerations

Michele Decker RN, MSN, MEd

Outcome

Upon completion of this learning unit, the student will be able to identify ethical and legal principles for nursing practice; and practice nursing within their scope of professional training across the nursing program.

Learning Objectives

1. Define ethics and ethical terminology.
2. Discuss the ANA Nursing Codes of Ethics and ANA Standards of Practice and Standards of Professional Performance.
3. Define the following ethical principles: Beneficence, Nonmaleficence, Autonomy, Fidelity, and Justice.
4. Describe the professional and legal regulations of nursing practice.
5. Analyze nursing errors and reflect on contributing factors.
6. Discuss the Oregon Nurse Practice Act.
7. Practice nursing within the legal scope while in school and upon graduation.
8. Describe the legal responsibilities and obligations of nurses, including providing the public with safe nursing care.

Learning Activities

Lecture with classroom learning activities [1 hour]

Required Reading

- **Potter:** 61-85

Learning Resources

- American Nurses Association (2001). *Code of Ethics for Nurses with Interpretive Statements*. Washington, D.C.: American Nurses Association.
- Dictionary of choice
- www.nso.com for case studies

Ethical Terminology

Allocation of resources: *Distribution of available resources—money, medicines, services—when supplies are not limitless. Same as resource allocation.*

Bioethics: *Discipline addressing the ethical issues raised by developments in science, the environment, health care, technology, and medicine.*

Decision Making Capacity: *The ability of a person to understand all information about a health condition, to communicate understanding and choices, and to reason and deliberate; and, the possession of personal values and goals that guide the decision.*

DNR: *Written directives placed in a patient's medical chart indicating that CPR is to be avoided.*

Ethical Dilemma: *Occurs when there are conflicting moral claims.*

Ethics: *A formal process for making logical and consistent decisions based upon moral beliefs.*

Faith: *A generic feature of the human struggle to find and maintain meaning flowing from an integration of ways of knowing and valuing.*

Futility: *Situations in which medical interventions are judged to have no medical benefit, or the chances of success are low.*

Human Rights: *Legal claims that persons have on society simply on the basis of their being human.*

Informed consent: *Agreement on the part of a patient to accept a treatment. An individual signs a consent form only after being adequately informed of the nature of the treatment and its likely risks and benefits.*

Morality: *What ethics studies. The actual practice of acting rightly or wrongly. Culturally received mores, often unarticulated or implicit. Social conventions about right and wrong human conduct. The conventions are widely shared in a community.*

Paternalism: *A gender biased term that literally means acting "fatherly". Well intended actions of benevolent decision making on behalf of patients without their full consent or knowledge.*

Quality of Life: *A subjective appraisal of factors that make life worth living.*

Religion: *The codification of beliefs and practices concerning the Divine and one's relationship with the Divine that are shared by a group of people.*

Slippery slope: *Ethical argument that asserts that one morally questionable action or policy will set a precedent for or lead to other actions or policies that are even more morally questionable. The concern is that, by permitting one type of action, the door is then open to more serious and widespread abuses that are similar to the original.*

Spirituality: *The animating force, life principle, or essence of being that permeates life and is expressed and experienced in multifaceted connections with self, others, nature, and God or Life Force.*

Standard of care: *Healthcare term for the most widely accepted prevailing therapy or treatment for a disease or condition.*

Values: *Ideals, beliefs, customs, modes of conduct, qualities, or goals that are highly prized or preferred by individuals, groups, or society.*

Values Conflict: *Internal or interpersonal conflict that occurs in circumstances in which personal values are at odds with those of patients, colleagues, or the institution.*

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

**As Member Within the Discipline of Nursing
Professional Concepts
Scope of Practice**

Michele Decker RN, MSN, MEd

Outcome

Upon completion of this learning unit the students will be able to identify the roles and responsibilities for professional nursing practice.

Learning Objectives

1. Differentiate levels of education and practice within nursing including the issue of entry into practice.
2. Describe the roles and functions of a nurse.
3. Discuss the Oregon Nurse Practice Act.
4. Describe the scope of practice of the Licensed Practical and Registered Nurse.
5. Describe the functions of the Oregon State Board of Nursing (OSBN).

Learning Activities

Lecture with classroom learning activities [1 hour]

On-line assignment

- See Blackboard for assignment and calendar for due date

Learning Resources

- Oregon State Board of Nursing Standards and Scope of Practice for LPN & RN Division 45 of Nurse Practice Act online at www.osbn.state.or.us

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

**As Provider of Care
Nursing Care of the Patient with
Peripheral Vascular Disease**

Kiri Simning, RN MS

Outcome

Upon completion of this learning unit, students will understand how to provide care for the patient with peripheral vascular disease.

Learning Objectives

1. Discuss components of safe and effective care of patient with peripheral vascular disease.
2. Explore health promotion and health maintenance strategies for vascular health.
3. Examine pathophysiology, diagnostic testing, and management strategies for arterial and venous disorders.
4. Describe nursing assessments and interventions essential for care of patients with peripheral vascular diseases.
5. Apply pharmaceutical therapies for management and comfort measures.
6. Explain potential complications associated with vascular disorders and measures to reduce risks of these complications.

Learning Activities

Lecture with classroom learning activities [4 hours]

- Worksheets
- Case studies

Required Readings:

- **Ignatavicius: 772-807**

Study Guide

1. Review the anatomy and physiology of the peripheral vascular system.
2. Discuss the pathophysiology of atherosclerosis in the peripheral vessels.
3. Identify signs and symptoms associated with peripheral vascular disease. Differentiate the key features for arterial disease versus venous disease.
4. Explain assessment findings of lower extremity ulcers: arterial, venous, and diabetic.
5. Discuss treatment options for patients with peripheral vascular disease: non-surgical management, drug therapies and anticoagulants, and surgical procedures.
6. Discuss the pathophysiology of hypertension. Explain the difference between essential hypertension and secondary hypertension. List risk factors for both.
7. List s/s from complications of uncontrolled hypertension: aneurysm, stroke, myocardial infarction
8. Describe the problems, prevention, and nursing care for the following venous conditions: venous insufficiency, varicose veins, phlebitis.
9. Describe pediatric issues: dyslipidemia, hypertension, MI, Kawasaki Disease



CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

**As Provider of Care:
Nursing Management for Pharmacology Related to
Hypertension**

Jane Morrow RN, MN

Outcome

Upon completion of this learning unit, the student will be able to recognize, describe and safely prepare, monitor and administer medications for hypertension.

Learning Objectives

1. Discuss the role of therapeutic lifestyle changes as synergistic in the management of hypertension.
2. Describe the nurse's role in the pharmacological management of patients receiving drugs for hypertension.
3. Categorize drugs used in the treatment of hypertension based on their classification and mechanism of action.
4. Differentiate between drug classes used for the primary treatment of hypertension and those secondary agents reserved for persistent hypertension.
5. For each of the drug classes listed in "Drugs at a glance" (page 328), know representative drug examples, and explain their mechanisms of drug action, primary actions, and important adverse effects.
6. Use the Nursing Process to care for patients receiving drug therapy for hypertension.

Learning Activities

Lecture with group learning activities [1 hour]

Required Readings:

- **Adams** chapter 25

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

**As Provider of Care
Nursing Care of the Patient with
Musculoskeletal Disorders**

Kiri Simning, RN MS

Outcome

Upon completion of this unit, the student will be able to provide care for the patient with musculoskeletal disorders.

Learning Objectives

1. Plan nursing care for fractures, including teaching for injury prevention and nursing interventions.
2. Describe the nursing care needed to prevent and treat complications of fractures.
3. Describe the different types of traction and nursing interventions appropriate for the patient in bucks traction and Halo traction.
4. Discuss the appropriate technique for simple cast removal.
5. Examine the pathophysiology of osteoporosis and apply prevention strategies for different age groups.
6. Describe diagnostic tests used for musculoskeletal problems and explain any nursing care needed.
7. Apply principles of pharmacology in planning and evaluating care of patients with musculoskeletal disorders.
8. Safely implement interventions for care of patients with musculoskeletal disorders and orthopedic surgery.
9. Describe pediatric musculoskeletal congenital and developmental problems.

Learning Activities

Lecture with PowerPoint and classroom learning activities [4 hours]

Required Readings: Ignatavicius: Assessment pp. 1107-1113, Musculoskeletal Problems pp. 1119-1142
Trauma p. 1143-1174

Learning Resources

- Medical dictionary

<http://www.youtube.com/watch?v=IMbVc2KGNQM&feature=related>

(Cast removal information needed for the C.N.A. 2 certification)

Learning Assignments

- Label fracture types
- View video on Hip Fracture and complete the worksheet
- Musculoskeletal Bingo for labs and fracture activity

Study Guide

1. Review the anatomy and function of the musculoskeletal system. Identify normal changes in the musculoskeletal system associated with aging.
2. Bone healing: describe the normal process and how it differs from adult to child. Identify those factors which interfere with fracture healing in the adult and child.
3. Define the following terms:

Contusion	Scoliosis	Flexion	Crepitus
Sprain	Lordosis	Extention	Contracture
Strain	Kyphosis	Subluxation	Abduction
Adduction	Arthrodesis	Paresthesia	
4. Diagnostic Tests: describe how they are used in diagnosing and/or managing musculoskeletal diseases and disorders.

Serum calcium	Erythrocyte sedimentation rate (ESR)
Alkaline phosphatase	Uric acid
Complement C3 and C4	Antinuclear antibody (ANA)
Rheumatoid Factor	Bone scan
CAT Scan	Magnetic resonance imaging (MRI)
5. Describe the following types of fractures:

Simple/Closed (non-displaced)	Compound (open)	Comminuted
Displaced	Avulsion	Spiral
Oblique	Greenstick	Impacted (telescoped)
Depressed	Compression	Transverse
6. Describe the treatment of fractures: reduction, immobilization, rehabilitation, casting, traction [skin and skeletal], internal and external fixators.
7. Describe the fracture complications, s/s, treatment, and nursing care.

Shock	Deep vein thrombosis
Compartment syndrome	Fat embolism
Pulmonary embolism	Delayed union or non-union
Osteomyelitis	Amputation
8. Describe the basic pathology, diagnosis, and nursing care of: osteoporosis, Gout, Osteoarthritis versus Rheumatoid arthritis, and the pediatric disorders of clubbed foot, congenital hip, and Leggs-Calves-Perthes Disease (avascular necrosis)
9. Discuss the role of antibiotics, analgesics, NSAIDS, muscle relaxants, and anticoagulants in the management of orthopedic patients.
10. Describe each surgery and nursing care for each: Total hip replacement, Total knee replacement, Fractured hip repair (open reduction, internal fixation = ORIF)

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

FALL

**As Provider of Care:
Nursing Management for Pharmacology related to
Bone and Joint Disorders**

Jane Morrow RN, MN

Outcome

Upon completion of this learning unit, the student will be able to recognize, describe and safely prepare and administer medications for bone and joint disorders.

Learning Objectives

1. Identify the types of calcium supplements
2. Describe the action of nonsteroidal anti-inflammatory drugs (NSAIDs)
3. Explain the use of disease-modifying antirheumatic drugs (DMARDs)
4. Differentiate between the side effects and adverse reactions of NSAIDs and DMARDs
5. Explain the pathophysiologic basis of the five cardinal signs of inflammation.
6. Explain the goals of pharmacotherapy with skeletal muscle relaxants.
7. Use the Nursing Process to care for clients who are receiving pharmacotherapy for bone, joint and muscle disorders.
8. Compare and contrast the actions and side effects of the nonsteroidal anti-inflammatory drugs (NSAIDs): aspirin, ibuprofen, celecoxib, ketorolac (Toradol).
9. For each of the classes listed in "Drugs at a Glance" on page 730, and on page 274. Know representative drug examples, and explain the mechanism of drug action, primary actions and important adverse effects.

Learning Activities

Lecture with group learning activities 1 hour

Required Readings:

Adams: chapter 47, pp 233 (Pharmacotherapy with NSAIDs) and chapter 21 (muscle relaxants)

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

**As Provider of Care
Nursing Management for Pharmacology Related to
Coagulation Disorders**

Jane Morrow RN, MN

Outcome

Upon completion of this learning unit, the student will be able to recognize, describe and safely prepare, monitor and administer medications for coagulation disorders.

Learning Objectives

1. Describe the action for anticoagulants, antiplatelets and thrombolytics.
2. Explain how laboratory testing of coagulation parameters is used to monitor anticoagulant pharmacotherapy.
3. Categorize drugs used in the treatment of coagulation disorders based on their classification and mechanism of action.
4. For each of the classes listed in "Drugs at a Glance" on page 406, know representative drug examples, and explain the mechanism of drug action, primary actions and important adverse effects.
5. Use the Nursing Process to care for clients receiving drug therapy for coagulation disorders.

Learning Activities

Lecture with group learning activities [1 hour]

Required Readings:

- **Adams:** Chapter 30 and pp 372-374 (thrombolytics)

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

**As Provider of Care
Holistic Approach to Care
Cultural Considerations**

Jane Morrow RN, MN

Outcome

Upon completion of this learning unit, the student will apply cultural considerations to the holistic care of patients.

Learning Objectives

1. Define culture, transcultural nursing, and culturally competent nursing care and identify key components of cultural assessment for clients.
2. Define cultural awareness as it relates to space and distance, communication patterns, eye contact, time, touch and diet.
3. Discuss cultural practices relating to religion and generic or folk medicine that the nurse should consider when assessing a client's culture.
4. Outline the current JCAHO guidelines regarding the provision of culturally and linguistically appropriate health care.
5. Identify methods for working with patients when beliefs may conflict with effective health care interventions.
6. Compare and contrast how cultural beliefs affect patient and family interactions with healthcare providers.
7. Discuss the current recommendations and mandates regarding use of interpreters.

Learning Activities

Lecture with DVD: *Cultural Competence* [2 hours]

Required Readings:

- **Ignatavicius:** Chapter 4, pp.30-38.
- **Adams:** Chapter 9 pp 89-94
- **Potter:** 535-547

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

**As Provider of Care
Nursing Management for Pharmacology Related to
Pain Control, Migraines and Anesthesia**
Jane Morrow RN, MN

Outcome

Upon completion of this learning unit, the student will be able to recognize, describe and safely prepare, monitor and administer medications for pain control, migraines and anesthesia.

Learning Objectives

1. Relate the importance of pain assessment to effective pharmacotherapy.
2. Compare indications for non-opioid and opioid analgesics.
3. Contrast the side effects of acetaminophen, aspirin and opioids.
4. Differentiate commonly used drugs for acute and chronic pain.
5. Compare and contrast the approximate equianalgesic dose for different opioids
6. Apply the nursing process to the patient with patient-controlled analgesia
7. Identify the actions of general anesthetics on the CNS.
8. Identify the four stages of anesthesia.
9. Categorize drugs used for pain control, migraines and anesthesia based on their classification and drug action.
10. For each of the classes listed in "Drugs at a Glance" on pages 222, 243 and 459, know representative drug examples, and explain the mechanism of drug action, primary actions and important adverse effects.
11. Use the Nursing Process to care for clients who are receiving pharmacotherapy for pain control, migraines and anesthesia.

Learning Activities

Lecture with group learning activities. [2 hours]

Required Readings:

- Adams: chapters 18, 19, and 33,



CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

**As Provider of Care
Foundations of Nursing Practice
Cancer Principles**
Kiri Simning, RN MS

Outcome

Upon completion of this learning unit, the student will be able to identify nursing care needs for patients with cancer.

Learning Objectives

1. Describe the incidence of cancer in the United States by gender, age, and race.
2. Review the terminology associated with abnormal cell growth and explain the difference between benign and malignant cells.
3. Discuss the mechanisms of cancer invasion and metastasis.
4. Discuss methods of diagnosing, grading and staging of cancer.
6. Discuss known causes of cancer and modifiable risks related to viruses, physical agents, genetic/familial factors, and hormonal agents
7. Discuss the three goals of cancer management: cure, control, or palliation.
8. Discuss how the modalities of surgery, radiation, chemotherapy, and non-traditional therapies are used in cancer management. List common side effects and risks of each modality.
9. Apply nursing interventions for management of symptoms associated with cancer and its therapy: nausea, vomiting, alopecia, constipation, diarrhea, cancer pain, fatigue, anemia, thrombocytopenia, neutropenia, sepsis, and intravenous access.

Learning Activities

Lecture with PowerPoint and classroom activities [2 hours]

Learning Resources

- **Ignatavicius:** 408-433
- Search the web site www.caring4cancer.com > Eating well > Nutrition >Symptom
 - Support for tips on managing nausea

Recommended

- Picoult, J. (2004). My Sister's Keeper. New York: Washington Square Press.
- Mukherjee, S. (2014). The Emperor of All Maladies. New York: Simon & Schuster.

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall

**As Provider of Care
Holistic Approach to Care
Grief and Loss**

Kiri Simning, RN MS

Outcome

Upon completion of this learning unit, the student will be able to apply principles of grief and loss to care of patients.

Learning Objectives

1. Define loss and differentiate the types of losses for which people may grieve.
2. Describe the grieving process and the various stages of grief as explained by Kubler-Ross and Bowlby.
3. Describe the types of grief.
4. Explore universal and culturally specific mourning rituals.
5. Apply nursing interventions to assist grieving patients and families.
6. Examine the Dying Person's Bill of Rights (2004).
7. Discuss care needed for clients during the dying process.
8. Begin reflection on your own feelings about death and dying.

Learning Activities

Lecture with classroom activities [2 hours]

Required Readings:

- **Potter:** Loss and Grief, 654-674

Learning Resources

- Loss Graph
- Kubler-Ross Stages of Grieving
- Cultural Considerations of Death Rituals

Recommended Readings:

- Callanan, M. & Kelley, P. (1992). *Final Gifts*. New York: Bantam Books. [ISBN 0-553-37876-7]
- Groves, R. & Klausner, H. (2005). *The American Book of Dying*. Berkley: Celestial Arts. [ISBN 1-58761-238- 0]
- James, J. & Friedman, R. (1998). *The Grief Recovery Handbook*. New York: HaperPerennial. [ISBN 0-06-095273-3]
- Lynn, J. & Harrold, J. (1999). *Handbook for Mortals: Guidance for People Facing Serious Illness*. New York: Oxford University Press. [ISBN 0-19-511662-3]
- Remen, R. (2006). *Kitchen Table Wisdom: Stories that Heal*. New York: Riverhead Books. [ISBN 978-1-59448-209-0]

NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

Fall

**As Provider of Care
Foundations of Nursing Practice
The Surgical Patient**

Mara Kerr RNC, MS

Outcome

Upon the completion of this learning unit the student will be able to identify the components and standards of care for the surgical patient.

Learning Objectives

1. Define safe and effective care for the perioperative patient through differentiating among the types and purposes of surgery.
2. Apply interview and assessment skills to the preparation of patients for surgical procedures.
3. Identify learning needs and teaching strategies for patients and families to prepare for surgery and to prevent complications.
4. Explain the importance of the sterile field and how it is maintained.
5. Explain nursing interventions for postoperative care.
6. Identify postoperative emergencies and how to collaborate with health care team members to perform emergency care procedures.

Learning Activities

Lecture with classroom activities and case studies [2 hours]

- OR Clinical Orientation with SCHS Perioperative Educator

Required Readings:

- **Ignatavicius:** Chapters 16 (Preoperative), 17 (Intraoperative), 18 (Postoperative).
- **Potter:** 1130-1173

Study Guide for Learning Objectives

1. Using Maslow's Hierarchy of Needs, indicate why surgery is a stressor to the patient.
 - Physiological needs
 - Safety and security needs
 - Belongingness and affection needs
 - Esteem and self-respect needs
 - Self-actualization needs
2. Explain the different categories of surgery as listed in Table 16-1 (p. 243).
3. List the criteria for Valid Informed Consent obtained prior to surgical procedures. Discuss the legal responsibilities of the nurse. Review the student nurse rules concerning consents.
4. Describe preoperative patient teaching instructions and rationale for the following exercises:
 - Diaphragmatic breathing
 - Coughing
 - Leg exercises
 - Turning to the side
 - Getting out of bed / ambulation
 - Incentive spirometer
5. Discuss preoperative checklist and nurse responsibilities immediately prior to surgery.
6. Discuss the following intraoperative nursing functions and responsibilities:
 - Circulating nurse & Scrub nurse
 - Operating room attire
 - Infection control and employee health
 - Occupational hazards
 - Sterile fields and rules of surgical asepsis
7. List use of and side effects associated with the following types of anesthesia:
 - General anesthesia (inhalation & intravenous)
 - Local or Regional anesthesia
 - Conscious sedation
8. Define the different stages of anesthesia. During which stages can the patient continue to hear conversation in the room?
9. Discuss risk factors that increase surgical risk or increase risk of post-surgical complications. [Table 16-2, pg. 244].
10. Discuss care of the postoperative patient upon return to the surgical floor.
11. Indicate nursing interventions for the following post-operative complications:
 - Hemorrhage
 - Infection
 - Dehiscence & Evisceration
 - Pain
 - Respiratory distress
 - Atelectasis
 - Nausea & vomiting
 - Paralytic ileus

Clinical Syllabus

NUR 106



- ✓ **Guidelines for Calling the Clinical Instructor**
- ✓ **Clinical Orientation Plan**
- ✓ **Clinical Assessment Tool**
- ✓ **Assignments and Grading Rubrics**

Guidelines for Calling Clinical Instructor NUR 106

See 'Nursing Program Student Handbook' for policy statement.

First Year Nursing Students (NUR 106) must adhere to the following guidelines related to skills performance in the clinical setting. Students must call the clinical instructor for assistance anytime the student 1). feels the need for further coaching, 2). questions the need for supervision, or 3). when supervision is known to be required. Skills in sections A and B may be performed independently by the student in the clinical setting. All skills identified in sections C and D, must be directly observed by the clinical instructor (or her designee), and skills in section E by the clinical instructor or RN. Sections F and G outline those skills that are not to be performed in this course.

Section A: The following *Nursing Assistant Level One Skills* are expected to be performed independently by students in the clinical setting:

1. Tasks associated with personal care:

- Bathing; Dressing; Grooming; Shaving; Shampooing and caring for hair; Providing and assisting with oral hygiene and denture care; Caring for the skin; Caring for the nails; Providing peri care; Bedmaking and handling linen; and Maintaining environmental cleanliness.

2. Tasks associated with maintaining mobility:

- Ambulating; Transferring; Transporting; Positioning; Turning; Lifting; Elevating extremities; Performing range of motion exercises; and Maintaining alignment.

3. Tasks associated with nutrition and hydration:

- Feeding and assisting client with eating; and Assisting client with drinking.

4. Tasks associated with elimination:

- Toileting; Assisting with use of bed pan and urinal; Providing catheter care, including the application of and removal of external urinary catheters; Administering enemas; Collecting specimens; Emptying ostomy bags or changing ostomy bags which do not adhere to the skin; and Inserting bowel evacuation suppositories available without a prescription.

5. Tasks associated with use of assistive devices:

- Caring for dentures, eyeglasses and hearing aids; Caring for, applying and removing anti-embolus stockings; Prosthetic devices; Orthotic devices; and Braces. Assisting with wheelchairs, walkers, or crutches; Using footboards; Assisting with and encouraging the use of self-help devices for eating, grooming and other personal care tasks; and Utilizing and assisting clients with devices for transferring, ambulation, and alignment.

6. Tasks associated with maintaining environment and client safety.

7. Tasks associated with data gathering, recording and reporting:

- Measuring temperature, pulse, respiration and blood pressure; Measuring height and weight; Measuring and recording oral intake; Measuring and recording urinary output, both voided and from urinary drainage systems; Measuring and recording emesis; Measuring and recording liquid stool; Measuring and recording pulse oximetry; and Collect responses to pain using a facility approved pain scale.

Section B: The following NUR 106 skills were assessed in the LRC and **may be performed** independently by students in the clinical setting:

- Performing physical assessments.

Section C: The following NUR 106 skills **must be observed and checked off** by your clinical instructor during patient care. Your instructor will inform you when you are permitted to perform these skills independently in the clinical setting.

Completion Date	Skill
	1. Applying a simple dressing, and applying ACE wrap or binders.
	2. CBG Monitoring
	3. Specimen collection
	4. Reapplying sequential compression devices that have been off for short periods of time (less than 1 hour).

Section D: The following NUR 106 skills **must always** be done with your clinical instructor:

- Performing sterile procedure or staple/suture removal and removing drains.

Section E: The following skills **must be done** with your clinical instructor or RN/CNA-2 assigned to your patient:

1. Assisting patients in or out of a Continuous Passive Motion (CPM) machine.
2. Initiating sequential compression devices.

Section F: The following CNA-2 and/or Additional tasks **cannot** be performed in NUR 106:

<ul style="list-style-type: none"> • Discontinue Foley catheter • Obtain sterile urine specimen from port of catheter • Apply warm and cold therapies 	<ul style="list-style-type: none"> • Add fluid to established post pyloric, jejunostomy and gastrostomy tube feedings • Change established tube feeding bags • Interrupt and re-establish suction (always excluding of chest tubes) • Suction oral pharynx • Clean ostomy sites and change dressings or appliances for established, non-acute ostomy
<i>To be taught Winter Term, NUR 107</i>	<i>To be taught Spring Term, NUR 108</i>

**NUR 106: Nursing I
Clinical Orientation Plan**

Week 4 & 5

Week 2 & 3

Week 1

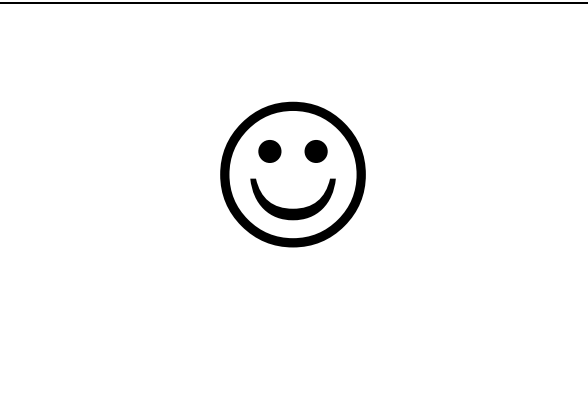
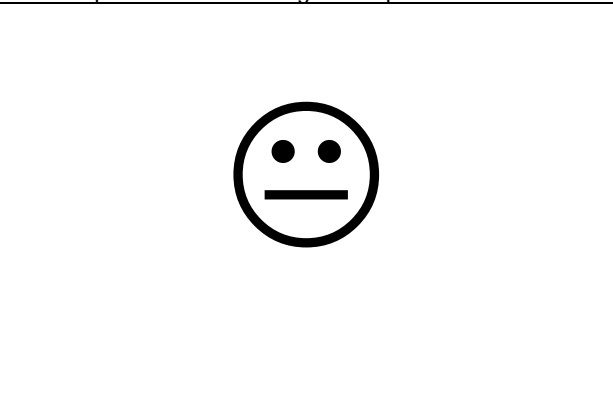


- **Pre-clinical:** Go to hospital for patient assignment and gather data and complete patient preparation.
- **Days of Care:** Care for 1 patient:
 - Responsible for assessment and vital sign, and document this in the EMR.
 - Responsible for providing ADL care, report to your CNA or RN for them to document or request supervision for data input.
 - Assist nursing team with the rest of your patient's care.
 - Collect 3 interactions for Communication Assignment. Turn in during week 5.

- **Pre-clinical:** Go to hospital for patient assignment and gather data and complete clinical preparation.
- **Days of Care:** Care for 1 patient:
 - Responsible for assessment, vital signs, and providing ADL care.
 - Begin charting vital signs & ADLs.
 - Assist nursing team with the rest of your patient's care.
 - Collect 3 interactions for Communication Assignment each week.
 - Prepare for Ethics Assignment presentation.

○

- Pre-clinical:** Attend hospital tour with assigned clinical group.
- Day 1:** Orient to unit, pick patient to care for Friday and gather patient information and complete clinical preparation.
- Day 2:** Care for one patient:
 - Responsible for Initial Assessment (like your check-off) and vital signs, and document this on your clinical reflection.
 - Assist Nursing team with your patient's care.
 - Collect 3 interactions for Comm Assignment.



NUR 106

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

FALL

Medical/Surgical Clinical Orientation First Day on Unit

Be on your unit ready to work at **0645/1330**. Check with your instructor for your RN assignment. Meet your RN and share your plans for the day. Tell him/her when you will be on and off the unit.

Tasks:

- Introduce yourself to unit staff.
- Orient with RN and the nursing team.
- Orient yourself to the physical layout of the unit and to the location of supplies.
- Observe the utilization of Pyxis, bar coding, and medication administration.
- Complete scavenger hunt list.
- Pick one patient preferably from your RNs assigned patients to care for during clinical on Friday. Write your patient selection in the COCC clinical notebook. Login to EMR and gather data.
- Day and Evening Shifts:** Attend post-conference Thursday, 2:00 – 3:00.



Guidelines for “Shadowing” the RN

- Observe how the RN obtains report on his/her patients from the previous shift.
 - ✓ What questions does s/he ask?
 - ✓ What initial checks are done?

- Observe how the RN organizes his/her worksheet (brain) and the SHARQ to:
 - ✓ Record pertinent assessment data.
 - ✓ Know when medications are due.
 - ✓ Know IV fluids, rates and when bags need to be changed.
 - ✓ Know when patients should be ambulated.
 - ✓ Know what treatments the patients have and when the treatments are scheduled to be done.
 - ✓ Know when to check on pertinent lab results.

- Observe how the RN competes a ‘focused assessment’ on his/her patient including:
 - ✓ IV fluids hanging on the patient.
 - ✓ Medications administered via an IV pump including the rate.
 - ✓ Patency of function of suction equipment and other emergency equipment.
 - ✓ What additional assessments were included in the focused assessment (in addition to Neurological, Cardiac, Respiratory, Gastrointestinal).

- Observe how the RN prioritizes care among his/her patients.

- Observe what other ancillary services care for your nurse’s patients.

- Observe your nurse therapeutically and professionally communicating with the patient, family, physician, and other healthcare team members.

- Observe how your nurse delegates to the CNA.

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

FALL 2014

Clinical Assessment Tool

NUR 106

Student's Name: _____ Term: _____ Year: _____

Instructor: _____ Absences: _____ /9 days

Grade (circle one): **Pass** **No Pass****Passing performance is achieved when:**

- o All Critical Elements* are rated as 2.
- o All competencies are rated or identified as N/O for no opportunity.
- o No zero rating on any performance criteria at the end of the term.
- o Any student performing at a rating of 0 on any performance criteria during the term will be progressed by the nursing faculty and a plan for improvement will be developed. Failure of the student to improve this rating to a ≥ 1 by the end of the term may result in failure of the course.

* *Performance criteria are indicated as Critical Elements when bolded***Rating Scale:**

S: Satisfactory. Consistently meets Performance Criteria. Bases actions on nursing rationale. Provides care, which reflects safety precautions. Receives guidance and structure with an attitude of engaged learner.

NI: Needs Improvement. Inconsistent Performance. Needs frequent guidance and repeated detailed instructions to successfully perform nursing care. Shows weak knowledge of nursing rationale.

U: Unsatisfactory or Unsafe for Practice. Demonstrated trend of unsafe clinical behavior. See Nursing Student Handbook Indicators of Unsafe Clinical Behaviors of Performance.

N/O: No Opportunity for skill/care performance.

STUDENT RATING	PERFORMANCE CRITERIA	INSTRUCTOR RATING
Upon completion of the <i>first</i> quarter of the Central Oregon Community College Associate Degree Nursing Program, the student will:		
I. As Provider of Care: Apply the nursing process to care of one patient.		
S U	<p>A. Nursing Process:</p> <p>A. Clinical Preparation: Meet or exceed outcome criteria for the NUR 106 Clinical Preparation.</p> <ol style="list-style-type: none"> Biographical Data Disease Summary Medication Administration Worksheet Nursing Process/ Standards of Care 	S U
S NI U	<p>B. Assess</p> <ol style="list-style-type: none"> Contribute to the comprehensive plan of care by collecting holistic data (Physiological, psychological, developmental, social, sexual, economic, cultural, and/or spiritual findings): <ul style="list-style-type: none"> Reason for seeking health care History of present health concern (COLDSPA) Lifestyle and health practices profile 	S NI U
S NI U	<ol style="list-style-type: none"> Complete vital signs and physical assessment on every patient. 	S NI U
S NI U	<ol style="list-style-type: none"> Systematically collect and organize patient data using a head-to-toe/body systems format. 	S NI U
S NI U	<p>B. Diagnose</p> <ol style="list-style-type: none"> Identify patient concerns. 	S NI U
S NI U	<p>C. Plan</p> <ol style="list-style-type: none"> Plan scheduled care for the shift using time management worksheet 	S NI U
S NI U	<p>D. Implement</p> <ol style="list-style-type: none"> Provide a safe physical and psychosocial environment for the patient: <ul style="list-style-type: none"> Maintain standard precautions Maintain asepsis. Monitor for safety: restraints, siderails, sharps, trip hazards. Responds to alarms while on the clinical unit. Ask for assistance when using unfamiliar equipment. Use equipment according to unit policy and manufacturing recommendations. Maintain appropriate professional boundaries in the nurse-patient relationship. 	S NI U
S U	<ol style="list-style-type: none"> Provide nursing interventions associated with personal care, mobility, nutrition, hydration, elimination, and assistive devices without prompting. 	S U
S NI U	<ol style="list-style-type: none"> Provide wound care including simple clean and sterile dressing changes, suture/staple removal and managing 	S NI U

	drains.	
S NI U	4. Perform capillary blood glucose monitoring and hemocult testing.	S NI U
S NI U	5. Assist patient with continuous passive motion (CPM) and sequential compression devices.	S NI U
S U	6. Obtains instruction and supervision as necessary when implementing nursing care.	S U
S NI U	F. Evaluate 1. Observe and report the patient's response to medications, treatments, activities of daily living, and procedures. 2. Reflection on Student Performance a. As Provider of Care	S NI U
II. As Manager of Care: Organize and deliver basic care to one patient.		
S NI U	A. Management of Patient Care Assignment: 1. Organize care for one patient. 2. Complete care in a timely manner for one patient. 3. Prioritize care for one patient. 4. Complete patient charting according to the unit policy.	S NI U
S NI U	B. Management of the Healthcare Team: 1. Advocacy (Staffing, Scope of Practice, Safety) ▪ Identify and reports situations that may impact patient/family well-being. ▪ Support the right of the patient to participate in their own health care decisions. ▪ Utilize knowledge of individual worth, uniqueness and differences in the values of the individual or family in the delivery of nursing care.	S NI U
S NI U	2. Delegation and Supervision: ▪ Participate as part of the interdisciplinary team in the delivery of person-centered care. ▪ Keep staff informed of patient status and care completion. ▪ Inform staff when leaving Nursing Unit for breaks, lunch, or procedures.	S NI U
III. As Communicator: Communicate therapeutically with individual patients and families.		
S NI U	A. Therapeutic Communication 1. Promote therapeutic relationships with the individual and/or family. 2. Maintain eye contact and check to see if the patient needs anything before leaving the room. 3. Shares progress on Therapeutic Communication Assignment during clinical conferences during the term. 4. Shows daily use of patient-centered communication in	S NI U

S NI U	delivery of care. 5. Refer to patient by preferred name. 6. Reflection on student performance <ul style="list-style-type: none"> ○ As Communicator 	S NI U
IV. As Teacher: Reinforce medication teaching to all assigned patients from established standards.		
S NI U	A. Teacher: <ol style="list-style-type: none"> 1. Assist in identifying patient learning needs for assigned patient. 2. Inform team members of any expressed information needs by patient. 3. Observe discharge teaching instruction. 4. Reinforce teaching to patient or significant support person(s). 5. Explain to patient all medications administered. 6. Responds appropriately to questions of the patient. 7. Participates in the evaluation of patient learning. 	S NI U
V. As Member within the Discipline of Nursing: Identify ethical and legal principles for nursing practice.		
S NI U	N: Nursing Values, Beliefs, Behaviors, and Professionalism <ul style="list-style-type: none"> ▪ Demonstrate person-centered care: uses appropriate tone of voice, effective touch, listens, and avoids terms of endearment. ▪ Recognizes sociocultural similarities and differences among patients and provides cultural sensitivity. ▪ Demonstrate trustworthy behavior. ▪ Dress in a professional manner according to policy for COCC, including lack of offensive odors, i.e. tobacco, perfume. 	S NI U
S NI U	U: Utilization of Change Process <ol style="list-style-type: none"> 1. Responsive to direction provided. 2. Demonstrate growth by change in behavior after constructive suggestions and feedback. 3. Recognize own level of anxiety in stressful situations and applies methods to reduce stress. 	S NI U
S U	R: Responsibilities and Accountability <ol style="list-style-type: none"> 1. Demonstrate accountability for delivery of nursing care by means of thorough preparation for assigned patients. 2. Practice within the parameters of individual knowledge and experience. 3. Notifies instructor per Nursing Student Handbook if late or absent. 4. Perform skills in clinical only after achieving competency in the LRC. 5. Report on time for clinical shift and clinical 	S U

	conferences.	
S NI U	S: <i>Scholarly</i> 1. Identify specific self –learning needs and seek out learning opportunities. 2. Apply knowledge attained in didactic nursing courses, learning resource center, and in clinical preparation to the care of patients. 3. Participate in clinical conferences. 4. Demonstrate skills for informatics and technology used in the clinical setting. 5. Submit assignments to instructor in complete form and at time specified.	S NI U
S NI U		S NI U
S U	E: <i>Ethical, Legal, Professional Scopes of Practice</i> 1. Apply ANA standards of ethical nursing practice. 2. Practice according to HIPAA regulations to protect confidential patient information and uses judgment in sharing this information in a manner consistent with current law. 3. Recognize situation beyond one knowledge and experience and reports appropriately.	S U

Student Comments:

Instructor Comments:

Student areas of focus for next term:

1.

2.

Student Signature and Date

Instructor Signature and Date

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

Fall 2014

Wellness Log Assignment

DIRECTIONS: Locate this document on Blackboard. Download to your computer.

Begin Week 1 of the term. Each week, type in a 3-5 sentence response about your effort at trying this wellness activity.

Grading: One point for each completed weekly activity (nine weeks).

One point for the APA wellness reference and paragraph on how it was of value to you.

Ten points total.

Week 1: The goal for this week is to take *at least* 10 minutes of quiet time, or something like meditation twice this week. I say at least because that is about what I can afford for time but some of you may be able to get up to 30 or so.

Suggested activities:

- Labyrinth walk at First Presbyterian Church, 230 NE 9th Street, Bend
- Heart breathing exercises with HeartMath® music
- Quiet time of gratitude for blessings in your life

Week 2: This week, choose one night (or two if you're able) that you will go to bed when you are tired and wake up without the aid of an alarm clock. Your body needs sleep, and this is one of the physiologic needs that we have that tends to be ignored or put on the bottom of the priority list. If you aren't able to swing this, a nap or two will do...

Suggested activities:

- Try to keep the same bedtime each night
- No caffeine beverages after 12noon
- Limit alcohol to one beverage early in the evening
- No TV or computer in your bedroom
- Turn off computer or TV one hour before bedtime

Week 3: Do something **special for yourself**...not for anyone else, but you. Whatever it takes to insure you are "taking care of yourself". This may include emotional or physical things or both. Suggestions are: Massage, Pedicure, Spa day, going with a close friend somewhere fun, talking to a counselor & asking yourself "why" am I doing this...HA! Do something nice for yourself...that you would enjoy. Make yourself feel special....be your own best friend.

Suggested activities:

- See list of suggested self-care activities above
- Learn to ask for help from family members for chores
- Find a way to add exercise to your week

Week 4: Make time for a nature experience. Share a favorite hiking, fishing, camping, or biking spot. Go either alone or with someone you love.

Suggested activities:

- Walk the River Trail at Farewell Bend Park

- Picnic at Shevlin Park and let the kids fish in the pond
- Canoe or kayak at Sparks Lake

Week 5: Our wellness goal this week has to do with diet. We are not going on a diet but we are going to take a look at our diets. They say “you are what you eat” and our diet plays such an important role in how we function in our daily lives. Our many different schedules shuffling school, clinical, work and family influence when, what and how we eat. So for this week count how many times you ate fast food. Come up with 2 ideas of how you could eat better. See <http://www.choosemyplate.gov/> for list of ways to improve diet.

Suggested activities:

- Pack lunch the night before
- Clean lettuce and make a large salad on Monday for several dinners that week
- Substitute water for soda

Week 6: For week six, experience laughter and experience what laughter can do for our spirit and our minds. Lets get the endorphins flowing. Rent a comedy video and escape to humor. If watching a video is not for you, try anything that will get you laughing, really laughing and describe how it made you feel; relaxed, energized, ready for a good nights sleep..... :-)

Suggested activities:

- Look at old scrap books, home videos
- Have a family dance session
- Challenge a friend to a Wii game

Week 7: This week's wellness endeavor is to **EXERCISE**. It is time to get physical. Walking is a good way to exercise, but do *something* to get your heart rate up...

Suggested activities:

- Add an exercise class at Juniper Swim & Fitness
- Jump rope in your driveway
- Park in lower BEC parking lot and walk to class

Week 8: Let the Games Begin: we want everyone to enjoy playing games. We enjoy playing board, card, and dice games with our children, spouses, family, and friends. Even if you have very young children, you can play Go Fish or Memory.

Suggested activities:

- Travel Scrabble could be done with during class breaks
- King's corner is an easy card game that incorporates solitaire

Week 9: Take 5-10 minutes or however long it takes to sit your family, significant other, fiancé, or the dog and cat down and thank them for their support of you through this process of class, clinical, and time away from home. Tell them how much you love them. It is never too late to say *I love you* nor can you not say it enough. The sacrifices they make on your behalf to achieve a dream or goal in life needs to be recognized by each and every one of us.

Wellness Reference: Provide one wellness resource (book, website, etc.) that helps motivate you to incorporate wellness in your life. Write your reference in APA format. Provide short paragraph on how the reference was helpful for you.

The ideas for this wellness log were provided by the NUR 108 AHEC Class of Winter 2005. Many thanks to them for their creativity.

CLINICAL PRACTICUM
Weekly Assignments & Activities

Clinical Week 1

Day 1 - orient to unit/get patient assignment (complete weekly clinical preparation to turn in to instructor on morning of day 2)

Day 2 – patient care/post conference with individual oral presentations of *the patient's disease summary & Standard of Care and priority assessments*

Clinical Week 2

Day 1 – patient care (completed weekly clinical preparation turned in at start of day)

Day 2 – patient care/post conference with individual oral presentations of *the patient's assessment & reflection on care*

Clinical Week 3

Day 1 – Darkness to Light & Children's Vision Foundation training on campus

Day 2 – patient care/post conference (completed weekly clinical preparation at clinical on Friday during first hour of shift) turn in. Present *ethics* assignment

Clinical Week 4

Day 1 – patient care/speaker presentation (completed weekly clinical preparation turned in at start of day)

Day 2 – ***Full clinical prep & reflection assignment turned in for grade*

Clinical Week 5

Day 1 – patient care/speaker presentation (completed weekly clinical prep turned in at start of day).

Day 2 – patient care/post conference turn in and discuss communication assignment

***E-mail Wellness Assignment to instructor on Monday, December 1st.*

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

NUR 106

FALL 2014

**CLINICAL PRACTICUM
WEEKLY CLINICAL PREPARATION****Student Name:****Dates of Care:****Biographical Data****Medical Record Summary**

Patient Age:

Sex:

Admission Date:

Advanced Directives:

Resuscitation Status:

Diet Orders:

Activity Orders:

Fall Risk:

Disease Summary**Medical Patients**

Admitting and Current Diagnoses:

Disease Summary:

Textbook Signs and Symptoms:

Actual Signs and Symptoms Patient Exhibited on Admission:

Potential Complication and Associated Signs and Symptoms:

Summary for One Additional Condition with Signs and Symptoms:

Potential Complication and Associated Signs and Symptoms:

Surgical Patients

Admitting and Current Diagnoses:

Underlying Disease/Condition:

Surgical Procedure:

Summary of Surgical Procedure:

Potential Complication and Associated Signs and Symptoms:

Summary for One Additional Condition with Signs and Symptoms:

Potential Complication and Associated Signs and Symptoms:

Medication Administration Worksheet

Patient medication allergies & associated reactions:

List of all prescribed medications:

Look up 5 Priority Medications for this patient:

Drug Name (Generic and Trade) Dose Time	Classification	Rationale for this Patient	Nursing concerns (side effects, lab, interactions, administration parameters)

Nursing Process:

List the standard of care referenced: book and page number

Priority Assessments & Rationales *(from the above standard of care)*

1. Assessment:

Rationale (why is this assessment important)

2. A:

R:

3. A:

R:

CLINICAL PRACTICUM
Clinical Preparation and Reflection Assignment
Week 4

CLINICAL PREPARATION DIRECTIONS: Complete the following clinical preparation steps in writing and be prepared to discuss with instructor and peers at the beginning of your first clinical day.

1. Medical Record Summary: Gather biographical data from the computer EMR. State the patient age, sex, and admission date. State the medical diagnosis/surgical procedure, allergies (medication, food, latex, environmental), advance directives, resuscitation status, diet order, activity order and fall risk. This is overall information needed to care for the patient. It will also help you become familiar with the location of information in the electronic medical record. Make as complete as possible on Wednesday.

2. Disease Summary:

For medical patients:

- a. List admitting diagnosis or current diagnosis if different than admission:
- b. Summarize the primary underlying disease or condition (short paragraph). *Use your medical-surgical textbook, care planning book, or medical dictionary.*
- c. List the textbook signs and symptoms:
- d. List the patient's actual signs and symptoms as reported in the EMR under the physician's history and physical, or the nursing admission assessment:
- e. List one potential complication and the associated signs and symptoms. List the signs and symptoms that would present if this complication started developing while you are caring for the patient. This will help you recognize problems that need to be addressed for patient safety.
- f. Summary for one additional condition with signs and symptoms:

Disease Summary Example:

Atherosclerosis develops after damage to the vascular wall. Inflammation occurs with platelet aggregation at the site. This causes the vessel wall to thicken. High levels of unhealthy lipids also contribute to plaque formation and calcification (hardening of the arteries). These plaques can break off and become an embolus in the coronary circulation. The result of atherosclerosis is inadequate perfusion of tissues because of decreased blood flow through the vessels.

Text book signs & symptoms: ↓ blood flow to heart = angina, ↓ blood to legs = cool feet, poor pulses, ↓ blood flow to kidneys = low urine output

Patient's signs & symptoms: chest pain unrelieved with nitroglycerin

Potential Complication with s/s: myocardial infarction s/s sudden severe chest pain, heavy, crushing pain, pain radiating to jaw, back, shoulder or left arm, indigestion, nausea and vomiting, diaphoresis, anxiety

Additional Condition with signs and symptoms: Diabetes mellitus type II: DM type II results from insulin resistance, with inadequate insulin production to meet metabolic demands. Signs and symptoms are hyperglycemia, polyuria, and polydipsia. Due to continued high blood sugars the patient may develop neuropathy and ulcerations of the feet, Nephropathy may lead to renal failure and retinopathy may cause blindness.

Patient's signs and symptoms: my patient has neuropathy of the lower extremities making walking difficult.

For surgical patients:

Admitting and Current Diagnoses:

Underlying Disease/Condition:

Surgical Procedure:

Summary of Surgical Procedure: *Note: read the operative report and summarize in your own words, please do not copy it word for word*

Potential Complication and Associated Signs and Symptoms:

Summary for One Additional Condition with Signs and Symptoms:

Potential Complication and Associated Signs and Symptoms:

Example:

Admitting and Current Diagnoses: knee pain

Summary of the underlying disease/condition: *Rheumatoid arthritis (RA) is an autoimmune disease that causes chronic inflammation of the joints. Inflammation of the joints is the primary feature, inflammation and injury can be present in other organs of the body. In the case of Rheumatoid arthritis the joint has become almost fused.*

Surgical Procedure: Right knee arthroplasty

Summary of Surgical Procedure:

Surgery is done to replace the knee joint. An 8 inch incision is created and osteotomies of the femoral and tibial condyles and of the posterior patella are performed and the surfaces are prepared for the prosthesis. The femoral component is fit specifically to the surface, and tibial component was cemented in place. Care was taken to make sure everything fit properly. A hemovac drain was left in place. The incision was sutured and dressed.

Potential Complication and Associated Signs and Symptoms:

My patient is at great risk for infection. She was taking immune modulating drugs prior to the surgery and they will put her at a higher risk for infection. The incision may look red and inflamed, She may develop increased pain and have a fever.

Summary for One Additional Condition with Signs and Symptoms: *Hypertension. Often the only symptom is an elevated blood pressure. My patient has had blood pressures in the normal range, but she is taking two different medications to keep it that way.*

Potential Complication and Associated Signs and Symptoms:

High blood pressure puts her at risk for stroke and for heart failure. Symptoms of a stroke are one sided facial drooping or weakness, slurring of words or inability to speak.

3. Medication Administration Worksheet:

- a. State any medication allergies.
- b. List and look up all scheduled and prn medications given in the last 24 hours. *(Check with your nurse for commonly given drugs for new admits.)*
- c. Complete the worksheet for up to 10 of these medications. *(For patients with more than 10 medications, write up those that provide the best learning for you.)*
- d. State the drug name, both generic and the trade name, dose, and time in the first column.
- e. State the drug classification in the second column.
- f. In the third column, state the rationale for why this patient is receiving the medication. *For example aspirin can be given for (1) antipyretic, (2) anti-inflammatory, and (3) anti-platelet action. Only write the reason your patient is receiving this drug.*
- g. In the final column, list any assessments that are required prior to administration of the medication (nursing considerations).

4. Nursing Process: Determine an appropriate standards of care from your Medical-Surgical Care Planning book or one of your classroom textbooks and list the title, resource and page number. Read through the plan in preparation for patient care. Be ready to discuss your selected plan with your instructor the key assessments and interventions appropriate for your patient.

5. Time Management Plan: Come to clinical Thursday, with a plan of how you think your day will go. Use this as your "paper brain" and update as needed. It appropriate for this page to be handwritten and messy looking!

CLINICAL REFLECTION DIRECTIONS: Complete the following clinical reflection steps in writing and be prepared to hand in the full completed assignment at the end of the second day of clinical.

1. **Health History Interview:** Complete on Thursday. History of the present health concern: use COLDSPA mnemonic to complete an in-depth assessment of health problem/concern. Complete the Lifestyle and Health Practice Profile questions with your patient.
2. **Physical Assessment:** Complete this Thursday after you have performed your physical assessment of the patient. Fill in the assessment form using subjective and objective data, utilizing correct terminology.
3. **Nursing Process- Interventions and Rationale:**
 - a. List four assessment and treatment interventions that you implemented for your patient on Thursday.
 - b. Determine rationale supporting the intervention from your textbooks and then individualize the rationales by incorporating your patient's disease/condition or risk factors for development of complications.

I: **[Assessment]** Measure vital signs and list what abnormalities you would anticipate.
R: Describe the underlying cause of the abnormal vital signs.

I: **[Assessment]** Describe the textbook signs and symptoms that you assessed.
R: Describe the underlying cause of the signs and symptoms.

I: **[Treatment]** Describe the specific treatment interventions that you carried out.
R: Describe how these interventions would improve your patient's health.

E.g.

I: Monitor vital signs for increased or decreased heart rate and low blood pressure.

R: Check heart rate for bradycardia or arrhythmia when patient is on digoxin. Check for hypotension with pain medications and nitroglycerin. Risk for cardiogenic shock after MI; look for tachycardia with falling blood pressure.

4. **Reflection on Student Performance:** Select one of the performance criteria listed under the role- ***As Provider of Care*** on your Clinical Assessment Tool (CAT) and reflect on your clinical performance. Describe your actions and how these are contributing to you meeting this criteria. Under the role- ***As Communicator***, describe something you learned during the handoff report that you didn't find in your initial preparation or a change since your preparation.
5. **Technology and Information Literacy:** This college level paper needs to reflect strong computer skills, correct grammar and spelling, and clean formatting. Areas that are allowed to be handwritten are noted in the directions.

CENTRAL OREGON COMMUNITY COLLEGE NURSING PROGRAM

CLINICAL PRACTICUM
WEEK 4
Clinical Preparation and Reflection Assignment
Template

Student Name:**Dates of Care:**

CLINICAL PREPARATION
Biographical Data

Medical Record Summary

Patient Age:

Sex:

Admission Date:

Medical diagnosis/Surgical procedures:

Allergies:

Advanced Directives:

Resuscitation Status:

Diet Orders:

Activity Orders:

Fall Risk:

Disease Summary

Medical Patients

Admitting and Current Diagnoses:

Disease Summary:

Textbook Signs and Symptoms:

Actual Signs and Symptoms Patient Exhibited on Admission:

Potential Complication and Associated Signs and Symptoms:

Summary for One Additional Condition with Signs and Symptoms:

Potential Complication and Associated Signs and Symptoms:

Surgical Patients

Admitting and Current Diagnoses:

Underlying Disease/Condition:

Surgical Procedure:

Summary of Surgical Procedure:

Potential Complication and Associated Signs and Symptoms:

Summary for One Additional Condition with Signs and Symptoms:

Potential Complication and Associated Signs and Symptoms:

**Time Management Plan
Day Shift**

Time	Thursday	Friday
0630	Report to Pre-Conference	Report to Pre-Conference
0700	Attend Hand-Off Report	Attend Hand-Off Report
0700-0800		
0800-0900		
0900-1000		
1000-1100		1115 Report off to Nurse Return Computer/Power Cord, Keys
1130-1230		Attend Post-Conference (Individual clinical group)
1315-1330	Report off to Nurse Return Computer/Power Cord, Keys	
1330-1430	Attend Post-Conference (All clinical groups)	

Time Management Plan
Evening Shift

Time	Thursday	Friday
1330-1400	Attend clinical preconference	Report to Unit Attend clinical preconference Obtain Report from RN
1400-1500	Attend Conference (All clinical groups)	
1500-1600	Get report from RN	
1600-1700		
1700-1800		1815 Report off to Nurse Return computer/power cord, keys Report off to Clinical Instructor
1830-1930		Post Clinical Conference
1900-2000		
2000-2100		Clinical ends at 2015
2115-2130	Report off to Nurse Return computer/power cord, keys Report off to Clinical Instructor	



CLINICAL REFLECTION

Nursing Assessment Health History

Reason(s) for Seeking Health Care:

"What is your major health problem or concerns at this time?"

"How do you feel about being hospitalized?"

History of Present Health Concern (COLDSIPA):

Character: *Describe the sign/symptoms, how does it feel, look, smell, sound...?*

Onset: *When did it begin? What do you think caused/or is causing the problem? Was the onset gradual or sudden? Is it better, worse or about the same since it began?*

Location: *Where in the body does the symptom occur? Does the symptom radiate to other areas of the body? Does it occur in other locations?*

Duration: *How long does the symptom last? Does it start and stop? How often does the symptom occur?*

Severity: *How severe is the symptom- mild, moderate or severe? How much does the symptom bother you? How would you rate the symptom on a scale of 0-10 with 10 being the most severe?*

Pattern: *What makes it better? What makes it worse? What treatments have you tried (OTC, RX or TX)?*

Associated Factors/Affect on Patient's ADLs: *What other symptoms do you have with it? Have you been able to continue doing your work or other activities (leisure/exercise)? Have the symptoms interfered with your ability to do everyday activities like cooking, cleaning, bathing or dressing?"*

Lifestyle and Health Practices Profile:

- **Sleep and rest:**
 - *"Do you normally feel well rested?"*
 - *"Do you have any problems sleeping?"*
- **Activity level and exercise:**
 - *"What is your typical activity level?"*
 - *"Do you exercise regularly? How often?"*
- **Nutrition and weight management:**
 - *"Have you had a recent weight loss or gain that wasn't intentional?"*
 - *"Do you have any concerns about your weight?"*
 - *"Have you experienced any appetite changes?"*
 - *"Are you on a special diet?"*
- **Substance use:**
 - *"Do you use any of the following: vitamins or herbal supplements, over-the-counter drugs, caffeine, alcohol, tobacco, recreational drugs or others such as prescription drugs?"*
- **Social activities (hobbies, recreation, involvement in the community):**
 - *"Do you participate in hobbies or recreational activities?"*
 - *"Are you involved in community activities?"*
- **Relationships (composition of family, significant others- including pets, role in the family):**

- "Do you live alone or with others?"
- "Do you have contact with family members?"
- "Do you have a significant other that is not a member of your family?"
- "Do you have pets?"
- "What is your role in your family?"
- **Values and belief system (philosophical, religious and/or spiritual beliefs):**
 - "What gives you strength and hope?"
 - "Are there any religious beliefs that affect diet, dress, or health practices?"
- **Education and work (level of education, job):**
 - "What level of education did you complete?"
 - "Are you working? What is your job?"
- **Stress level and coping styles (causes of stress, stress relief measures, help in times of need):**
 - "What typically causes you to experience stress in your life?"
 - "What type of things do you do to help relieve stress?"
 - "Do you have someone or something that you turn to for help during stressful times?"
- **Environmental risks (physical, chemical, psychological):**
 - "Are you exposed to any physical, chemical, or psychological risks at work or at home?"

Physical Assessment

Record your findings for those systems you assessed.

VITAL SIGNS: T, P, R, BP, SaO₂

PAIN STATUS: (COLDSPA: Character, Onset, Location, Duration, Severity, Patterns, Associated Factors/Affect on Life)

PSYCHOLOGICAL, SOCIOCULTURAL, AND DEVELOPMENTAL

General appearance:

Psychological:

Sociocultural:

Developmental level:

Other:

NEUROSENSORY

Orientation:

LOC:

Eyes:

Sleep and rest/ difficulty sleeping:

Other:

NEUROMUSCULAR/NEUROVASCULAR

Upper and lower extremity strength:

Color/Motion/Sensation:

Impairment/Assistive devices:

Activity Level:

Other:

RESPIRATORY

Inspection:
Palpation:
Auscultation:
Supplemental oxygen:
Other:

CARDIOVASCULAR

Inspection:
Palpation:
Auscultation:
Capillary refill:
Pulses:
Edema:
Other:

GASTROINTESTINAL

Inspection:
Auscultation:
Palpation:
Flatus/Last BM:
GI tubes:
Other:

GENITOURINARY

I/O for shift:
Urine color, amount:
Type of urinary catheter:
Other:

INTEGUMENTARY:

Color/Temperature:
Turgor:
Mucous Membranes:
Dressing(s)/surgical drains/wound appearance:
Other:

ENDOCRINE:

CBG:
Other:

Interventions with Rationale (minimum of 4)

I: Monitor vital signs for:

R:

I:

R:

I:

R:

I:

R:

Reflection on Student Performance

Describe ways that you met these outcomes for the week.

As Provider of Care:

- Provide a safe physical and psychosocial environment for the patient

- Provide nursing interventions associated with personal care, mobility, nutrition, hydration, elimination, and assistive devices without prompting.

As Communicator:

- Promote therapeutic relationships with the individual and/or family.

Clinical Preparation and Reflection Assignment Rubric

Name _____

Total Points ____/50 or Feedback only

Clinical Preparation Section

Dimensions	Exemplary	Competent	Developing	Needs Improvement
Medical Record Summary Score: 3 - 2 - 1 - 0	Gathers information with very little or no assistance. Patient biographical information complete.	Gathers information with some assistance from staff and instructor. Some data missing.	Gathers data with assistance from clinical instructor or staff. Provides only minimal information.	Gathers data only with direct assistance from clinical instructor or staff. Provides information that is seriously lacking.
Disease Summary Score: 10 - 9- 8 - 0	Medical: Identifies and completely summarizes current medical diagnosis with complete list of textbook signs and symptoms. Locates and provides a list of signs and symptoms exhibited by patient at admission. Provides one appropriate complication with associated signs and symptoms. Surgical: States procedure, completely summarizes underlying condition and procedure. Provides one appropriate complication with associated signs and symptoms. Lists one additional condition with signs and symptoms.	Identifies and provides concise summary of medical diagnosis or surgical procedure with full list of textbook signs and symptoms. Locates and provides signs and symptoms exhibited by patient at admission. Provides complication that is unlikely in this patient with associated signs and symptoms.	Identifies and copies definition of medical diagnosis/surgical procedure without evidence of summarization in own words. Provides abridged list of textbook signs and symptoms. Requires assistance to locate signs and symptoms exhibited by patient at admission. Provides a list of all potential complications with associated signs and symptoms.	Identifies incorrect medical diagnosis, or underlying disease requiring a surgical procedure. Provides incomplete listing of textbook signs and symptoms, and fails to provide symptoms exhibited by patient. Fails to provide complications. Fails to prepare before clinical day begins.
Medication Administration Worksheet Score: 6 - 5- 4 -0	Lists all medications received in last 24 hours, or those likely given to new admit. Completes the medication administration worksheet and clearly relates the purpose of the drug to this patient's illness for up to 10 medications. Identifies nursing considerations and lists appropriate assessments.	Lists all medications patient received in last 24 hours or all medications for new admit. Completes the medication administration worksheet for up to 10 medications. Identifies purpose of medication for the disease process. Lists nursing considerations.	Requires assistance to identify prescribed medications. Provides an incomplete medication administration worksheet.	Medication administration worksheet not prepared prior to clinical day.

Nursing Process Score: 4 – 3 – 2 – 0	Identifies all related standards of care to be utilized to deliver patient care. Discusses relevant nursing standard of care and appropriate interventions for this patient. States text resource and page numbers.	Identifies most of the related standards of care to be utilized to deliver patient care. Provides a general discussion of nursing standard of care and appropriate interventions for this patient. States text resource and page number.	Identifies one standard of care to be utilized to deliver patient care. Provides a minimal discussion of nursing standard of care and interventions for a patient with this diagnosis.	Fails to identify standard of care for patient care.
Time Management Plan Score: 3 – 2 – 1 – 0	Provides thorough and organized time management plan prepared prior to beginning of shift and updates plan throughout shift of care.	Provides basic time management plan created to direct patient care.	Displays inadequate time management plan or poorly organized care.	Prepared no time management plan.

Clinical Reflection Section

Dimensions	Exemplary	Competent	Developing	Needs Improvement*
Nursing Assessment: Health History Physical Assessment Score: 6 – 5 – 4 – 3	Provides a full written description of the patient's problem utilizing the COLDSIPA format. Provides a complete set of data collected with the health history questions. Completes a detailed physical assessment including S/Sx of complications, using correct terminology to describe normal and abnormal findings.	Provides a written description of the patient's problem utilizing the COLDSIPA format. Provides data for each health history question. Completes a head-to-toe assessment using correct terminology to describe normal and abnormal findings.	Summarizes the patient's problem. Provides data for most of the health history questions. Completes a basic assessment with some incorrect terminology to describe findings.	Identifies an incorrect patient problem. Provides an incomplete health history. Performs an incomplete assessment and fails to use correct terminology to describe findings.
Nursing Interventions and Rationale Score: 10 – 9 – 8 – 7	Provides four priority interventions and rationale utilized in the care of the patient. Started with action verb and includes all parameters. Rationale describe underlying cause of assessment findings, or purpose of treatment interventions in the	Provides four individualized interventions and rationale utilized in the care of the patient. Some interventions missing parameters. Rationale define underlying cause of assessment findings, or purpose	Provides textbook interventions rather than those carried out during clinical. Rationale are underdeveloped, or restate parameters.	Fails to develop appropriately formatted interventions. Rationale missing or underdeveloped.

N:\Group Folders\Accreditation\DRAFT Reports - Development\2015 (Mid-Cycle)\DRAFT versions\Appendix B Items\Evidence Links from Michele\NUR 106 Course Syllabus, 15.docx

Michele Decker RN, MSN, MEd, Kiri Simning RN, MS Updated 6/9/14 MD/JM/KS

	solving of patient problems.	of treatment interventions.		
Reflection on Student Performance Score: 5 – 4 – 3 – 2	Provides an insightful reflections on personal performance in areas of As Provider of Care, and As Communicator	Provides reflections that support meeting performance criteria in the areas of As Provider of Care, and as Communicator.	Provides an incomplete reflection on performance and fails to demonstrate how progressing towards meeting the performance criteria on the Clinical Assessment Tool.	Relates examples from clinical practice that are unsupportive of performance criteria on Clinical Assessment Tool
Technology and Information Literacy and Writing Standards Score: 3 – 2 – 1 – 0	Demonstrates advanced computer skills in the application of the Clinical Preparation and Reflection Assignment template. Entire document is word processed. Demonstrates a high level of writing skills resulting in a well written paper.	Demonstrates adequate computer skills in the use of the Clinical Preparation and Reflection Assignment template. Hand writes approved sections. Demonstrates adequate writing conventions with 1-2 errors. (E.g. misspellings, poorly constructed sentences and difficulty conveying meaning).	Demonstrates beginning level of computer skills. Hand writes sections that were not approved. Multiple Grammar or spelling errors. Demonstrated adequate writing conventions with multiple errors. (E.g. misspellings, poorly constructed sentences and difficulty conveying meaning).	Hand writes full document. Crowds information on template forms. Difficult for instructor to read handwriting. Does not reflect college level work. Demonstrates multiple writing errors making the paper difficult to read

***Any category not addressed will receive a score of " 0"**

THERAPEUTIC COMMUNICATION ASSIGNMENT

*Be prepared to share with your clinical group during conference each week.
Final paper due to your clinical instructor on November 21.*

Purpose: Strong communication skills remain central to excellent nursing care. This quarter you will begin examining your communication efforts with clients and identify specific techniques employed in the conversations. Evaluation of these interventions will provide you with insight into the impact of your comments, and contribute to the development of therapeutic communication skills.

Reference: Potter & Perry (2015) *Essentials for Nursing Practice* (8th Ed.), pp. 181-200.

Directions:

Part 1: Provide therapeutic responses to each of the patient scenarios. Identify the techniques used.

Part 2: Identify the non-therapeutic technique. Provide an alternative therapeutic response. Identify that technique.

Part 3: Using the table below or a similar format, record 2 or 3 interactions per week and identify the communication techniques used. Evaluate the effect.

Part 4: Reflection. Critical evaluation of your communication with clients will provide insight into why you're successful with clients and what you might do to enhance your communication skills.

Date	Client Comment	Nurse Thought	Nurse Response	Technique	Evaluation of effort or effectiveness of technique
9/29	"I'm just about done here on the planet, so good luck with your nursing career..."	There's no way I'm up for talking about dying- clinical is over in 5 minutes, I still have to write a note, and what do I know about dying?	"You're not done! Don't think for a minute that you won't beat this metastatic cancer!"	Rejecting	Non-therapeutic. Missed opportunity to discuss dying and support patient in saying goodbyes. Saved nurse from having to discuss hard topic.
9/29	"My roommate died last night."	Holy smokes- I almost selected her as my patient!	"I'm sorry....How are you doing with that?"	Encouraging expression	Therapeutic. Pt took opportunity to share fears and frustrations. Tearful.
9/30	"In sounds cold, but in a way it was a blessing. She was so ready to go and was so miserable here..."	I wonder if I'll ever be that comfortable with people dying?	"It sounds like you had a chance to get to know her a bit before she died."	Exploring	Therapeutic. This worked. Pt kept talking about dying.
9/30	"We did get to talk about dying. She was ready."	Be brave....	"So how are you with dying?"	Encouraging comparison.	Therapeutic. Transition from friend's death to pt's thoughts on death. Patient looked away and then responded.

Name _____

Communication Assignment

Due November 21, 2014 to clinical instructor

Part 1: Patient Scenarios

✚ The nurse walks into a patient's room and finds the patient crying and twisting facial tissues in her hands. The patient looks apprehensive. How should the nurse approach this patient?

✚ Next, list three (3) therapeutic statements the nurse could make in this situation. Identify the communication technique for each of the statements.

1.

2.

3.

✚ The nurse walks in a patient's room for the beginning of the shift. The nurse states, "You seem a little sad today, Mrs. Smith." The patient responds, "Yes, it is the anniversary of my husband's death." Give three (3) examples of how the nurse could respond therapeutically. Identify the communication technique for each of the examples.

1.

2.

3.

✚ During the nurse's morning assessment, the patient says, "I don't believe my doctor knows what he's doing." Write a response and your rationale.

✚ While volunteering at a sports physical clinic, the nurse meets a high school student who seems unusually euphoric. The nurse states, "You seem happy about something. Tell me what's going on." The student replies, "Can you keep a secret?"

Write a reply for the nurse:

The student next says, "I'm going to run away with my boyfriend."

Write a reply for the nurse:

Part 2: Identify the non-therapeutic techniques.

Give an alternative therapeutic response and identify the therapeutic technique.

- ✚ The patient says, "My mom and I argued last night. I screamed 'I hate you'." Nurse replies, "That sounds awful."

Non-therapeutic technique:

Alternative response:

Therapeutic technique:

- ✚ Patient states, "My doctor says if I want to live, I have to quit smoking. I'm going to start on the nicotine patch today." Nurse replies: "That's good. I'm glad you're going to try."

Non-therapeutic technique:

Alternative response:

Therapeutic technique:

- ✚ Patient states, "I'm worried about my back surgery. My doctor said she had to tell me the potential risks. I could end up paralyzed!" Nurse states, "I wouldn't worry about that. We have never had that happen here. They just have to tell you for legal reasons."

Non-therapeutic technique:

Alternative response:

Therapeutic technique:

- ✚ Patient states, "I just want this all to end." Nurse replies, "What you really mean is that you want to go home."

Non-therapeutic technique:

Alternative response:

Therapeutic technique:

- ✚ Patient states, "My blood pressure is too high. My doctor says it would be helpful if I lost weight." Nurse replies, "He's just trying to give you a drug-free way to work on the problem."

Non-therapeutic technique:

Alternative response:

Therapeutic technique:

Communication Assignment Rubric

Name _____
Points _____ / 30 = _____ %

Dimensions:	Proficient	Competent	Needs Improvement
Part 1: Patient Scenarios 5 – 4 – 3	Addresses all patient scenarios in Part 1 with highly appropriate therapeutic responses.	Addresses most scenarios with appropriate therapeutic responses.	Addresses half or less of the scenarios correctly.
Part 2: Identify Non-therapeutic techniques 5 – 4 – 3	Identifies each non-therapeutic response correctly. Provides an alternative appropriate therapeutic response. Correctly identifies the therapeutic response using classroom textbook. Recognizes yes/no questions as non-therapeutic.	Identifies most nontherapeutic statements correctly. Provides appropriate therapeutic response & technique. Does not identify yes/no questions as incorrect.	Identifies 4 or less of the nontherapeutic techniques or provides 4 or less appropriate therapeutic responses.
Part 3: Interactions 5 - 4 - 3	Recorded 3 interactions each clinical week (Total 12)	Recorded 2-3 interactions each clinical week (Total 8-11)	Recorded fewer than 2 interactions each week. (Total < 8)
Identify technique 3 - 2 - 1	Used references to label all therapeutic communication techniques correctly. Experimented with 6-8 different techniques.	Identified correctly 90% of therapeutic communication techniques. Utilized 5 different techniques.	Identified correctly 80% or less of therapeutic communication techniques. Utilized 4 or less different techniques.
Evaluate Effect 2 - 1 - 0	Described the verbal and nonverbal effect of technique used with patient.	Described the verbal effect of technique used with patient.	Described the effects minimally.
Part 4: Reflection 5 – 4 – 3	Addressed own progress towards using therapeutic communication techniques by identifying techniques that came easily, those that were difficult and next steps for growth.	Addressed partially his/her skill in using therapeutic communication techniques. Identified next areas for growth.	Addressed poorly areas of strength and weakness in using therapeutic communication techniques. Identified few or no areas of growth.
Computer & Information Literacy 5 – 4 – 3 0 points for handwritten paper.	Downloads assignment from Blackboard, completes a professional looking paper with appropriate use of font size, with no spelling or grammar errors, eliminates unnecessary spacing, and submits on time.	Downloads assignment from Blackboard. Creates an intermediate-level, visually appealing paper with a few spelling or grammar errors, or unnecessary spacing. Submits on time.	Creates an amateur- looking paper with no additional flair with some spelling or grammar errors, and some unnecessary spacing. Or submits one day late.

TEMPLATE FOR VALUES AND ETHICS ASSIGNMENT

COCC Outcome:

Students will evaluate the ethical dimensions of arguments and the consequences of decisions

NUR 106 outcome:

Upon completion of this learning unit, the student will be able to identify ethical and legal principles of nursing practice.

Instructions:

- Prepare a 5-7 minute oral presentation using the template below.
- Present during clinical conference to peers and clinical instructor.

Template

Please follow when presenting your ethical issue:

1. The ethical issue I want to discuss is:
2. The universal moral, bioethical principle is:
3. An ethical theory to interpret the acceptability of the healthcare practitioner's actions is:
4. The portion of the ANA Nursing Code of Ethics that applies to this ethical issue is:
5. Possible solution(s) to the issue based on ethical concepts is/are:
6. My personal understanding of how values & ethics apply to my issue is: [or what I learned]

VALUES AND ETHICS ASSIGNMENT RUBRIC

COCC Outcome for Values & Ethics: Students will evaluate the ethical dimensions of arguments and the consequences of decisions.

NUR 106 outcome: Upon completion of this learning unit, the student will be able to identify ethical and legal principles of nursing practice.

Components	Exceeds – 4	Mastery –3	Beginning Competency –2	Developing –1
Identify Ethical Issue	Identifies and describes a complex, patient-focused ethical issue	Identifies and describes a patient-focused ethical issue.	Identifies and describes a simple patient-focused ethical issue.	Identifies and describes an employee-performance issue rather than an ethical issue.
Explain Moral Principle	Selects the applicable universal moral, bioethical principle and fully explains how the identified issues fit this category.	Selects the applicable universal moral, bioethical principle and adequately explains how the identified issue fits this category.	Selects a somewhat applicable moral, bioethical principle and provides a beginning level explanation of how the issue fits this category.	Selects a non-applicable universal moral, bioethical principle and/or inadequately explains how the identified issue fits this category.
Apply Ethical Theory	Applies an ethical theory to interpret the acceptability of the healthcare practitioner's actions.	Applies an ethical theory to describe the acceptability of the healthcare practitioner's actions.	States an ethical theory and briefly describes the acceptability of the healthcare provider actions.	Applies an unrelated ethical theory to describe the acceptability of the healthcare practitioner actions.
Integrate ANA Nursing Code of Ethics	Integrates a discussion of the ANA Nursing Code of Ethics into the evaluation of the ethical issue.	Relates the ANA Nursing Code of Ethics into the evaluation of the ethical issue.	Refers to the ANA Nursing Code of Ethics.	Fails to relate the ANA Code of Ethics to the discussion.
Propose solutions	Poses and evaluates several possible solutions to the issue based on ethical concepts.	Poses and evaluates at least two possible solutions to the issue based on ethical concepts.	Poses and evaluates a single solution to the issue based on ethical concepts.	Provides no solutions to the issue.
Personal understanding	Demonstrates an ability to apply a fully developed personal understanding of values & ethics of healthcare professionals to the identified issue.	Demonstrates an ability to apply personal understanding of values and ethics of healthcare professionals to the identified issue.	Demonstrates a beginning ability to apply personal understanding of values and ethics of healthcare professionals to ethical issues in general.	Demonstrates little or no personal understanding of values and ethics of healthcare professionals.

***Any category not addressed will receive a score of " 0"**