Course Number: NURS 115
Course Title: Foundations of Nursing
Course Term and Year: Spring 2010

Course Section: NURS 115 at Alcoa City Center (Blount)
St. Mary's Medical Center (Knoxville)
Meeting Time and Place: See attached lecture schedule for specific site information.
Course Credit Hours: 6 credit hours

FACULTY CONTACT INFORMATION
Course Coordinator: Robin Zachary RN, MSN, 865-545-8107, robin.zachary@lmunet.edu
SMMC: Robin Zachary RN, MSN, 865-545-8107, robin.zachary@lmunet.edu
ACC: Diana R. Beckner RN, MSN, 865-273-1541, diana.beckner@lmunet.edu

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I. COURSE DESCRIPTION: A lecture/laboratory course introducing the nursing process with a focus on the development of psychomotor and psychosocial skills. The Roy Adaptation Model (RAM) of Nursing is introduced and is utilized as basis for promotion of adaptation in human persons as evidenced in the four adaptive modes: physiologic, self-concept, role function, and interdependence; emphasis on beginning recognition of adaptive human responses versus ineffective responses. History of nursing, selected theories of nursing, nursing roles, and definitions of human person, environment, health, and nursing are discussed; beginning skills related to basic nursing care, communication, and assessment are included. Clinical learning experiences occur in the campus laboratory and in structured health care facilities with adults. Pre-requisite: Admission to the A.S.N. program. Pre- or co-requisite – BIOL 250; INFL 100.

II. COURSE OBJECTIVES:

Students who successfully complete NURS 115 will be able to demonstrate, in the clinical/campus laboratory setting, in individual and group conferences, and on written materials, the ability to:

1. Recognize selected theories related to nursing and definitions of human person, environment, health and nursing.
2. Utilize Roy's Adaptation Model of Nursing (RAM) to promote adaptation in human persons as evidenced in the four adaptive modes: physiologic, interdependence, role function and self-concept.
3. Identify adaptive human responses to behavior or stimuli that affect identified physiologic mode needs: oxygenation, nutrition, protection, senses and comfort, safety, activity and rest.
4. Identify ethical/legal principles in provision of nursing care.
5. Define and differentiate nursing roles and the roles of the various members of the health care team.

6. Identify and utilize basic communication skills and differentiate between therapeutic and non-therapeutic communication techniques.
7. Identify principles of the teaching-learning process and teaching-learning strategies.
8. Utilize critical thinking to develop the steps of the nursing process to write a nursing care plan applying RAM and provide care to selected clients.
9. Demonstrate basic assessment skills utilizing RAM.
10. Demonstrate beginning level technical skill mastery and performance of basic nursing procedures with assistance.
11. Recognize and utilize research on the practice and principles of nursing.

III. TEXTS/MATERIALS FOR THE COURSE:

Ackley, B. & Ladwig, G. (2007). *Nursing diagnosis handbook: A guide to planning care. (8th ed.). St. Louis, MO:* Mosby.

Brownell, Christiane L., & Priff, Nancy (Eds.). (2009). *Nursing 2010 student drug handbook*. Philadelphia, PA: Lippincott, Williams and Wilkins.

Dean, T. (2009). *Dosage calculation packet 2009-2010*. Harrogate, TN: Lincoln Memorial University.

Dirckx, J. (2005). S*tedman's concise medical dictionary for the health professions*. (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

Fischbach, F. & Dunning, M. (2006). *Nurses' quick reference to common laboratory and diagnostic tests*. (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Kee, J., Hayes, E., and McCuistion, L. (2008). *Pharmacology: A nursing process approach* (6th ed*.)*. Philadelphia: Elsevier.

Lynn, P. (2008). *Taylor's clinical nursing skills: A nursing process approach (*2nd ed*.)*. Philadelphia: Lippincott Williams & Wilkins.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Fundamentals of nursing: The art and science of nursing care.* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Study guide to accompany f*u*ndamentals of nursing*: *The art and science of nursing care* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

IV. COURSE REQUIREMENTS, ASSESSMENT (LEARNING OUTCOMES) AND EVALUATION METHODS:

A. Fulfill course requirements.(See LMU Nursing Student Handbook Online 2009- 2010.)

1. Attendance requirements:

a. Attendance will be taken each class period (lecture/exam). To be counted present, the student must be present for the ENTIRE class period.

b. Study labs will be provided in each ASN clinical course for faculty to expand on

content presented in lecture. Attendance at these study labs is mandatory for ALL students until after the first course exam. After this time, the study labs are mandatory for students who do not have a course average of 83 or greater. Students with course averages of 83 or greater are encouraged to attend the study labs. Attendance will be taken at each study lab. To be counted present, the student must be present for the ENTIRE study lab.

c. After two (2) absences (lecture/exam/study lab) in one semester, it may necessitate that the student withdraw from this NURS course. The student is to contact the Lead Faculty to arrange for withdrawal from this NURS course.

2. **Cell phone usage is NOT permitted in the classroom or clinical area.** This includes, but not limited to, talking on the phone, checking messages and text messaging. If a student uses a cell phone during class or clinical, they will be asked to leave and counted absent for that day.

3. Taping of lectures is a privilege which may be granted by the individual faculty member, but it is up to students who wish to tape lectures to ask permission, and not simply assume permission. Students should ask for permission at the beginning of the semester with each individual faculty member. Faculty members reserve the right to discuss with students their desire to tape lecture and what benefit it will have for the student.

B. Written Requirements

1. **<u>Tests and Examinations</u>**:

a. Six (6) exams, a comprehensive final, and standardized course assessment exams are scheduled. The standardized course assessment exam will be April 16 at the West Knoxville Site. Test dates and times for the 6 classroom exams are specified on the lecture schedule. Completion of ALL exams (classroom and course assessment exams) is required to Receive credit for NURS 115.

b. A dosage quiz(zes) will also be administered at the beginning of the scheduled campus lab time and are considered to be part of the lab day. Students can not take the dosage quiz if they do not attend the remainder of the lab. The best dosage quiz score of 80% or higher (of 3 attempts) will be worth 3% of the overall grade for the course. Students will be allowed 30 minutes to complete each of the dosage quizzes.

All students must make a minimum of 80% on a dosage quiz prior to medication administration in the clinical setting. Students will be given three (3) opportunities to score 80% on the dosage quiz. If a student scores an 80% or better on the first attempt, the student will not be required to take the other quizzes. The best dosage quiz grade will be factored into the overall grade for the course. Students who are unable to achieve 80% on the third attempt will not be allowed to administer medication and therefore the student will not be allowed to continue in the course.

The dosage proficiency quiz will include special types of intravenous calculations and/or pediatric dosage calculations. The dosage proficiency quizzes will cover the material included in the Dosage Calculation Packet 2009-2010. Students should refer to the Campus Lab Schedule to determine what assigned material they are responsible for each week.

Instructions regarding Course Assessment Exams:

1. The student must register get a user name and password for the ATI Course Assessment Exams.
2. If technical assistance is needed call: 1-800-667-7531. Office hours of support are Monday – Friday, 7am-6pm Central Standard Time.
3. The faculty at each site will make arrangements for each Course Assessment Exam. Some exams will be administered via paper/pencil and some via the computer.
4. If the Course Assessment Exam is for completion only (satisfactory/ unsatisfactory), the student will be required to take the exam and turn in the grade sheet by a date specified by the faculty. If the Course Assessment Exam is not taken, completed and turned in by the specified time, the student will not be allowed to take a specific scheduled course exam and will receive a zero for that course exam.
5. If the Course Assessment Exam is for a % of the course grade and the student does not complete the exam at the scheduled time, a grade of zero (0) will be recorded.

Rules regarding tests and examinations:

1. All students are expected to take exams as scheduled. Students are required to notify the faculty by phone or email prior to the scheduled exam time if they are not going to be present. Students are given faculty contact information in each NURS course syllabi and are expected to have it available at all times. If for any reason a student is unable to leave a message for the faculty member via the contact information provided, it is the student's responsibility to contact the Nursing Office on campus (1-800-325-0900, ext. 6324) and talk to the Nursing Secretary or leave a message on her voice mail. Please remember to state you are unable to take the exam and be specific as to the course, the faculty's name and the site you attend. **Any student that does not notify the appropriate faculty will receive a zero for the exam.**
2. The faculty will determine the date and time of any alternate make-up exam. **If the student does not make up the exam on the scheduled date and time, the student will get a zero on the exam.**
3. All electronic devices (pagers, cell phones, PDA's, etc), personal belongings (book bags, purses, coats) are prohibited during examination times. Students may only bring into the exam room pencils and a simple calculator. Students must make arrangements for their other personal belongings during test time.
4. Ball caps or hats with any type of brim will not be allowed to be worn during exam administration.
5. Simple calculators are the ONLY calculators allowed during test time. Scientific calculators or those combined with cell phones, PDA's, or other electronic devices are not permitted. If a student presents to an exam with any calculator other than a simple calculator the faculty will collect the calculator and the student will be required to do mathematic calculations by hand only. Calculators collected prior to the exam will be returned after the exam.
6. Editorial corrections will be given at the beginning of the exam. If corrections to the exam are needed once the exam has started, the faculty will interrupt the exam and announce the correction and also write it on the board.
7. Any student who has questions during the exam must raise his/her hand and stay seated.
8. The student must not leave his/her seat until the exam is finished, except for emergencies.
9. The exam will be timed. The time for exam booklets to be turned in and for class

to resume will be written on the board. Any student entering late will be required to turn his/her exam at the stated time.

10. **Violation of ANY of the above policies will result in a zero (0) for that exam.**
11. After the exam is finished, the student has the following options:
    a) Return to his/her seat, and remain quiet until class resumes.
    b) Leave the classroom. (If the student chooses to leave the room, he/she may not reenter until class resumes.)
12. Nursing Faculty will review and score exams during the week after the exam is given. Individual student grades will be available and posted one week after the exam has been given. Faculty will post exam grades on Blackboard.
13. Faculty reserves the right to correct any clerical error. This includes both increases and decreases to adjusted exam grades.
14. Exam reviews will be scheduled outside of class time. Attendance for exam review is strongly recommended. No books, pencils electronic devices or taping are allowed during the exam review.
15. Students have one calendar week after the test review to meet with their instructor for clarification of any exam related issue. For the last exam of the semester (final unit exam or final comprehensive exam), students must contact the instructor within 24 hours for clarification of any exam related issue. If a student wants to appeal any exam related issue, it must be presented via email within the time frame listed above and addressed to the instructor who taught the content.

2. **<u>Clinical Written Work:</u>** Assigned by the clinical supervisor, these works shall be college level submissions.

A. Daily Written Work

Daily care plans/concept maps will be completed by the student in the clinical setting. These completed daily care plans/concept maps will be submitted to the clinical instructor as instructed. The completed daily care plans/concept maps will be included in the clinical evaluation of the student in the clinical setting. If the daily written work is not completed as instructed and/or is unsatisfactory, this will constitute an unsatisfactory grade for the clinical and will result in an "F" for the course.
If a student reports to the clinical area unprepared, he/she will be sent home and the absence will be recorded as an unexcused absence.

B. Comprehensive Clinical Work

As stated above, these works shall be assigned by the clinical instructor and shall be **college level** submissions. The student will be allowed one rework of the assignment. All written work **MUST BE SUBMITTED** in a manila envelope.

<u>Comprehensive Nursing Project:</u> As assigned by clinical instructor. A minimum satisfactory grade of 80% on this assignment must be achieved to receive a satisfactory clinical evaluation. If after the 2nd attempt, a student has not scored 80% on the comprehensive nursing project, this will constitute an unsatisfactory grade for the clinical and will result in an "F" for the course.

All concept maps and reworks must be submitted on the date indicated by the clinical instructor. In case of an absence, arrangements must be made with the clinical instructor regarding the late submission. One point per day will be subtracted for any late assignment. Any late assignment will not be accepted if turned in greater than one week past the assigned due date. IF THE STUDENT'S FIRST ATTEMPT IS TURNED IN

LATER THAN ONE WEEK FOLLOWING THE DUE DATE, THE ASSIGNMENT WILL RECEIVE A ZERO AND A SECOND ATTEMPT WILL NOT BE ACCEPTED.

3. **Mandatory Coaching Material:**
Coaching material is available through the ATI Review Modules, ATI DVD's and student customized review guides generated through practice ATI exams. Students are expected to utilize this ATI material to supplement all NURS course material in order to successfully complete this course. See unit lesson plans for required readings. Proof of completion of the questions at the end of each chapter must be submitted prior to taking each unit exam.

C. Campus Lab/Clinical Requirements: There will be a total of 90 campus lab/clinical hours for NURS 115 Attendance is required in clinical/campus lab experiences. See LMU Nursing Student Handbook Online 2009-2010). All clinical/campus lab absences must be made up. A make up day will be required for both unexcused and excused absences. (A doctor's excuse will be required.)

1. Campus Lab: Begins the week of Jan 11, 2020. (Refer to the Campus Lab schedule for the specific dates of the campus labs and clinicals.) There will be a total of 6 campus lab days. Each campus lab is 8 hours in length including a 30 minute lunch break. **ATTENDANCE IS MANDATORY.**

a. All clinical/campus laboratory absences must be made up.
An absence in campus lab must be made up **before** the next campus lab. It is the responsibility of the student to make arrangements with the campus lab instructor for the make-up lab. The student may be required to travel to another site for this make-up. **(All campus lab work must be completed prior to the student beginning the clinical experience.)**

b. Campus lab time will be available for students to practice skills and students are expected to utilize these opportunities to improve clinical skills at any time during the program. If a student demonstrates deficiency(ies) in clinical skills, clinical instructors may require the student to return to campus lab for remedial work. The student may be required to travel to any of the LMU sites for remedial campus lab work.

c. A list of critical campus lab and clinical skills will be provided to each student. The successful performance of these skills will be essential to the completion of the campus lab/clinical portion of NURS 115.

2. Clinical: Each clinical day in a health care facility will be _8_ hours in length including a ½ hour lunch break. Students will be in the clinical setting one day per week. Clinical group assignments will be made at the individual sites by the nursing faculty. Clinical days will occur as assigned on the Nursing 115 clinical rotation schedule from the week of March 1, 2010 through April 14, 2010. A clinical make-up day, if needed, is scheduled for the week of April 19, 2010.

a. After two (2) clinical/campus lab absences (excused and/or unexcused) in one semester, it may necessitate that the student withdraw from this and any other clinical NURS course in which the student is enrolled. The student is to contact the Lead Faculty to arrange for withdrawal from this course/courses. If the student in enrolled in both this course and a specialty NURS course the policy of two (2) clinical/campus lab absences relates to the combined number of absences between these two NURS

courses.

b. A tardy is defined as arriving to the clinical facility ANY time after the scheduled start time. If a student is more than 15 minutes late to the clinical area the clinical supervisor has the right to inform the student to go home and the absence will be counted as an unexcused absence.

c. A student who has unexcused absences and/or tardies will have a point for each absence and each tardy deducted from his/her final exam grade. The only absences that will be recognized as an excused absence will be illness accompanied by a doctor's excuse or a death in the immediate family.

d. In order to receive a satisfactory grade in clinical, the student must perform the critical behaviors identified in the Clinical Outcomes Tool.

e. In order for a student to be eligible to go into the clinical areas, he/she must produce evidence of an annual negative PPD or negative chest x-ray, record of Hepatitis B vaccination or declination form, a Rubella titer and/or second MMR, and current CPR certification the first time this course meets this semester. **If this documentation is not on file before the first clinical day of the semester, the student will not be allowed to attend clinical and the absence(s) will be counted as unexcused.**

f. Students are reminded that any time they are in the clinical setting for pre-planning, pre-conference, clinical and/or post-conference, they are to adhere to the Caylor School of Nursing uniform policy.

D. Methods of Evaluation

Exam #1	12%
Exam #2	12%
Exam #3	16%
Exam #4	12%
Exam #5	12%
Exam #6	12%
Comprehensive Final Exam	16%
Dosage Quizzes (highest dosage quiz grade)	3%
Standardized course assessment exam	5%
Comprehensive Nursing Project	Satisfactory/Unsatisfactory
Clinical Evaluation	Satisfactory/Unsatisfactory
Clinical /Campus Lab Attendance	Satisfactory/Unsatisfactory

E. Incomplete Policy

Students are expected to complete all requirements as assigned during the semester. Incompletes are only given in extreme circumstances deemed by the instructor. If the request for an "I" is approved, the work must by completed within the first six weeks of the following semester (excluding summer terms); otherwise the grade automatically becomes "F". The grade of "I" is calculated in the grade point average with zero points.

F. ASN Caylor School of Nursing Grading Scale:

A = 90-100%
B = 80-89%
C = 70-79%
D = 60-69%
F = below 60%

The minimal acceptable grade in nursing is a "B" in theory, and a satisfactory in clinical. An unsatisfactory grade in clinical will result in an "F" for the course. See the LMU Student Handbook Online 2009-2010 or obtain one from the secretary of the Caylor School of Nursing.

A failing grade for either theory or clinical performance will result in a failing grade for the course. The student must attain an overall average of 80% to pass NURS 241 with a "B". **There will be NO rounding of earned grades within the course and NO rounding of the final grade for the course.**

E. Clinical Facilities

Tennessee Facilities	**Phone #**
Blount Memorial Hospital	865-983-7211
Claiborne County Hospital	423-626-4211
Ft. Loudoun Medical Center	865-271-6000
NHC Healthcare of Knoxville	865-524-7366
St. Mary's Medical Center	865-545-8000
St. Mary's Medical Center-Campbell Co	423-907-1200
Sweetwater Hospital Association	423-337-6171

Kentucky Facilities	**Phone #**
Christian Care Communities	606-528-2886
Middlesboro Appalachian Regional Hospital	606-242-1100
Oak Tree	606-523-5150
Pineville Community Hospital	606-337-3051
Saint Joseph London	606-878-6520
The Heritage	606-526-1900

V. METHODS OF INSTRUCTION:

Lecture	Small Group Activities
Discussion	Independent Study
Audiovisual Materials	Required & Recommended Readings
Campus/Clinical Laboratory Experiences	Written Assignments
Self-Evaluation	Role playing
Guest Lecturers	Individual Guidance & Assistance from Instructors
Computer Assisted Learning	Case Studies

VI. INFORMATION LITERACY/TECHNOLOGICAL RESOURCES:

Blackboard will be used for this course to post announcements and individual course grades. In

addition the student's email address will be used for all correspondences. Students must have computer skills necessary to participate in this course.

VII. UNIVERSITY POLICIES:

Students with Disabilities Policy: As a rule, all students must read and comply with standards of the LMU Student Handbook and LMU Catalogue. Any student needing assistance in accordance with the Americans with Disabilities Act (1990 as amended) should contact the instructor and the LMU ADA Compliance Officer, Donna Treece-Paul, in order to make appropriate arrangements. Contact information: donna.treece-paul@lmunet.edu and/or 423-869-6251 (800-325-0900 ext. 6251). Office is located on the third floor of the Student Center.

Discrimination Policy: Lincoln Memorial University is committed to maintaining study and work environments that are free from discriminatory harassment based on sex, race, color, national origin, religion, pregnancy, age, military status, disability or any other protected discriminatory factor. Sexual or other discriminatory harassment of its students is strictly prohibited, whether by non-employees (such as contractors or vendors), other students, or by its employees, and LMU will take immediate and appropriate action to prevent and to correct behavior that violates this policy. Likewise, students are strictly prohibited from engaging in harassing behavior directed at LMU's employees, its visitors, vendors and contractors. All students must comply with this policy and take appropriate measures to create an atmosphere free of harassment and discrimination. Appropriate disciplinary action, up to and including, as appropriate, suspension, expulsion, termination from employment or being banned from LMU properties, will be taken against individuals who violate this policy.

Scholastic Dishonesty: It is the aim of the faculty of LMU to foster a spirit of complete honesty and a high standard of integrity. The attempt of any student to present work as his/her own that he/she has not honestly performed is regarded by the faculty and the administration as a very serious offense and renders the offender liable to several consequences and possible suspension.

Cheating: LMU prohibits dishonesty of any kind on examinations or written assignments. These include unauthorized possession of examination questions, the use of unauthorized notes during an examination, obtaining information during an examination from another student, assisting others to cheat, altering grade records, or entering any campus office without permission. Violations will subject the students to disciplinary action.

Plagiarism: LMU prohibits offering the work of another as one's own without proper acknowledgment. Any student who fails to give credit for quotations or essentially identical material taken from books, magazines, encyclopedias, or other reference works, or from the themes, reports or other writings of a fellow student has committed plagiarism.

LMU's Inclement Weather Policy: Local radio and television stations will be contacted and every effort made to have morning or daytime cancellations posted/announced by 6:00 a.m., along with a recorded announcement on the LMU main campus telephone number: (423) 869-3611. You may also check the university's website for class cancellation notices; they will be posted on http://www.lmunet.edu/curstudents/weather.html.

VIII. LINCOLN MEMORIAL UNIVERSITY MISSION STATEMENT:

This may be found at http://www.lmunet.edu/about/mission.html

IX. CAYLOR SCHOOL OF NURSING MISSION STATEMENT:

In agreement with the University's mission and goals, the Faculty of the Caylor School of

Nursing strives to instill responsibility and high moral/ethical standards in the preparation of quality nurses, at multiple levels of nursing education, through superior academic programs at undergraduate and graduate level. Specifically, the mission of the Faculty is to prepare nurses with the A.S.N., B.S.N., and M.S.N. degree, to assist individuals, families, communities, and society as they adapt to changes in physiological needs, role function, self-concept, and interdependent relationships during health and illness. The Caylor School of Nursing seeks to respond to the needs of nursing education and healthcare in the surrounding communities by preparing nurses at multiple levels and by providing continuing education/professional development opportunities that are rooted in knowledge, research, and other scholarly activities.

X. COURSE OUTLINE/ASSIGNMENT OR CLINIC SCHEDULE:

NURS 115 LECTURE SCHEDULE – Spring 2010
ACC Site
Scheduled class: Friday 9:00 AM- 1:50 PM (including lunch break)
Study Lab: Friday 2 PM – 3 PM

Date	Lecture Content
Jan 4	**Handbook and Syllabus review (8 AM – 10:30 AM)**
Jan 6	Finish Handbook and Syllabus Begin Unit I Foundations (12 Noon- 4:00 PM)
Jan 8	Unit I Foundations (9 AM – 11:00 PM) Begin Unit II Nursing Process (12:00- 1:50 PM)
Jan 15	**Exam #1 (Unit I *Foundations*- 50 questions)** **(9 AM – 10 AM) ATI Chapters: 1, 2, 3, 4, 5, 59, 63, 64** Nursing Process (10:00 AM – 1:50 PM) **Study Lab: ATI (TEAS Test) (2:00-3:00 PM)**
Jan 22	Nursing Process (9 AM – 11:00 PM) Begin Unit III Nursing Health Assessment (12:00-1:50)
Jan 29	**Exam #2 (Unit II *Nursing Process*- 50 questions)** **(9 AM- 10 AM) ATI Chapters: 7, 8, 9, 10, 11, 12** Unit III Nursing Health Assessment (11 AM – 1:50 PM)
Feb 5	Unit III Nursing Health Assessment (9 AM – 1:50 PM)
Feb 12 Wear Red Day!	Unit III Nursing Health Assessment (9AM-11 AM) Begin Unit IV Nutrition (12:00 PM- 1:50 PM)
Feb 19	**Exam #3 (Unit III *Nursing Health Assessment*- 100 questions)** **(9 AM- 11 AM) ATI Chapters: 23-26,27-39, 55** Nutrition (12 PM- 1:50 PM)
Feb 26	Bowel Elimination (9 AM- 11 AM) Urinary Elimination (12 PM- 1:50 PM)
March 5	**Exam #4 (Unit IV *Nutrition & Elimination*- 50 questions)** **(9 AM- 10 AM) ATI Chapters: 56, 76,78,79** Begin Unit V Oxygenation (11 AM- 1:50 PM)
March 12	Oxygenation (9 AM- 1 PM) Begin Unit VI Sensory & Safety (1 PM- 1:50 PM)
March 15-19	**Spring Break! No Class**
March 26	**Exam #5 (Unit V *Oxygenation*- 50 questions)** **(9 AM- 10 AM) ATI Chapters: 68, 70** Sensory & Safety (12 PM- 1:50 PM)
April 2	**Good Friday No Class**
April 9	**Exam # 6 (Unit V *Sensory & Safety* - 50 questions)** **(9 AM- 10 AM) ATI Chapters: 47, 80** Begin Unit VII Protection, Rest, & Immobility (11 AM- 1:50 PM)
April 16	**Course Assessment Test (West Knoxville Site)**
April 23	Protection, Rest, & Immobility (9 AM- 1:50 PM)
April 28	**Comprehensive Nursing 115 Final (100 Questions)** **(Time: 12:00- 2:00 PM) ATI Chapters: 49, 50, 52, 57, 58, 54, 53**

NURS 115 LECTURE SCHEDULE – Spring 2010
SMMC Site
Scheduled class: Friday 9:00 AM- 1:50 PM (including lunch break)
Study Lab: Friday 2 PM – 3 PM

Date	Lecture Content
Jan 4	**Handbook and Syllabus review (9 AM – 12 PM)**
Jan 7	Unit I Foundations begins (9 AM – 1:50 PM)
Jan 8	Unit I Foundations (9 AM – 11:00 PM) Begin Unit II Nursing Process (12:00- 1:50 PM)
Jan 15	**Exam #1 (Unit I *Foundations*- 50 questions)** **(9 AM – 10 AM) ATI Chapters: 1, 2, 3, 4, 5, 59, 63, 64** Nursing Process (10:00 AM – 1:50 PM) **Study Lab: ATI (TEAS Test) (2:00-3:00 PM)**
Jan 22	Nursing Process (9 AM – 11:00 PM) Begin Unit III Nursing Health Assessment (12:00-1:50)
Jan 29	**Exam #2 (Unit II *Nursing Process*- 50 questions)** **(9 AM- 10 AM) ATI Chapters: 7, 8, 9, 10, 11, 12** Unit III Nursing Health Assessment (11 AM – 1:50 PM)
Feb 5	Unit III Nursing Health Assessment (9 AM – 1:50 PM)
Feb 12 Wear Red Day!	Unit III Nursing Health Assessment (9AM-11 AM) Begin Unit IV Nutrition (12:00 PM- 1:50 PM)
Feb 19	**Exam #3 (Unit III *Nursing Health Assessment*- 100 questions)** **(9 AM- 11 AM) ATI Chapters: 23-26,27-39, 55** Nutrition (12 PM- 1:50 PM)
Feb 26	Bowel Elimination (9 AM- 11 AM) Urinary Elimination (12 PM- 1:50 PM)
March 5	**Exam #4 (Unit IV *Nutrition & Elimination*- 50 questions)** **(9 AM- 10 AM) ATI Chapters: 56, 76,78,79** Begin Oxygenation (11 AM- 1:50 PM)
March 12	Oxygenation (9 AM- 1 PM) Begin Sensory & Safety (1 PM- 1:50 PM)
March 15-19	**Spring Break! No Class**
March 26	**Exam #5 (Unit V *Oxygenation*- 50 questions)** **(9 AM- 10 AM) ATI Chapters: 68, 70** Sensory & Safety (12 PM- 1:50 PM)
April 2	**Good Friday No Class**
April 9	**Exam # 6 (Unit V *Sensory & Safety* - 50 questions)** **(9 AM- 10 AM) ATI Chapters: 47, 80** Begin Protection, Rest, & Immobility (11 AM- 1:50 PM)
April 16	**Course Assessment Test (West Knoxville Site)**
April 23	Protection, Rest, & Immobility (9 AM- 1:50 PM)
April 28	**Comprehensive Nursing 115 Final (100 Questions)** **(Time: 12:00- 2:00 PM) ATI Chapters: 49, 50, 52, 57, 58, 54, 53**

XI. IMPORTANT DATES IN THE ACADEMIC CALENDAR SPRING 2010:

Spring Semester 2010

Residence halls open (8:00 a.m.)	January 3
Registration and New Student Orientation	January 4
Classes begin	January 5
Last day to complete registration/add classes	January 13
Martin Luther King Day (no classes)	**January 18**
Convocation (9:30 a.m. in session classes & resident students)	February 2
Lincoln Day/Founders Day (special activities)	February 12
Last day to drop course without "WD"	**February 19**
Mid-term	February 22-26
Last day to drop course without "F"	**March 10**
Residence halls close (5:00 p.m.)	March 12
Spring break (no classes)	March 15-19
Residence halls open (1:00 p.m.)	March 21
Early registration begins	March 29
Good Friday (no classes)	**April 2**
Classes end	April 23
Final exams	April 26 - 30
Commencement (11:00 a.m.)	May 1
Residence halls close (2:00 p.m.)	May 1

XII. THE INSTRUCTOR RESERVES THE RIGHT TO REVISE, ALTER AND/OR AMEND THIS SYLLABUS, AS NECESSARY. STUDENTS WILL BE NOTIFIED IN WRITING AND/OR BY EMAIL OF ANY SUCH REVISIONS, ALTERATIONS AND/OR AMENDMENTS.

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
NURS 115
Skills Lab Schedule

Students will attend campus lab one day each week for 6 weeks. The lab will be 8 hours in length (with a 30 minute lunch break) based on the schedule at the individual sites.

Students must complete the assigned readings prior to the beginning of campus lab time. ATI skill module(s)- the entire module needs to be reviewed/watched. *The Interactive CD and the Skills Book CD assignments are optional assignments.*

In the ATI module: Both the pre-test and post-test need to be completed prior to the beginning of campus lab time. Please print the post-test- this will be your "Ticket" to attend Lab.

Lynn= pages
ATI= chapter or module

Lab #1- Week of January 11

Skills:	**Readings & ATI Skill Modules** **Optional:** Interactive CD: Asepsis and Infection Control module; Hygiene module Skills book CD (Watch and Learn): Asepsis - Performing hand hygiene; and Hygiene: Bath/Changing an occupied bed **Sk**ills book CD (Watch and Learn): Activity: Range of Motion *(Or Video: Tape 2- Asepsis, Tape 7- Hygiene, Tape 9 – Activity)
Hand Hygiene	ATI Skill Module: Infection Control skill module
Personal Hygiene	ATI Skill Module: Personal Hygiene skill module
Body Mechanics	ATI Skill Module: Ambulation, transferring, and range of motion skill module Lynn: 461-464
Bedmaking: occupied/unoccupied	Lynn: 361-371.
Turning & Moving	Lynn: 465-469; 479-484.
Transfer: stretcher/wheelchair/lift	Lynn: 485-500.
Ambulation- walker, cane, crutches	Lynn: 501-515.
Antiembolism Hose (TEDs) Pneumatic Compression Devices	ATI Chapter: 72 Promoting Venous Return Lynn: 356-361; 516-519.
Safety Devices	Lynn: 94-96; 103-110; 116-119.

Supplies Needed: None from Nursing Bag

Dosage Calculation Review/Practice Unit #1 and #2 of Dosage Calculation Packet

Lab #2 – Week of January 25

Skills:	**Readings & ATI Skill Modules** **Optional:** Interactive CD: Vital Signs module Skills book CD (Watch and Learn): Vital Signs: Oral Temperature, Radial Pulse, Respiratory Rate and Blood Pressure; and Vital Signs: Apical Pulse *(Or Video: Tape 1 Vital Sign) Interactive CD: Assessment module Skills book CD (Watch and Learn): Assessment: Performing a Physical Examination *(Or Video: Physical Assessment)
Weight/height measurements	ATI Skill Module: Vital Signs Skill Module; Lynn:
Temperature: oral, axillary, rectal and tympanic	Lynn: 6-15
Pulse and respirations	Lynn:16-26
Blood pressure	Lynn: 26-35; Taylor: Chapter 24
Pulse Oximetry	Lynn: 747-751.
Range of Motion	ATI Skill Module: Range of Motion; Lynn: 469-479.
Admission, transfer and discharge	ATI Chapter: 41,42; Taylor: 173-182.
Begin documentation – types of charting	Taylor: Chapter 17.
Begin Adult Physical Assessment	ATI Skill Module: Physical Assessment Adult Taylor: Chapter 25.

Supplies Needed: Blood pressure cuff, stethoscope, reflex hammer, watch with second hand, gloves, tongue depressor, and penlight.
**Bring "clean" copy of Comprehensive Nursing Project to Lab (Nursing Health History Guidelines & Form, Nursing Physical Assessment Guidelines & Form).*
Dosage Calculation Review/Practice Unit #3 of Dosage Calculation Packet

Lab #3 – Week of February 1

Skills:	**Readings & ATI Skill Modules**
Continue adult physical assessment	ATI Skill Module: Review Physical Assessment Adult Skill Module
Positioning: prone, supine lateral, Trendelenburg, Sims, Fowler's lithotomy dorsal recumbent	ATI Chapter: 48 Lynn: 48-49 Taylor: 895; 1291-1293
Continue documentation	Taylor: Chapter 17

Supplies needed: Blood pressure cuff, stethoscope, reflex hammer, watch with second hand, gloves, tongue depressor, and penlight.

Dosage Calculation Review/Practice Unit #4 and Unit #5 of Dosage Calculation Packet

Lab #4 – Week of February 8

Skills:	**Readings & ATI Skill Modules** **Optional:** Interactive CD: Nutrition module (Omit NG insertion information); Skin Integrity and Wound Care module; and Bowel Elimination module (Omit ostomy information) Skills book CD (Watch and Learn): Skin Integrity and Wound Care: Irrigating a wound using sterile technique; and Nutrition: Tube Feeding *(Or Videos: Tape 8 Skin Integrity/Wound care; Tape 10 Nutrition; and Tape 13
Feeding patient	ATI Skill Module: Nutrition, Feeding, and Eating Module
Fluid Balance	Lynn: 833; Taylor: 1693
Administering tube feedings	Lynn: 610-617
Caring for a gastrostomy tube	Lynn: 625-628
Administration of enemas	ATI Skill Module: Enemas Lynn: 711-724
Digital removal of stool	Lynn: 724-727
Administration of rectal tube	Lynn: 707-711
Wound care/Wound culture	ATI Skill Module: Wound Care Lynn: 380-401; 401-404; 418-426
Bandaging/Binding/Stump care	Lynn: 523-530; Taylor: 1213-1215
Removal of sutures and staples	Lynn: 432-438.

Supplies needed: enema bag, wound care kit, sterile gloves, and ACE wrap.

Dosage Proficiency Quiz #1

Lab #5 - Week of February 15

Skills:	**Readings & ATI Skill Modules** **Optional:** Interactive CD: Urinary Elimination module Skills book CD (Watch and Learn): Urinary Elimination: Applying condom catheters; and Catheterizing Male Urinary Bladder-Indwelling Catheter *(Or Videos: Tape 11 Urinary Elimination; and Tape 12 Indwelling and Intermittent Catheters)
Bedpan and urinal	Lynn: 635-641; 643-645
Urinary catheterization and catheter Perineal care	ATI Skill Module: Urinary Catheter Care Lynn: 652-670, 335,
Condom catheter application and care	Lynn: 682-686
Bladder irrigation (continuous and intermittent)	Lynn: 673-682
Specimen collection from catheter	Lynn: 972-975

Discontinuation of catheter	Lynn: 671-673
Suprapubic catheter care	Lynn: 691-695
Specimen collection: urine: 24 hour and clean catch stool: hemoccult sputum	ATI Chapters 78, 79 Lynn: 967-971; Taylor: 1496-1497 Lynn: 953-960 Lynn: 964-967

Supplies needed: Urinary Catheter Kit

Dosage Proficiency Quiz #2

Lab #6– Week of February 22

Skills	**Readings & ATI Skill Modules** **Optional:** Interactive CD: Medications module Skills book CD (Watch and Learn): Medications: 3 Checks and 5 Rights; Medications: Eye and Ear drops; and Medications: Intramuscular injections *(Or Videos: Tape 3 Oral and Topical Medications; Tape 4 Injectable Medications; and Tape 5 IV
Administration/recording ampoules lM medications (vial, ampoules and reconstitutions) for adult and pediatric clients. Intradermal intramuscular and z-track subcutaneous mixing insulin	ATI Module: Medication Administration Modules 1, 2, and 3 Lynn: 177-181 Lynn: 189-197 Lynn: 182-188 Lynn 172-176
Administration/recording medications oral sublingual suppositories (rectal, vaginal) nasal, otic and ophthalmic nebulizers and inhalers vaginal cream topical/transdermal	Lynn: 157-163 Taylor: 791 Lynn: 267, 286-289 Lynn: 240-262 Lynn: 268-281 Lynn: 262-266 Lynn: 236-240

Dosage Proficiency Quiz #3

A **campus lab** absence by the student must be made up as scheduled by the campus lab instructor **prior to the start of the clinical experience** according to the specifics in the syllabus.

*=Arrangements to view videos will be arranged on an individual basis.

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
NURS 115
Clinical Rotation Schedule

Clinical Days – There will be six **(6)** clinical days. These will be held during the **weeks of March 1-April 12.** All clinical days will be 8-hour days including a 30 minute lunch break. See individual site schedules for these dates.

Clinical Day #1 Week of March 1
Before Clinical: watch and review the HIPAA and Infection Control ATI Skill Modules

Clinical Day #2
Perform a complete Nursing Health History and Nursing Physical Assessment on one patient on the clinical floor. This is the beginning of your Comprehensive Nursing Project.

Clinical Day #3
Create Nursing Concept Map on above patient.
Perform Nursing Physical Assessment and Create a Nursing Concept Map on assigned patient.

Clinical Day #4
Comprehensive Nursing Project is due.
Perform Nursing Physical Assessment and Create a Nursing Concept Map on assigned patient.

Clinical Day #5
Perform Nursing Physical Assessment and Create a Nursing Concept Map on 1-2 assigned patients (Per clinical instructor).

Clinical Day #6

Perform Nursing Physical Assessment and Create a Nursing Concept Map on 1-2 assigned patients (Per clinical instructor).

Make up clinical day will be during the **week of April 19.** This is intended for any **clinical** absence by the student.

There will be no clinicals on the week of March 15 due to Spring Break.

Revised: December 9, 2009

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Technical Skills

Student: _____

Technical Skills	**Campus Lab**			**Clinicals**						
Course	**115**	**124 125**	**241**	**115**	**124 125**	**126**	**241**	**242 244**	**245**	**246**
1. Perform Hand washing										
2. Don/remove gloves: clean & sterile										
3. Don gown & mask for isolation										
4. Perform bed making: occupied & unoccupied										
5. Perform hygiene care: bath, hair, & oral										
6. Assist with gown change with/without IVF/IV pump										
7. Change adult brief										
8. Provide bedpan & urinal										
9. Use proper body mechanics										
10. Turn & position:										
A. Prone										
B. Supine										
C. Lateral										
D. Trendelenburg										
E. Sims										
F. Fowler's										
G. Lithotomy										
H. Dorsal recumbent										
11. Move patient up in bed										
12. Perform range of motion										
13. Apply/care for antiembolic devices: TED hose & pneumatic compression devices										
14. Transfer patient:										
A. Bed to chair										
B. Bed to stretcher										
C. Bed to wheelchair										
15. Assist with ambulation										
16. Apply safety devices (restraints)										
17. Perform height/weight measurement										
18. Obtain temperature:										
A. Oral										
B. Rectal										
C. Axillary										
D. Tympanic										
19. Assess apical & radial pulse rates										
20. Assess respiratory rate										
21. Determine blood pressure										
22. Perform physical assessment & document findings										

Technical Skills	Campus Lab			Clinicals						
Course	**115**	**124 125**	**241**	**115**	**124 125**	**126**	**241**	**242 244**	**245**	**246**
23. Administer oxygen via NC & mask										
24. Instruct deep breathing, coughing, & use of incentive spirometer										
25. Utilize pulse oximetry										
26. Perform oral & tracheal suctioning										
27. Provide tracheostomy care										
28. Collect sputum specimen										
29. Perform throat culture										
30. Provide care of chest tubes										
31. Apply telemetry leads										
32. Feed/assist adult to eat										
33. Calculate intake & output										
34. Insert NGT										
35. Verify tube placement: NG & GT										
36. Irrigate NG & GT										
37. Care of NGT connected to suction										
38. Remove NGT										
39. Care of GT										
40. Administer tube feeding										
41. Perform wound care										
42. Collect wound culture										
43. Clean & dress surgical site										
44. Apply bandages & binders										
45. Perform stump wrapping & care										
46. Remove sutures & staples										
47. Care for & remove surgical drains										
48. Assist with a pelvic exam & Pap smear										
49. Perform breast examination										
50. Perform postpartal examination										
51. Perform postpartal breast care & demonstrate use of/care of breast pumps										
52. Provide perineal/episiotomy care										
53. Perform newborn assessment										
54. Provide cord care										
55. Provide circumcision care										
56. Use bulb syringe & DeLee suction										
57. Care of the infant receiving phototherapy										
58. Collect infant/pediatric urine specimen										

Technical Skills	Campus Lab	Clinicals

Course	115	124 125	241	115	124 125	126	241	242 244	245	246
59. Administer & record medications:										
A. Oral										
B. Sublingual										
C. Suppositories: rectal & vaginal										
D. Nebulizer/inhaler										
E. Topical										
F. Transdermal										
G. Nasal										
H. Otic										
I. Opthalmic										
J. Intramuscular										
K. Subcutaneous										
L. Insulin										
M. Intradermal										
60. Reconstitute medication										
61. Withdraw medication from a vial & Ampule										
62. Initiate IV Fluids										
63. Regulate, monitor, & discontinue IVF										
64. Add medication to an IV container										
65. Label & calculate IV intake										
66. Administer IV medications:										
A. Intermittent infusion										
B. IV bolus & IVP										
67. Initiate & provide care of intermittent infusion device										
68. Initiate & monitor blood products										
69. Initiate & monitor TPN/Lipids										
70. Perform glucometer check										
71. Care of central venous access device										
A. Change dressing										
B. Withdraw blood										

Technical Skills	Campus Lab			Clinicals						
Course	**115**	**124 125**	**241**	**115**	**124 125**	**126**	**241**	**242 244**	**245**	**246**
72. Perform catheterization:										
A. Straight										
B. Indwelling										
73. Provide catheter care:										
74. Collect urine specimen:										
A. Clean catch										
B. Indwelling catheter										
C. 24 hour										
75. Apply condom catheter										
76. Irrigate catheter										
77. Intermittent & continuous bladder Irrigation										
78. Discontinue indwelling catheter										
79. Administer fleets & soap suds enema										
80. Assess for & remove fecal impaction										
81. Insert rectal tube										
82. Provide stoma care										
83. Change ileostomy/colostomy appliance										
84. Irrigate colostomy										
85. Collect stool specimen										

Clinical Faculty Signature

Course	Semester	Initial	Signature

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Comprehensive Nursing Project Guidelines
Nursing 115

1. The clinical instructor will set a due date for the **comprehensive nursing project**. As stated in the syllabus, if the nursing project is not turned in on the assigned date, a point will be deducted for each day late. This deduction remains as a part of the grade. **This is to be original work – copied work from anyone else = cheating!!**

2. The first part of the comprehensive nursing project contains several sections that must be addressed. These include, the nursing health history and nursing physical assessment; definition of all medical diagnoses (a thorough definition – not just copied from a dictionary); symptom comparison; Erickson developmental comparison; lab value sheet with patient findings compared to normal and rationale for abnormal lab values. If a section is not addressed, the care plan will be handed back to the student, not graded, and this will count as the first attempt.

3. The second part of the nursing project addresses the nursing process in the form of a concept map:
   a. Assessment
   This should include thorough assessment specific for each nursing diagnosis. It should include objective as well as subjective data. In addition, lab values, medications and diagnostic test results specific to that nursing diagnosis should be included.

   b. Nursing Diagnosis
   These nursing diagnoses must be stated in the correct 3 part form, i.e., nursing diagnosis…related to etiology as evidenced by signs and symptoms. Short-term and long-term outcomes should be stated for each nursing diagnosis. These outcomes should be measurable and written in terms of patient behavior, not nurse behavior. An expected outcome should be stated.

   For NURS 115 there should be a minimum of 3 nursing diagnoses, 2 can be from the physiological mode and the 3rd from either the self-concept, role function or interdependence mode.

   For NURS 124/125 there should be a minimum of 4 nursing diagnoses, 3 can be from physiological mode and the 4th can be from either self-concept, role function or interdependence mode.

   c. Nursing Interventions
   These should be realistic and individualized to the patient. Include interventions that you as a nurse would implement. DO NOT copy from a textbook or use standardized care plans.

   d. Rationale
   All rationale must be documented from a resource book. You must cite the source at the end of each stated rational. **At least one rationale must be documented with an article from an accepted nursing journal.** You were given the list of accepted journals in your first semester course. Internet information is not acceptable unless it is a full-text article from one of the accepted nursing journals. A copy of the article must accompany the nursing project.
   e. Evaluation
   There should be an evaluation statement for each expected outcome. Simply state the outcome, i.e., Did it happen? Did it not happen? Why? Why not? What changes will you make to your nursing interventions?, etc.
   Rev 7/09

Lincoln Memorial University
Caylor School of Nursing
Grading Rubric - NURS 115 Comprehensive Nursing Project

Student:_____ **Faculty:**_____

Part I: Comprehensive Assessment of patient which includes the following sections: (40 points)

A. Nursing History
B. Nursing Physical Assessment
C. Definition of medical diagnosis
D. Symptom Comparison
E. Erickson Developmental comparison
F. Laboratory Value Sheet with rationales for abnormal lab values
G. Medication Cards or Medication Sheet

40 points	35 points	30 points	25 points	20 points	0 points	Points Earned
All areas complete with NO errors	1-2 areas incomplete or with errors	3-4 areas incomplete or with errors	5-6 areas incomplete or with errors	All areas incomplete or with errors	Not the student's original work.	

Part II: Concept Map of patient problems which includes the following sections: (40 points)

A. Assessment
B. Nursing diagnoses and outcomes
C. Nursing interventions
D. Rationale
E. Evaluation

40 points	35 points	30 points	25 points	20 points	0 points	Points Earned
All areas complete with NO errors	1 area incomplete or with errors	2 areas incomplete or with errors	3-4 areas incomplete or with errors	All areas incomplete or with errors	Not the student's original work	

III. References - (5 points) must have at least 5 references documented.

5 points	4 points	3 points	2 points	1 points	0 points	Points Earned
5 references documented	4 references documented	3 references documented	2 references documented	1 reference documented	No references documented	

IV. Journal (5 points)

5 points	3 points	0 points	Points Earned
Appropriate article/journal chosen AND article documented in project	Inappropriate article/journal OR article not documented in project	Inappropriate article/journal AND article not documented in project	

V. Professionalism (10 points) Includes, but not limited to, APA format, correct grammar, spelling, punctuation, spacing, and neatness.

10 points	8 points	6 points	4 points	2 points	0 points	Points Earned
No errors in professionalism	1-3 errors in professionalism	4-6 errors in professionalism	7-9 errors in professionalism	10-12 errors in professionalism	>12 errors in professionalism	

Points Earned	Days Late (1 point per day deducted) Later than 1 week = zero for entire care plan	Final Grade

Lincoln Memorial University
Caylor School of Nursing
Nursing Health History Guidelines
NURS 115

Biographical Data

- Patient/Resident Initials only in compliance with HIPPA
- Age Gender Marital Status Religion Occupation
- Access to Healthcare (How is the healthcare paid for?) Fixed Income (Yes or No)

Present Illness

- Date of Admission to Facility
- Health Care Provider (Include name of MD, NP, etc.)
- Reason for Admission in the words of the Patient or Resident
- Medical Diagnosis on Admission (May include more than one)

Health History

- Advance Directive (Living Will, DNR, Power of Attorney)
- Medication/Food Allergies (Must include the reaction type)
- Tobacco Use to include Pack Per Day, years, and the years quit if former usage
- ETOH Use to include type, amount, and frequency
- Recreational Drug Use to include type, amount, and frequency
- Childhood Illnesses (Chicken pox, meningitis, polio, and whooping cough)
- Immunizations up to date (Include childhood immunizations, Flu, PPD, and pneumonia)
- Prior Hospitalizations (Include reason, year, and the length of stay)
- Surgeries (Include reason, year, and the length of stay)
- Personal/Family History (Include type of disease for each body system affected)

Self-Concept Mode

- Body Sensations (How does the individual physically feel: Tired, weak, or rested?)
- Physical Sensations (What physical sensations are being felt: Hot, cold, or pained?)
- Sexual Sensations (Does the individual have sensations, how often, & is there satisfaction?)
- Body Image (How does the individual perceive his/her body? Satisfied? Changes to Make?)
- Age Appropriate Physical Development (Has the individual met growth and development milestones for age?)
- Erickson's Developmental Stage (**See Taylor, Lillis, LeMone, & Lynn p. 399-400**)
- Describe Self as a person (What is the individual's self-perception? Personal characteristics?)
- Goals (What goal(s) does the individual have?)
- Changes in goals (Has the individual experienced a change in those goals?)
- Describe Spiritual Beliefs (What belief(s) does the individual hold?)
- Satisfied with spiritual self?

- Current/Past Coping Mechanisms (How does the individual cope? Crying, Laughter, Prayer, Talking)
- Recent Major Life Changes (Has the individual experienced life changes? Birth, Death, Divorce, Marriage, Move)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Role Function Mode

- Primary/Secondary Role (Primary: Age, Sex, & Developmental Stage) (Secondary: Husband, wife, father, mother, sister)
- Able to meet roles (Is the individual able to meet these roles? If not, why?)
- Anticipate change in role (Does the individual anticipate a change in these roles?)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Interdependence Mode

- Significant other (Does the individual have a significant other? If naming, use initials only)
- Support system (Who does the individual rely on for support? Remember to include staff if in an acute or long term setting)
- Independent aspects (In what aspect(s) does the individual feel independent?)
- Family structure (**See Taylor et. al, p. 31**)
- Gravida (How many times a female has been pregnant including current pregnancy if any?)
- Para (How many deliveries a female has had?)
- AB (How many abortions either elective or spontaneous?)
- Adopted Children (How many?)
- Living Children (How many? Include adopted children and step-children)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit

Physiologic/Physical Mode

Neurosensory

- Visual Aids (Contacts, Glasses, Magnifier, or Prosthetic)
- Hearing Aids (Hearing Aids or Cochlear Implants)
- Pain (Location, quality, intensity, onset, duration, referred, relief measures, acute/chronic, exacerbations)
- Sensation (Test the senses for decreased sensation)
- Neurosensory Exams (CT, EEG, MRA/MRI to include date & result)

Oxygenation

- Respiratory Exams (ABG, CT, CXR, PFT, VQ scan to include date and result)

Cardiac

- Cardiac Exams (Cardiac Catherization, Echo, EKG, Stress Test and to include date and results)

Nutrition

- Recent Gains/Losses & Amount (Has there been recent gains/losses? If so, what is the amount?) **Remember to include unit of measure**.
- Type of diet (Diabetic, mechanical soft, pureed, regular, soft, or tube feeding)
- Dietary Supplements (Does the patient/resident require supplements: ensure, magic cup, etc?)
- Dietary Restrictions/Preferences (Does the patient/resident have dietary restrictions or preferences?)
- Pain or Discomfort r/t Oral Intake (Does the patient/resident have pain or discomfort r/t oral intake? If so, describe)
- Chewing/Swallowing Difficulty (Does the patient/resident have chewing/swallowing difficulty? If so, describe)
- Gastrointestinal Exams (Colonoscopy, CT of the abdomen & pelvis, Esophagogastroduodenoscopy (EGD), Upper/lower GI series, Swallowing Evaluation, Video Esophagram and to include date and results)

Elimination

Gastrointestinal

- Daily Dietary Fiber Intake (Estimate from the 24 hour sample diet the daily dietary fiber intake)
- Daily Fluid Intake (Calculate the oral intake for the clinical day). **Remember to record the unit of measure.**
- Gastrointestinal Exams (Barium Enema, Colonoscopy, CT of the abdomen & pelvis, Esophagogastroduodenoscopy (EGD), Upper/lower GI series, Stool Specimens and to include date and results)

Genitourinary

- Genitourinary Exams (Urine culture/specimen and to include date and results)

Protection

- Burns, Lacerations, Lesions, Incisions, Scars, & Ulcerations (Does the patient/resident have any of the following? If so, include the location, appearance, and treatment)

Activity and Rest

Mobility

- Physical Activity (What is the activity level of the patient/resident: Independent, assisted, or dependent?)
- Strength (What is the strength of the upper and lower extremities: Strong or weak, equal or unequal?)
- Mobility (What is the ROM ability of the patient/resident: Full, active, passive, or limited?)

- Posture (Observe and describe the posture of the patient/resident: Upright or other)
- Gait (Observe and describe the gait of the patient/resident: Balanced, equal, unequal, or limp)
- Aids (Does the patient/resident require any mobility aids? If so, describe the type?)
- Current Exercise Regimen (What is the current exercise regimen for the patient/resident?)
- Leisure Activities (Does the patient/resident have leisure activities? If so, how often does the patient/resident engage in those activities?)

Sleep

- Sleep (Describe the patient/resident's hours of nighttime sleep, quality, and frequency and duration of naps)
- Environmental disturbances (Are there environmental disturbances?)
- Appearance (What is the appearance of the patient/resident in relation to sleep: Rested, red eyes, puffy eyes, or yawns frequently?)
- Sleep Rituals (Does the patient/resident have sleep rituals? If so, describe)

References

Roy, C. & Andrews, H. (1999). *The Roy Adaptation Model*. (2nd ed.). Stamford, CT. Appleton & Lange.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Fundamentals of Nursing: The Art and* s*cience of nursing care.* (6th ed.). Philadelphia: Lippincott Williams & Wilkins

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Nursing Health History
NURS 115

Directions: Please fill in each space. Nothing should be left blank. Submissions for grading should be 12 font typed or handwritten in black ink. Submissions in pencil or colored ink will not be accepted. Refer to course syllabus for further submission guidelines. For additional comments or data, please use the back of each page.

Student Name: _____ **Date of Care**: _____

Facility: _____ **Clinical Supervisor**: _____

Biographical Data

Patient/Resident Initials: _____ Age: _____ Gender: _____ Marital Status: _____

Religion: _____ Occupation: _____

Access to Healthcare: Insurance _____ Fixed Income: _____

Present Illness

Date of Admission: _____ Health Care Provider: _____

Reason for Admission: _____

Medical Diagnosis on Admission: _____

Health History

Advance Directive (Include Type): _____

Medication/Food Allergies (Include Reaction Type): _____

Tobacco Use: # PPD _____ # Years _____ # Years Quit _____

ETOH Use: Type/Amount _____ Frequency _____

Recreational Drugs: Type/Amount _____ Frequency _____

Childhood Illnesses: _____

Immunizations Up To Date: _____

Prior Hospitalizations (Reason, Year, & LOS):_____

Surgeries (Reason, Year, & LOS): _____

Personal/Family History (Include Type of Disease in Each Column):

	Deceased (Age)	Neuro Disease	Cardiac Disease	Endo Disease	GI Disease	GU Disease	MS Disease	Resp Disease	Chronic Pain	Mental Illness
Self										
Mother										
Father										
Sibling (s)										

Self-Concept Mode

Body Sensations: _____ Physical Sensations: _____ Body Image (Self-description): _____

Age Appropriate Physical Development: _____ Erikson's Developmental Stage: _____

Describe Self as a Person: _____ Goals: _____

Changes in Goals_____Describe Spiritual Beliefs: _____

Satisfied With Spiritual Self: _____

Current/Past Coping Mechanisms: _____

Recent Major Life Changes: _____

Deficit: Yes ___ No ___ Nursing Diagnosis: _____

Role Function Mode

Primary/Secondary Role: _____

Able to Meet Roles: _____ Anticipate Change in Role: _____

Deficit: Yes ___ No ___ Nursing Diagnosis: _____

Interdependence Mode

Significant Other: _____ Support System _____

In Which Aspects do you feel Independent? _____

Family Structure: _____ Gravida ___ Para ___ AB ___ Adopted Children ___ Living Children ____

Deficit: Yes ___ No ___ Nursing Diagnosis: _____

Physiologic/Physical Mode

Neurosensory

Visual Aids: _____ Hearing Aids: _____

Pain: Location _____ Quality _____ Intensity _____ Onset _____

Duration _____ Referred _____ Relief Measures _____

Acute _____ Chronic _____ Exacerbation _____

List Area of Decreased Sensation: _____

Neurosensory Exams (Include Date & Result): _____

Oxygenation

Respiratory

Respiratory Exams (Include Date & Result): _____

Cardiac

Cardiac Exams (Include Date & Result): _____

Nutrition

Gastrointestinal

Recent Gains & Amount: _____ Recent Losses & Amount: _____

Type of Diet: _____ Supplements: _____ Restrictions: _____ Preferences: _____

Pain or Discomfort r/t Oral Intake: _____

Chewing/Swallowing Difficulty: _____

Gastrointestinal Exams (Include Date & Result): _____

Elimination

Intestinal

Daily Dietary Fiber Intake: _____ Daily Fluid Intake: _____

Gastrointestinal Exams (Include Date & Result): _____

Genitourinary

Genitourinary Exams (Include Date & Result): _____

Protection

Burns, Lacerations, Lesions, Incisions, Scars, & Ulcerations: (Include Location, Appearance, & Treatment):

_____

_____

Activity and Rest

Mobility

Physical Activity: _____ Strength of Extremities: _____ ROM: _____
Posture: _____ Gait: _____ Mobility Aids: _____

Current Exercise Regimen: _____ Leisure Activities: _____

Sleep

Hours of Nighttime Sleep _____ Quality _____ Naps: Frequency _____ Length _____

Environmental Disturbances: _____

Appearance: _____ Sleep Rituals: _____

References

Roy, C. & Andrews, H. (1999). *The Roy Adaptation Model*. (2nd ed.). Stamford, CT. Appleton & Lange.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Fundamentals of Nursing: The Art and science of nursing care.* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Physical Assessment Guidelines
Nursing 115

Physiologic/Physical Mode

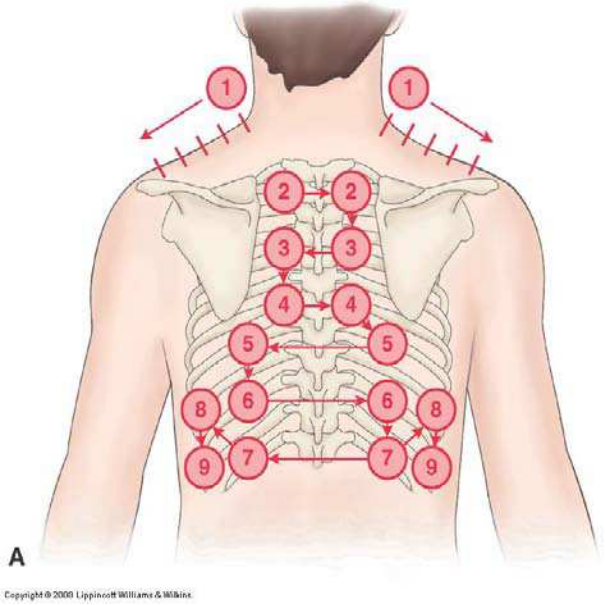
Neurosensory

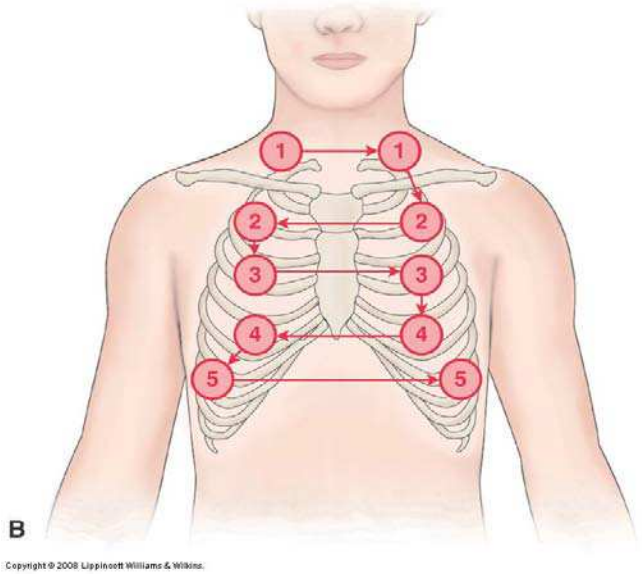
- LOC (Level of Consciousness. Patient/Resident's degree of wakefulness or ability to be aroused.) (**See Taylor et al. p. 1022 Box 34-1**)
- Orientation (Patient response to questions regarding person, place, & time)
- Memory (Question immediate recall and recall of past events)
- Pupils (PERRLA: Pupils equal, round, reactive to light and accommodation) (**See Taylor et al., p. 619 Guidelines for Nursing Care 25-2**)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Oxygenation

Respiratory

- Rate (What is the rate of the respirations?) (**See Taylor et al., pp. 571-572**).
- Rhythm (Irregular, regular)
- Effort (Observe for difficulty versus normal relaxed breathing)
- Abnormal pattern (**See Taylor et al., p. 572 Table 24-7**)
- Cough (How often? Non-productive or productive? If productive, describe color and consistency)
- Breath Sounds (Auscultate breath sounds & determine if normal or abnormal) (**See Taylor et al., p. 631 Table 25-8 & p. 632 Table 25-9**)



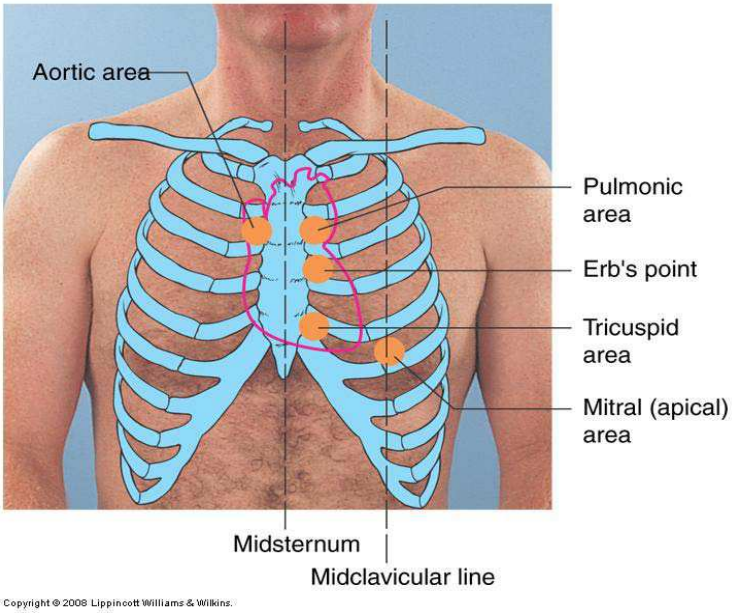


- Subjective Data (What the Patient/Resident complains of in own words)

- Oxygen (How many liters per minute and what delivery device?)
- Pulse Oximetry (What is the pulse oximetry reading? Include if taken on oxygen or at room air)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Cardiac

- Apical pulse (Rate and rhythm) (**See Taylor et al., p. 566**)
- Capillary refill: Observe light pink nail bed coloring. Depress the nail bed with finger to lighten nail bed coloring. Observe and time the return of circulation to the nail bed.
- Heart sounds (Auscultate heart sounds & determine if normal or abnormal) (**See Taylor et** al**., p. 634 Box 25-5**)

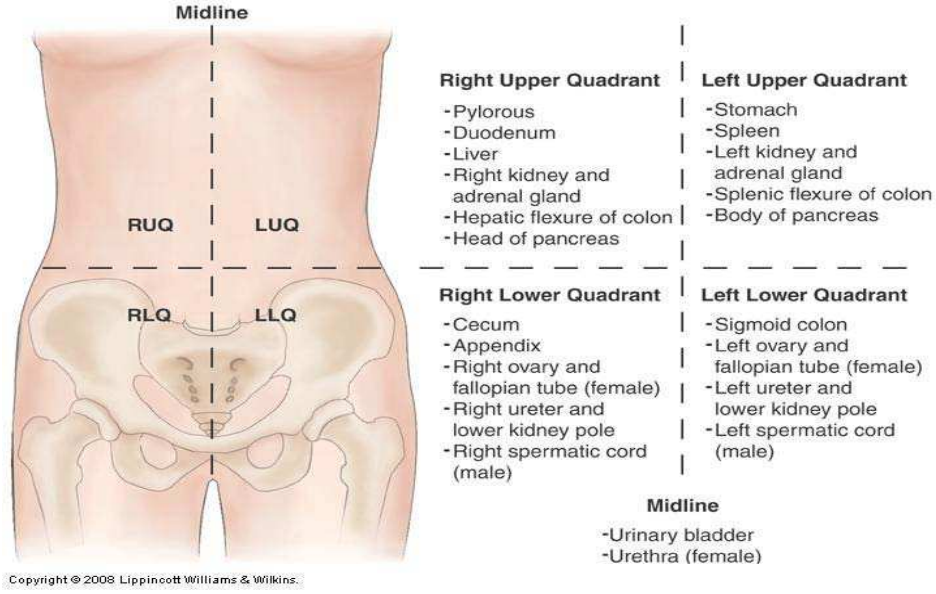


- Blood pressure (What is the blood pressure? Automatic or manual? What arm?)
- Edema (Location, pitting or non, and degree if pitting) (**See Taylor et al., p. 612**)
- Peripheral Pulses (Location, rate, rhythm, & amplitude) (**See Taylor et al., p. 567 Table 24-6**)
- Extremity Color (Coloring of upper and lower extremities)
- Extremity Temperature (Palpate temperature of the upper and lower extremities)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Nutrition

- Height, Weight, IBW/BMI (What is the height, weight, ideal body weight/body mass index of the patient/resident?) **Remember to include unit of measure**.
- Mucous Membranes (Describe the color and texture of the mucous membranes)

- Teeth (Does the patient/resident have teeth? If so, describe condition)
- Dentures (Does the patient/resident have dentures? If so, describe condition)
- Dental Caries (Does the patient/resident have dental caries?)
- Abdomen (Palpate the abdomen and describe)
- Bowel Sounds (Auscultate the abdomen and describe)
    - Absent: No sounds
    - Hyperactive: More than 35 bowel sounds per minute
    - Hypoactive: Less than 5 bowel sounds per minute
    - Normoactive: 5-34 bowel sounds per minute



- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the def

Elimination

Gastrointestinal

- Stool (What is the frequency, color, and consistency of the patient/resident stool?)
- Continent (Is the patient/resident continent of bowel?)
- Ostomy (Does the patient/resident have an ostomy? If so, where is the site, what is the stoma appearance, and what type of collection device does the patient/resident use?)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Genitourinary

- Urine (What is the frequency, amount, and color of the urine?)
- Ostomy (Where is the site, what is the stoma appearance, & what type of collection device does the patient/resident use?)

- Foley Catheter (What is the size and insertion date of the foley catheter?)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit)

Protection

- Body Temperature (What is the body temperature of the patient/resident? Include the route and result?) (**See Taylor et al., p. 561 Table 24-3**)
- Braden Score (What is the Braden Scale Score? (**See Taylor et al. p. 1205**)
- Skin Color (What is the color of the skin?) (**See Taylor et al., pp. 610-611**)
- Skin Condition (What is the condition of the skin: Turgor, dry, moist, intact, or rash?)
- Education/Discharge Needs (Is there a need for education? If so, describe in detail)
- Deficit (Is there a deficit in this area? If so, describe in detail)
- Nursing Diagnosis (If there is a deficit in this area, there should be a nursing diagnosis included to address the deficit.)

Narrative Summary of Findings

- Write or type a detailed narrative summary of findings in a head to toe manner.
    - Alert and oriented X 2. Disoriented to time of day. PERRLA with glasses noted in place. O2 at 2 LPM/NC. Pink, moist, mucous membranes noted. Upper and lower dentures noted to be clean and intact. Apical heart rate 60 beats per minute, regular rhythm, S1 and S2 audible. Respiratory rate 16 breaths per minute, regular, and unlabored. Rhonchi noted in BUL. Denies cough or SOB. Nail beds pink, brisk capillary refill. Abdomen soft with active bowel sounds X 4. FC # 18 to BSD with 500 mL of clear yellow urine. Active ROM with equal strength bilaterally. NAD noted. Lying supine watching TV. Side rails up X 2. M. Humfleet, SN, LMU.

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Nursing Physical Assessment
NURS 115

Physiologic/Physical Mode

Neurosensory

LOC: _____ Orientation: _____Memory: _____
Pupils: PERRLA _____ Unequal _____ Unresponsive _____
Education/Discharge Needs _____
_____
Deficit: Yes _____ No _____ Nursing Diagnosis: _____

Oxygenation

Respiratory

Rate: _____ Rhythm: _____ Effort: _____ Abnormal Pattern: _____
Cough: _____ Frequency: _____ Nonproductive: _____ Productive: _____
Breath Sounds: _____ Subjective Data:_____
Oxygen: Liters/Minute (Include Delivery) _____Pulse Oximetry _____
Education/Discharge Needs _____
_____
Deficit: Yes _____ No _____ Nursing Diagnosis: _____

Cardiac

Apical Pulse: Rate _____ Rhythm _____ Capillary Refill _____
Heart Sounds:_____ Abnormal Sounds:_____Blood Pressure:_____
Edema: Location _____ Pitting _____ Degree _____
Peripheral Pulses: Location _____ Rate _____Rhythm _____ Volume _____
Extremity Color: _____ Extremity Temperature: _____
Education/Discharge Needs _____
_____
Deficit: Yes _____ No _____ Nursing Diagnosis: _____

Nutrition

Gastrointestinal

Height: _____ Weight: _____ IBW/BMI: _____
Mucous Membranes: _____ Teeth _____ Dentures _____ Dental Caries _____
Abdomen: _____ Bowel Sounds: _____
Education/Discharge Needs _____
_____
Deficit: Yes _____ No _____ Nursing Diagnosis: _____

Elimination

Gastrointestinal

Stool: Frequency _____ Amount _____Color _____ Continent _____
Ostomy: Location _____ Stoma appearance _____Device_____

Genitourinary

Urine: Frequency _____ Amount _____ Color _____ Continent _____
Ostomy: Location _____ Stoma appearance _____ Device _____
Foley catheter: Size _____ Insertion date _____

Education/Discharge Needs _____

_____

Deficit: Yes _____ No _____ Nursing Diagnosis: _____

Protection

Body Temperature (Route & Result): _____ Braden Score: _____

Skin Color: _____ Skin Condition: _____

Education/Discharge Needs_____

_____

Deficit: Yes _____ No _____ Nursing Diagnosis: _____

Narrative Summary of Findings

References

Roy, C. & Andrews, H. (1999). *The Roy Adaptation Model*. (2nd ed.). Stamford, CT. Appleton & Lange.

Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2008). *Fundamentals of Nursing: The Art and* s*cience of nursing care.* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

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Laboratory Value Sheet
Nursing 115

Laboratory Test	Normal Values	Admission	Date/Time	Date/Time	Reason for Abnormal Values
CBC					
White Blood Cells (WBC)					
Red Blood Cells (RBC)					
Hemoglobin (Hgb)					
Hematocrit (Hct)					
Platelets					
Coagulation Studies					
Prothrombin time (PT)					
International normalized ratio (INR)					
Activated partial thromboplastin time (PTT)					
Comprehensive Metabolic Panel					
Sodium (Na)					
Potassium (K)					
Chloride (Cl)					
Calcium (Ca)					
Magnesium (Mg)					
Phosphorus					
Glucose (FBS)					
Hemoglobin A1C					
BUN					
Creatinine					
Lipid Panel					
Cholesterol					
HDL					
LDL					
Triglycerides					
Liver Function Tests (LFT)					
Albumin					
Bilirubin					
ALT					
AST					
GGT					
Ammonia					
Cardiac Enzymes					
CPK					
CK MB					
Troponin					
B natriuretic peptide BNP					
Arterial Blood Gasses (ABG)					
pH					
PCO2					

P02					
HCO3					
Urinalysis					
Color					
Appearance					
Specific Gravity					
pH					
Glucose					
Ketones					
Nitrates					
Bacteria					
RBC					
WBC					
Crystals					
Culture Results					
Sensitivity					
Therapeutic Drug Level (ex. Digoxin, Dilantin, Theophylline, etc)					
Sputum Culture and Sensitivity					
Biopsy					
CT Scan					
X-Ray					
EKG					

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Medical Definition and Symptomatology Comparison Patient/Textbook
NURS 115

Angina Pectoris

Angina pectoris is characterized by chest pain or pressure. It results from insufficient coronary blood flow resulting in decreased oxygen supply. This decreased oxygen supply occurs when there is increased myocardial demand such as during exercise or emotional stress. The severity of angina is dependent upon the precipitating activity and its effect on activities of daily living (Smeltzer, Bare, Hinkle, & Cheever, 2008, p. 867).

Symptom	Textbook	Patient
Chest Pain	X	X
Weakness	X	
Numbness	X	
Shortness of Breath	X	X
Pallor	X	
Diaphoresis	X	X
Dizziness	X	
Nausea & Vomiting	X	X
Anxiety	X	

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Erikson's Developmental Comparison
NURS 115

Comprehensive Care Plan Example:

Chronological Age - 32 y/o According to Erikson, this client is in the middle adult years and should be dealing with the generativity vs. stagnation conflict. This is the period when a person's interest is toward establishing and guiding the next generation (generativity) or the person may turn inward and become self-absorbed or stagnant (stagnation) (Taylor, Lewis, Lemone, & Lynn, 2008, p. 397).

This client is clearly in the generativity side of Erikson's conflict for the middle adult.
He feels that he has an important role and contribution to make to his children and to the children he teaches. He is active in his church, provides for his family and is concerned about how his illness affects his work, family and the delays to his responsibilities at work. He displays no aspects of stagnation -nonproductive, self-absorbed, personal impoverishment and/or self-indulgence.

Example developed by: Karen C. Stephens, MSN: 10/07; 09/08; 12/12/08

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Student _____ Date _____ Room # _____ Pt. Initials: _____ Age: _____
Diagnosis(es) _____

Name (generic & trade), **Time, Route, Recommended SafeDose** (calculate for peds)	**Drug Classification**	**MOA** (Mechanism of Action)	**Reason YOUR client is receiving**	**Adverse Effects**	**Nursing Considerations**

Please make photocopies as needed. This form must be completed & submitted to the clinical instructor for each clinical day. Revised 6/09

Name of Medication (generic & trade)_____
Drug Classification_____ **Route**_____
Time/frequency_____**Dosage**_____
Recommended Safe Dose (calculate for peds)_____
_____
Reason YOUR patient is receiving medication_____
_____
MOA_____
_____
_____
Adverse Effects_____
_____
_____
_____
_____
Nursing Considerations_____
_____
_____
_____
_____
_____
Rev 6/09

Name of Medication (generic & trade)_____
Drug Classification_____ **Route**_____
Time/frequency_____**Dosage**_____
Recommended Safe Dose (calculate for peds)_____
_____
Reason YOUR patient is receiving medication_____
_____
MOA_____
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Adverse Effects_____
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Nursing Considerations_____
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Rev 6/09

LINCOLN MEMORIAL UNIVERSITY
Caylor School of Nursing
Nursing 115

DAILY CONCEPT MAPPING GUIDELINES

1. A daily concept map must be completed on each assigned patient in order to receive a grade of satisfactory in the clinical area. **This is to be original work – copied work from anyone else = cheating!!**

2. Daily concept maps are due on the last clinical day of each week unless the instructor states otherwise.

3. Fully address all areas of the concept map:
   a. **Nursing Diagnosis**

NURS 115 - Write 2 nursing diagnoses in complete form, i.e., nursing diagnosis related to etiology….as evidenced by….. signs/symptoms. (There should be three (3) parts.) Write these on the concept map.

NURS 124, 125, 241, 245 & 246 - Write 4 nursing diagnoses in complete form, i.e., nursing diagnosis related to….as evidenced by….. (There should be three (3) parts.) Write these on the concept map

   b. **Assessment**

Include the following: assessments, lab data, diagnostic test results, medications and past medical/psych history if appropriate.

   c. **Interventions**
   State interventions for each nursing diagnosis. These interventions should be realistic and individualized to the specific patient. Include interventions that you as the nurse would implement. Include rationale for nursing interventions. Your nursing care plan book is a great resource to find interventions but you need to individualize the interventions to your patient**.** DO NOT copy word for word from your text book or any other book or journal. **This = plagiarism!!**

   d. **Patient Outcomes**
   State short-term goals long term outcomes for the nursing diagnoses. These outcomes should be measurable and written in terms of patient behavior,
   not nurse behavior. Evaluate the outcomes.

4. Medication cards or medication sheet must be completed for each medication your patient is receiving. These are to be turned in with concept map

Nursing 115
Concept
Map

Miscellaneous Information

Nursing Diagnosis:

ST Goal:

LT Goal:

Interventions:

Problem

Assessment