COURSE SYLLABUS

RNSG 1105 (1:0:4)

NURSING SKILLS I

****

ASSOCIATE DEGREE NURSING PROGRAM

DEPARTMENT OF NURSING

HEALTH OCCUPATION DIVISION

LEVELLAND CAMPUS

SOUTH PLAINS COLLEGE

SCANS COMPETENCIES

RESOURCES: Identifies, organizes, plans and allocates resources.

C-1 **TIME**--Selects goal--relevant activities, ranks them, allocates time, and prepares and follows schedules.
C-2 **MONEY**--Uses or prepares budgets, makes forecasts, keeps records, and makes adjustments to meet objectives
C-3 **MATERIALS & FACILITIES**-Acquires, stores, allocates, and uses materials or space efficiently.
C-4 **HUMAN RESOURCES**--Assesses skills and distributes work accordingly, evaluates performances and provides feedback.

INFORMATION--Acquires and Uses Information

C-5 Acquires and evaluates information.
C-6 Organizes and maintains information.
C-7 Interprets and communicates information.
C-8 Uses computers to Process information.

INTERPERSONAL--Works With Others

C-9 Participates as members of a team and contributes to group effort.
C-10 Teaches others new skills.
C-11 Serves clients/customers--works to satisfy customer's expectations.
C-12 Exercises leadership--communicates ideas to justify position, persuades and convinces others, responsibly challenges existing procedures and policies.
C-13 Negotiates-Works toward agreements involving exchanges of resources resolves divergent interests.
C-14 Works with Diversity-Works well with men and women from diverse backgrounds.

SYSTEMS--Understands Complex Interrelationships

C-15 Understands Systems--Knows how social, organizational, and technological systems work and operates effectively with them
C-16 Monitors and Correct Performance-Distinguishes trends, predicts impacts on system operations, diagnoses systems' performance and corrects malfunctions.
C-17 Improves or Designs Systems-Suggests modifications to existing systems and develops new or alternative systems to improve performance.

TECHNOLOGY--Works with a variety of technologies

C-18 Selects Technology--Chooses procedures, tools, or equipment including computers and related technologies.
C-19 Applies Technology to Task-Understands overall intent and proper procedures for setup and operation of equipment.
C-20 Maintains and Troubleshoots Equipment-Prevents, identifies, or solves problems with equipment, including computers and other technologies.

FOUNDATION SKILLS

BASIC SKILLS--Reads, writes, performs arithmetic and mathematical operations, listens and speaks.

F-1 Reading--locates, understands, and interprets written information in prose and in documents such as manuals, graphs, and schedules.
F-2 Writing-Communicates thoughts, ideas, information and messages in writing, and creates documents such as letters, directions, manuals, reports, graphs, and flow charts.
F-3 Arithmetic--Performs basic computations; uses basic numerical concepts such as whole numbers, etc.
F-4 Mathematics--Approaches practical problems by choosing appropriately from a variety of mathematical techniques.
F-5 Listening--Receives, attends to, interprets, and responds to verbal messages and other cues.
F-6 Speaking--Organizes ideas and communicates orally.

THINKING SKILLS--Thinks creatively, makes decisions, solves problems, visualizes, and knows how to learn and reason.

F-7 Creative Thinking--Generates new ideas.
F-8 Decision-Making--Specifies goals and constraints, generates alternatives, considers risks, and evaluates and chooses best alternative.
F-9 Problem Solving--Recognizes problems and devises and implements plan of action.
F-10 Seeing Things in the Mind's Eye--Organizes and processes symbols, pictures, graphs, objects, and other information.
F-11 Knowing How to Learn--Uses efficient learning techniques to acquire and apply new knowledge and skills.
F-12 Reasoning--Discovers a rule or principle underlying the relationship between two or more objects and applies it when solving a problem.

PERSONAL QUALITIES--Displays responsibility, self-esteem, sociability, self-management, integrity and honesty.

F-13 Responsibility--Exerts a high level of effort and preservers towards goal attainment.
F-14 Self-Esteem--Believes in own self-worth and maintains a positive view of self.
F-15 Sociability--Demonstrates understanding, friendliness, adaptability, empathy, and politeness in group settings.
F-16 Self-Management--Assesses self accurately, sets personal goals, monitors progress, and exhibits self-control.
F-17 Integrity/Honesty--Chooses ethical courses of action.

NURSING SKILLS I
TABLE OF CONTENT

Campuses: Levelland

TITLE: RNSG 1105 Nursing Skills I

INSTRUCTORS: Jan Buxkemper, MSN, RN-Level I Semester I Coordinator, Assistant Professor
Delia Gonzales, MSN, RN-Course Leader, Instructor
Connie Wilde, MSN, RN, Instructor
Dawn Kineman, MSN, RN, CPN, Instructor

OFFICE LOCATION, PHONE/ E-MAIL:

Delia Gonzales 716-2393, dgonzales46@southplainscollege.edu
Jan Buxkemper 716-2387, jbuxkemper@southplainscollege.edu
Connie Wilde 716-2977, cwilde@southplainscollege.edu
Dawn Kineman 716-2392, dkineman@southplainscollege.edu

OFFICE HOURS: Posted on each instructor's door.

SOUTH PLAINS COLLEGE IMPROVES EACH STUDENT'S LIFE

I. GENERAL COURSE INFORMATION:

A. COURSE DESCRIPTION:

Study of the concepts and principles necessary to perform basic nursing skills for the adult patient; and demonstrate competence in the performance of nursing procedures. Content includes knowledge, judgment, skills, and professional values within a legal/ethical framework. This course lends itself to a blocked approach. It is designed to provide the student with an overview of nursing and the role of the associate degree nurse as a provider of patient-centered care, patient safety advocate, member of health care team, and member of the profession. The student will identify concepts for the provision of nursing care; describe the roles of the nurse in the delivery of comprehensive care; describe the use of a systematic problem-solving process; and utilize critical thinking skills. Lab is required. This course is designed to provide the learner with basic knowledge and skills to function within the four roles of nursing (provider of patient-centered care, patient safety advocate, member of health care team, and member of the profession). RNSG 1105 involves the development of basic nursing skills essentials in caring for the individual who is influenced by genetic inheritance, life experiences, and cultural background and is a part of a larger community. The learner will develop observational, communicative, and technical skills. This course allows for basic safe and effective nursing principles and skills to be demonstrated in practical applications in a variety of settings to the adult client experiencing stressors of illness.

1. Placement: Level I Semester I
2. Time Allotment:
   Eight (8) weeks. The course allows one (1) semester hour credit. Including both didactic and laboratory instruction.
3. Teaching Strategies:
   Team teaching, demonstrations, independent assignments, Nursing Learning Resource Laboratory (NLRL), Center for Clinical Excellence, audiovisual media, group presentations, and discussions.
4. Teaching Personnel:
   Associate Degree Nursing faculty and guest speakers.

B. COURSE LEARNING OUTCOMES

Upon satisfactory completion of RNSG 1105 the student will meet the following:

a. The SCANS (Secretary's Commission on Attaining Necessary Skills) Competencies Foundations Skills found within this course are: C1, C2, C3, C5, C9, C10, C12, C13, C14, C16, C18, C19, C20, F6, F7, F8, F9, F11, F12, F13, F15, F16.
b. SPC ADNP Graduate Outcomes: 1, 2, 3, 4, & 5.
c. DECs (Differentiated Essential Competencies) are listed in each unit.

C. COURSE COMPETENCIES

1. Successful completion of this course requires:
   a. a minimal average grade of "77" on examinations
   b. satisfactory achievement of unit and clinical outcomes
   c. regular classroom/laboratory attendance
   d. successful completion of all assigned skills
   e. assigned ATI Assessments must be completed by date assigned.
   f. the Course Point Assignments must be completed by date assigned.

D. ACADEMIC INTEGRITY

1. Refer to the SPC Catalog and the SPC ADNP Nursing Student Handbook for policies related to academic integrity.
2. Specific examples related to this course of academic integrity violations may include, but are not limited to the following:
   a. Student coaching during the validation of skill competency [this includes ANY communication (verbal or nonverbal) from the "patient" to the SN that is not necessary for the completion of the actual skill].
   b. Presenting work as your own when you have worked in pairs or groups to complete it. All work in this course is intended to be completed on your own unless it is specified by the instructor as group work.
   c. Professional Standards: Students are expected to adhere to the professional standards set forth in the Associate Degree Nursing Program School of Nursing Student Handbook, as well as the American Nurses Association Code of Ethics for Nurses (http://nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html). Nurses are held to an extremely high standard of professional and academic conduct. It is the responsibility of the School of Nursing to teach and model professional behaviors, and it is the responsibility of the student to demonstrate professional and academic integrity. The student is representing the School of Nursing any time they are in the student role, in any location, and are expected to maintain the highest standards. Any point deductions will be taken from the final course average.

Professional Standards	***Point deduction from final course grade***
Professional Integrity	
Applies legal and ethical standards	- 1 point per variance
Maintains patient confidentiality	- 1 point per variance
Professional Behaviors	
Exhibits professional attitude	- 0.5 points per variance
Accountable for learning	- 0.5 points per variance
Responds to SON faculty/staff contact within 24 hours	- 0.5 points per variance
Attends all appointments, including appointments with faculty and retention counselors	- 0.5 points per variance
Adheres to dress code	- 0.5 points per variance
Scheduling and Attendance	
Adheres to institutional policies and procedures related to scheduling	- 0.5 points per variance
Accountable for developing and adhering to schedule	- 0.5 points per variance

d. Plagiarism Declaration

Plagiarism Declaration
Department of Nursing
South Plains College

By signing this plagiarism declaration I acknowledge that I have received a copy of the honesty policy and been made aware that the penalty for plagiarism is dismissal from the program.

Examples of student plagiarism[1]

- Copying material without quotes, in-text citations, and/or referencing
- Paraphrasing content without in-text citation and/or referencing
- Copying ideas, words, answers, exams, or shared work from others when individual work is required
- Using another's paper in whole or in part
- Allowing another student to use one's work
- Claiming someone else's work is one's own
- Resubmitting one's own coursework, when original work is required (self-plagiarism)
- Falsifying references or bibliographies
- Getting help from another person without faculty knowledge or approval
- Purchasing, borrowing, or selling content with the intent of meeting an academic requirement for oneself or others

_____
Printed Name

_____
Signature

_____
Date

E. VERIFICATION OF WORKPLACE COMPETENCIES:

No external learning experiences are provided in this course but learning experiences in the lab provides the setting in which the student applies workplace competencies. Successful completion of the designated Level I Semester I course outcomes will allow the student to continue to advance within the program. Successful completion of RNSG 1105 meets the requirements as stated in the Differentiated Essential Competencies of Graduates of Texas Nursing Program.

II. SPECIFIC COURSE/INSTRUCTOR REQUIREMENTS:

A. ATTENDANCE POLICY

1. The SPC ADNP policy must be followed. Refer to the SPC ADNP Nursing Student Handbook to review this policy. In addition, refer to the attendance policy found in the South Plains College Catalog.
2. Punctual and regular class and lab attendance, as stated in the SPC Student Handbook, is required of all students attending South Plains College. According to the SPC Student Handbook there are no excused absences. The instructor/course leader has the prerogative of dropping the student from the course for any absences.
3. Skills lecture attendance is mandatory. The instructor will initiate a student's withdrawal if a student misses 3 hours or more of class. Reinstatement is handled on an individual basis by the course leader. ***Do not be tardy for lecture, it is cumulative.** If lecture has begun before you enter the classroom, you must wait until the break period to enter the classroom. Pagers and cellular phones **must be turned off** during the lecture period. Cell phones found to be turned on during the lecture period or while in the NLRL will be confiscated and given to the Health Occupation Dean.
4. Skill/Computer Lab
   a. Students are expected to attend all scheduled days of skills/lab experience. In the event of illness, it is the student's responsibility to notify his/her instructor. Should the student miss two skill/lab hours, a Formal Learning Contract Record will be completed. This contract will become a part of the student's permanent record.
   b. The student is responsible for coordinating with the lab director for skills practice, checking off and/or recording of the skill. The student must notify the lab director prior to the scheduled check off time/recording session prior to scheduled time if unable to keep the appointment. Failure to cancel a skill check off/recording session prior to scheduled time will constitute as a recording/check off session. Thus the student's missed recording session/check off time will be counted as one of their three recording /check off sessions.
   c. If the student misses 3 hours of skills/lab, the instructor/course leader has the prerogative of dropping the student from the course. The student may be referred to the Health Occupation Dean. If the student is in good standing, has properly notified the instructor when absent, and resolved the problem causing the absence, the course leader has the option to allow the student to continue in the course.

B. GRADING POLICY: Refer to SPC ADNP Nursing Student Handbook Grading System.

1. There will be three (3) preliminary tests.
2. The final exam will be administered at the end of the course.
3. Assigned ATI Assessments by the assigned date
4. The Point Assignment must be completed by date assigned.
5. A student course grade worksheet can be found on the following page.
6. A student must receive a minimum course grade of "C" to progress.
7. *Grading Scale:*
   A = 90% - 100%
   B = 80% - 89.99%
   C = 77% - 79.99%
   D= 60% - 76.99%
   F= Below 60%
8. Student must pass the didactic component and all skills to pass RNSG 1105. If a student fails didactically or fails a skill, the student may not drop the course and will be assigned a grade in this course.
9. Failure of RNSG 1413, 1160, 1144, 1105, and/or 1115 will necessitate repeating all Level I Semester I courses. When repeating any course, the student is required to complete all aspects of the course including the required written work.

C. ATTENDANCE POLICY

1. The SPC ADNP policy must be followed. Refer to the SPC ADNP Nursing Student Handbook to review this policy. In addition, refer to the attendance policy found in the South Plains College Catalog.
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3. Skills lecture attendance is mandatory. The instructor will initiate a student's withdrawal if a student misses 3 hours or more of class. Reinstatement is handled on an individual basis by the course leader. ***Do not be tardy for lecture.** If lecture has begun before you enter the classroom, you must wait until the break period to enter the classroom. Pagers and cellular phones **must be turned off** during the lecture period. Cell phones found to be turned on during the lecture period or while in the NLRL will be confiscated and given to the Health Occupation Dean.
4. Skill/Computer Lab
   a. Students are expected to attend all scheduled days of skills/lab experience. In the event of illness, it is the student's responsibility to notify his/her instructor. Should the student miss two skill/lab hours, a Formal Learning Contract Record will be completed. This contract will become a part of the student's permanent record. This record will indicate any additional work required and dates for completion.

b. If the student misses 3 hours of skills/lab, the student will be referred to the Health Occupation Dean and/or the ADNP Admission/Academic Standards Committee with the instructor's recommendation. The instructor has the prerogative of dropping the student from the course. If the student is in good standing, has properly notified the instructor when absent, and resolved the problem causing the absences the course leader has the option to allow the student to continue in the course. Assignments for missed experiences will be determined by the instructor. Assignments must be completed within two weeks of the date of the absence. If the student fails to complete the assignment during specified time a Formal Learning Contract will be written. This contract will become a part of the student's permanent record. Failure to complete the assignment by the date specified in the Formal Learning Contract will result in the student being brought before the Health Occupation Dean and/or the ADNP Admission/Academic Standards Committee for disciplinary action. The student's right of appeal is through the ADNP Admission/Academic Standards Committee.

c. Extenuating problems such as surgery, severe illness, pregnancy, delivery, or emergencies of immediate family should be communicated to faculty, as soon as possible, for consideration for continuance in the course.

SOUTH PLAINS COLLEGE ASSOCIATE
DEGREE NURSING PROGRAM

COURSE GRADE WORKSHEET
FOR
RNSG 1105

Student's Name:_____

1. Preliminaries:

    1. _____ X 0.25 = _____
    2. _____ X 0.25 = _____
    3. _____ X 0.25 = _____

2. Final Exam Grade _____ X 0.25 = _____

3. Professional Standard Deductions_____

4. Final Grade (add all the above) _____

5. Assigned ATI Assessments _____

6. The Course Point Assignments _____

C. EXAMINATION POLICY

1. **Exams will not be retained by the student.**
2. A student must communicate with the course leader if unable to take an exam on a scheduled day. If there is no communication prior to the time the exam is administered, a "0" will be given.
3. Alternate exams may be given as make up exams.
4. Name badge must be worn when testing in the computer lab.

E. ASSIGNMENT POLICY

1. All required work must be in on time in order that the student may benefit from the corrections and study for future examinations. Assigned outside work is due on the dates specified by the instructor. Assignments turned in later than the due date will not be accepted unless the student clears the circumstances with the instructor. Late work will be assessed penalty points by the instructor. The assignment will be docked five (5) points per day for each late day. Students should keep a copy of all assignments to prevent repeating the assignment should the assignment be lost.
2. Laboratory Component:
   a. The skill must be passed by the assigned date. Failure to successfully pass the skill by the assigned date will result in course failure.
   b. The skill laboratory component serves the following functions:
      1) Provides the opportunity for students to practice their skills prior to clinical performance of those skills. The nursing faculty expects the nursing student to develop safe beginning level proficiency with procedures by utilizing the Nursing Learning Resource Lab. This will maximize positive productive outcomes for both the client and the nursing student.
      2) Provide the opportunity for students to be evaluated according to the criteria of adequacy.
   c. Required skills will be demonstrated during class time. Students must arrange to be checked off on all required skills prior to performing these skills in the clinical setting. Students must validate practice time with learning lab faculty before arrangement for skill competency validation. Skills competency validation must be completed successfully by the assigned date. Failure to validation skills competency by the assigned date will result in failure of RNSG 1105.
   d. The student will have no more than, two recording sessions prior to submitting the skill for grading.
   e. If the skill submitted for grading is failed, a second opportunity will be allowed following documented lab practice as determined by the instructor. A Skills Enhancement Record will be made and completed before the student is allowed to schedule a second appointment. The student will have no more than two recording sessions prior to submitting the skill for the second grading.
   f. If the skill is failed on the second attempt, a third opportunity will be allowed following completion of a second Skills Enhancement Record.

The student will have no more than two recording sessions prior to submitting the skill for the third and final grading.

g. The skill must be passed by the scheduled assigned date. Therefore, the three opportunities to validate the skill must be used before the assigned date scheduled. Failure of the third attempt of validation of skill competency will result in the student's failure of the course.
h. Questions and/or assistance regarding the skill need to be addressed to the instructor demonstrating the skill.
i. The student is responsible to view and watch the recording prior to submission. The student is also responsible for indicating the place where the instructor is to begin grading. If the student indicates the wrong time and/or date for the instructor to start grading and the student fails, the instructor is not obligated to watch a corrected time and/or date of the recording.
j. The instructor grading a skill recording may stop the grading process at the point of the first failure and is not obligated to continue grading. Any additional infractions of the recorded skill are the responsibility of the student to identify.
k. Laboratory experience will be graded on a Pass/Fail (P/F) basis. The student must pass all skills and have a minimum grade of 77% in the didactic component to pass the course. If a student fails didactically or fails a skill, the student may not drop the course and will be assigned a grade in this course.
l. Lab/clinical evaluation session will be scheduled based on student/instructor identified need and/or at the end of the semester.
m. The student must wear the SPC ADNP lab coat or SPC ADNP uniform while in the skills lab. Long hair and bangs must be contained. Failure to comply with the lab dress code will result in the student being required to leave the NLRL or will result in a failed recording. The student is expected to be in total compliance with the uniform dress code anytime the SPC uniform is worn.

E. GRIEVANCE POLICY

The student is responsible for scheduling an appointment with the instructor/course leader to discuss the final grade or discipline action. If the student is not satisfied, he/she should schedule an appointment with Level I Semester I Coordinator. The next chain of command is the Health Occupation Dean. The procedure will follow the same as found in the student handbook.

F. COURSE REQUIREMENTS

1. Prerequisites: Psychology 2314, Biology 2401 & 2420, and English 1301. Concurrent enrollment in RNSG 1413, RNSG 1160, RNSG 1115, and RNSG 1144. If RNSG 1115 has been successfully completed it is not required for concurrent enrollment.
2. Meet all requirements for admission into the Associate Degree Nursing Program.
3. Completion of student contract for Level I Semester I.
4. Regular classroom/skills laboratory attendance.
5. Satisfactory grade average on written examinations (77 or above).

6. Satisfactory achievement of behavioral course outcomes (see unit outcome) and all skills.

III. COURSE OUTLINE

Unit I Critical Thinking In Nursing Practice
Unit II Patient Education
Unit III Documentation and Informatics
Unit IV Infection Prevention and Control
Unit V Vital Signs
Unit VI Medication Administration
Unit VII Mobility and Immobility
Unit VIII Hygiene

IV. ACCOMMODATIONS

Diversity Statement

In this class, the instructor will establish and support an environment that values and nurtures individual and group differences and encourages engagement and interaction. Understanding and respecting multiple experiences and perspectives will serve to challenge and stimulate all of us to learn about others, about the larger world and about ourselves. By promoting diversity and intellectual exchange, we will not only mirror society as it is, but also model society as it should and can be.

ADA Statement

Students with disabilities, including but not limited to physical, psychiatric, or learning disabilities, who wish to request accommodations in this class should notify the Disability Services Office early in the semester so that the appropriate arrangements may be made. In accordance with federal law, a student requesting accommodations must provide acceptable documentation of his/her disability to the Disability Services Office. For more information, call or visit the Disability Services Office at Levelland (Student Health & Wellness Office) 806-716-2577, Reese Center (Building 8) 806-716-4675, or Plainview Center (Main Office) 806-716-4302 or 806-296-9611.

Unit I: Blended Competencies, Clinical Reasoning, and Processes of Person-Centered Care

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Blended Competencies, Clinical Reasoning, and Processes of Person-Centered Care A. Definition B. Application	1. Describe each element of thoughtful, person-centered practice: the nurse's personal attributes, knowledge base, and blended and QSEN competencies; clinical reasoning, judgment, and decision making; person-centered nursing process; and reflective practice leading to personal learning. 2. Assess one's capacity for competent, responsible, caring practice. 3. Contrast three approaches to problem solving. 4. Use the clinical reasoning model. 5. List three patient benefits and three nursing benefits of using the nursing process correctly. 6. Identify personal strengths and weaknesses in light of nursing's essential knowledge, attitudes, and skills. 7. Value reflective practice as an aid to self-improvement.	Group 1. Lecture 2. Discussion 3. Demonstration Assignments 1. Taylor, Lillis, Lynn Chapter 10 2. Define key terms 3. The Course Point Evaluation 1. Pen & Paper or Computer Test	D4	A1		A2
				A2		A3
				A4		B1
				B1		D2
				B3		D3
				B11		D4
				C2		E1
				C4		
				C6		
				D3		
				D5		
				E13		
				F1		

Unit II: Teacher and Counselor

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Teacher and Counselor A. Client Education 1. Teaching - Learning Process a) Purpose b)Facilitators c) Barriers d) Domains B. Student Involvement in the Teaching/Learning Process 1. Principles of learning 2. Principles of teaching 3. Principles of evaluation	1. Describe the teaching–learning process, including domains, developmental concerns, and specific principles. 2. Describe the factors that should be assessed in the learning process. 3. Discuss strategies that improve health literacy and promote patient safety. 4. Describe the factors that influence patient compliance with the therapeutic plan. 5. Explain how to create and implement a culturally competent, age-specific teaching plan for a patient. 6. Discuss the role of a nurse coach in promoting behavior change. 7. Name three methods for evaluating learning. 8. Explain what should be included in the documentation of the teaching–learning process. 9. Discuss the nurse's role as a counselor. 10. Summarize how the nursing process is used to help patients solve problems. 11. Describe how to use the counseling role to motivate a patient toward health promotion.	Group 1. Lecture 2. Discussion 3. Demonstration Assignment 1. Taylor, Lillis, Lynn Chapter 21 2. The Course Point Evaluation 1. Pen & Paper or Computer Test	A3 A4 B3 B7 C3 C4 C5 D2 D3	A3 A4 C2 C6 D5 E10 F1 G3		A2 B1 B3 C3 C5 C8 E2

Unit III: Documenting, Reporting, Conferring, and Using Informatics

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Documenting, Reporting, Conferring, and Using Informatics A. Purpose of Records B. Types of Medical Records 1. Problem Oriented Record 2. Source Oriented Record 3. Computerized Record 4. Narrative Record C. Guidelines for Recording D. Legal Considerations E. Reporting	1. List guidelines for effective documentation, including those of the American Nurses Association. 2. Identify measures to protect confidential patient information. 3. Identify approved abbreviations and symbols used for documentation and distinguish these from error-prone abbreviations and symbols. 4. Describe the purposes of patient records. 5. Compare and contrast different methods of documentation: electronic health record, source-oriented record; problem-oriented record; PIE—problem, intervention, evaluation; focus charting; charting by exception; and case management model. 6. Describe the purpose and correct use of each of the following formats for nursing documentation: nursing assessment, nursing care plan, critical/collaborative pathways, progress notes, flow sheets, discharge summary, and home care documentation. 7. Document nursing interventions completely, accurately, currently, concisely, and factually—avoiding legal problems. 8. Describe the nurse's role in communicating with other health care professionals by reporting and conferring. 9. Describe nursing informatics and its contributions to nursing and health care.	Group 1. Lecture 2. Discussion 3. Demonstration Assignment 1. Taylor, Lillis, Lynn Chapter 16. 2. Define key terms 3. The Course Point Evaluation 1. Pen & Paper or Computer Test 2. Charting Assignment	A2 A4 B8	B1 B2 B3 B4 B6 B7 B8 B11 C2 C3 C5 D3 D5 E1 E2 E12 F1 F2 G3	A2 A4 B1 B2 B3 C1 D1 E2	B1 C4 D1 D3 E1

SOUTH PLAINS COLLEGE ASSOCIATE
DEGREE NURSING PROGRAM

ROOT WORDS, PREFIXES, SUFFIXES, AND COMMONLY-USED SYMBOLS

WORD ELEMENT	MEANING	WORD ELEMENT	MEANING

ROOT WORDS

CIRCULATORY SYSTEM

cardio	heart
angio, vaso	vessel
hem, hema, hemato	blood
vena, phlebo	vein
arteria	artery
lympho	lymph
thrombo	clot (of blood)
embolus	moving clot

DIGESTIVE SYSTEM

bucca	cheek
os, stomato	mouth
gingiva	gum
glossa	tongue
pharyngo	pharynx
esophago	esophagus
gastro	stomach
hepato	liver
cholecyst	gallbladder
pancreas	pancreas
entero	intestines
doudeno	duodenum
jejuno	jejunum
ileo	ileum
caeco	cecum
appendeco	appendix
colo	colon
recto	rectum
ano, procto	anus

SKELETAL SYSTEM

skeleto	skeleton

RESPIRATORY SYSTEM

naso, rhino	nose
tonsillo	tonsil
laryngo	larynx
tracheo	trachea
bronchus, broncho	bronchus
pulmo, pneuma pneum	lung (sac c air)

NERVOUS SYSTEM

neuro	nerve
cerebrum	brain
oculo, ophthalmo	eye
oto	ear
psych, psycho	mind

URINARY SYSTEM

urethro	urethra
cysto	bladder
uretreo	ureter
reni, reno, nephro	kidney
pyelo	pelvis of kidney
uro	urine

WORD ELEMENT	MEANING	WORD ELEMENT	MEANING

FEMALE REPRODUCTIVE SYSTEM

Vulvo	vulva
Perineo	perineum
Labio	labium (plural: labia)
vagino, culpo	vagina
cervico	cervix
utero	womb, uterus
tubo, salpingo	fallopian tubes
ovario, oophoro	ovary

MALE REPRODUCTIVE SYSTEM

Orchido	testes

REGIONS OF THE BODY

Crani, cephalo	head
Cervico, tracheo	neck
Thoraco	chest
Abdomino	abdomen
Dorsum	back

TISSUES

Cutis,dermato	skin
Lipo	fat
Musculo, myo	muscle
Ostoe	bone
Myelo	marrow
Chondro	cartilage

MISCELLANEOUS

Cyto	cell
Genetic	formation, origin
Gram	tracing or mark
Graph	writing, description
Kinesis	motion
Laparo	flank; through the abdominal wall
meter	measure
oligo	small, few
phobia	fear
photo	light
pyo	pus
roentgen	x-ray
scope	instrument for visual examination

PREFIXES

a,an, ar	without or not
Ab	away from
Acro	extremities
ad	toward, to
adeno	glandular
aero	air
ambi	around, on both sides
Amyl	starch
Ante	before,forward
anti	against counteracting
bi	double
bili	bile
bio	life
bis	two
Brachio	arm
Brady	slow
cardio	heart
cervico	neck
chole	gall or bile
cholecysto	gallbladder
circum	around

WORD ELEMENT	MEANING	WORD ELEMENT	MEANING
Co	together	inter	between
Contra	against, oppisite	intra	within
Costo	ribs	intro	in, within, into
Cysto	bladder	juxta	near, close to
Cyto	cell	lapar	abdomen
Demi	half	laryngo	larynx
Derma	skin	latero	side
Dis	from	leuk	white
Dorso	back	macro	large, big
Dys	abnormal	mal	bad, poor
	Difficult	mast	breast
Electro	electric	medio	middle
En	into, in within	mega, megalo	large, great
Encephal	brain	meno	menses
Entero	pertaining to	myo	muscle
	The intestine	neo	new
Equi	equal	nephro	kidney
Eryth	red	neuro	nerve
Ex	out, out of	nitro	nitrogen
	Away from	noct	night
Extra	outside of	non	not
	In addition to	ob	against in
Ferro	iron		front of
Fibro	fiber	oculo	eye
Fore	before, in	odonto	tooth
	Front of	ophthalo	eye
Gastro	stomach	ortho	straight,
Glosso	tongue		normal
Glyco	sugar	os	mouth, bone
Hemi	half	osteo	bone
Hemo	blood	oto	ear
Hepa, Hepato	liver	pan	all
Histo	tissue	para	beside,
Homo	same		accessory to
Hydro	water		
Hygro	moisture		
Hyper	too much, high		
Hypo	under, decreased		
Hyster	uterus		
Ileo	ileum		
In	in, within, into		

WORD ELEMENT	MEANING	WORD ELEMENT	MEANING
Path	disease	super	above, excess
Ped	child, foot	supra	above
Per	by, through	syn	together
Peri	around	tachy	fast
Pharyngo	pharynx	thyro	thyroid gland
Phlebo	vein	trache	trachea
Photo	light	trans	across, over
Phren	diaphragm, mind	tri	three
Pneumo	air, lungs	ultra	beyond
Pod	foot	um	not, back, reversal
Poly	many, much		
Post	after	uni	one
Pre	before	uretero	ureter
Proct	rectum	urethro	urethra
Pseudo	false	uro	urine, urinary organs
Psych	mind		
Pyel	pelvis of the kidney		
Pyo	pus	<u>SUFFIXES</u>	
Pyro	fever, heat	able	able to
Quadri	four	algia	pain
Radio	radiation	cele	tumor, swelling
Re	back, again		
Reno	kidney	centesis	surgical puncture to remove fluid
Retro	backward		
Rhin	nose		
Sacro	sacrum	cide	killing, destructive
Salpingo	fallopian tube		
Sarco	flesh	estasia	dilating, stretching
Sclero	hard, hardening		
Semi	half	ectomy	excision, surgical removal of
Sex	six		
Skeleto	skeleton		
Steno	narrowing Constriction	emia	blood
		esis	action
Sub	under	form	shaped like
		Genesis, genetic	formation Origin
		Gram	tracing mark
		Graph	writing

COMMONLY USED ABBREVIATIONS

ABBREVIATION	MEANING
aa	of each
abd.	abdomen
a.c.	before meals
ad.lib.	as desired
A.M.	morning
amb.	ambulatory, walking
amt.	amount
approx.	approximately (about)
Aq.	aqueous (water)
ax.	axillary (armpit)
b.i.d.	twice per day
B.M.R.	basal metabolic rate
B.M.	bowel movement
B/P.	blood pressure
B.R.P.	bathroom privileges
C	centigrade
c	with
CA	cancer
C.D.	Communicable disease

ABBREVIATION	MEANING
cmpd.	compound
et., +, &	and
c/o	complains of
dr.	drainage
dsg.	dressing
ECG (EKG)	electrocardiogram (tracing of heart function)
EEG	electroencephalogram (brain wave tracing)
E.R.	emergency room
elix.	elixir
exam	examination
ext.	extract
F.	Fahrenheit
Fe	iron
fld.	fluid
G.I.	gastrointestinal (stomach and intestine)
gm. or g	gram (measurement)
gr.	grain (measurement)
gtt.	drop (measurement)
G.U.	genitourinary (pertaining to organs of reproduction and urinary excretion)
h	hour
Hgb	hemoglobin
hi-cal	high-calorie
hi-vit	high vitamin
H.O.B.	head of bed
H_2O	water
h.s.	bedtime
invol.	involuntary (without knowledge of)
irrig.	irrigate
I and O, I+O, I&O	intake and output
IM	intramuscular
IV	intravenous (within vein)
kg.	kilogram (weight)
lab.	laboratory
lb.	pound
liq.	liquid
L or lt.	left
L.L.Q.	left lower quadrant (left lower section of abdomen)

ABBREVIATION	MEANING
L.U.Q.	left upper quadrant (See Figure)
MAE	moves all extremities
med.	medical or medication
mid.	middle
min.	minute
mg.	milligram (measurement)
N + V	nausea and vomiting
noc.	night
N.P.N.	non-protein nitrogen (content of blood)
NPO	nil per os or nothing by mouth
#, no.	number
nsq	non sufficient quantity
O	oxygen
o	none
O.R.	operating room
oh	every hour
o.u.	each eye
oz.	ounce
p.	pulse
Ped., Peds, Pedi	pediatrics
per	by or through
PERRLA	pupils equal, round, react to light and accommodate
Pil	pill
p.o.	per os or by mouth
post-op	post-operative (after surgery)
p.r.n.	when necessary
pre-op	preoperative (before surgery)
psych.	psychologic, psychiatric
pt.	patient
P.M.	afternoon
P.T.	physical therapist or physical therapy
q	every
q.h.	every hour
q.i.d.	four times per day
q.n.s.	quantity not sufficient
r. resp.	respirations
R.B.C.	red blood cell
rt.	Right

ABBREVIATION	MEANING
R.L.Q.	right lower quadrant (right lower quarter of abdomen) (See Figure)
R.U.Q.	right upper quadrant of abdomen (See Figure)
Sol.	solution
sp.gr.	specific gravity (measure)
s	without
S.S.E.	soapsuds enema
stat	at once
staph	staphylococcus (germ)
tab	tablet
TL	team leader or tubal ligation
TPR	temperature, pulse, respiration
UT dict	ut dictum (as directed)
V.D.	venereal disease
via	by way of
W.B.C.	white blood cell
wt	weight

UNACCEPTABLE ABBREVIATION AND SYMBOL LIST

Do Not Use any of the Following When Ordering or Prescribing:

Unacceptable Abbreviation/Symbol	Why this is not to be used	Why is acceptable practice
Trailing or terminal zero after decimal point – Example: 3.0 mg	Can be mistakenly read as multitudes of the intended amount without notice of the decimal point	Do not use trialing or terminal zeros. Write doses as whole number
Decimal pint preceding dose without preceding zero – Example: .05 mg	Can be mistakenly read as multitudes of the intended amount without notice of the decimal	Include the preceding zero (o) before a decimal point when the dose is less than a whole unit
AU	Can be mistaken for OU	Write out the term "each ear"
D/C	Can be interchanged to mean discontinue or discharge	Write out your intent, either "discontinue" and the name of the drug or "discharge the patient"
The "μ "can be mistaken for "m" and microgram then becomes mistaken for milligram		Use the abbreviation "mcg" or write out the word "microgram"
OD or o.d.	Can be mistakenly interchanged to mean right eye or once daily	If you mean right eye, write out "right eye", if you intend once daily, use the word "daily"
TIW or tiw	Can be mistaken for three times per day	Write out three times per week, do not use the abbreviation TIW or tiw
Per os	The word "os" can be mistaken for left eye	Write out the term "per mouth', or the word "orally" or use the abbreviation "PO"
qn	Can be mistaken for every hour	Write out the word "nightly"
U or u	Frequently mistaken for the number zero or the number four	Write out the word "unit"
IU	Can be mistaken for intravenous	Write out the word "units"
cc	Can be mistaken for units (with the cc looking like a "u")	Use the term mL or write out the term "cubic centimeters"

UNACCEPTABEL ABBREVIATION AND SYMBOL LIST (continued)

Unacceptable Abbreviation/Symbol	Why this is not to be used	What is acceptable practice
X3d	Can be mistaken for three doses	Write out the phrase "for three days"
BT	Can be mistaken for twice daily	Use the abbreviation "hs" or write out the phrase "at bedtime"
ss	Can be mistaken for the number 55	Write out the phrase "sliding scale"
1/2	Can be mistaken for 55	Write out the phrase "one-half" or use quotes around the numbers "1/2"
Use of the slash mark (/)	Can be mistaken for the number 1	Do not use a slash mark to separate doses, write out the word "per"
Apothecary symbol for the word dram	Can be mistaken for the number three (3)	Use the metric system instead of this apothecary symbol
Apothecary symbols for the word minim	Can be mistaken for the abbreviation mL	Use the metric system instead of this apothecary symbol
The following Drug Abbreviations are not to be used: ARA-A- Vidarabine AZT- Zidovudine (Retrovir) CPZ- Prochlorperazine (Compazine) DPT- Abbreviation for Demerol-Phenergan-Thorazine HCI- Hydrochloric Acid HCT- Hydrocortisone HCTZ- Hydrocortisine MgS04- Magnesium sulfate MS04- Morphine sulfate MTX- Methotrexate TAC- Triamcinolone ZnS04- Zinc sulfate		Write out the complete name of the drug
Do not Shorten Names of Drugs- Example: "Nitro drip"	Can be mistaken for other drug names, such as in the example – "Nitro" drip can mean nitrogrlycerin or sodium nitroprusside	Write out the complete name of drug

Official "Do Not use" List

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "O" (zero), The number "4" (four) or "cc" Mistaken for IV (intravenous)	Write "unit"
IU (International Unit)	or the number 10 (ten) Mistaken for each other	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Period after the Q mistaken for "I" and "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg) Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.Xmg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate"
MSO_4 and $MgSO_4$	Confused for one another	Write "magnesium sulfate"
>(greater than) <(less than)	Misinterpreted as the number "7" (seven or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug	Misinterpreted due to similar Abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many Practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
CC	Mistaken for U (unites) when Poorly written	Write "ml" or "milliliters"
Ug	Mistaken for mg (milligrams) Resulting in one thousand fold overdose	Write "mcg" or "micrograms"

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

COMMON DESCRIPTIVE TERMS

The following specific terms are suggested for use in charting. Be as specific as possible at all times. Exact amounts, conditions, and behaviors should be documented whenever possible.

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
abdomen	black and blue color noted……..	bruised (appears); ecchymotic
	bloated; filled with gas……	tympanitus; distended
	hurts when touched…….	sensitive to touch; tender
	hard; board-like…….	Rigid
	large; extends out……	Protruding
	soft; flabby; flat……...	soft; flaccid; flat
amounts	large amount……	copious; excessive; profuse
	moderate amount…….	moderate; usual
	small amount……...	scanty; slight; small
appearance	thin and undernourished……..	emaciated
	fat; overweight…….	obese
	seems very sick……	acutely ill
	fails to notice things……	apathetic; indifferent
	extremely worried; nervous…….	anxious; shows anxiety
	appears to have blue color……...	cyanotic
	extremely happy; fails to accept reality as it is……...	euphoric
	skin appears yellowish……	jaundiced
appetite	craves certain foods……	parorexia
	desires to eat material not accepted as food……..	perverted appetite
	eats everything served and asks for more food……..	hearty appetite
	appears never to get enough food……	insatiable appetite
	eats all food served……..	good appetite
	eats little of food served……..	poor appetite
	loss of appetite…….	anorexia
arm (extremity)	shoulder to elbow……	upper arm
	elbow to wrist……..	lower arm
	with much extra tissue…….	plumb to obese
	appears puffy or swollen…….	edematous; edema
attitude	afraid; worried…….	anxious; fearful
	does not believe what is said……...	distrustful; suspicious
	fixed idea (right or wrong)……..	obsession
	behavior that forces self or ideas on others……...	aggressive
	false belief insisted upon…….	delusion
	centers attention upon self……...	introvert

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
attitude (cont.)	"don't care" attitude……	apathetic
	not interested in surroundings…….	indifferent
	happy; carefree……	cheerful; optimistic
	seems to feel guilt and worries about unreal things……	appears depressed
back	upper back……..	shoulder area; thoracic area; interscapular
	small back……...	lumbar area
	end of spine…….	sacral area
	buttocks……...	gluteal area
	humped back……...	kyphosis
	sway back……	lordosis
	curved back…….	scoliosis
baths	given when patient arrives……..	admission bath
	entire body……...	complete bath
	face, neck, arms, back, and genitals……	partial bath
	special bath……..	state method and materials
	taken in bed…….	bed bath
	taken in tub or special tub……...	tub bath or sitz bath
belch	noise made in mouth area……	eructation; burping
bleeding	in large amount and in spurts……..	spurting blood; profuse
	very little…….	oozing; minimum amount
	nosebleed…….	epistaxis
	blood in vomitus……..	hematemesis
	blood in urine……..	hematuria
	blood in sputum……...	hemoptysis
blister	raised area on skin filled with water……	vesicle
blood pressure	reading on measuring instrument……	BP 120/80/68 (example); strong; weak
breast	each appears same size……	of equal size
	inflammation……...	mastitis
	large; hard…….	engorged
	appears average for person……..	developed normally
	nipple always depressed……..	inverted nipple
	period of milk formation…….	lactation
breath	taking in air……..	respiration; inspiration
	breathing air out……..	respiration; expiration
	difficulty breathing……..	dyspnea
	short time without breathing……...	apnea
	rapid breathing…….	hyperpnea
	cannot breathe lying down……..	orthopnea
	snoring sounds of breathing……	stertorous respiration
	unpleasant odor……...	halitosis
	increasing dyspnea with periods of non-breathing……..	Cheyne-Stokes respiration (a terminal breathing condition)
	no breath from suffocation……..	asphyxia

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
breath (cont)	large amount of air taken……	deep breathing
	small amount of air taken……	shallow breathing
	abnormal variation of breath……...	irregular respiration
	sweet, fruitlike odor…….	fruity; sweet
care	wash face, hands, oral hygiene, comb hair, BR……...	early A.M. care
	bed bath, backrub, oral hygiene……..	A.M. care
	wash face, hands, back, backrub…….	P.M. care
	special attention to mouth……...	special mouth care
	special attention to back……..	special back care
chest	abnormally shaped……..	deformed
	looks rounded front and back……..	barrel-chest
	looks abnormally small……...	shrunken
chill	came on suddenly……	sudden onset
	how long it lasts……..	duration of (state time); prolonged, short, persistent, or intermittent
	extent of chill……...	moderate, severe, or slight
color of excretion: urine	without color……...	clear; colorless
	normal urine……	straw-colored to amber
color of excretion: feces	resembling clay……...	clay-colored B.M.
	looks black as tar…….	tarry B.M.
	tinged with blood…….	blood-tinged
coma	does not respond to stimuli……..	coma (partially comatose or in profound coma)
consciousness	aware of surroundings…….	alert; conversant; fully conscious
	partly conscious……...	lethargic; semiconscious
	not conscious, but can be aroused……...	stuporous
	unconscious, cannot be aroused……..	comatose
consistency	remains together; retains shape……...	formed
	running like water……	liquid
	thick and sticky……	concentrated; viscous
	looks like mucus……..	mucoid
convulsion	muscles contract and relax……..	clonic tremor or convulsion
	muscle contraction maintained for a time……..	tonic tremor or convulsion
	localized muscle contraction……...	Jacksonian
	began without warning……	sudden onset
	spasm or convulsive seizure……	paroxysm

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
cough	coughs all the time……..	continuous
	coughs up material……..	productive
	coughs over long period of time…….	persistent
	coughs without producing material…….	non-productive
	coughs with a "whoop"……..	whooping cough
	coughs with certain attacks…….	paroxysmal
	various types……	loose; deep; dry; painful; exhaustive; tight; hacking; hollow
decay	teeth…….	caries
	tissue……	necrosis; necrotic
defecation or bowel movement	bowel movement…….	feces; stool; defecation
	excessive…….	diarrhea
	gray color……	clay-colored
	dark, liquid……..	brownish-black; loose
	soft material……	soft, formless, or soft-formed stool
	constipated……..	hard-formed stool expelled with difficulty; pellet-like
dizziness	feeling of being unstable, unsteady…….	vertigo
drainage	watery (from nose)…….	coryza
	sticky……..	viscous
	contains pus…….	purulent
	watery; bloody…….	sanguineous; sero-sanguineous
	fecal (contains bowel material)……...	fecal
	contains mucus and pus……...	mucropurulent
	from vagina after delivery……...	lochia
dressings	dressing over original one……...	dressing reinforced
	dressing removed, reapplied……	dressing changed
	sterile dressings……...	sterile dressing applied
ears	wax in ears……...	cerumen
	ringing sensation…….	tinnitus
	dizziness……..	vertigo
	abnormally shaped……...	deformed
emesis	material coming from mouth……...	emesis
	produced by effort of patient……...	self-induced
	ejected forcefully without warning…….	projectile
	blood particles in content……	blood-tinged
	material given to produce vomiting……	emetic
enemas	liquid given to induce expulsion of feces	cleansing enema
	for nourishment……...	nutritive
	to rid gas……..	carminative
	to expel worms……	anthelmintic
	to remain for some time……..	retention

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
enemas (cont)	to soothe and protect……..	emollient
	for diagnostic exam…….	barium
expectoration	spitting up saliva……..	expectorate
	much or little amount……..	profuse, or small or scant
	spitting up blood……..	hemoptysis
	mucus with blood particles……..	blood-tinged
eyes	ability to see well…….	visual acuity
	nearsightedness……	myopia
	farsightedness……..	hyperopia
	inability to see clearly…….	blurred vision
	dilation of pupil……...	enlarged pupil
	small pinpoint……..	pupil contracted; “pinpoint”
	see double (two of things)……...	diplopia
	squinting……..	strabismus
	puffy; appear swollen……..	edematous
	drooping eyelids……..	ptosis
	white of eyes appear yellow……	jaundiced
	appear to be staring; will not move…….	fixed
	eyeballs appear to stick out of socket…..	exophthalmia (as in hyperthyroidism or goiter)
	inflammation of socket and lid lining….	conjunctivitis
	stye on eyelid……...	hordeolum
	other descriptive terms……	burning; smarting; clear; dull; inflamed; sunken; bloodshot; crossed
face	without normal color……...	pale
	unusually pink…….	flushed
	broken areas of skin…….	acne or rash
	black and blue color……	appears bruised
	expressions……..	defiant; angry; sad; fearful; worried; happy; anxious; dissatisfied; stressful; pained
	scars and pits……...	pock-marked
faint	losing consciousness……...	syncope
feet	reddened; blistered……..	pressure area present
	puffy; appear swollen……..	edematous
	other descriptive terms……	warm; cold; hot; painful; gangrenous
fever	no evidence of fever……..……..	afebrile
	temperature above normal……...	pyrexia
	temperature greatly above normal……...	hyperpyrexia
	elevated temperature suddenly returns to normal……..	crisis (peak of anything)
	elevated temperature gradually returns to normal…….	lysis (falling)

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
fingers	appear square across and curved at the end……	clubbed (as in some cardiac conditions)
	come to fine point at end…….	tapered
gas	digestive tract appears full (with or without sound)…….	flatulence
gums	tender; inflamed……..	gingivitis
	pull away from teeth……	receding; shrunken
	other descriptive terms……	bleeding; spongy; firm; pink
hair	clean; good appearance……...	clean; glossy
	unclean; coarse……	dirty; greasy; coarse
	absence of hair…….	alopecia
	other descriptive terms……	tangled; neglected; bleached; dyed; uncombed
hallucination	abnormal senses not observed by others.	hallucination
	--hearing……..	auditory hallucination (voices or sounds)
	--sight……..	visual hallucination (visual images not observed by others)
	--smell……..	olfactory hallucination (abnormal odors)
	--taste……...	gustatory hallucination
hands	abnormally large……..	massive
	fingers square and curved……	clubbed fingers
	shaking continuously……...	trembling
	other descriptive terms……	dirty; rough; wet; dry; hot; cold; broken nails
head	forehead……...	frontal
	near ear……	temporal
	side of head at top part……	parietal (right or left)
	back of head……	occipital
	unusually large head……	macrocephalous
	unusually small head……...	microcephalous
heartbeat	irregular beating……..	arrhythmia
	slow…….	bradycardia
	fast……...	tachycardia
hives	hives (raised areas on skin)…….	urticaria
	itching……..	pruritus
joints	bent……..	flexion
	straightened…….	extension
	turned downward…….	pronation
	turned upward……..	supination
	revolve around…….	rotation
	move away form center line……	abduction
	move toward center line……..	adduction

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
joints (cont)	stiff joint……..	ankylosis
	inflammation……...	arthritis
	stretching or wrenching……...	sprain
legs	between knee and hip……..	thigh
	thigh to knee……	upper leg
	knee to ankle……	lower leg
lice	animal parasites on body…….	pediculi
	of head area…….	pediculosis capitis
	of body area…….	pediculosis corporis
	of pubic area……	pediculosis pubis
lips	pale; lacking normal color……...	pale
	blue in color…….	cyanotic
	with tiny cracks……...	fissured; cracked
	blistered appearance……	herpes simplex (cold sore)
lungs	abnormal sounds……..	rales; rhonchi; pleural friction rub
memory	loss of memory……	amnesia
mucous	relates to a sensitive membrane or lining……	mucous lining of the intestinal tract (example)
	relates to drainage from mucous membrane……	clear; yellow; sanguineous (bloody); purulent (pus)
muscle	loss of normal tone or size……...	atrophy
	inflammation……...	myositis
	stretching…….	strain
	blue in color…….	cyanotic
	other descriptive terms……	clean; dirty; broken; manicured; brittle
nails	blue in color ……	cyanotic
	other descriptive terms ……..	clean; dirty; broken; manicured; brittle
nose	nosebleed…….	Epistaxis
odor	not pleasant; pungent; spicy……	aromatic
	like fruit…….	fruity
	unpleasant……	offensive; foul
	belonging to a particular thing……	characteristics
pain	much pain……	severe
	little pain…….	Slight
	comes in seizures…….	Spasmodic
	spreads to certain areas……	radiating
	begins suddenly…….	sudden onset
	hurts when moving……..	increased by movement

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
pain cont'd	other descriptive terms……	dull; aching; faint; burning; throbbing; gnawing; acute; chronic; generalized; superficial; excruciating; unyielding; cramping; shooting; darting; colicky; continuous; shifting; agonizing; piercing; intense; cutting; transient; localized; remittent; persistent
paralysis	face muscles unable to move……...	facial paralysis
	leg muscles unable to move……	paraplegia, right or left
	one side of the body……	hemiplegia, right or left
	four extremities unable to move……..……..	monoplegia
perspiration	large amount…….	profuse; excessive
	small amount…….	scanty; slight
position of the body	flat on back……	dorsal
	on left side (right leg flexed)…….	sims'
	head elevated to at least 45^0, legs Prone, knees extended……...	Fowler's
	head and knees elevated (head lower than 45^0……	semi-Fowler's
	on back with heels brought close to buttocks; knees bent…….	Lithotomy
	on back; knees flexed……	
	resting on knees and chest……	
	on back; pelvis higher than head……..	
	on abdomen; head turned to one side...	
pulse	force of blood exerted against artery wall…….	(taken at) radial; temporal; femoral; pedal; carotid; apical
	number of beats per minute……	
	rhythm……	
	beat missed…….	
	over 100 per minute……	
	below 60 per minute……	
	beats indistinct (rapid)……	
	beats hardly perceptible……..	
	rapid, distinct beats……	
	cannot be felt……..	
sensation	feeling experienced…….	tingling; burning; stinging; prickling; hot; cold

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
skin	descriptive terms……	pale; red; moist; dry; clear; coarse; tanned; scaly; thick; loose; rough; tight; infected; discolored; jaundiced; mottled; calloused; edematous; excoriation; abrasion; bruised; oily; painful; scarred; black; brown; white; pink; clammy; rash; wrinkled; smooth
sleep	inability to sleep…….	insomnia
	tired on awakening	awakens fatigued
speech	unable to be understood……	incoherent
	meaningless……	rambling
	runs words together……..	slurring
	difficulty in speaking……	dysphasia
	inability to speak……..	aphasia
	other descriptive terms…….	slammering; stuttering; hoarse; feeble; fluent
symptoms	observed by the patient…….	subjective
	observed by others……	objective
teeth	false teeth……..	dentures
	decay…….	caries
	collection of material on…….	sordes
	other descriptive terms……...	decayed; notched; crooked; protruding; broken; loose; irregular; dirty
tongue	descriptive terms……	dry; furrowed; cracked; raw; coated; swollen; ulcerated; pink; inflamed; geographic; strawberry; furry; hairy
throat	difficulty in swallowing…….	dysphagia
	inability to swallow……	aphagia
treatment	to prevent…….	prophylactic
	to give temporary relief……	palliative

WORD	IDEA TO BE CHARTED	SPECIFIC TERM
Urination	Pass fluid from bladder…….	Void; micturate; urinate
	Unable to control……..	Incontinent; involuntary
	Large amount……	Diuresis
	No urine passes……	Anuria
	Frequent and much urination……	Polyuria
	Pus in urine……	Pyuria
	Blood in urine……	Hematuria
	Sugar in urine……	Glycosuria
	Albumin in urine……..	Albuminuria
	Scantiness of urine……	Oliguria
	Bed-wetting……..	Enuresis
	Stones in urine……..	Calculi
	Other descriptive terms……	Cloudy; with sediment; straw-colored; coffee-colored; excessive amount
Wounds	Surface……..	Superficial
	Without infection…….	Clean
	Discharging pus……	Suppurating
	Infected…….	Infected
	Torn……..	Lacerated
Weight	Overweight……	Obese
	Thin; underweight……	Emaciated

SOUTH PLAINS COLLEGE
ASSOCIATE DEGREE NURSING

A GUIDE TO CHARTING

Accurate reporting and reporting of client information is an essential function of the nurse. Information that is not recorded, illegibly recorded, or poorly organized may threaten the client's welfare. It is the nurse's responsibility to successfully communicate, in oral and written form, all information pertinent to the client's well-being and plan of care. Written records are permanent documentation of a client's health management plan and as communicated information is of a high caliber, the nurse should incorporate six essential characteristics into written and oral reports. All reports should be accurate, concise, thorough, current, well organized, and legible. (For a more complete review on the above aspects of charting, consult Potter and Perry)

General Steps to Follow:

1. Addressograph each page. Admission nurses' notes are followed by daily nurses' notes, each new page placed on top.
2. Chart in **black ink only**, using military time. All entries dated and time noted. Do not leave blank lines on the page, either between shifts or at the bottom of the page; however, if a notation has not been made for a shift, allow space for this leaving a reminder on the top of the chart for this purpose. Each line must be filled to the signature column with information or a line as in a check, e.g.:

   2400 hrs. – Eyes closed, supine position at this time ----------A. Doe, R.N.

   At 2400 hours (12 midnight), the day and date are written across the page indicating a new day. Also, indicate the month and date in the date column, e.g.:

   Date Hour

   Any nurses' notes that continue from one page to another will need the month, date, and time repeated on the top of the new page.

3. Chart only pertinent information in the nursing notes:
   a. Objective and subjective symptoms.
   b. Entry is made as determined by agency policy and procedure.
   c. A continuous assessment of the client's physical conditions and emotional acceptance of his illness.
   d. Cases such as problem diabetics, contagious and/or communicable diseases, or emotional family problems, etc., that influence the client's rehabilitation.
   e. For complaints made by the client regarding pain, nausea, and nervousness, the p.r.n. medications or nursing measures taken to relieve the complaint should be followed and so noted. State reason p.r.n. given. If for pain or discomfort, note the location and type of pain, area injection was given with pulse and respiration before injection. Any narcotic charted as given must have the same time indicated in the nurses' notes, medication Kardex, medication record, or narcotic checkout sheet. One hour later, an entry in the nurse's notes is made to inform the physician and nurses how the client is feeling at the time.

f. All nursing procedures prescribed by the physician, diagnostic or therapeutic procedures performed, recorded, time done, and reaction of the client.

g. All instructions, demonstrations, and return demonstrations to the client or specified others as ordered by the physician, with a verbal statement that the patient or specified others understands those instructions.

h. Describe the amount, color, odor, and consistency of emesis or drainage from Foley catheters, chest tubes, NG tubes, colostomies, on dressings, etc. Chart whether new dressings were applied, stitches removed, tubes removed (such as chest tubes, NC tubes, Hemovac, etc.) by whom and what time.

i. Time of physician's visits to the client and any verbal instructions he gives to the client but for which he does not write orders.

j. Errors are corrected by making a single line through the word(s) and initialing as per institution's policy and procedure. **Do not erase! Do not use white out**

4. IN CASE OF DEATH: Notation regarding disposition of valuables, time pronounced dead, presence of family, and name of physician in attendance. If postmortem is to be done, name of physician notified and by whom and any special requests made by him. Note disposition of body from unit.
5. Any great lapse of time from the admission sheet time to the time the client is admitted should be explained. (Perhaps, the client was delayed in lab or an X-ray was requested to be done before admission to the floor.)
6. Chart the presence of parents at the bedside of a minor taken for surgery, returning from recovery room, and upon dismissal. The nurse transferring a client is named by the receiving nurse as having given report.
7. Upon dismissal of the client, state time, date, and mode of transportation from the unit, accompanied by whom, apparent condition, any instructions or prescriptions, and any doctor's appointments made for the client.
8. Write only those things you actually perform or indicate by whom.
9. Write legibly or print. Spell correctly. Use only accepted abbreviations and standards as per institution's policy.
10. Remember, this is a legal document and can be taken to court!
11. Signature (first initial and last name) and job classification should follow the last entry.

Date	Hour	
10/28	0800	Wound approximated, no redness, or drainage noted.

J. Doe, S.N.,S.P.C., A.D.N.P.

Specific Steps to Follow:

Specific charting guidelines for the clinical facility utilized will be provided during the orientation at the beginning of each semester's clinical experience.

Examples of Pertinent Observations That Are Charted and Usually Also Reported

All Symptoms	Complained of by the client. (This also includes symptoms observed but not complained of.)
Change in Vital Signs	Temperature, pulse, and respiration, and blood pressure.
Change in General Appearance	As weakness, depressed, apathetic, apprehension, and hysteria.
Change in Skin Color	As difficult breathing (dyspnea), rapid respiration, gasping, inability to breathe except when sitting or standing erect, (orthopnea), and painful breathing.
Breath	Peculiar odors as unpleasant, foul, sweet, fruity, or smell of alcohol.
Cough	As exhausting, harsh, tight, dry, hacking, painful, or wheezing. If productive, report quantity, color (rusty, green, bloody), thick, or mucoid.
Dizziness	Any loss of balance, complaint of dizziness, or faintness.
Nausea or Vomiting	Report whether self-induced by client, projectile (with force projection), describe color (bloody, coffee-ground color, greenish), and consistency (liquid or undigested food).
Convulsions	As to time, duration, whether intermittent or continuous or mild or violent.
Mental Disturbance	Anxiety, tension, or stress may be revealed in a combination of symptoms such as rapid breathing with occasional deep sigh and restlessness. Trembling, increased perspiration, or itching. "White as a sheet, hot under the collar, covered with goose flesh." Failure to answer questions, rambling conversation, shaky voice.
Delirium	As continuous or intermittent. Observe if there is a rambling of ideas or one persistent idea. Coma or unconscious or failure to respond.
Chills	As to time and duration, severity of chill (violent or shivering), temperature at time chill is completed. Temperature 30 minutes after chill is completed.
Crying	Describe fretful, sharp, whining, or moaning. Reason if known.
Discharges	Report any unusual body discharge. Describe location and type as bloody, pus, or clear.
Swelling	(Edema) as to location, whether generalized or local as legs and fee. Also color change accompanying swelling.
Skin Condition	As dryness, scales, rashes, hives, blotching, boils, itching, reddened areas, bruises, abrasions, bedsores, or open raw areas.
Abdomen	As directed, hard, rigid, painful, or tender.
Eyes	Unusual observations as blood shot, dull, yellowish color, anxious, inflammation, watery, and teary. Sensitive to light, twitching. Pupils contracted, dilated, or unequal. Constant involuntary movement of eyeballs or fixed look.
Appetite	As loss of appetite, failure to eat a meal. (May be diabetic.) Eating of additional foods while on restricted diet. Report any difficulty the patient may have swallowing, chewing, or feeding himself.
Accidents or Incidents	As to time, witnesses, observation of injury, (bruises and abrasions), and cause or suspected cause. (**Note:** hospital policy)

Sleep	As moaning, restless, inability to sleep, or sleeps at short intervals.
Oral Hygiene	Report lost or broken dentures or bridgework, mouth sores tenderness, or bleeding gums
Physical Activities	Report failure of ambulatory patient to get out of bed. Refusal to walk and exercise. Chart time, distance, and how the client tolerated walking.
Bowel	As diarrhea, stool of unusual color (clay, black with blood), hard-formed stool. Failure to defecate or variation from his normal established bowel habits.
Urine	As unusual odor, color, cloudy, or bloody. Change in output, failure to void. Catheter drainage system not open or draining an adequate amount of urine.
Bath	Failure to give bath. Refusal of client to receive bath or other routine nursing services for which you are responsible.

There are two main methods of recording information, the source record which utilizes a **NARRATIVE** format and the problem oriented medical record which utilizes a **SOAP** or **SOAPIER** format. Because practice may vary from region to region and hospital to hospital, we will review both methods.

NARRATIVE STUDY GUIDE

Overview of Narrative Method of Charting

As the name implies, the nurse charts a narrative description of the nursing care delivered when utilizing this method. In a hospital, at least on entry should be made for each shift of duty. In the description, pertinent data and observations should be entered relating to the client's condition, all nursing care delivered, medical therapy administered, and client's responses to nursing and medical therapy. All entries should be dated, timed, and signed.

S.O.A.P.I.E.R. STUDY GUIDE

Overview of S.O.A.P.I.E.R. Method of Charting

The S.O.A.P.I.E.R. method of charting provides a means of recording information utilizing all of the steps involved in the nursing process. Because it is more detailed than a S.O.A.P. note, we will review this method first. Then, the first four steps may be applied for situations warranting only a S.O.A.P. notation.

S.O.A.P.I.E.R. is only one part of the entire Problem-Oriented System of Recording (see pp. 224-230, Potter). It is that part that organizes the data, analysis, and plan related to a specified problem that your client is experiencing. That "problem" may very well be a nursing diagnosis. The SOAPIER method of charting and the nursing process go "hand-in-hand."

Components of S.O.A.P.I.E.R. Charting:

S: The **S** in S.O.A.P.I.E.R. means subjective. Subjective means symptoms. These are statements made by the client about how he/she is feeling. If he/she is unable to verbalize, the subjective will be the statements of significant others who accompany the client or know of this illness and/or problems.

An example of a subjective recording is as follows:

S. client reports continued substernal aching pain; pain medication "didn't work"; also has a "smothering" sensation.

O: The **O** in S.O.A.P.I.E.R. means objective. Objective data are the measurements, tests and physical signs that impress the observer's senses. For example, a client's description of his pain are subjective data: his wincing, tears are objective data. Objective data requires the observer to utilize all of his senses.

An example of objective recording is a follows:

O. BP fall to 106/80 in past hour. P 100 regular, and strong; skin warm and dry; restlessness noted.

A: The **A** in S.O.A.P.I.E.R. is assessment. It is better to remember this an Analysis which means that the **S** and **O** are reviewed and a conclusion is made. Assessment answers the questions: What is the status of the problem at this time? Assessment is based on the

subjective and objective findings. That's the beauty of this system. You can't possibly make an assessment without your "back-up" – that is provided by subjective and objective documentation. Although assessment looks simple, it is the most difficult part of S.O.A.P.I.E.R We, as nurses, are very used to writing our observations and what we do. However, we are not used to recording our problem analysis (the **A** in SOAPIER). Although we make assessments and we communicate them verbally, we find it difficult to record them. Assessment or analysis is an intellectual process, a challenge. One needs only to be honest. Assessment: "Don't Know" is acceptable if it is true. Of course your plan is to collect more data or refer to one who probably will know.

Let's put the subjective, objective and assessment together in the following example:

New Problem: Aching numbness R. leg

S. client reports coolness and aching pain in R. calf after getting into bed.

O. skin cool to touch over entire R. leg below knee; toes blanched; venous return more than three seconds; no pulses felt in either leg below knee; 2+ femoral pulses both sides; neg. Homan's sign.

A. altered tissue perfusion both lower extremities.

P: The **P** in SOAPIER is plan. Plan here generally means the immediate plan related to the problem. Plans are the culmination of logical thought about the subjective data, objective data and assessment of a problem. Sometimes the plan is to call for immediate help, to consult with someone else or to provide comfort, obtain specimens, teach, etc. The plan includes the diagnostic plan; i.e., specimen collection, sending to X-ray, etc.; the treatment plan, i.e., progressive ambulation, skin care, ROJM, etc.; and the education plan, i.e., pre-op teaching, demonstration of insulin administration, etc.

Examples of **P** – Plan:

P. Talk with client about medications being taken.

I: The **I** in SOAPIER means intervention. This refers to the actual nursing actions done at that time. If the plan was immediate then the **I** section will have the actions done at that time. If the plan is future oriented, e.g., **P:** consult with physical therapy, there may be no **I** or intervention for this particular recording.

Example of **I** – intervention:

I = Instructed in aseptic technique of wound cleansing with ½ H_20 / ½ H_20_2 with DSD application.

E: The **E** in SOAPIER means evaluation. This section is used to record the effectiveness or ineffectiveness of the intervention. What evidence or client feedback was collected that supports the care plan? That's the question that this section should answer.

Example of **E** – evaluation:

E: client returned demonstration of wound care as instructed.

R: The **R** in SOAPIER means revision. If the care plan has to be changed – this is the section where the changes are to be recorded. You cannot revise the plan of care without an evaluation – so the revision directly correlates to the evaluation. If there is no need to

change the plan of care, then there is no **R** or revision.
Example or **R** – revision:

E: client unable to ambulate to chair, reports incisional pain interferes with his willingness.

R: will give prescribed pain medication one hour prior to next attempt at ambulation.

S.O.A.P.I.E.R NOTE

Problem: Sleep Pattern Disturbance

5-3-93

6 p.m. - **S:** Client reports inability to sleep last night, even after two sleeping pills; usually sleep 8-10 hours during HS at home.
O: Awake all night; reading and taking short walks; two doses of Seconal given last night as prescribed; no naps during day; second day of hospitalization.
A: Change in usual sleep patterns may be secondary to new/strange environment.
P: Consult with physician re: questionable effectiveness of Seconal. Discuss with client any concerns and learning needs re: hospitalization.

7 p.m. - **I:** Reviewed with client usual hospital routines and preparation re: her scheduled Barium Enema. Designed list of questions for M.D. that had been on "client's mind." M.D. visited with client 8 p.m. Medicated with Nembutal at 10 p.m.

11 p.m. **E:** Client asleep.
R: None.

J. Riley, R.N.

Another Example of SOAPIER Charting:

Problem: Preoperative for Cholecystectomy

6-5-93
8 a.m. - **S:** "I'm a little nervous. I'll be glad when surgery is over."
O: T. 99.9, P.88, R. 18, BP 124/78, IV infusing at prescribed rate ante cubital Space. Operation area shaved and betadine scrubbed.
A: Experiencing expected pre-op teaching plan.
P: Follow routine pre-op teaching plan.
I: Recovery room explained; coughing, turning, deep breathing and leg exercises explained and demonstrated. Client told that pain med. will be available post op and to request at onset of pain.
Pre-op check list reviewed.
9:30 a.m. Pre-op med. given as ordered.
E: Client returned C.D.B. and T. demonstration as instructed.
10:00 a.m. Client drowsy and relaxed after pre-op med. given.

R: None. J. Riley, R.N.

CHARTING EXAMPLES

Charting Example of: 1. **Simple Narrative Charting**
2. **POMR – Progress Note (SOAP)**

Nursing Situation

A seventy year-old female is bedridden with a CVA (Cerebrovascular Accident) left side paralysis. You feed her breakfast which she swallows without difficulty, and give her a complete bed bath at which time you notice that her skin is clear with the exception of a large reddened area on her right elbow (size of half-dollar). She states "hurts." You observe she cannot move left side, but that she assists in turning from side to side in the bed with her right arm and leg. You do ROM exercises; client experiences no discomfort. After bath and linen change, she falls asleep for two hours.

1. Simple Narrative Charting

Narrative Charting is time sequenced. Begin your statement with date observed or what occurred first and move forward in time.

7:30 a.m. – Ate 100% of soft diet consumed-orange juice (100cc) – coffee (150cc) – cereal (75cc) – toast (1 slice) recorded on I & O – B.Bop SN, SPC
8:00 a.m. - Complete bed bath given – large reddened area (size of half dollar) on R elbow noted – states, "hurts." – B. Bop SN, SPC
8:30 a.m. - Inability to move L side, however assists in turning from side to side with R arm and leg. – B. BOP SN, SPC
8:40 a.m. - ROM given – No complaint of discomfort voiced. – B.Bop SN, SPC
9:30 – 11:30 a.m. – Resting: eyes closed. – B. BOP SN, SPC

2. POMR – Progress Note – (SOAP):

The problem-oriented medical record has a variety of flow sheets and graphs for routine information or information that is more easily followed an interpreted in graphic form.

Problem – Identified by number and title.
Subjective date – the client's perception or statements regarding the problem
Objective data -You observation regarding the problem and data from the chart that is relevant; e.g., temperature
Assessment - Your interpretation of the meaning of the data. (Slightly different meaning for assessment than is commonly used. Some persons call this section analysis.)
Plan -You plan of action to deal with the problem.

This format is commonly referred to as **SOAP Notation** and the process has been called **SOAPING.**

Reddened area to right elbow.

S: States has burning sensation, discomfort right elbow.

O: Area on right elbow reddened (size of half-dollar)

A: Turning frequently side to side – rubbing skin on sheets causes irritation.

P: Provide elbow pads to reddened area to prevent skin breakdown. Massage area frequently with lotion – inspect frequently. Encourage foods high in protein, Vitamin C to encourage tissue repair.

When using a POMR, it is possible to have a plan S.O.A. P. notation instead of a S.O.A.P.I.E.R. notation. The I.E.R. portion of the notation will be dependent on the plan. If the plan is future-oriented, there will not be an intervention recorded with this particular note. Evaluations and revisions are dependent upon an implementation. Thus, is the plan is future-oriented, you would not have an intervention, evaluation, or revision. The S.O.A.P.I.E.R. note may be utilized if the plan is immediate **OR** after the implementation phase has been instituted. You may indicate an implementation was applied at a later time by time sequencing your note (see S.O.A.P.I.E.R example).

Unit IV: Asepsis and Infection Control

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Asepsis and Infection Control A. Body's Defense against Infection B. Chain of Infection C. Course of Infection D. Asepsis and Hospital Acquired Infections E. Assessment F. Nurse's Role in Infection Control G. Surgical Asepsis H. Client Education	1. Utilize basic nursing concepts in providing hygienic care. 2. Utilize nursing principles that pertain to environmental and protective factors. 3. Define terms related to asepsis. 4. Perform medical/surgical aseptic techniques essential to providing basic nursing care. 5. Explain conditions that precipitate the onset of hospital acquired infections. 6. Identify measures of prevention and control and hospital acquired infection (environmental, urinary, wound, and respiratory infections). 7. Describe nursing interventions designed to break each link in the infection chain. 8. Utilize CDC recommended blood & body fluid precautions for all clients. 9. Identify community approaches to infection control. 10. Describe medical/surgical aseptic practices essential for the prevention of infection in illness. 11. Identify clients most at risk for acquiring an infection. Identify the body's normal defenses against infection. 12. Describe immunization programs. 13. Discuss the teaching/learning needs of the client with regard to their compliance and infection control practice. Identify categories of isolation precautions. 14. Describe general approaches for each of the categories of isolation precautions. 15. Identify CDC guidelines for protection of health care workers from communicable disease. 16. Discuss basic medical aseptic/surgical technique prior to the administration of nursing care to clients.	Group 1. Lecture 2. Discussion 3. Demonstration Assignment 1. Taylor, Lillis, Lynn Chapter 23 2. Define key terms 3. Abrams: Anti-microbial Drugs 4. Review/sign SPC Communicable Disease Policy 5. The Course Point Evaluation 1. Return Demonstration 2. Pen & Paper or Computer Test	A2 A4 B8	B1 B2 B3 B4 B6 B7 B8 B11 C2 C3 C5 D3 D5 E1 E2 E12 F1 F2 G3	A2 A4 B1 B2 B3 C1 D1 E2	B1 C4 D1 D3 E1

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
2. Beginning Pharmacology Related to Asepsis 1. Anti-infectives a) Normal Flora of the Human Body b) General Principles of Anti-Infective Therapy c) Common Anti-Infective Medications Used	17. Describe the nature of signs of a localized infection chain. 18. Identify medications commonly used as anti-infective medications 19. Explain nursing responsibilities involved in administering anti-infectives. 20. Discuss general principles of anti-infectives therapy. 21. Describe client teaching information to include when counseling clients on anti-infectives.		A2	B1	A2	B1
			A4	B2	A4	C4
			B8	B3	B1	D1
				B4	B2	D3
				B6	B3	E1
				B7	C1	
				B8	D1	
				B11	E2	
				C2		
				C3		
				C5		
				D3		
				D5		
				E1		
				E2		
				E12		
				F1		
				F2		
				G3		

ANTIMICROBIAL AGENTS

A. AMINOGLYCOSIDES
1. Amikacin (Amikin)
2. Gentamicin (Garamycin)
3. Neomycin (Mycifradin)
4. Streptomycin (Streptomycin)
5. Kanamycin (Kantrex)
6. Tobramycin (Nebcin)

B. PENCILLINS
1. Penicillin G (Bicillin)
2. Penicillin V (Pen-Vee)
3. Amoxicillin Trihydrate (Amoxil)
4. Carbenicillin disodium (Geopen)
5. Dicloxacillin (Dynapen)
6. Nafcillin (Unipen)
7. Piperacillin (Zosyn)
8. Ticarcillin (Timentin)

C. CEPHALOSPORINS
1. Cephalexin (Keflex)
2. Cefaclor (Ceclor)
3. Cefazolin (Ancef, Kefzol)
4. Cefoxitin (Mefoxin)
5. Cefepime (Maxipime)
6. Cefixime (Suprax)
7. Cefoperazone (Cefobid)
8. Cefotetan (Cefotan)
9. Ceftazidime (Fortaz)
10. Ceftriaxone (Rocephin)
11. Cefuroxime (Ceftin)
12. Cefprozil (Cefzil)
13. Cefadroxil (Duracef)
14. Cefdinir (Omnicef)
15. Cefditoren-pivoxil (Spectracef)
16. Cefpodoxime (Vantin)
17. Ceftibuten (Cedax)

D. TETRACYCLINES
1. Doxycycline (Vibramycin)
2. Demeclocycline hydrochloride (Declomycin)
3. Tetracycline hydrochloride (Sumycin)
4. Minocycline hydrochloride (Minocin)

E. MACROLIDES
1. Erythromycin (E-mycin)
2. Erythromycin stearate (Erythrocin sterate.)
3. Erythromycin lactobionate (Erythrocin)
4. Erythromycin ethylsuccinate (E.E.S.)
5. Azithromycin (Zithromax)

6. Clarithromycin (Biaxin, Biaxin XL)

F. CARBAPENEMS
1. Imipenem-Cilastatin NA (Primaxin)
2. Doripenem (Doribax)
3. Ertapenem (Invanz)
4. Meropenem (Merrem)
5. Primaxin (Imipenem, Cilastatin)

G. MONOBACTAM
1. Aztreonam (Azactam)

H. ANTITUBERCULAR AGENTS
1. Isoniazid (INH)
2. Rifampin (Rifadin)
3. Ethambutol (Myambutol)

I. FLUOROQUINOLONES
1. Ciprofloxacin (Cipro)
2. Gatifloxacin (Tequin)
3. Gemifloxacin (Factive)
4. Levofloxacin (Levaquin)
5. Moxifloxacin (Avelox)
6. Norfloxacin (Noroxin)
7. Ofloxacin (Floxin)
8. Gripafloxacin (Raxar)

J. SULFONAMIDES
1. Sulfisoxazole (Sulfafurazole)
2. Mafenide acetate (Sulfamylon)
3. Sulfadiazine (Microsulfon)
4. Silver sulfadiazine (Silzadene)
5. Sulfasalazine (Azulfidine)
6. Trimethoprim-sulfamethoxazole (TMP-SMZ, Bactrim, Septra, others)

K. MISCELLANEOUS
1. Chloramphenicol (Chloromycetin)
2. Clindamycin hydrochloride (Cleocin)
3. Daptomycin (Cubicin)
4. Linezolid (Zybox)
5. Metronidazole (Flagyl)
6. Quinuppristin-dalfopristin (Synercid)
7. Rifaximin (Xifaxan)
8. Tigecycline (Tygacil)
9. Vancomycin (Vancocin)

L. ANTIVIRAL AGENTS

1. Acyclovir (Zovirax)
2. Ganciclovir (Cytovene)
2. Ribavirin (Virazole, Rebetol, Ribasphere)
4. Amantadine hydrochloride (Symmetrel)
5. Oseltamivir phosphate (Tamiflu)
6. Lamivudine (Epivir, Epivir/Hepatitus B Virus [HBV])
7. Zidovudine (AZT)
8. Efavirenz (Sustiva)
9. Saquinavir mesylate (Invirase)
10. Raltegravir (Isentress)

M. ANTIFUNGAL AGENTS

1. Amphotericin B (Fungizone)
2 Nystatin (Mycostatin)
3. Miconazole (Monostat)
4. Terbinafine (Lamisile)

SOUTH PLAINS COLLEGE
COMMUNICABLE DISEASES POLICY

OUTCOMES OF THE POLICY

1. Minimize the risk of student or employees acquiring or transmitting communicable diseases
2. Through an organized education program which shall emphasize primary prevention.
3. Protect the confidentiality of students or employees with communicable disease.
4. Provide for an annual review of the Communicable Disease Policy in light or current information.
5. Establish a Communicable Disease Review Committee, the purpose of which shall be to review any cases of communicable diseases that may be of public health concern as they arise.

GENERAL POLICY STATEMENT

South Plains College recognizes that students or employees with communicable diseases may wish to engage in as many of their normal pursuits as their condition and ability to perform their duties allows, including attending classes or working. As long as these students or employees are able to meet acceptable performance standards, and medical evidence indicates that their conditions are not a threat to themselves or others, the Administration of the College should be sensitive to their condition and ensure that they are treated consistently and equally with other students and employees. At the same time, South Plains College has an obligation to provide a safe environment for all students and employees. A student or employee with a communicable disease is required to report the condition to his or her immediate supervisor or to the Student Services Office as appropriate. Failure to inform the College may result in dismissal of the student or employee from the College. Every precaution should be taken to ensure that a student's or employee's condition does not present a health and/or safety threat to others. The fact that a student or employee has a communicable disease does not relive that individual of the requirement to comply with performance standards as long as he or she is enrolled in classes or remains employed with the College. All reasonable efforts will be made to protect the student's or employee's right to confidentiality.

GENERAL GUIDELINES

The following general guidelines are adopted:

1. South Plains College will make information on the prevention of communicable diseases available to students and employees.
2. A student's or employee's health condition is personal and confidential, and reasonable precautions should be taken to protect information regarding an individual's health condition. The Student Services Office should be contacted if it is believed that students need information about communicable diseases, or if further guidance is needed in managing a situation that involves a communicable disease. The appropriate Dean should be contacted for any situation involving a communicable disease.

3. The Dean and the Student Services Office should be contacted if there is concern about the possible contagious nature of any student's or employee's illness.
4. A student or employee with a communicable disease should be encouraged to provide current reports from his or her treating physician concerning the individual's condition, whether the student or employee should be in contact with other students or employees, and if current health status permits him or her to attend classes or to perform the essential functions of his or her job. South Plains College reserves the right, with the consent of the student or employee, to require a medical examination by a physician appointed by the College.
5. A student or employee with a communicable disease may attend classes or perform duties at South Plains College if his or her presence does not pose a threat or danger to that individual or to others in the College, or to the academic process.
6. Temporary removal of a student or employee with a communicable disease may be made by the Administration of the College. The removal may be made summarily pending receipt of documentation by a physician that the individual does not pose a substantial threat or danger to himself or herself or other persons at South Plains College.
7. The Administration of South Plains College will determine whether a student or employee with a communicable disease may continue to attend classes or perform his or her duties at the College on a case-by-case basis, after hearing the recommendations of the Communicable Disease Review Committee.
8. Due process, including the issuance of recommendation by the Communicable Disease Review Committee shall be afforded the individual.
9. Students or employees with communicable disease should be encouraged to seek assistance from established community support groups for medical treatment and counseling services. Information can be requested from the Student Services Office.

ADDITIONAL GUIDELIENS FOR ALLIED HEALTH PROGRAM STUDENTS AND EMPLOYEES

Realizing that students and employees who are placed in clinical or laboratory setting are subject to added risk for communicable diseases through practice or invasive procedures and patient contact, these additional guidelines are adopted:

1. All Allied Health programs will be required to complete the unit before they may be assigned to clinical training facilities. The unit should emphasize primary prevention and precautionary measures for the protection of staff, students, and their patients as outlined in current Center for disease Control guidelines. The instructor and each student in the program will sign a certification statement that such training has been successfully completed and the student understands the risk involved in caring for patients with communicable diseases before the student begins clinical training.
2. Students and employees of the College should routinely follow precautionary measures for the protection of themselves and patients as outlined in current Center for disease control guidelines.

3. A student or employee with a communicable disease should provide current reports from his or her treating physician concerning whether the student or employee should begin contact with patients, and whether he or she can perform the functions of his or her job or training site without exposing patients or other students or employees to an unreasonable risk in light of current medical knowledge.
4. Students place in a clinical affiliate are expected to follow the affiliates guidelines governing caring for patients with communicable disease provided that the care is within the student's level of training and consistent with the Center for Disease Control guidelines. The supervising staff in clinical affiliates should see the students assigned to the affiliate are familiar with the health status of all patients under the students' care.

COMMUNICABLE DISEASE REVIEW COMMITTEE

A Communicable disease Review committee is to be established, and will be composed of a physician appointed by the College, a public health official, administrative representatives of South Plains College, and one or more representatives from South Plains College health care programs. The individual who has a communicable disease and his or her representatives, which may include a physician appointed by the individual, are encouraged to consult with the committee.

The purpose of the Communicable Disease Review Committee shall be to review any case of communicable disease that may of public health concern on a continuing basis. The committee will issue recommendations to the administration on the individual's potential threat or danger to himself or herself and others in South Plains College or its clinical affiliates. Final disposition and action rests solely with the Board of Regents of South Plains College or its designated representatives.

When considering recommending the dismissal of a student or the discharge of an employee with a communicable disease, the Committee will consider the interest of the affected individual, other students and employees, patients in clinical affiliates, and the College.

6-27-05

SOUTH PLAINS COLLEGE
DEPARTMENT OF NURSING

COMMUNICABLE DISEASE STATEMENT

I, _____, hereby acknowledge that as an Allied Health student I am subject to added risk or communicable diseases through practice of invasive procedures and patient contact in clinical and laboratory settings.

While in the clinical setting, I will follow the Center for Disease Control precautionary measures to protect myself and patients to the best of my ability.

If asked, I will provide current reports to the communicable disease Review committee from a physician regarding any communicable disease or unreasonable health risk that I might expose patients, other students and instructors to.

I, _____ , have satisfactorily completed the Asepsis Unit as required by South Plains College Department of Nursing.

_____
Date

_____
Signature

_____
Print Name

Unit V: Vital Signs

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Vital Signs A. Importance of accurate assessment and incorporating this skill into practice. B. Body Temperature 1. Norms 2. Physiology 3. Mechanisms of Temperature Control 4. Factors Affecting Temperature 5. Assessment of Temperature C. Pulse 1. Norms 2. Cardiovascular function D. Respiration 1. Norms 2. Physiology 3. Assessment of Respiration	1. Explain the physiologic processes involved in homeostatic regulation of temperature, pulse, respirations, and blood pressure. 2. Compare and contrast factors that increase or decrease body temperature, pulse, respirations, and blood pressure. 3. Identify sites for assessing temperature, pulse, and blood pressure. 4. Assess temperature, pulse, respirations, and blood pressure accurately. 5. Demonstrate knowledge of the normal ranges for temperature, pulse, respirations, and blood pressure across the lifespan.	Group 1. Lecture 2. Discussion 3. Demonstration Assignment 1. Taylor, Lillis, Lynn Chapter 24 2. Define key terms 3. The Course Point Evaluation 1. Return Demonstration 2. Pen & Paper or Computer Test	A2 A4 B8	B1 B2 B3 B4 B6 B7 B8 B11 C2 C3 C5 D3 D5 E1 E2 E12 F1 F2 G3	A2 A4 B1 B2 B3 C1 D1 E2	B1 C4 D1 D3 E1

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
E. Blood Pressure 1. Norms 2. Physiology 3. Assessment of Blood Pressure		Practice 1. Assessing B/P on different people of varying age and gender 2. Assessing temperature with all of the following equipment: A. Glass Thermometer B. Electronic Thermometer C. Tympanic Thermometer 3. Assessing pulse & respirations on different people of varying age and gender.	A2 A4 B8	B1 B2 B3 B4 B6 B7 B8 B11 C2 C3 C5 D3 D5 E1 E2 E12 F1 F2 G3	A2 A4 B1 B2 B3 C1 D1 E2	B1 C4 D1 D3 E1

Unit VI: Medication Administration

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Medication Administration A. Orientation to Drugs 1. Definitions 2. Historical Development 3. Sources of Drugs 4. Legislation and Federal Government 5. OTC Drugs 6. Drug Classifications 7. Abuse B. Pharmacokinetics 1. Concentration 2. Equilibrium 3. Absorption 4. Distribution 5. Metabolism 6. Excretion C . Types of Drug Actions D. Drug Interactions E. Factors Influencing the Effects of Drugs F. Drug Dose Response G. Principles of Drug Administration H. Legal Responsibilities of the Nurse	1. Discuss drug legislation in the United States. 2. Describe basic principles of pharmacology, including drug nomenclature and types of drug preparations. 3. Develop an understanding of basic principles of pharmacology, including mechanisms of drug action, adverse drug effects, and factors affecting drug action. 4. Discuss principles of medication administration, including an understanding of medication orders, dosage calculations, and medication safety measures. 5. Obtain patient information necessary to establish a medication history. 6. Describe principles used to prepare and administer medications safely by the oral, parenteral, topical, and inhalation routes. 7. Use the Nursing Process to safely administer medications. 8. Develop teaching plans to meet patient needs specific to medication administration.	Group 1. Lecture 2. Discussion 3. Demonstration Assignment 1. Taylor, Lillis, Lynn Chapter 28 2. Abrams: Introduction to Pharmacology 3. Define key terms 4. The Course Point Evaluation 1. Pen & Paper or Computer Test 2. Return Demonstration	A2 A4 B8	B1 B2 B3 B4 B6 B7 B8 B11 C2 C3 C5 D3 D5 E1 E2 E12 F1 F2 G3	A2 A4 B1 B2 B3 C1 D1 E2	B1 C4 D1 D3 E1

TABLE 1: Check this list before altering a drug.

A. Don't crush or alter these common sustained-release, enteric-coated, and sublingual tablets.

Afrinol Repetabs
Asbron G Inlay-Tab
Avazyme
Azulfidine EN-tabs

Belladenal-S
Bellergal-S
Bisacodyl
Bronkodyl S-R

Diamox Sequels
Dimetane Extentabs
Dimetapp Extentabs
Donnatal Extentabs
Donnazyme
Drixoral
Dulcolax

Easprin
Ecotrin
E-Mycin
Eskalith CR

Fero-Grad-500
Fero-Gradumet
Festal II

Hydergine Sublingual)

Iberet Filmtabs
Iberet-500 Filmtabs
Ilotycin
Indocin SR
Isordil (Sublingual)
Isuprel Glossets

Kaon-Cl
Kaon-Cl-10
K-Dur
Klor-Con
Klotrix
K-tab

Lithobid

Mestinon Timespan
Micro-K Extencaps
MS Contin

Nico-Span
Nitro-Bid
Nitrostat
Norflex

Pabalate
Pancrease
Peritrate SA
Permitil Chronotab
Phazyme-PB
Phyllocontin
Polaramine Repetab
Preludin Enduret
Procan SR
Pronestyl-SR

Quibron-T/SR
Quinaglute Dura-Tabs

Ritalin SR
Roxanol SR

Slow-K
Sorbitrate
Sustaire

Tedral SA
Theo-Dur
Theolair-SR
Trilafon Repetabs

B. You can open these sustained-release capsules and carefully mix the contents in a liquid or with a soft food, such as applesauce. Vigorous mixing, however, could alter the rate of release.

Artane Sequels

Combid Spansules
Compazine Spansules

Dexedrine Spansules

Feosol Spansules

Inderal LA
Inderide LA
Isordil Tembids (capsules)

Nicobid
Nitrostat SR

Ornade Spansules

Pavabid

Slo-bid Gyrocaps
Slo-Phyllin Gyrocaps
Sudafed SA

Temaril Spansules
Theobid
Theo-Dur Sprinkle
Thorazine Spansules
Tuss-Ornade Spansules

Valrelease

C. Because of the makeup of these miscellaneous drugs, you shouldn't crush or alter them.

☐ *Accutane* (liquid-filled capsule). Liquid can irritate mucous membrane.

☐ *Chymoral*. Crushing may interfere with enzymatic activity.

☐ *Depakene* (liquid-filled capsule). Liquid can irritate mucous membrane.

☐ *Feldene*. Powder from this capsule can irritate mucous membrane.

☐ *Klorvess* (effervescent table). If this tablet isn't dissolved before it's given, gastrointestinal upset will occur, and gastrointestinal damage may occur.

TABLE 2: Watch for these names as a tip-off.

A. These drugs manufactures' names indicate a sustained-release or an enteric-coated form of a drug.			B. When attached to a drug name, these terms indicate a sustained-release form of a drug.
BidCap	Duracap	Lontab	Bid
Cenule	Dura-tab	Repetab	Dur
Chronosule	Enduret	Sequel	Plateau Cap
Chronotab	Enseals	Spansule	SA
D-Lay	EN-tab	Tab-in	Span
Dospan	Extencaps	Tembid	SR
	Extentabs	Tempule	
	Gradumet	Tentab	
	Granucap	TimeCap	
	Gyrocaps	Timecelle	
	Kronocap	Timespan	
	Lanacaps		

Generic Name Trade Name	**Route, Pt. Dose, Normal Dose**	**Classification Purpose of the drug (Why is the pt getting it?)**	**If applicable Lab values to check prior to administering**	**Nursing Assessment before giving, during and after**	**Drug-Drug Interaction Drug-Food Interaction Contraindications**	**Side Effects**	**Pt teaching**
Potassium Chloride K-Dur	po, 20 mEq, 40-80 mEq/l	Electrolyte - Prophylaxis of K+ depletion (hypokalemia) due to pt on diuretic (Lasix)	K+ level 3.5 to 5.3 mEq/L panic values <2.5 mEq/L or >7.0 mEq/l	If lab values are not available - assess for S/S of hypo/hyperkalemia	Lasix depletes K+ Aspirin decreases K+ digitalis glycosides - cardiac arrhythmias	N&V, diarrhea, flatulence, abd. Discomfort	Take with foods - Report any S/S of hypo/hyperkalemia to physician. Do not change the dose prescribed
furosemide Lasix							
Aspirin							
Digitalis							

Generic Name Trade Name	Route, Pt. Dose, Normal Dose	Classification Purpose of the drug (Why is the pt getting it?)	If applicable Lab values to check prior to administering	Nursing Assessment before giving, during and after	Drug-Drug Interaction Drug-Food Interaction Contraindications	Side Effects	Pt teaching

Unit VII: Activity

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Activity A. Body Mechanics 1. Regulation of movement 2. Overview of body mechanics B. Physiologic Influence 1. Development C. Pathological Influence D. Assessment 1. Body alignment 2. Range of motion 3. Physiological effects of exercise on body systems E. Nursing Diagnoses 1. Associated with body alignment 2. Associated with altered joint mobility F. Assisting clients to move 1. Lifting technique 2. Positioning 3. Transferring 4. Range of motion 5. Walking G. Hazards of Immobility 1. Mobility 2. Altered mobility 3. Physiological response 4. Decubitus ulcer	1. Describe how body movement occurs. 2. Discuss the components of assessment that enable the nurse to plan care. 3. State the principles basic to body mechanics. 4. Identify the developmental stages that have the greatest impact of physiological change on the musculoskeletal system. 5. State how exercise positively affects health. Explain range of motion exercises. 6. Demonstrate proper alignment in a sitting position in a chair. 7. Describe exercises taught by the nurse in preparing the client for amputation. 8. Discuss assistive devices/medical aids that provide mobility. State physical effects of immobility on body systems. Reposition a client in a bed. 9. Discuss safe transfer from bed to stretcher. 10. Identify common problems of adult skin and skin changes as the adult ages. 11. Review nursing measures that help maintain skin integrity. Identify major causes of skin breakdown. 12. State nursing measures that counteract the physical effects of immobility.	Group 1. Lecture 2. Discussion 3. Demonstration Assignment 1. Taylor, Lillis, Lynn Chapters 32 2. Define key terms 3. The Course Point Evaluation 1. Pen & Paper or Computer Test 2. Return Demonstration	A2 A4 B8	B1 B2 B3 B4 B6 B7 B8 B11 C2 C3 C5 D3 D5 E1 E2 E12 F1 F2 G3	A2 A4 B1 B2 B3 C1 D1 E2	B1 C4 D1 D3 E1

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
H. Assessment for Hazards of Immobility 1. Physiological 2. Psychosocial 3. Developmental						

Unit VIII: Hygiene

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Hygiene A. Factors influencing hygiene practices. B. Components of hygiene 1. Skin C. Special considerations D. Room environment	1. List factors, which may influence hygiene practices. 2. Discuss the influences of age on skin integrity. Identify the different types of baths. 3. Explain the purpose of the back rub. 4. Identify the characteristics of some common foot and nail problems 5. State the interventions for the problems identified. 6. Explain the basic care involved in care of the eyes, ears, and nose. 7. Explain the basic care involved in shaving the skin. 8. Explain the purpose of perineal care. 9. Identify the steps in providing perineal care. 10. Demonstrate correct techniques assisting the client with bowel and bladder elimination.	Group 1. Lecture 2. Discussion 3. Demonstration Assignment 1. Taylor, Lillis, Lynn Chapter 30 2. Define key terms 3. The Course Point Evaluation 1. Pen & Paper or Computer Test 2. Return Demonstration	A2 A4 B8	B1 B2 B3 B4 B6 B7 B8 B11 C2 C3 C5 D3 D5 E1 E2 E12 F1 F2 G3	A2 A4 B1 B2 B3 C1 D1 E2	B1 C4 D1 D3 E1