COURSE SYLLABUS

RNSG 1413 (4:4:4)

FOUNDATION FOR NURSING PRACTICE

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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.

SOUTH PLAINS COLLEGE ASSOCIATE DEGREE NURSING PROGRAM

FOUNDATION FOR NURSING PRACTICE

TABLE OF CONTENT

Campus: Levelland

COURSE SYLLABUS

COURSE TITLE: RNSG1413FoundationsforNursingPractice

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

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OFFICE HOURS: Posted on each instructor's door.

SOUTH PLAINS COLLEGE IMPROVES EACH STUDENT'S LIFE

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I. GENERAL COURSE INFORMATION:

A. COURSE DESCRIPTION:

Introduction to the role of the professional nurse as provider of patient-centered care, patient safety advocate, member of health care team, and member of the profession. Content includes fundamental concepts of nursing practice, history of professional nursing, a systematic framework for decision-making and critical thinking. The mechanisms of disease and the needs and problems that can arise are discussed and how the nursing process helps manage the patient through these issues. Emphasis on knowledge, judgment, skills and professional values within a legal/ethical framework.

RNSG 1413 involves the development of basic nursing principles essential in caring for the individual who is influenced by genetic inheritance, life experiences and cultural background and is part of a larger community. The student will develop observational, and communication skills. Emphasis is placed on the unifying concepts of basic human needs, roles of the nurse and nursing practice. The focus is on the client in a state of homeostasis with attention to interruptions, caused by common stressors that prevent need attainment.

College laboratory and clinical agency experiences offer opportunities for beginning nursing practice and application of classroom learning applied to the adult client experiencing stressors of illness. Through classroom and laboratory/clinical experiences the student explores basic concepts and skills related to nursing process, communication, safety, problem solving, critical

thinking, collaboration, delegating, referrals, cost effectiveness, quality care, ethical/legal practice, self-awareness/self-monitoring and client advocacy.

1. Placement: Level I Semester I
2. Time Allotment:
   Sixteen (16) weeks. The course allows four (4) semester hours credit including didactic and laboratory.
3. Teaching Strategies:
   Team teaching, demonstrations, independent assignments, Nursing Resource Learning Laboratory, Center for Clinical Excellence, audiovisual media, group presentations, and discussions.
4. Teaching Personnel:
   Associate Degree Nursing faculty and guest speakers.

B. COURSE LEARNING OUTCOMES

1. Upon satisfactory completion of RNSG 1413, 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,C3, C4, C5, C6, C7, C9, C11, C12, C13, C14, C15, C16, C17, F1, F2, F3, F4, F5, F6, F7, F8, F9, F11, F12, F13, F14, F15 & F17.
   b. SPC ADNP Graduate Outcomes: 1, 2, 3, 4, & 5.
   c. DECs (Differentiated Essential Competencies) are listed in each unit.

C. COURSE COMPETENCIES

Successful completion of this course requires:

a. A minimal average grade of "77" on examinations
b. Satisfactory achievement of unit and course outcomes
c. Regular classroom attendance
d. Personal Belief Paper
e. Assigned ATI Assessments must be completed by date assigned.
f. The Point Assignment 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 not limited to, the following:
   a. 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.

b. 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

c. 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 1 Semester 1 course outcomes will allow the student to continue to advance within the program. Successful completion of RNSG 1413 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. Lecture attendance is mandatory. The instructor may initiate a student's withdrawal if a student misses 4 hours or more of class. Reinstatement is handled on an individual basis by the course leader. ***Do not be tardy for lecture, missed time 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 or while in the NLRL will be confiscated and given to the Health Occupation Dean.

B. 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 may be assessed penalty points by the instructor. The assignment may be docked five (5) points per day for each late day. Students should keep a copy of all assignments turned in, to avoid having to redo an assignment if it should be lost.
2. Examination Policy:
    a) **Exams will not be retained by the student.**
    b) 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.
    c) Alternate exams may be given as make up exams.
    d) Name badge must be worn when testing in the computer lab.

C. GRADING POLICY

1. Refer to SPC ADNP Nursing Student Handbook Grading System
2. There will be four preliminary tests, and a comprehensive final examination to determine the course grade.
3. The final exam will be administered at the end of the semester.
4. A student course grade worksheet can be found on the following page.
5. A student must receive a minimum course grade of "C" to progress to the next nursing course.
6. *Grading Scale:*
   A = 90% - 100%
   B = 80% - 89%
   C = 77% - 79.99%
   D = 60% - 76.99%
   F = below 60%
7. A Personal Belief paper must be turned in as assigned, meeting all stated criteria. The paper has a pass/fail grade: but, is required for completion of the course.
8. Assigned ATI Assessments must be completed by date assigned.
9. The Point Assignment must be completed by date assigned.
10. Failure of RNSG 1413, 1160, 1144, 1105, and/or 1115 and/or will necessitate repeating 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.

SOUTH PLAINS COLLEGE ASSOCIATE
DEGREE NURSING PROGRAM

COURSE GRADE WORKSHEET
FOR
NURSING FOUNDATIONS

Student's Name:_____

1. Prelims:

    1. _____ X 0.20 = _____
    2. _____ X 0.20 = _____
    3. _____ X 0.20 = _____
    4. _____ X 0.20 = _____

2. Final Exam Grade X 0.20 = _____

3. Professional Standard Deductions_____

4. Final Grade (add all the above) = _____

5. Personal Belief Paper Dated Submitted _____

6. Assigned ATI Assessments_____

7. The Course Point Assignments _____

D. 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 the Level I Semester I Coordinator. The next chain of command is to make an appointment with the Health Occupation Dean. The procedure will follow the same as found in the student handbook.

E. COURSE REQUIREMENTS

1. Prerequisites: Psychology 2314, Biology 2401, and English 1301, & Biology2420.
2. Meet all requirements for admission into the Associate Degree Nursing Program.
3. Concurrent enrollment in RNSG 1105, RNSG 1144, RNSG 1160, and RNSG 1115. If RNSG 1115 has been successfully completed, concurrent enrollment is not required.
4. Completion of student contract Level I Semester I.
5. Regular classroom attendance.
6. Completion of personal belief paper and all assigned student presentations, charting exercises, and assigned computer programs.
7. Satisfactory grade average on written examinations (77 or above).
8. Satisfactory achievement of behavioral course outcomes (see unit outcomes).

III. COURSE OUTLINE

I. Introduction to Nursing and Theory, Research and Evidence-Based Practice
II. Assessing, Diagnosing, Outcome, Identification and Planning, Implementing, Evaluating
III. Aging Adult
IV. Health Illness, and Disparities, Health of the Individual, Family and Communities
V. Communicator
VI. Health Care Delivery System
VII. Stress and Adaptation
VIII. Self-Concept
IX. Complimentary & Alternative Therapies
X. Values, Ethics, and Advocacy, Legal Dimensions of Nursing Practice
XI. Sensory Functioning
XII. Spirituality
XIII. Cultural Diversity
XIV. Rest and Sleep
XV. Safety, Security and Emergency Preparedness
XVI. Loss, Grief & Dying
XVII. Comfort and Pain Management

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: Introduction to Nursing

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/	DEC's (Knowledge)			
			1	2	3	4
1. Introduction To Nursing 2. Theoretical Foundations of Nursing Practice 3. Caring in Nursing Practice A. Historical Developments B. Inter-related Roles 1. Provider of Care 2. Manager/Coordinator of Care 3. Member of Nursing Profession 4. Safety C. Current Trends	1. Describe the historical background of nursing, definitions of nursing, and the status of nursing as a profession and as a discipline. 2. Explain the aims of nursing as they interrelate to facilitate maximal health and quality of life for patients. 3. Describe the various levels of educational preparation in nursing. 4. Discuss the effects on nursing practice of nursing organizations, standards of nursing practice, nurse practice acts, and the nursing process. 5. Identify current trends in nursing. 6. Compare and contrast systems theory, adaptation theory, and developmental theory. 7. Explain the significance of the four concepts common to all nursing theories. 8. Discuss the evolution of nursing research. 9. Describe evidence-based practice in nursing, including the rationale for its use.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapters 1 & 2 2. Define key terms 3. Nurse Practice Act 4. The Course Point Evaluation 1. Pen & Paper or Computer Test 2. The Course Point Assignment	A1 A2 A3 B1 B2 B4 B7 C1 C2 C3 C4 C5 D1 D2 D4	A3 A4 B8 B12 C1 C4 D1 D2 D3 D4 E3 E5 E8 E9 E10 E11 H1 H2 H3	A1 A2 A3 A4 B5 D1 E1 F1	A1 A4 A5 B2 C2 C4 C5 C6 D2 D3 F1 F2

Unit II: Nursing Process

CONTENT	OBJECTIVES	LEARNINGACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
I. Nursing Process A. Theoretical Approaches 1. Systems Theory 2. Problem Solving Methods 3. Scientific Methods 4. Evidence Based Practice B. Overview and Organization of the Nursing Process 1. Assessment 2. Nursing Diagnosis 3. Planning 4. Implementation 5. Evaluation C. Steps in the Organization of the Nursing Process 1. Nursing History 2. Data Collection a) Observation b) Interviewing c) Physical Assessment d) Consultation e) Records and Reports 3. Problem Statement/ Nursing Diagnosis a) Analysis of Data b) Writing the Nursing Diagnosis 1. Problem (P) 2. Etiology (E) 3. Signs & Symptoms (S)	1. Describe systems theory, the problem-solving method, and the scientific method. 2. Compare systems theory, the problem-solving method, and the scientific method with the nursing process. 3. Describe 5 steps of evidence based practice. 4. Describe benefits of evidence based practice. 5. Describe ways to apply evidence based practice. 6. Obtain additional data about the client from other appropriate sources. 7. Organize all data according to a predetermined format. 8. Differentiate between subjective and objective data. 9. Describe the five components of the nursing process. 10. Define the term nursing diagnosis. 11. Name the three major components of the nursing diagnosis. 12. Identify five methods of data collection. 13. Discuss advantages of a nursing diagnosis. 14. Discuss the limitations of nursing diagnosis. 15. List five common errors in formulating a nursing diagnosis. 16. Identify needs and problems of an assigned client, including identifying information and the client's perception of the illness and/or situation, including any reasons for seeking assistance. 17. Discuss techniques the nurse utilizes to observe clients. 18. Develop a nursing process applying the five steps of assessment, diagnosis, planning, implementation, and evaluation.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapters 11, 12, 13, 14 & 15 2. The Course Point 3. Define key terms Evaluation 1. Pen & Paper or Computer Test				
			A1	A1	A1	B1
			A2	A2	A2	B2
			B1	A3	B1	C1
			B8	A4	B2	C3
				B1	B3	C4
				B2	D1	C5
				B3	E1	D1
				B4	F1	E1
				B5		F1
				B6		F2
				B7		F3
				B8		
				B9		
				B10		
				B11		
				C1		
				C2		
				C3		
				C4		
				C5		
				C6		
				C7		
				C8		
				D1		
				D2		
				D3		
				D4		
				D5		
				E1,E3		

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
4. Planning a) Setting priorities b) Resources c) Establishing d) Writing a Plan of Action Nursing Orders 5. Implementation 6. Evaluation	19. Distinguish between a need and a problem. Distinguish between actual and potential problems. 20. Distinguish between independent, interdependent, and dependent nursing functions. 21. Address safety needs, developmental phase, pharmacology, nutrition, and stress adaptation in nursing process. 22. Utilize assigned sections of data collection guidelines to assess the client. 23. Discuss application of the nursing process in today's client care assignment. 24.Explain four aspects of the planning component. 25. Describe five different implementation methods.			E4		
				E5		
				E6		
				E8		
				E9		
				E11		
				E12		
				E13		
				F1		
				F2		
				F3		

DATA COLLECTION FORM

Now that you have accomplished the skill of determining a nursing problem or diagnosis you will use only the data collection form for history and assessment. The Data Collection Form is contained in this section along with a Nursing Process Form. Use the following directions to compile the data you collect.

DIRECTIONS FOR USE OF DATA COLLECTION FORM

1. Fill in the blanks at the top of the data form. Remember to use only one of the client's initial to maintain privacy.

2. Complete status categories by filling in the subjective and objective information specified. Data may be repeated in some categories due to the inter-relatedness of the body's systems.

3. Review each area for actual or potential problems. Determine the nursing diagnosis from the data collected in each category if appropriate. Write the nursing diagnosis in the category, You will also list your nursing diagnosis in the Problem, Etiology, Signs and Symptoms (PES) format at the end of the database.

   NURSING DIAGNOSIS

   Priority

High (H)	P. Problem/Nursing Diagnosis
Medium (M)	E. Etiology or Cause
Low (L)	S. Subjective and Objective Data to Support Diagnosis

   a. Determine nursing diagnosis from status categories. Review each area for risk or actual problems.

   b. Write your nursing diagnosis using the PES format.

   c. List the nursing diagnosis in order of priority according to Maslow's Hierarchy of Needs, i.e., oxygenation--------□ self-esteem.

   High

   P. Alteration in respiratory function related to impaired gas exchange
   E. Smoking
   S. Smoking Hx. 1-2 pks/day X 20 years;
   freq. prod. cough
   past hx. bronchitis, chest x-ray atelectasis
   cough p smoking, lethargy and fatigue pursed-lip breathing

Medium	P. Alteration in Nutrition: less than body requirement E. Loss of appetite due to stress of illness and smoking S. Wt. Loss 20 lbs./past mo. Hgb 11 gm, Hct 35%, Ht 5'10" eats small amounts
Medium	P. Noncompliance E. Previous unsuccessful experience with advised regimen S. Personal behavior deviates from health related advice.

4. Determine priority of each of your nursing diagnoses; in other words, establish the degree of urgency of each actual or potential problem. It is possible to have more than one diagnosis at each level, i.e., High (H), Medium (M), Low (L).

5. List the client's strengths/assets, those factors that the client possesses, which can be utilized by the nurse to assist in meeting his/her needs, and/or preventing and solving problems.

   EXAMPLES OF STRENGTHS/ASSETS

   Intact family
   Able to read/write
   Available support system
   Financially independent

6. After you have become proficient at this stage; you will transfer the nursing diagnosis to the assessment column of the Nursing Process Sheet. You will then continue with the planning (Step III) and complete this step as directed by your instructor.

PLANNING

The nursing assessment and the formulation of nursing diagnoses initiate the individualization, coordination, and the continuity of nursing care that is planned during the third component of the nursing process. Planning is a category of nursing behaviors in which the goals of care are set for an individual client and a strategy is designed to achieve goals. During planning, the client's goals are determined, priorities are established, outcomes of nursing care and are projected, and a nursing care plan is written. The planning of nursing care includes consulting other health professionals, modifying care, and recording information relevant to client management (Potter & Perry, 2012).

DETERMINING GOALS OF CARE

Goal Statement – specific aim planned by the nurse to assist the client in achieving his/her maximal level of wellness.

Ultimately the goal is the intended outcome of the nursing intervention. Goal statements assist caregivers in focusing on exactly what you hope to accomplish with the client. The first step in determining a goal statement is to ask yourself, "What can or should be done about the problem identified in the nursing diagnosis?" For the client with a diagnosis of Alteration in Respiratory Function/Impaired Gas Exchange, a specific goal planned by the nurse would be to improve the client's gas exchange. This goal is individualized to this client and sets the framework for planning care. Goals include prevention and rehabilitation as well as emergency need. Goal setting should include the client and/or family and significant others.

The current trend in setting goals is to develop a statement (goal) that is client centered and specifies measurable evaluative outcome criteria (EOC). When projected outcomes are clearly specified in the planning stage, evaluation becomes a much easier task.

Utilize the following suggestions when writing goal statements:

1. The statement should designate a client outcome which shows reduction or alleviation of the identified problem (nursing diagnosis). This suggestion will make the goal client centered and measurable.
2. A realistic time span should be set within the goal statement.
3. The goal should be realistic for the nurse's level of skill and experience.
4. The goal should be congruent with and supportive of the client's medical regime.
5. If possible, the goal should be important and valued by the client, the nurses, and the physician.
6. The goal should be very specific.

A goal may be achieved quickly, such as during a period of hospitalization, or at a clinic visit. A goal may focus on rehabilitation, prevention, or education.

Alteration in respiratory function related to impaired gas exchange.	Client will demonstrate ↑ respiratory effort by _____ as evidenced by: a. resp. rate of 20-24/min b. lack of nasal flaring c. lack of sternal retractions d. ability to speak without gasping e. expectoration of secretions and following treatments as ordered.

	Client will maintain optimal ventilation after discharge as evident by resp. rate of 12-20. No evidence of cyanosis. No SOB	
Alteration in nutrition, less than body requirement.	Client will ↑ present weight of 98 lbs By 1 lb weekly. 99 lbs by _____. Date	Client will maintain 15 lb. Gain for a period of 6 months.

100 lbs by _____.
Date

101 lbs by _____.
Date

Having established the goals and EOC's are the specific aims planned by the nurse to assist the client in achieving his maximal level of wellness, the specific actions by the nurse are planned. Nursing actions are those things the nurse plans to do to help the client achieve a goal. Nursing actions are instructions for the care of the client. Although nursing actions are considered as part of the planning phase of care for our purposes, these actions will be written in the implementation column of the NCP. This brings us to the fourth step of the nursing process, Intervention or Implementation.

IMPLEMENTATION

Adequate planning of nursing care results in the individualization, coordination, and continuity of nursing care. Planning established the framework of nursing care to be delivered during the fourth step of the nursing process, implementation. This step of the nursing process delineates the actions necessary for accomplishing the health care plan. A nursing action/intervention may be any act by a nurse that implements the nursing care plan/goals. Intervention may be in the form of support, medication, treatment for the current condition or treatment to prevent future health problems.

Implementation of interventions may include the nurse's performing or assisting in the performance of the clients ADL's counseling and teaching, giving care to achieve therapeutic goals and facilitate the achievement of the client's health goals, supervising, delegating, and evaluating the work of staff members involved in the client's care, and recording and exchanging information relevant to the client's continued health care (Potter & Perry, 2000).

NURSING INTERVENTIONS

Nursing intervention is what the nurse does for, with, and to a client to achieve client goals.
Nursing interventions are based on scientific principles.
Nursing interventions should answer the following questions:

a. What is the intervention?
b. When should each intervention be implemented?
c. How should the intervention be performed?
d. Who should be involved in each aspect of intervention?

Nursing interventions may be dependent, independent, or interdependent.

a. Dependent-interventions by the nurse are based on instruction or written orders of professional, i.e. physician's orders.
b. Independent interventions are designed and carried out by the nurse without a specific doctor's order. These interventions involve aspects of nursing encompassed by licensure and law.
c. Interdependent interventions are carried out by the nurse in collaboration with another health care professional. These interventions require nursing judgment within the framework of standard protocols and/or standing orders.

In the following situation: The client is anxious about going to surgery.

Goal Statement	Nursing Interventions
The client will demonstrate decreased anxiety level by end of the evening shift. EOC a. Pulse rate 60-80/min b. Ability to communicate pre and post-op instructions. c. Lack of observable signs of agitation such as restlessness and wringing of hands. d. Verbalize feelings of less anxiety.	The nurse will: 1. Visit with the client at the beginning of the shift. 2. Explain preoperative preparations at 0800. 3. Allow client to ventilate fears prior to going to surgery.

Situation II: The client is developing a pressure area on the sacral region.

Goal Statement	Nursing Interventions
Client's skin integrity will be maintained while on complete bed rest as evidenced by: EOC a. Lack of reddened areas in the sacral region. b. No disruption of skin integrity. c. Maintenance of proper positioning to prevent skin breakdown. d. Lack of signs and symptoms of infection.	The Nurse will: 1. 2. 3.

Did you think of some? Check the interventions listed below with your answers.

Answers to Interventions:

Nursing Interventions-Situation II:

1. Egg crate mattress to bed
2. Turn and reposition q. 2
3. Assess area after turning

As a final thought concerning the process of implementation, remember that this step is more than just the giving of nursing care. Implementation involves reviewing your plan of care with other professionals to validate that it is based on proper scientific principles and is individualized for your client.

Implementation also includes proper documentation of the plan in the client record as well as continual data collection to be utilized in revising and updating the plan.

Professional nursing care is based on scientific principles. The body of scientific knowledge, which is the foundation of nursing, is constantly enlarging and, therefore, principles are continuously being revised. It is impossible for the nurse to depend on a learned repertoire. She/he must, instead, base her/his practice on relatively unchanging principles to guide her/him in modifying techniques.

A principle can be defined as a proven scientific fact, a law of science, or a generally accepted theory. The scientific basis of nursing is drawn from many areas, including the biophysical sciences, medical sciences, nutrition, and the psychosocial sciences.

For example, the nurse will orient a client to the nursing unit as a means of meeting his/her security needs, based on Maslow's Hierarchy of Needs derived from psychosocial theory.

When planning care for a client, the nurse's interventions must be guided by scientific principles. A scientific or psychosocial principle for each nursing intervention should be included in the appropriate column on the care plan. Each principle should reflect the nursing intervention as it relates to the problem. Each principle must be documented with the information source.

Example:

PLANNING/IMPLEMENTATION	SCIENTIFIC PRINCIPLES
Observe client for disorientation.	Because nervous tissue is very sensitive to oxygen deficiency, the client with respiratory problems may show signs of impaired brain functioning (Dugas: 590).

When writing nursing interventions that assist the client in goal achievement, state a scientific rationale for each action, or for each group of similar actions, that answers the following questions.

1. Why is this action effective?
2. What is the intent of this action?

For all scientific rationales, document with a source, e.g. Potter & Perry, FundamentalsofNursing, page 132, or Smeltzer & Baer, EssentialsofMedicalSurgicalNursing, page 140.

EVALUATION

Evaluation is the final step of the nursing process. We learned that evaluation determines the extent to which goals have been achieved. Evaluation is the process used to reassess the client to determine whether the problems identified in the nursing diagnosis have been resolved. Without evaluation it is impossible to determine if the care given to the client has been effective in reducing or alleviating the problem. Nursing assessment skills are used to evaluate the need for continued care.

Evaluation of nursing care includes four steps:

1. Establishment of evaluation criteria
2. Comparison of client response to the criteria
3. Analysis of variables affecting outcomes and conclusions
4. Modifications in the nursing care plan (Potter & Perry, 2012)

Evaluation criteria are based on the projected outcomes developed during the planning step of the nursing process. EOC's (evaluation outcome criteria) are also based on scientific principles, the quality of care in relation to accepted standards of care and internal nursing audits. A properly stated nursing goal will make the task of evaluating how well nursing interventions met the goals much easier.

To determine whether the goal was accomplished, the nurse must observe what happened to the client during the intervention and describe his response. The nurse evaluates client response to each nursing intervention and this evaluation should include any additional data relating to the problem. Therefore, we can see that problems identified in the nursing diagnosis in conjunction with the nursing goals, serve as the criteria against which nursing care is evaluated. Remember, the nurse evaluates goal achievement specifically whether or not the client was able to perform the outcome designated in the goal statement. The evaluative statement is not an evaluation of nursing actions. The appropriateness of nursing actions is reviewed during the reassessment phase.

The evaluative statement should state whether the goal was met, partially met, or not met. The statement should also contain the client behaviors which support the conclusion drawn. If the goal is met and the problem identified in the nursing diagnosis is completely resolved, the nurse should state that no further nursing actions or follow up is necessary and sign and date this statement. At times, a goal may be met but the problem is not resolved. Reassessment of the plan at this point will determine if the plan needs modification or can remain unchanged for a while. If the plan is not changed include a date for reevaluation following the evaluative statement. Whenever a goal is partially met, the plan must be reassessed.

Through analysis of variables affecting outcomes, the nurse determines the degree, which a plan was effective and draws conclusions about factors that led to the success or failure of the plan of care. Behavioral responses allow the nurse to determine the outcome of the evaluation. Responses may be any one or a combination of the following:

1. The client responded with behavior that indicates the problem has been reduced or alleviated.

2. The client's responses (signs and symptoms) indicate his problem has not been resolved.

3. The client's responses indicate new problems.

4. The client's responses indicate the need for more data or that the data collected was incorrectly interpreted resulting in incorrect problem.

Analysis of outcomes and conclusions allow the nurse to determine the success of the care plan or whether the plan must be reassessed and modified. Reassessment is the process of changing or eliminating previous nursing diagnoses, goals, and actions based on new client information. If changes are necessary (based on evaluation of client responses), discontinue the plan by stating "plan not effective; see revision." Date and sign this statement. Following modifications, the plan must be re-implemented and reevaluated. Therefore, the

evaluation of nursing care is an ongoing process, which assists the nurse in maintaining care suitable to the client's problems.

Let's think back to the previous situation in the planning section. The example referred to a client anxious about impending surgery.

After nursing intervention was the client less anxious? What observations would you make to determine if you decreased the client's anxiety about surgery?

Example: 1. When questioned, the client stated that the information given to her had "relieved her fears."

Example: 2. The client was smiling and appeared calm and relaxed.

What is your conclusion? Was the client's anxiety alleviated?

Conclusion: Goal met – Smiling, the client stated "her fears had been relieved." Care plan related to this problem is discontinued.

N. Nurse –
9/1/2015

Now, you evaluate Situation II.

After your nursing interventions did you prevent scores on the client's sacral area?

List what observations you would make.

1.

2.

3.

4.

5. Now what is your conclusion? Were you successful in meeting your nursing goal? If your nursing intervention were not effective, how would you revise it?

GoodWork! Completion and periodic review of this supplement should assist you in preparing your nursing care plan, as assigned, to meet clinical outcomes.

Unit III: Aging Adults
Unit IV: Health of the Individual, Family, and Community

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge) 1	2	3	4
1. Aging Adult A. Developmental task B. Common Physiological Changes C. Common Psychosocial Changes D. Nursing Interventions	1. Summarize the theories that describe how and why aging occurs. 2. Describe major physiologic, cognitive, psychosocial, moral, and spiritual developments and tasks of middle and older adulthood. 3. Describe common health problems of middle and older adults. 4. Discuss physiologic and functional changes that occur with aging. 5. Describe common myths and stereotypes that perpetuate ageism. 6. Describe nursing interventions to promote health for middle and older adults. 7. Identify the health care needs of older adults in terms of chronic illnesses, accidental injuries, and acute care needs.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 19 2. Define key terms 3. The Course Point	B7	B4		
				B5		
				B6		
				B8		
				B9		
				B12		
				C3		
				C4		
				C8		
				D1		
				D2		
				E1		
				E4		
				E5		
				E10		
				G1		
2. Health of the Individual, Family, and Community A. Maslow's Hierarchy of Human Needs B. Physiological Needs C. Safety and Security D. Love and Belonging Needs (closeness) E. Esteem and Self-Esteem Needs F. Self-Actualization Application of Basic Needs Theory	1. Describe each level of Maslow's hierarchy of basic human needs. 2. Explain nursing care necessary to meet needs in each level of Maslow's hierarchy. 3. Discuss family concepts, including family roles, structures, functions, developmental stages, tasks, and health risk factors. 4. Identify aspects of the community that affect individual and family health. 5. Describe nursing interventions to promote and maintain health of the individual as a member of a family and as a member of a community.	Assignment 1. Taylor, Lillis, Lynn Chapter 4 2. The Course Point Evaluation 1. Pen & Paper or Computer Test				

Unit V: Communicator

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge) 1	2	3	4
1. Communicator A. Verbal B. Non-Verbal C. Techniques 1. Facilitative 2. Inhibitory D. Effective Nurse/Client Relationship 1. Guideline for communication techniques 2. Phases of the helping relationship a) pre-interaction b) introductory c) working d) termination 3. Interviewing a) sources of data for nursing assessment b) objective data c) subjective data	1. Define communication. 2. Define verbal and non-verbal communication. Identify the communication process. 3. Identify developmental levels in the communication process. 4. Describe ways to incorporate teaching with routine nursing care. 5. Describe how to integrate the communication process into nursing care. 6. Describe characteristics of a good learning environment. 7. Discuss four functional components of the communication process. 8. Discuss five characteristics of effective verbal messages. 9. Differentiate between social/therapeutic nurse/client relationships. Identify do's and don'ts in interviewing. 10. Discuss the purposes of nursing assessment.	Group 1. Lecture 2. Discussion 3. Communication Interactive CAI Assignment 1. Taylor, Lillis, Lynn Chapter 20 2. Define key terms 3. Observe your own family and identify the communication patterns that they are using 4. The Course Point Evaluation 1. Pen & Paper or Computer Test	B7	C2		A1
				D5		A2
				E2		A5
						D1
						D2
						E1
						F4
						G2

Unit VI: Health, Illness, and Disparities and Health Care Delivery System

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Health, Illness, and Disparities 2. Health Care Delivery System A. Health and Illness B. Health Care Delivery C. Problems in Health Delivery D. Use of Services in Illness- Wellness	1. Identify types of agencies and mechanism of reimbursement. 2. Identify purposes of health care referrals. 3. Describe the restorative team approach to care. 4. Discuss the client's right to the health care delivery care system. 5. Describe the health belief model, the agent-host-environment model, and the high level wellness model. 6. Describe the nurse's role for clients in health and illness. 7. Discuss the variables that influence a person's health beliefs and practices. 8. Discuss the stages of illness behavior. 9. Discuss health definitions and concepts. 10. Discuss the differences between acute and chronic health care.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 3 & 8 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test	A2 B2 B3 B4 B6 C2 C4	A2 A3 B6 B7 B8 C3 C5 D2 D4 E1 E3 E4 E5 E13 F2 G3 H2 H3	A6 C2	A1 A3 B3 B4 C1 C6 C7 C8 D3 E1

Unit VII: Stress and Adaptation

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Stress and Adaptation A. Models of stress B. Prolonged stress 1. Physical 2. Development results 3. Emotional results C. Dimension of adaptations D. Homeostasis 1. Mechanisms 2. Limitations	1. Describe stress management techniques. 2. Recognize ego-defense mechanisms that serve as responses to stress. 3. Define homeostasis. 4. Discuss three mechanisms of homeostasis and how they function. 5. Discuss the concept of stress and how the body responds to stress according to Selye's adaptation syndrome. 6. Summarize the mechanisms involved in maintaining physiologic and psychological homeostasis. 7. Explain the interdependent nature of stressors, stress, and adaptation. 8. Differentiate the physical and emotional responses to stress, including local adaptation syndrome, general adaptation syndrome, mind–body interaction, anxiety, and coping and defense mechanisms. 9. Discuss the effects of short-term and long-term stress on basic human needs, health and illness, and the family. 10. Compare and contrast developmental and situational stress, incorporating the concepts of physiologic and psychosocial stressors. 11. Explain factors that cause stress in the nursing professions.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 41 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test	D4	B5		A3
				C1		B1
				C6		D2
				D4		
				D5		
				E7		
				F2		
				H2		
				H7		

Unit VIII: Self Concept
Unit IX: Complementary & Alternative Therapies

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge) 1	2	3	4
1. Self-Concept A. Development B. Components C. Stressors D. Nurse's effect on client's self-concept 1. Nurse's self-concept 2. Responding to client's needs	1. Identify specific threats to the development process that may occur at each stage of an individual's growth. Describe how the self-concept develops. 2. Identify stressors that affect each of the four components of self -concept. 3. Assess the developmental level of a client. 4. Define behaviors that may indicate the following: low images, role strains, identify confusion, and depersonalization. 5. Describe how these either enhanced or hindered the relationship.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 40 2. Define key terms 3. The Course Point Assignment	B4 B5 C4 D4	E7 H6		A2 A3 B2 C3 F3
2. Complementary & Alternative Therapies A. Scope of Practice B. Purposes & Principles	1. Differentiate between complementary/alternative therapies. 2. Describe the clinical application of complimentary/alternative therapies.	1. Taylor, Lillis, Lynn Chapter 27 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test	C2	A1 A3 B2 B5 B9	B2 E2	B1 C6

Unit X: Values, Ethics, and Advocacy and Legal Dimensions of Nursing Practice

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Values, Ethics, and Advocacy 2. Legal Dimensions of Nursing Practice A. Nursing Licensure B. Legal Liability C. Legal Concepts D. Legal Issues	1. State criteria necessary for informed consent. 2. Explain the Good Samaritan Law. 3. Define legal concepts that the nurse encounters. 4. Compare negligence and malpractice. 5. Describe basic philosophies of ethics.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapters 6 & 7 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test	A1 A2 A3 A4 B1 B2 D1	D1	A1 A2 A3 A4 B1 C2 D1 E1	B1 F1 F4 G4

Unit XI: Sensory Functioning

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge) 1	2	3	4
1. Sensory Functioning A. Physiology of normal sensation B. Sensory Alterations 1. Overloads 2. Deprivation C. Factors influencing sensory function	1. Describe the four conditions that must be met in each sensory experience. 2. Explain the role of the reticular activating system in sensory experience. 3. Identify etiologies and perceptual, cognitive, and emotional responses to sensory deprivation and sensory overload. 4. Perform a comprehensive assessment of sensory functioning using appropriate interview questions and physical assessment skills. 5. Develop nursing diagnoses that correctly identify sensory/perceptual alterations that may be treated by independent nursing interventions. 6. Describe specific nursing interventions to prevent sensory alterations, stimulate the senses, promote health literacy, and assist patients with sensory difficulties. 7. Develop, implement, and evaluate a plan of nursing care to help patients safely meet individualized sensory/perceptual outcomes.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 43 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test		A3 B1 B2 B4 B5 C5 E3 E4 F2		

Unit XII: Spirituality
Unit XIII: Cultural Diversity

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge) 1	2	3	4
1. Spirituality	1. Identify three spiritual needs believed to be common to all people. 2. Describe the influences of spirituality on everyday living, health, and illness. 3. Differentiate life-affirming influences of religious beliefs from life-denying influences. 4. Distinguish spiritual beliefs and practices of major religions practiced in the United States. 5. Identify five factors that influence spirituality. 6. Perform a nursing assessment of spiritual health, using appropriate interview questions and observation skills. 7. Develop nursing diagnoses that correctly identify spiritual problems. 8. Describe nursing strategies to promote spiritual health, and state their rationale. 9. Plan, implement, and evaluate nursing care related to select nursing diagnoses involving spiritual problems.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 45 2. Define key terms 3. The Course Point Assignment	B3 B7	B4 B5 C1 C4 C8 D1 E1 G1		D1
2. Cultural Diversity A. Concepts of culture and ethnicity B. Influence of culture C. Difference and similarities among ethnic-cultural groups	1. Explain concepts of cultural diversity. 2. Describe influences that affect culturally competent health care. 3. Discuss examples of how diversity affects health and illness care, including culturally based traditional care. 4. Identify factors commonly included in a transcultural assessment of health-related beliefs and practices. 5. Practice cultural competence when assessing and providing nursing care for patients from diverse cultural groups. 6. Discuss factors in the health care system and in nursing that facilitate or impede culturally competent nursing care.	1. Taylor, Lillis, Lynn Chapter 5 2. Define key terms 3. Review guidelines for cultural belief paper 4. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test				

SOUTH PLAINS COLLEGE ASSOCIATE
DEGREE NURSING PROGRAM

RATIONALE AND GUIDELINES FOR PERSONAL BELIEFS PAPER

If a nurse is to respond to and meet clients' needs, then he/she must learn that the evaluation of one's actions and behaviors is part of becoming a nurse. This means that the nurse must first grow in self-knowledge thereby, establishing a base on which to apply this knowledge in a helping relationship. Self-awareness is a process of becoming conscious of one's values and goals. Knowledge of one's self enhances the effect of the therapeutic relationship.

Everyone has values, needs, and feelings--many of which are not consciously recognized and may diminish our effectiveness within the therapeutic nurse--client relationship. These values, needs, and feelings are never static. Just as our life experiences change, person's attributes also change. We enter nursing with different experiences and values. The nurse is expected to understand the values, needs, and feeling of the client without attaching any right or wrong, in order to establish empathy.

The faculty appreciates and understands that people sometimes feel threatened when asked to share values, needs, and feelings. When risk is involved, an atmosphere of trust and safety must exist in order for students to comfortably express themselves without being rejected or ridiculed. Vulnerability is inevitable with self-disclosure but disclosure will enhance the process of increased self-awareness.

Criteria

Examine your beliefs and attitudes toward people who are different from you physically, culturally, racially, religiously, socio-economically, and in life-style.

State any known intolerance you may have toward others who are different from yourself.

Identify those life experiences that have contributed to the formation of your beliefs and

attitudes.

Discuss you feelings regarding providing personal care for persons of the opposite sex and persons of different ethnic/cultural groups.

Discuss your attitudes about spiritualism and witchcraft practices as means of treatment for health problems.

Discuss how these beliefs and attitudes may enhance and/or inhibit your effectiveness as a nurse.

The paper should be three to five pages in length and typewritten.

Unit XIV: Rest and Sleep

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge) 1	2	3	4
1. Rest & Sleep A. Differences between sleep and rest B. Physiology of sleep 1. Circadian rhythm 2. Sleep cycles C. Functions of sleep D. Sleep requirements E. Factors affecting sleep F. Sleep disturbances G. Nursing Process 1. Assessment a) components of sleep	1. Describe the functions and physiology of sleep. 2. Identify variables that influence rest and sleep. 3. Describe nursing implications that address age-related differences in the sleep cycle. 4. Perform a comprehensive sleep assessment using appropriate interview questions, a sleep diary when indicated, and physical assessment skills. 5. Describe common sleep disorders, noting key assessment criteria. 6. Develop nursing diagnoses that correctly identify sleep problems that may be treated through independent nursing interventions. 7. Describe nursing strategies to promote rest and sleep based on scientific rationale. 8. Plan, implement, and evaluate nursing care related to select nursing diagnoses involving sleep problems.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 33 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test		A3 B1 B2 B4 B5 C5 E3 E4 F2		

Unit XV: Safety, Security, and Emergency Preparedness

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Safety, Security, and Emergency Preparedness A. Elements of safe environment 1. Basic needs influence on safety 2. Pollution control 3. Preventing illness or injury 4. Environmental considerations a) Falls b) Fires c) Poisoning d) Electrical hazards 5. Absence of injury	1. Identify factors that affect safety in a person's environment. 2. Identify patients at risk for injury. 3. Describe specific safety risk factors for each developmental stage. 4. Select nursing diagnoses for patients in unsafe situations. 5. Describe health-teaching interventions to promote safety for each developmental stage. 6. Describe strategies to decrease the risk for injury in the home. 7. Describe nursing interventions to prevent injury to patients in health care settings. 8. Identify alternatives to using restraints. 9. Explore resources for developing and evaluating an emergency management plan. 10. Evaluate the effectiveness of safety interventions.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 26 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test	A1 A2 A3 B1 B2	D1 D2 D3 D4 E8 E9 H3	A1 A2 A3 A4 B1 B2 B3 B4 B5 C1 C2	

Unit XVI: Loss, Grief & Dying

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Loss, Grief & Dying A. Definitions 1. Loss 2. Grief 3. Hope 4. Crisis Theory applied to grieving B. Assessment 1. Factors affecting reaction to loss a) Age, growth & development b) Nature of relationship c) Nature of death of loss d) Support e) Cultural and Spiritual beliefs f) Sex roles g) Socio-economic status C. Phases of grief reaction (uncomplicated) 1. Precipitation events 2. Phases in loss 3. Potential problems 4. Phases in dying 5. Physical symptoms of grief	1. Define loss, grief, and hope. 2. Describe six dimensions of hope. 3. Identify the nurse's role in assisting patient's with problems related to loss, death, and grief. 4. Assess a patient's reaction to grief and ability to cope. 5. Describe characteristics of a person experiencing grief. 6. Compare grief after loss, anticipatory grief, and resolved grief. 7. Discuss the impact of growth and development, cultural and spiritual beliefs, sex roles, and other factors or reactions to loss. 8. Develop a care plan for a client or family experiencing grief. 9. Describe intervention principles for grieving patients. 10. Describe how the nurse helps meet the dying clients' needs for comfort. 11. Discuss the purposes of hospice. 12. Explain ways for the nurse to assist the family in caring for a dying patient. 13. Discuss important factors in caring for the body after death. 14. Recognize issues of loss, grief, and death in patients and their families. 15. Formulate nursing diagnoses on patients and families experiencing loss, and/or death and dying. 16. Evaluate nursing care of clients and families experiencing loss, grief, death and dying.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 42 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test	B3	B4 B5 C1 C4 D1 E10 E12	A4	A4 C4

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
D. Nursing Diagnosis in grief, loss, & death 1. Anticipatory grieving 2. Coping ineffective relative to situational crisis 3. Hopelessness 4. Powerlessness 5. Grieving - dysfunctional 6. Spiritual distress 7. Social isolation E. Planning 1. Goals 2. Principles F. Implementation 1. Therapeutic 2. Care after death G. Evaluation						

Unit XVII: Comfort and Pain Management

CONTENT	OBJECTIVES	LEARNING ACTIVITIES/ EVALUATION	DEC's (Knowledge)			
			1	2	3	4
1. Comfort and Pain Management A. An individual experience B. Components of the pain experience 1. Reception 2. Perception 3. Psychological factors 4. Reaction C. Acute and Chronic Pain D. Assessment 1. Vital Signs 2. Subjective report 3. Pain history 4. Effects of pain on the patient 5. Non-verbal responses to pain	1. Discuss cultural expectations regarding the significance of pain. 2. Differentiate nursing, medical, and surgical measures, which provide pain relief. 3. List the goals of planning care for a patient experiencing pain. 4. Explore individual beliefs regarding pain toleration. 5. Identify a common misconception health care workers may have about a patient's pain. 6. Name physical sources of pain. 7. Discuss the gate control theory of pain. 8. Compare the characteristics of acute and chronic pain. 9. Identify the key elements to be included in an assessment of a patient's pain. 10. Explain specific measures for individualizing pain therapy. 11. Define intractable pain. 12. Discuss measures that may be effective in alleviating the intractable pain. 13. List physiological responses to pain.	Group 1. Lecture 2. Discussion Assignment 1. Taylor, Lillis, Lynn Chapter 34 2. Define key terms 3. The Course Point Assignment Evaluation 1. Pen & Paper or Computer Test		A1 B1 B2 B4 B5 B6 B7 E1 E5 E12	B1 B2 B3 B4 D1 E1 F1	

APPENDIX A

ANALYSIS Problem/Nursing Diagnosis	PLAN Goal Statements With Outcome Criteria	IMPLEMENTATION Nursing Interventions Actions	Scientific Rationale	EVALUATION Evaluative Outcome Criteria
3/8 1) Ineffective airway clearance as related to recent surgery, narcotic analgesics used for pain, acute pain upon coughing et deep breathing, et imposed restrictions on mobility as manifested by minimal coughing attempted, little sputum produced, et congestion in lungs heard upon auscultation. *High Priority*	3/8 #1 Pt. Will demonstrate better ability to cough effectively by 3-9 as evidenced by 1) Demonstration of effective coughing by inhaling deeply et coughing during expiration. *Psychomotor-rehabilitation* 2) Demonstration of effective splinting of surgical wound while coughing to reduce incisional pressure et pain. *Psychomotor-rehabilitation*	3/8 NSG Orders #1 1) At 0800, TPC nurse will demonstrate technique of breathing deeply et coughing with return demonstration from patient. *Teaching* 2) At 0800, TPC nurse will demonstrate splinting of the incision site while coughing with fingers interlocked across abdomen to provide support to incisional site with return demonstration from patient. *Teaching* 3) At 0800, TPC nurse will encourage use of pain medication as needed for pain for control of pain to enable coughing et deep breathing exercises. *Therapeutic* N. Nurse SN SPC	For #1 1) "Explain these possible complications and encourage the client to practice deep breathing and controlled coughing" (Ames et Kneisl p. 239). 2) "Splinting the incision providing external support reduces movement of involved tissues, reduces pain, and this facilitates coughing and deep breathing. Either the nurse or client can splint the incision by supporting it with a pillow or interlocked hands." (Ames et Kneisl p. 239).	3/10 #1 met as evidenced by: 1) Pt. effectively demonstration deep inhalation or continuous coughing throughout exhalation. 2) Pt. effectively demonstrating splinting of the surgical wound while coughing et pt statement while coughing et patient statement "It doesn't hurt as bad when I hold my hands like that." Reassessment indicates objectives completed. NSG intervention at this time should include encouragement of these procedures but teaching goals no longer necessary for these techniques. See revision to plan dated 3/10 and re-evaluate on 3/12 N. Nurse S SPC

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ANALYSIS Problem/Nursing Diagnosis	PLAN Goal Statements With Outcome Criteria	IMPLEMENTATION Nursing Interventions Actions	Scientific Rationale	EVALUATION Evaluative Outcome Criteria
	Goal #2 Patient will demonstrate better airway clearance by 3-10 EOC's 1) No cyanosis noted. 2) Effective coughing with more sputum produced. 3) Decreased congestion heard upon auscultation of lungs. *Psychomotor-rehabilitation*	Revision to Plan 3/10 1) NSG orders 1 & 2 discontinued. 2) TPC nurse will encourage patient demonstration of above techniques every 2 hours. *Therapeutic* 3/8 Nsg. Orders #2 1) TPC nurse will encourage cough et deep breathing exercises at least every 4 hours while awake. *Therapeutic* 2) TPC nurse will auscultate pt.'s lungs every 2 hours to monitor for worsening lung congestion et report any significant changes to physician. *Therapeutic* 3) TPC nurse will encourage use of spirometer, brought in by RT, every 2 hours during lung assessment. *Therapeutic* N Nurse SN SPC	2) "Encourage client to practice deep breathing and controlled coughing prevents possible complications." (Ames et Kneisl p. 239). 3/8 for #2 1) "Coughing and deep breathing should be encouraged at least every hour in the early post-operative period and periodically thereafter." (Ames et Kneisl p. 258). 2) "Auscultate the lungs periodically to sure secretions are not building up." (Ames et Kneisl p. 256).	#2 was partially met by target date as evidenced by: 1) No cyanosis noted. 2) Pt. coughing more effectively with more sputum being produced. 3) Congestion is still heard in lungs, however it seems to be higher up in the lobes of the lungs and sounds as though it is breaking up. Reassessment indicates current plan still effective. Continue interventions as listed et re-evaluate on 3/15 N. Nurse SN SPC

ANALYSIS Problem/Nursing Diagnosis	PLAN Goal Statements with Outcome Criteria	IMPLEMENTATION Nursing Interventions Actions	Scientific Rationale	EVALUATION Evaluative Outcome Criteria
	3/8 #3 Patient will demonstrate complete airway clearance by 3-22 as evidenced by: 1) No cyanosis noted. 2) No congestion heard in lungs in either lobe on auscultation. 3) Minimal coughing with sputum coughed up easily when it builds up. *Psychomotor-rehabilitation*	3/8 Nsg. Orders of #3 1, 2, 3 same as for Goal #2 4) TPC nurse will encourage coughing after ambulation to allow better clearance of secretions. *Therapeutic* 5) At 1000, TPC nurse will encourage fluids immediately upon doctors orders to allow secretions to become more liquid for easier clearance from the body. *Therapeutic* 6) TPC will encourage patient to drink 8 oz of fluid every 2 hours when fluids are allowed. N. Nurse SPC ADN	For #3 1, 2, 3 same as for goal #2 4) "Recommend the sitting position or Fowler's position because they allow for maximum lung expansion and aeration." 5 & 6) "Keep the client hydrated to loosen secretions so they can be more easily expectorated and to prevent dehydration." (Ames et Kneisl p. 385).	3/10 #3 was partially met as evidenced by: 1) No cyanosis noted/ 2) Congestion higher up in the respiratory tract or sounds as if it's breaking up. 3) Continued coughing but with better sputum production. Pt. is moving toward the goal as evidenced by the criteria above. Continue interventions as listed er re-evaluate on 3-15. N. Nurse SN SPC

Problem/Nursing Diagnosis	Goal Statements with Outcome Criteria	Nursing Interventions Actions	Scientific Rationale	Evaluative Outcome Criteria
2) Acute pain as related to post-operative status and compression of spinal nerves upon movement or coughing as manifested by verbal expression of pain, grimacing of face when turning or moving, et, use of morphine frequently via PCA pump. *High Priority*	3/8 #1: Patient will demonstrate improved control of pain by 3-10 as evidenced by: 1) Decreased in morphine dosage from 18 mg every 8 hours to 12 every 8 hours. 2) Verbalizes pain severely decreased from 9 to 5 on a scale of 1-10 (with 10 being most severe pain) *Affective-Rehabilitation*	3/8 Nsg. Orders for # 1 1) At 1000, TPC nurse will demonstrate relaxation et imagery techniques to patient with return demonstration (explanation) from the patient. *Teaching* 2) At 1000, TPC nurse will demonstrate splinting of the surgical area with hands across abdomen et fingers interlocked while coughing et deep breathing to reduce pain et pressure with return demonstration from pt. *Teaching* 3) TPC nurse will check clients position and assists with repositioning every 2 hours. *Therapeutic* 4) At 0800, TPC nurse will assess for and correct all factors that may increase client's perception of pain e.g. straighten lines prn, keep all tubing properly positioned. *Diagnostic*	Orders for #1 1) "Acute pain is usually successfully treated with an analgesic medications and/or relaxation techniques." (Ames et Kneisl p. 52). 2) "Clients having surgery of the chest, joints, back and upper abdomen generally experience the greatest postoperative pain as movement causes incisional pain. These areas should be supported for coughing and movement." (Ames et Kneisl p. 257). Dx #2 3/8 Additional Rationalizing 3) Positioning client in anatomical alignment is a measure used to control painful stimuli I the clients environment. (Potter & Perry p. 956) 4) These factors also assist in controlling painful stimuli within one's environment. (Potter & Perry p. 941)	3/10 #1 was partially met as evidenced by: 1) Patient using only 12-15 doses of morphine every 8 hours. 2) Pt's statement, "It doesn't hurt quite as bad today. 3) Pt's use of relaxation et imagery techniques seemingly correct. Pt. states: "I thought you were crazy when you first started telling me about this imagery stuff but it really works. I feel more relaxes after I do it." Reassessment indicates current plan still effective. Continue with interventions as listed et re-evaluate on 3-22. N. Nurse SPC ADN

ANALYSIS Problem/Nursing Diagnosis	PLAN Goal Statements with Outcome Criteria	IMPLEMENTATION Nursing Interventions Actions	Scientific Rationale	EVALUATION Evaluative Outcome Criteria
		5) TPC nurse will assess pts. Level of pain every 4 hours and prn by having patient rate pain on a descriptive scale with 10 being the most severe and 1 being little or no pain. *Diagnostic* 6) TPC nurse will also assess pt. for objectives signs of pain (crying, guarding, facial expression, changes in vital signs) every 4 hours and prn. *Diagnostic* N. Nurse SN SPC	5) Descriptive scales are an objective means of measuring pain intensity and they help to evaluate changes in the client's condition. (Potter & Perry p. 958)	
	3-8 #2 Patient will demonstrate complete alleviation of pain by 3-22 as evidenced by: 1) No use of pain medication. 2) Ability to move, cough et deep breathe without verbal or non-verbal expression of pain.	1) 2) same as for #1 3) At 0900, TPC nurse will explain importance of reducing dosage of pain medication as pain gets more tolerable to the patient to allow the body to get used to pain management and to avoid withdrawal symptoms. *Teaching* N. Nurse SN SPC	For #2 1) et 2) same as above 2) "Narcotic analgesics should be decreased over a few days before being discontinued to avoid drug withdrawal. (Ames et Kneisl p. 56).	3/22 #2 was not met at this time, due to the long term nature of this goal. Pt. continues use of pain medication et some verbal et non-verbal expressions of pan upon movement. After reassessment of plan, the plan determined still effective. Continue interventions as listed and re-evaluate on 3-22 N. Nurse SN SPC

ANALYSIS Problem/Nursing Diagnosis	PLAN Goal Statements with Outcome Criteria	IMPLEMENTATION Nursing Interventions Actions	Scientific Rationale	EVALUATION Evaluative Outcome Criteria
3) Impaired physical mobility as related to recent post-op status, acute pain, et medical restrictions on mobility as manifested by inability to walk without assistance et verbal et non-verbal expressions of pain upon movement. *Medium priority*	#1 Pt. will demonstrate improved physical mobility by 3-10 as evidenced by: 1) Decreased amount of support necessary when standing and ambulating from 1 person and assistance of walker to use of walker on own. 2) Decreased nonverbal expression of pain upon movement. 3) No verbal expression of pain upon movement. 4) No c/o fatigue and pain after ambulation. *Psychomotor-Rehabilitation*	3/8 Nsg Orders for #1 1) TPC nurse will assist pt. to turn every 2 hours as tolerated. *Therapeutic* 2) TPC nurse will provide supportive assistance when pt. sits up, stands up, ambulates, et returns to bed with the aid of physical therapy staff when available. *Therapeutic* 3) Before ambulating, TPC nurse will assess pt's blood pressure or pulse upon lying down, sitting up, et then standing to monitor changes due to position change, monitoring closely for orthostatic hypotension related to narcotics et bed rest. *Diagnostic*	For #1 1) "Pressure relief can be achieved by frequent changing of position (at least every two hours). (Ames et Kneisl p. 1274) 2) "Clients who are able to move without help should be prepared to move their extremities and to turn from side to side within the limits that may be imposed by the surgeon. Tell the client that will be unable to move or turn that the nurse activities." (Ames et Kneisl p. 239) 3) "Postural hypotension (a drop in blood pressure when moving from a lying or sitting to a standing position) is often associated with the dizziness or weakness." (Ames et Kneisl p. 259)	3/10 #1 partially met as evidenced by: 1) Support needed decreased from maximum support of three people to only minimal support of two people for balanced et assistance. 2) Minimal amt. Of wincing et. pt. no longer moans or groans upon movement. 3) Pt. statement, "It doesn't hurt to move like it did a couple of days ago." 4) Pt. only sleeps about 30 minutes in between times of ambulation now three times a day. Reassessment indicates plan still effective with revision of nsg. Order #4 as follows: N. Nurse SN SPC

ANALYSIS Problem/Nursing Diagnosis	PLAN Goal Statements with Outcome Criteria	IMPLEMENTATION Nursing Interventions Actions	Scientific Rationale	EVALUATION Evaluative Outcome Criteria
		4) At 1000, TPC nurse will teach pt. to splint incision site with arms across abdomen when moving to relieve pain et pressure related to stress on the incision. *Teaching* N. Nurse SN SPC	5) "Splinting the incision - providing external support - reduces movement of the involved tissues, reduces pain and thus facilitates coughing et deep breathing. Either the nurse or client can splint the incision by supporting it with a pillow or interlocked hands." (Ames et Kneisl p. 259	

ANALYSIS Problem/Nursing Diagnosis	PLAN Goal Statements with Outcome Criteria	IMPLEMENTATION Nursing Interventions Actions	Scientific Rationale	EVALUATION Evaluative Outcome Criteria
	3/8 #2 Pt .will demonstrate complete mobility independence by 3-29 EOC's 1) No support necessary for pt to sit, stand, et ambulate. 2) Pain experienced upon movement assessed by pt's verbalization of pain relief et no verbal signs of pain observed. 3) No fatigue experienced after mild exertion. *Psychomotor-Rehabilitation*	3-8 Nsg. Orders for #2 1), 2), 3), et 4) TPC nurse will encourage pt. splinting of abdominal incision site when moving. Other orders still effective. Continue as written et. Re-evaluate on 3-15. *Therapeutic* N. Nurse SN SPC 5) TPC nurse will encourage and assist as needed with ambulation increasing distance and length of time ambulating from 5 feet to 25 feet and 5 minutes to 10 minutes and decreasing intervals between ambulation from every 6 hours to every 3 hours as tolerated by the patient. *Therapeutic*	3/8 for #2 orders 1), 2), 3), et 4) same as for #1 4) Activity will gradually increase as tolerated. As recovery progresses, the client should gradually become capable of a wider range of activity." (Ames et Kneisl p. 259	3/10 21 partially met as evidenced by patient progressing toward complete mobility independence. Progression toward long term goal is evidenced by: 1) Minimal support needed for ambulation. 2) Decreased pain upon ambulation as manifested by decreased verbal expression of pain et minimal nonverbal expression of pain. 3) Decreased fatigue after ambulation. Reassessment indicates current plan still effective with revision stated in #1 evaluation. Continue with plan as written et re-evaluate on 3-15. N. Nurse SN SPC

SOUTH PLAINS COLLEGE
NURSING PROCESS

Client's Initials:_____ Student:_____

Diagnosis:_____ Date:_____

Age:_____ Room:_____ Instructor:_____

ANALYSIS Problem/Nursing Diagnosis	PLAN Goal Statements with Outcome Criteria	IMPLEMENTATION Nursing Interventions Actions	Scientific Rationale	EVALUATION Evaluative Outcome Criteria

SOUTH PLAINS COLLEGE
ASSOCIATE DEGREE NURSING
HOSPITAL NURSING PROCESS GRADE SHEET

NAME:_____ SCORE:_____ (Maximum score 4)

NURSING DIAGNOSIS_____

1. Data Base (maximum score 4)_____

_____ (4) 1. Objective Data

_____ (4) 2. Subjective Data

_____ (4) 3. Lab Values, Normals, Abnormals & Explanation of Abnormals

_____ (4) 4. Diagnostic Studies

_____ (4) 5. Diagnosis Evident from Data Base

_____ (4) 6. Medical Diagnosis Form Completed

_____ (4) 7. Medication Knowledge (Rating Score)

2. Analysis (maximum score 4)_____

_____ (4) 1. Strengths & Assets Identified

_____ (4) 2. Additional Diagnosis in PES format & prioritized

_____ (4) 3. Diagnosis in analysis column of NCP prioritized

_____ (4) 4. Diagnosis in PES format

_____ (4) 5. Signs & Symptoms are in the data base

A nursing diagnosis and medical diagnosis may be used only one time during the semester. If either is duplicated, a zero will be given. Only one nursing diagnosis is required, any additional diagnosis will not be graded. *Nursing diagnosis from "Handbook of Nursing Diagnosis are only acceptable

3. Planning (maximum score 4)_____

_____ (4) 1. Client-centered goals & EOC's, enough to resolve, lesson or prevent the problem

_____ (4) 2. Who

_____ (4) 3. Target Dates

_____ (4) 4. Measurable Goals

_____ (4) 5. Realistic Goals

4. Implementation & Scientific Rationale (maximum score 4)_____

_____ (4) 1. Intervention for each goal statement & correctly labeled for each goal statement

_____ (4) 2. Scientific Rationale for each intervention and correctly labeled

_____ (4) 3. Date & Signature for each set of interventions

_____ (4) 4. Interventions specific for "what" & by "whom"

_____ (4) 5. Interventions state "when" & where" (if applicable)

_____ (4) 6. Interventions state "how" (if appropriate)

5. Evaluation (Maximum score 4)_____

_____ (4) 1. Evaluation of each goal statement

_____ (4) 2. Evaluation includes client behaviors supporting conclusion

_____ (4) 3. Steps to be taken are based on 2 & 3

_____ (4) 4. Statements are dated and signed

A nursing diagnosis and medical diagnosis may be used only one time during the semester. If either is duplicated, a zero will be given. Only one nursing diagnosis is required, any additional diagnosis will not be graded. *Nursing diagnosis from "Handbook of Nursing Diagnosis are only acceptable