

# **NURSING 301**

## **FOUNDATIONS OF NURSING**

### **THEORY SYLLABUS**

**OHLONE COLLEGE**  
**Fall 2009 and Spring 2010**

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**Note: In classes 6,7,8 and 9 some topics are split between classes. See calendar for specifics.**

**Skill Labs and Clinical Guidelines-** See Skills Lab/Clinical Syllabus

## **Student Performance Objectives**

### **Nursing 301**

The student will:

1. Perform basic physical and psychological assessments of culturally diverse clients using the Roy Adaptation Model.
2. Explain the professional role of the registered nurse incorporating expectations generated from the current health care system, BRN and the Roy Adaptation Model.
3. Explore the health illness continuum within the context of various health delivery systems and its application for promoting adaptation.
4. Demonstrate beginning skills in therapeutic communication through process recordings and practice in clinical settings.
5. Explain the effects of cultural differences, values and prejudices on communication.
6. Describe the effect of cultural and ethnic health practices on adaptation to health and illness.
7. Demonstrate a proficiency in fundamental nursing skills.
8. Use critical thinking skills to relate basic pathophysiology to a client's medical diagnosis and implement a standardized and individualized nursing care plan.
9. Identify caring and non-caring behaviors of a nurse.
10. Distinguish nursing care to promote wellness and adaptation related to age-related changes in the geriatric population.

OHLONE COLLEGE  
NURSING PROGRAM

**Course #:** N 301

**Units** 5.5

**Lec Hrs** 7

**Title:** Nursing Theory and Communication

**Lab Hrs** 17

**Prerequisites:** Admission to Nursing Program

Completion of BIOL 103A and B and BIOL 10

**Corequisites:** CFS 109, PSY 108 (must be completed by end of second semester in Nursing Program).

**Course Description:**

**Course Content:**

This is a short course in which theory, skills, and clinical components are taught simultaneously.

Nursing 301 is the first course in the nursing sequence taught in 8 weeks. The weekly contact hours are in this 8 week course are 6.75 hours lecture and 16.9 hours lab. Students are introduced to the theory and practice of nursing based on the adaptation model. A focus of this course is assessment of patients' physical and psychological adaptation to health and illness across the adult life span, including variations for the geriatric client. The health illness continuum is explored within the context of the health care delivery system. Common health problems, which adult and geriatric clients have developed adaptive responses, are introduced. Students begin the socialization process into the role of the registered nurse. A special emphasis is placed on the nurse as communicator and critical thinker in a culturally diverse setting. The definition of cultural diversity includes ethnic, cultural and psychological effects in response to wellness, illness, health practices, and value systems among cultural groups. This course focuses on assessing, developing, implementing and evaluating a plan of care that respects the individual's cultural beliefs related to variations in concept of health and illness, use of health care delivery systems, communication differences and barriers such as cultural groups, variances in time and personal space. Detailed objectives are written for each class and correlate with required preparation. Simulated practice of fundamental nursing skills in a multimedia setting and utilization of low fidelity mannikins is included. Clinical application of both theory and skills occurs in the hospital.

### III. Course Outline:

This is a short course in which theory, skills and clinical components are taught concurrently over eight weeks.

#### Theory Content:

##### A. What is Nursing?

1. Role of the Nurse: Past and Current
  - a. Patient Advocacy
  - b. Patient Rights and Confidentiality
  - c. The legal responsibilities of the college, the hospital, the nursing instructor, and the student nurse in the delivery of nursing care to a patient.
2. Health Care Delivery system
3. Roy Adaptation Nursing Theory and Process
  - a. Homeostasis, Stress and Adaptation
4. Nursing Process
5. Nursing Care Planning
6. Community Based Nursing
  - a. Healthy People 2010
  - b. Health-illness continuum
  - c. Concepts of health and illness
7. Health Beliefs and Practices
  - a. Health promotion vs prevention
  - b. Levels of prevention
8. Self-care
  - a. Stress and time management

##### B. Nursing assessments of patients in the Physiologic and Psychosocial Modes, including age-related changes in each mode:

1. Respiration
2. Circulation
3. Ingestion/Elimination
  - a. Nutritional and Elimination needs of the geriatric client
  - b. Hospital diets
4. Fluid and Electrolytes
  - a. Hydration
5. Neuro/Sensation
  - a. Pain Assessment
  - b. Altered Mental Status in the geriatric client
  - c. Sensory Changes in the geriatric client
6. Exercise/Rest
  - a. Complications of Immobility
  - b. Mobility in the geriatric population
  - c. Sleep Needs in the geriatric population
7. Endocrine/Protection
  - a. Wound Assessment
  - b. Braden Scale
  - c. Chain of Infection
    - i. Blood borne pathogens

- 8. Psychosocial
  - a. Self-Concept
    - i. Spiritual
  - b. Role Function/Interdependence
  - c. Erikson
    - i. Changes in the adult role over time
- C. Critical Thinking
  - 1. Apply to Nursing Process
- D. Communication as a Nursing Skill
  - 1. Nurse as a Communicator
  - 2. Communication Process
  - 3. Social vs Therapeutic Communication
  - 4. Stages of Interviews, Interviewing Techniques
  - 5. Formal interviewing
  - 6. Therapeutic and Non-therapeutic Communication Techniques
  - 7. Process Recordings
  - 8. Language Awareness
  - 9. Nonverbal Communication
  - 10. Active Listening
  - 11. Assessment of Nurse Communication: Values, Attitudes, Perceptions, Prejudice, Culture
  - 12. Communicating with Elderly Clients
- E. Cultural Diversity
  - 1. Culture related to Communication Barriers
  - 2. Special Problems in establishing trust
  - 3. Differences of Verbal and Nonverbal Language among cultures
  - 4. Expression of Feelings, Privacy, Disclosure,
  - 5. Time and space variances.
  - 6. Values
  - 7. Prejudices
  - 8. Perception, stereotypes, discrimination
  - 9. Cultural and ethnic health practice variables
- F. Basic Nursing Care of select patient conditions:
  - 1. Cardiovascular Mode
    - a. Hypertension
  - 2. Respiratory Mode
    - a. Pneumonia
  - 3. Endocrine/Protective Mode
    - a. Pressure Ulcers
  - 4. Ingestion and Elimination
    - a. Incontinence
    - b. Diarrhea
    - c. Constipation
    - d. Urinary Tract Infection
  - 4. Exercise and Rest Mode
    - a. Degenerative Joint Disease
- G. Pharmacology
  - 1. Introduction to generic concepts

## H. Geriatrics

### 1. Age-Related Changes

#### a. Physical Assessment

#### b. Biologic

##### i. Sleep

##### ii. Nutrition

##### iii. Elimination

##### iv. Sensory

##### v. Mobility

## Skills Content:

A. Handwashing, Medical Asepsis

B. Applying Mask, Gloves, Gown

C. Standard Precautions

D. Instructing Patient to Deep Breathe and Cough

E. Instructing Patient to Use a Spirometer

F. Collecting a Sputum Specimen

G. Patient Safety, Siderails

H. Body Mechanics

I. Patient Position changes in bed

J. Dangling

K. Logrolling

L. Patient Transfers

1. Stretcher Transfer

2. Transfer to a Wheelchair

M. Making the Unoccupied Bed

N. Making the Occupied Bed

O. Making the Occupied Bed

P. Making a Surgical Bed

Q. Applying Restraints

R. Assisting the Adult to Eat

S. Bed Bath: Complete

T. Mouth Care for the Conscious & Unconscious Patient

U.. Care of Dentures

V. Assisting a Patient on a Bedpan

W. Changing Gown for Patient with IV

X. Applying and Removing Antiembolic Stockings

Y. Vital Signs

1. Temperature Routes

2. Radial and Apical Pulse

3. Blood pressure

Z.. Measurement and Recording TPR, BP

A@. Measurement of Fluid Intake and Output

AA. Range of Motion

AB. \*Using the Hoyer Lift or Bedscale

AC. \*Collection of Specimens (urine and stool)

AD. Mathematics for Medication Exam: Decimals, Conversions

AE. Documentation: graphics, flow sheet

AF. Medical Records

AG. Abbreviations, Medical Terminology

AH. \*Nursing Care Plan Practical Application

1. Clinical Settings: Acute Care Hospital

AI. Basic Head-to-Toe Assessment

1. Physical assessment of the geriatric patient

2. Quick head to toe assessment

3. Lung Assessment

4. Cardiac Assessment

a. CMST

5. Integument Assessment

6. Abdominal Assessment

7. Basic neurologic assessment

a. Reflexes

## NURSING 301 - EVALUATION OF STUDENT ACCOMPLISHMENT

Welcome to your first nursing class!

I. To pass the course, the student must:

1. Attain a cumulative average of 74% or above on theory exams.
2. Complete Bed Number 10 Assignment at 74% or above.
3. Receive a satisfactory clinical grade on all critical elements of the clinical evaluation tool by the final evaluation.
4. Receive a satisfactory rating in all skills lab requirements.
5. Pass the math exam according to the Math Contract.
6. Obtain a satisfactory rating on four nursing care plans, which include Exercise & Rest and Psychosocial Nursing Care Plans.
7. Receive a satisfactory on the Abbreviation Test. (at 74% or above).

If the student successfully completes all of the above criteria, he/she will receive a letter grade according to the Theory average attained. If the student passes Theory but does not meet any one of the remaining criteria, a grade of D will be assigned.

Students must attain a minimum average of 74% on required theory exams to pass the course.

Theory Grade will be based on the following:

Four Theory Exams-worth 90% of total theory grade

Each exam weighted as follows:

-Exam 1- 24%

-Exam 2- 24%

-Exam 3- 24%

-Exam 4- 18%

Bed Number 10- 7%

Abbreviation Test – 3%

II. Class attendance and participation in discussion is expected. Clinical attendance is mandatory – skills lab is part of clinical experiences. Read assignments and complete objectives before class. Make notes of any questions that arise when reading, then ask in class. Come to class ready with your questions and ready to share your views.

If, at any time during the course, a student does not understand the content of a lecture or the readings, contact the instructor for clarification. Feedback for the instructor will be appreciated at anytime.

If for some unexpected reason a student cannot take the exam when scheduled, the following steps are to be taken in order to obtain credit for the exam. It is expected that the situation is a true emergency and would occur only under very extreme circumstances.

1. Call instructor on morning of the exam explaining your need.
2. Make arrangements for the exam to be taken the first day back to school (class or clinical).
3. If the above procedure is not followed, a grade of zero will be recorded for the exam in question, no make-up will be given.

All course work (skills check-offs and course assignments) must be completed satisfactorily by the course's official ending date in order to progress to N 302.

III. Full attendance in the clinical area is expected in order for objectives to be met and to provide adequate opportunities for evaluation. In the unavoidable event that the student must miss clinical time, the student must obtain permission for this absence by contacting the assigned clinical instructor. Further, it is the responsibility of the student to plan for compensatory activities with the instructor before returning to the clinical area. Absences may result in a clinical grade of unsatisfactory for the course. Absences in any clinical rotation of more than 1 day will prompt the instructor to review clinical progress with the student. Repeated absences across courses will be reviewed by the total faculty and specific attendance expectations will be set. **Skills lab sessions are considered clinical experiences, therefore the above mentioned applies to them also.**

Students must have evidence of required current immunizations and proof of immunities, satisfactory health as certified by a MD, and CPR prior to hospital orientation. Failure to meet the health requirements will result in student being barred from clinical setting. Pregnant students are required to inform their clinical instructor.

The course instructor has the prerogative to reassign students to skills and clinical group.

#### LIST OF REQUIRED TEXTS (see Website)

**Ackley, B. and Ladwig, G,** (2008). Nursing diagnosis handbook, A guide to planning care. 8<sup>th</sup> ed. St. Louis: Mosby. (Elsevier website)

**Alfaro-LeFevre, R.** (2009). Critical thinking and clinical judgment. 4<sup>th</sup> ed. St. Louis: Saunders Mosby.

**Anderson,** Editor (2009). Mosby’s medical, nursing, and allied health dictionary (8<sup>th</sup> ed.), St. Louis: Mosby (Elsevier website)

**Baier & Schomaker,** (1986). Bed number ten. Florida: CRC Press Inc. ISBN: 0-8493-4270-8 (bookstore)

**D’Avanzo, C. and Geissler, E.** (2008) Cultural health assessment, 4th ed. St. Louis: Mosby. (Elsevier website)

**Ebersole, P.** (2008). Toward healthy aging. 7<sup>th</sup> ed. St. Louis: Mosby (Elsevier website)

**Elkin, Perry and Potter.** (2007) Nursing interventions and clinical skills, 4th ed. St. Louis: Mosby (Elsevier website)

**Ignatavicius and Workman,** (2010). Medical-surgical nursing, patient centered collaborative Care 6<sup>th</sup>. ed. Philadelphia: W. B. Saunders Company. (Virtual Clinic Excursions) (Elsevier Website)

**Jarvis** (2008). Physical examination and health assessment. 5<sup>th</sup> ed. St. Louis: Saunders (Elsevier website)

**Kee and Marshall** (2009) Drug Calculations Clinical Calculations, 6<sup>th</sup> edition. (Elsevier website)

**Lilley, Harrington and Snyder** (2007). Pharmacology and the nursing process. 5<sup>th</sup> ed.(Elsevier website)

**McCance** (2006) Pathophysiology—biological basis of disease. 5th ed. St. Louis: Mosby (Elsevier website)

**Potter & Perry** (2009) Fundamentals of nursing. 7<sup>th</sup> ed. St. Louis: Mosby. wrapped with Nursing Skills CD ROM set. (Elsevier website)

**Preusser, B.** Critical thinking cases in nursing. 4th ed. St. Louis: Mosby (Elsevier website)

**Nursing N 301 Theory and Communication Syllabus** – online at Ohlone Nursing RN home page look under course documents listed on left hand side of page – **Student download**

**Nursing Student Handbook** - online on Nursing RN Home Page (Ohlone), left side of web page – **Student download**

#### REQUIRED SPECIAL MATERIALS

Patches/Name Tags	\$ 15	Nursing uniform, shoes, and lab coat	\$175
Watch with second hand or digital watch	\$ 20	Stethoscope, pen light, scissors.	\$ 75
Skills Kit (special order)	\$ 95	Approximate cost of all texts/supplies:	<u>\$1000</u>

## **N 301 ASSIGNMENTS**

### **Bed Number Ten**

Read Bed Number Ten by Sue Baier. Identify five therapeutic, five non-therapeutic and five social communications used by the health care team member. For each type of communication, state the situation, write a direct quote, and include the page number. Further evaluate the therapeutic and non-therapeutic communications by using the lists “Techniques of Therapeutic Communication” and “Techniques of non-Therapeutic Communication” found in syllabus under Class #4 – **use this list when labeling, identifying techniques (pgs 40-49)**. See sample interactions in the Syllabus, p. 13.

Read p. 12 of the syllabus for further directions and grading criteria. See calendar for due date. Bed Number Ten consists of 7% of your final grade.

### **Nursing Care Plans (Weekly)**

Refer to Skills Lab/Clinical Syllabus for **clinical prep guidelines**.

1. Prep for your assigned patient on Wednesday afternoons by reading patient’s history, Kardex/Patient Care Activity Report (PCAR), physician’s progress notes.
2. Exercise and rest care plan. Complete assessment with patient. Identify two nursing diagnoses involving exercise and rest. One nursing diagnosis on another aspect of patient’s needs. Total nursing diagnoses: three. See **calendar** for due date.
3. Psychosocial care plan. Complete assessment with patient. Identify at least one nursing diagnosis involving the psychosocial mode and two on other aspects of the patient’s needs. Total nursing diagnoses: three. See **calendar** for due date.

**Math Exam: SEE Skills Lab Syllabus:** Review math contract for scoring criteria. Administered during skills lab time – see calendar. Prep on own time. Follows sample test in syllabus. Actual exam is 30 questions. Review Chapters 1, 2 in Kee and Marshall. Resources in skills lab – Math CDs. Math faculty available for tutoring– Mylene Pelimiano ([mpelimiano@ohlone.edu](mailto:mpelimiano@ohlone.edu)) and Victoria Loukianoff ([vloukianoff@ohlone.edu](mailto:vloukianoff@ohlone.edu)) – contact via email to set up appt.

**Abbreviation Test:** A 100 question exam on abbreviations. Answers must be spelled correctly for credit. Students may be given the abbreviation and be expected to provide the correct term and/or be given the term and be expected to provide the abbreviation. Review the **list in skills portion** of syllabus including do not use abbreviation list. 3% of theory grade.

## CRITERIA FOR BED 10 ASSIGNMENT

(Students may not utilize any of the communication examples from the syllabus sample in their assignment.)

**Turn in this criteria sheet with your assignment.**

**Assignment is due at the BEGINNING of the class on the designated due date. No late papers will be accepted.**

Directions for assignment:

State the situation, write a direct quote, and include the page number from Bed number ten. Identify and then label the communication technique used by the health care team members as therapeutic, non-therapeutic or social. Further evaluate the therapeutic and non-therapeutic communications by using the lists “Techniques of Therapeutic Communication” and “Techniques of Non-therapeutic Communication” found in the syllabus (pp. 40-49) to guide you in this process. Be prepared to discuss this assignment and your personal reactions to the book in class.

All communication techniques identified need to occur between **health professionals and the patient**, including social communication examples. When stating the situations, use a direct quote, include page number and a brief description of the scenario in which the quote occurred. When identifying the type of communication style, utilize techniques identified on the tables in the syllabus, include your rationale for your choice. Identify a variety of communication techniques—do not use any one technique more than once. See example on next page. (The sample quotes may not be utilized in your paper.)

Students will also identify one example of caring behavior and one example of non-caring behavior by a nurse. Include page number and your rationale why behavior was caring or non-caring.

Student Name: \_\_\_\_\_

Correct labeling of communication type (20 pts)	_____
Description of each situation (10 pts)	_____
Identification of type of techniques delineated in syllabus (pp 40-49) (30 pts)	_____
Rationale clearly delineated for labeling of technique (30 pts)	_____
Identification of one example of caring behavior (5 pts)	_____
Identification of one example of non-caring behavior (5 pts)	_____

## SAMPLE—BED 10 ASSIGNMENT

(Students may not utilize any of these communication examples in their assignment.)

### **Therapeutic Communication:**

**Technique:** Reassuring

**Interaction:** “All you have to do is blink when you want me to put you back on.,” and “I would like to go five minutes if you can, but you don’t have to.” p. 173

**Background:** Gary Stiller came in during a visit with friends wanting to increase Sue’s time off the machine. She had her friend, Bess, there for support and two nurses, Harriet and Kay. Sue was unsure, but decided to go ahead with the challenge.

**Reason:** This showed the hospital personnel encouraging the patient to further their progress, but not pushing and insisting that it be done. They gave a positive suggestion if the patient becomes uncomfortable and needs to stop.

### **Non-Therapeutic Communication:**

**Technique:** Disagreeing

**Interaction:** She just laughed. “Sue, you couldn’t need a bedpan.” p. 50

**Background:** In ICU, Sue’s nurse that day was Sandra. She was not a nurse that Sue liked. The day before, Sandra gave Sue an enema and it didn’t begin to work until the next day. When Sue tried to tell Sandra what she needed, the nurse didn’t listen and walked away. She said that she would return in a minute. When the nurse returned, there was a messy bed and a look of betrayal given by Sue.

**Reason:** The nurse didn’t listen to the patient when the patient tried to tell her what he needed. They assumed that what was needed was *not really* necessary.

### **Social Communication:**

**Interaction:** “I’ve parked Rob and our bags of dirty clothes over at the laundromat again.” p. 70

**Background:** Ginnie, a nurse, worked Sunday nights and was newly married. Sue felt bad that she had to come to work and not be with her new husband on Sunday nights.

**Reason:** The nurse did not need to tell the patient about her personal life or how she and her husband couldn’t be together because of work. This worried the patient unnecessarily.

Ohlone College  
Nursing 301

FOCUS: What Is Nursing?  
**Class One**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Chapters 1, 4, 8.
2. Read Handouts.
3. Complete “Student Survey and Self Assessment”. Hand in at beginning of class.

STUDENT OBJECTIVES:

1. Discuss the historical development of professional nursing.
2. Formulate a definition of nursing today as an evolving profession.
3. Differentiate between the ANA definition of nursing, the Ohlone College Philosophy of Nursing and the Roy Theory of Nursing Practice.
4. State the importance of “Standards of Nursing” and the “Nurse Practice Act”.
5. Identify the “Caring” behaviors of a nurse.
6. Give three examples that illustrate “patient/client advocate” as a nursing role.
7. Assess the differences in the nurse’s role in various healthcare settings.
8. Evaluate present day influences on nursing practice.

## Ohlone College Nursing Program Philosophy

The nursing faculty plans and implements a program of study organized around Roy's Adaptation Model of nursing practice and derived from the following beliefs:

### **Humankind**

Every human being is a unique person with complex biologic, psychosocial, cultural, and spiritual components in constant mutual interaction with their environment. The continuum between health and illness can be seen as the ability to adapt to a changing environment. An adaptive response promotes integration of life processes to work as a whole to meet human needs. An ineffective adaptation response fails to contribute to this integration, resulting in unmet human goals.

### **Health and Illness**

Health is a process of becoming integrated and whole that reflects the positive interaction of the person and environment. Health is a dynamic state that continually changes as an individual and family interacts with their internal and external environments. Health in itself is not negative or positive, but a reflection of the individual's/family's physical, emotional, intellectual, social, developmental, and spiritual well being. Illness is a state of imbalance in human environmental integration. The most positive state of health is the maximum level of adaptation at any given time and place. Many variables affect the level of health, including genetics, age, life-style, perception of health and illness, health promotion activities, values, beliefs, and culture.

### **Nursing**

Based on the above definitions of health and illness, the nurse's role is one of identifying adaptive and ineffective responses to illness, and helping to expand adaptive abilities by enhancing human and environmental transformation. We believe that optimum health is a right for all people and not a privilege. This nation's most valuable resource is the health of its people. We advocate equal access to health care, and encourage individuals/families to make autonomous and informed health care decisions.

Nurses have a responsibility to be knowledgeable about theories, principles, and applications of biological and social sciences. The nurse uses this knowledge to promote the health of individuals/families/groups, or when necessary, to dignify death and ease the dying process. Nursing is practiced through the framework of the nursing process. The nurse uses the following skills and resources in nursing practice which are identified as program themes: critical thinking, communication, management, teaching, professionalism, and community. Nurses must interact with health professionals in a collaborative effort to provide effective health care. Patient advocacy is central to the nursing role. Nurses are obligated to behave in a professional, ethical manner. The curriculum threads include: pain management, pharmacology, nutrition, human maturation, cultural diversity, and caring.

We believe human beings are integral with their physical and social environments, existing in a vast network of interdependent relationships within our Earth community. The health of individuals is directly related to the health of the various groups and communities upon which they depend and to which they belong. The future well-being of humankind in environmental interactions approaches as a defining moment for nursing. The role of the nurse is to promote health in individual, community, and environmental contexts, since these contexts must be addressed together in creating a healthy future.

## **Associate Degree Nursing Practice**

The purpose of the nursing program at Ohlone College is to prepare beginning practitioners who will function in the common domain of registered nurse practice after licensure. Graduates are prepared to care for a group of clients within a variety of structured health care settings, to collaborate with other health professionals, and to carry out independent, dependent, and interdependent nursing measures. Graduates are also prepared to continue learning through experience and education. In addition, the graduate is expected to participate in the development of the profession through engagement in the mentoring role and through affiliation with professional organizations. The faculty supports education and practice in nursing at its multiple levels. The faculty recognize that the scope of practice for all levels of nursing is influenced by a variety of factors, both within and external to the nursing profession.

## **Nursing Education**

Nursing education is the process by which students are socialized into the profession of nursing. We believe the educational experience is stimulating and desirable, and that it supports growth in individuals. We believe nursing education is obligated to base curriculum decisions on realistic conceptions of nursing roles and practice as a multi-level occupation. At the associate degree level, the curriculum must provide students with skills and knowledge utilized in the common domain of nursing practice and when possible derived from evidence based research. Prior learning achieved by some students is acknowledged through formal procedures. The Nursing Faculty encourages life-long learning in nursing and recognize that the Associate degree can be an end point for formal nursing education or can be a bridge for advanced practice.

## **Teaching and Learning**

Learning is the process by which behavior is changed as the individual acquires, retains, and applies knowledge, attitudes, skills, or modes of thought. The ultimate responsibility for learning rests with the learner. A person learns when a need or problem is encountered. This need motivates the search for information as an individual progresses toward a goal or problem solution. A by-product is the reinforcement of desire for further learning and an increased belief in one's ability to continue to be successful in learning situations.

Human beings have a natural potential for learning. This desire for expansion of knowledge and experience can be achieved through and built upon the student's previous experience, actively involving the learner in the process, and thereby moving from the familiar to the unfamiliar. Significant learning takes place when the subject matter is perceived by the adult learner as having meaning for one's own purpose. Learning is acquired through the repetition and reinforcement of successful behaviors which contributes to desired behavior patterns. A variety of opportunities for application of knowledge encourages the learner to develop and apply critical thinking skills

Teaching is the facilitation of learning and requires valuing the student as a person and understanding the student's learning needs. Learning is facilitated by timely feedback which is understandable to the learner. Lack of feedback prevents progress and leads to frustration. Essential to the student's ability to incorporate constructive feedback (i.e., to make necessary changes in behavior) is a clearly understood plan collaboratively developed by learner and teacher to meet the learner's individual learning needs. The plan includes objectives, timelines, and evaluation.

## PATIENT ADVOCACY

### I. Definition

Advocate—One that pleads the cause of another; one that defends or maintains a cause or proposal (Webster, 1981)

### II. Characteristics of Advocacy

- being informed
- taking a side, stand, a position
- helping an individual or group do what they can't do for themselves or assisting them to do in some way.
- acting on what “we ought to do,” the ethical thing.
- going against the status quo at times (rocking the boat)
- protecting the patient
- protecting the patient's rights
- doing what needs to be done
- pressing the patient's case in the strongest possible manner
- promoting informed consent
- planning for appropriate referral to other health professionals or agencies

### III. Philosophy:

The nursing faculty view advocacy as a fundamental principle on which nursing practice is based. Nursing students are taught to apply the principle of advocacy to many aspects of the nurses' role. Some of those aspects include teaching, supporting, counseling and communicating. Advocacy also involve doing for patients what they are unable to do for themselves, informing them of their rights, supporting the patient's right to make decisions related to care and reporting concerns regarding quality of care to the appropriate person. The faculty believes that nurses act as patient advocates at many levels of practice and in many settings.

## STUDENT SURVEY AND SELF-ASSESSMENT

**Student Objective:** Be able to state personal goals, strengths, areas to improve, and expectations of instructors.

Reaching your goal of becoming a nurse will demand a combined effort from you and your instructors. Getting to know each other is important; the following survey/assessment will get things off to a good start. Please complete as thoroughly as possible. It will be shared with your clinical instructors.

1. Name \_\_\_\_\_ Age \_\_\_\_\_
  
2. State your reason for choosing nursing as a career \_\_\_\_\_
  
3. Have you attended college previous to entering this nursing program? \_\_\_\_\_
  - a. If yes, what subjects have you studied? \_\_\_\_\_
  
  - b. Do you hold a degree in another field? \_\_\_\_\_  
If yes, what specific degree(s)? \_\_\_\_\_
  
4. Have you worked for pay as a Nurse Aid? \_\_\_\_\_ LVN? \_\_\_\_\_  
If yes?
  - a. In what agency(ies)? \_\_\_\_\_
  
  - b. Part-time? \_\_\_\_\_ Full-time? \_\_\_\_\_
  
  - c. Approximate length of employment? \_\_\_\_\_
  
  - d. On what shift? \_\_\_\_\_
  
5. Are you presently employed? If yes, where are you employed and in what capacity? \_\_\_\_\_

Student Survey and Self-Assessment (continued)

6. Do you speak a language other than English? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, what specific Language(s):

7. State your expectations for this program.

8. State your future plans in nursing.

9. State your ambitions, ideals, and outside interests.

10. Describe your home background and family relationships (attitude of family toward nursing as a career choice; economic situation; family responsibilities; if married, how many children, etc.).

11. Self-Evaluation: Identify your strengths and areas you want to improve.

12. Describe ways an instructor would be most helpful to you?

13. Are there any questions you would like to ask about your instructor (for example, philosophy of teaching, strengths, weaknesses) which might make the student-instructor relationship more productive and meaningful?

Ohlone College  
Nursing 301

FOCUS: **Class One** Healthcare Delivery System.

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Ch. 2 & 23 (pages 325-327, 329, 333-334)
2. Review: <http://www.hcqualitycommission.gov/cborr/>
3. Review Board of Registered Nursing Regulations <http://www.rn.ca.gov/regulations/index.shtml>
4. Read Ohlone College Nursing Student Handbook- Pages 47-49
5. Read Board of Registered Nursing Handout (to be given out before class).

STUDENT OBJECTIVES:

1. List the major occurrences in the evolution of the health care system.
2. Discuss the principal factors influencing health care reform.
3. Differentiate between the levels of health care: preventative, primary, secondary, tertiary, restorative and continuing care.
4. Compare and contrast the financing of health care services: Private Insurance, Managed Care Plans, Long Term Care Insurance, Medicare and Medical.
5. Discuss current health care issues confronting the health care provider.
6. Define Health Insurance Portability and Accountability Act (HIPAA) and how it affects communication between health care providers.
7. List five "Patient Rights" that affect nursing care.
8. Describe how patient's rights and responsibilities are protected in health care using Advanced Directives
  - A) Patient Self-Determination Act (PSDA)
    - i. Living Will
    - ii. Durable Power of Attorney for Health Care
9. Summarize the legal responsibilities of the college, the hospital, the nursing instructor, and the student nurse in the delivery of nursing care to a patient.
10. Describe the guidelines for nursing practice
  - a. Standards of Care
    - i. California State Board of Nursing
    - ii. The Joint Commission on Accreditation of Hospitals (JCAHO)
    - iii. Hospital Policies & Procedures
    - iv. American Nurses Association

OHLONE COLLEGE  
NURSING 301

FOCUS: Overview of Community-Based Nursing  
**Class 2**

REQUIRED PREPARATION:

Read Porter and Perry. Fundamentals of Nursing, Chapter 3.

STUDENT OBJECTIVES:

1. Describe the factors that define community.
2. Compare and contrast community based nursing, community health nursing and acute care nursing.
3. Describe major issues leading to the development of community based nursing.
4. Discuss the current reimbursement system for health care and how it has affected nursing practice.
5. Describe the philosophy and components of community based nursing.
6. Summarize the competencies the community based nurse must demonstrate in order to effectively assist clients with their health care needs in the community.
7. Analyze the challenges community based nurses face in developing and implementing effective interventions for vulnerable populations.
8. Discuss how culture impacts community based care.

OHLONE COLLEGE  
NURSING 301

FOCUS: Health Illness Continuum  
**Class 2**

REQUIRED PREPARATION:

Read Potter & Perry, Fundamentals of Nursing, Chapter 6.

STUDENT OBJECTIVES:

1. Assess your own philosophy of man, life, health, and illness.
2. Define and give examples of the following concepts according to the Adaptation Nursing Theory:  
(See Adaptation Nursing Glossary.)
  - Health
  - Illness
  - Health-illness continuum
  - High-level wellness
3. Differentiate between disease and illness.
4. Analyze cultural factors influencing health beliefs and practices and illness behavior.
5. Describe health-promotion and illness-prevention activities.
6. Define and give examples of types of risk factors across the lifespan illustrating how culture might impact these factors.
7. Illustrate the five stages of illness behavior through discussion of a personal health problem.
8. Distinguish "sick role" behavior in selected situations.
9. Describe the effects of illness on the patient and his family.

OHLONE COLLEGE  
NURSING 301

FOCUS: Health Promotion and Disease Prevention, Community Focus  
**Class 2**

REQUIRED PREPARATION:

1. Potter & Perry, ch. 6 **and** p.1086
2. Review Healthy People 2010 Document @ <http://www.health.gov/healthypeople>

STUDENT OBJECTIVES:

1. Relate the two goals of *Healthy People 2010* to community-based nursing.
2. Choose a priority or focus area from *Healthy People 2010*, discuss current issues with a classmate and recommend strategies for health improvement.
3. Determine some client needs in your community which a nurse could be an advocate.
4. Utilizing the three levels of prevention, identify strategies for emergency preparedness within a community.

OHLONE COLLEGE  
NURSING 301

FOCUS: Nurse as a Communicator  
**Class 3**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Chapter 24.

STUDENT OBJECTIVES:

1. Discuss the importance of communication to nursing practice.
2. Define the role of communication in community-based nursing.
3. Describe the goal and process of communication.
4. Examine the characteristics of an effective communicator.
5. Illustrate the basic components of the interpersonal communication process model.
6. Differentiate between one-way (no feedback) and two-way (with feedback) communication.
7. Discuss factors influencing communication.
8. Discuss nursing skills and competencies in communication used by the nurse in the care of the individual and family.
9. Examine the impact of culture on communication.

OHLONE COLLEGE  
NURSING 301  
COMMUNICATION IS A DYNAMIC PROCESS

Goal: Shared understandings; The message given is the message received.

Types: Effective - Therapeutic, mutually understood, enhances growth, receiver interprets the sender's message the way the sender intended it.

Ineffective- Non-therapeutic, some part or all is not understood  
Does not hurt patient, but is not effective.  
Hinders or blocks communication.  
i.e., It's time we took our bath.

What Makes A Communicator Effective?

Effective professional interpersonal communication depends on the ability to:

- a. Understand a mutual language - make the message appropriate to the receiver's frame of reference.
- b. Decode NON VERBAL behaviors - make your verbal and nonverbal messages congruent.
- c. Reduce potential barriers of misperception, bias, and prejudice.

Be aware of the impact of your own messages (verbal and non-verbal) on the feelings and behavior of the patient and conversely, how your responses and behaviors as a nurse are influenced by the style and content of messages from the patient.

- d. Clearly "own" your messages by using first person singular pronouns: "I", "My".
- e. Make your messages clear, complete, and specific, yet brief. Examples of what not to do - The following quotes were taken from letters to a welfare department in application for support:

"I cannot get sick pay. I have 6 children, can you tell me why?"

"In accordance with your instructions, I have given birth to twins in the enclosed envelope".

"You have changed my little boy to a girl. Will this make a difference?"

- f. Provide messages that are relevant to a person's interests and concerns and timed appropriately.
- g. Actively engage in listening.
- h. Ask for feedback concerning the way your messages are being received.  
Helping locate and address areas of confusion, concern & misunderstanding.
- i. Be assertive.
- j. Be credible

OHLONE COLLEGE  
NURSING 301

FOCUS: Social vs. Therapeutic Communication

**Class 3**

\* Bring Bed Number Ten to class

REQUIRED PREPARATION:

1. Read syllabus handouts
2. Read Elkin, Perry & Potter, Chapter 2, Introduction and Skill 2.1.
3. Bensing, K. (2007, July 2). Within boundaries: Professionals walk a thin line to maintain therapeutic relationships with patients. *Advance for Nurses, Northern CA and NV*. 15-19. (in web ct).
4. Stiles, K. A. (1997, April). Being there: The healing power of presence. *Alternative and Complementary Therapies*, 133-140. (in web ct)

STUDENT OBJECTIVES:

1. Define and give examples of social and therapeutic communication.
2. Compare and contrast characteristics of social and therapeutic communication.
3. Determine guidelines for therapeutic communication.
4. Compare and contrast different types of therapeutic presence.
5. Differentiate between appropriate and inappropriate use of self-disclosure as an interpersonal communication technique personally and professionally.
6. Discuss ways to refocus the communication when the patient asks you a personal question.
7. Given a clinical situation, select appropriate and inappropriate social communication.

OHLONE COLLEGE

NURSING 301

SOCIAL COMMUNICATION

THERAPEUTIC COMMUNICATION

<p>DEFINITION:</p> <p>An interaction between two persons primarily for reasons of pleasure or companionship.</p>	<p>A single or short-term interaction engaged in by a nurse and a particular patient, for the purpose of assisting the patient to move in the direction of improved (mental or physical) health.</p>
<p>CHARACTERISTICS:</p> <p>A. Goals often unstated: usually goal is personal pleasure or companionship.</p>	<p>A. Interaction is goal-directed for therapeutic ends for the patient.</p> <ol style="list-style-type: none"><li>1. Usually short-term goals.</li><li>2. Involves problems currently causing difficulties in daily life.</li></ol>
<p>B. Relationship develops spontaneously with no conscious plan.</p>	<p>B. Relationship is carefully developed purposeful; nurse controls conditions for patient contact; i.e., setting time, duration, purpose.</p>
<p>C. The interaction involves meeting mutual needs and mutual satisfaction.</p>	<p>C. Focus of interaction is on physical and emotional needs of the patient. (It is always patient-centered.)</p>
<p>D. May terminate if one person becomes disinterested. Movement is free; one can move in and out at will.</p>	<p>D. Responsibility to stay and help. (Even in anxiety-provoking situations.)</p>
<p>E. Decisions, if any, often based on intuitions and hunches.</p>	<p>E. Decisions based on sound use of a problem-solving approach, the nursing process.</p>

OHLONE COLLEGE  
NURSING 301

GUIDELINES FOR PROMOTING THERAPEUTIC INTERACTION

1. Select a quiet, private area in which to hold interactions. Pull the curtain in a semiprivate room and speak in softer tones if discussing personal material.
2. Provide for comfortable seating arrangements. Make sure both you and the patient are comfortable before beginning the interaction. You may want to sit first.
3. If patient is uncomfortable with the interview, allow him some room for retreat or a way of distancing, but provide an avenue for return.
4. Be aware that behavior usually satisfies several needs at the same time.
5. Keep in mind that when a person is trying to satisfy a need that is of primary importance to him, he may either ignore or fail to recognize that other needs exist.
6. Recognize that a person should be accepted as he is. You must accept that he has strengths and weaknesses, and positive and negative emotions.
7. Observe the patient's behavior. Appearance reflects how a person feels about himself. Emotional states can be determined by observation.
8. Allow a person to proceed at his own pace. The less threatened the person feels, the more quickly rapport can be established.
9. Be consistent when interacting. This facilitates the establishment of security, rapport, and trust in a relationship.
10. Try to keep the patient's anxiety at a minimum. High anxiety decreases one's ability to perceive, and learning is less likely to occur.
11. Explain routines and procedures in terms that a person can understand. A nurse needs to assess a person's level of anxiety and level of understanding, evaluate the influence of the person's past experiences, and explain technical terminology.
12. Offer your patient realistic reassurance. To give false reassurance, or to reassure a patient before a situation has been fully explored, blocks communication.
13. There is always potential for growth from every interaction.

- Don'ts:
1. Pry
  2. Ask questions to satisfy curiosity
  3. Give out personal information
  4. Push for too much too soon

OHLONE COLLEGE  
NURSING 301

FOCUS: Active Listening  
**Class 3**

REQUIRED PREPARATION:

1. Complete exercises in syllabus prior to class.
2. Read Elkin, Perry & Potter, Chapter 2, Skills 2.2 and 2.3.

STUDENT OBJECTIVES:

1. Differentiate between listening and hearing.
2. Identify the components and different levels of listening.
3. Analyze characteristics of active listening.
4. Identify reasons for distorted receipt of messages.
5. Examine ways to improve active listening skills.
6. Differentiate between thoughts and feelings
7. Practice the following techniques used to increase the effectiveness of active listening:  
(do the syllabus exercise)
  - a. reflecting feelings (acknowledging feelings)
  - b. acceptance (use of general leads)
  - c. encouraging evaluation
  - d. helping express thoughts and feeling
  - e. stating observations
  - f. encouraging comparison
  - g. placing events in time or sequence
  - h. exploring
  - i. problem-solving
  - j. verbalizing the implied
8. Illustrate when and how to use open and closed questions effectively.

## ACTIVE LISTENING EXERCISES

### IDENTIFYING FEELINGS

1. A man, age 46 says, "I don't know what to do. My wife is a patient on Ward 3. She's had a gallbladder attack, and I just don't know how to help her." He feels:
2. A female patient, age 8, hospitalized for an appendectomy, says, "I don't want to stay here. I want to go home. Where's my mommy? Please get my mommy." She feels:
3. A female patient, age 25, says, "I didn't have any pain last night. It was the first good night's sleep I had in a week!" She feels:
4. A male patient, age 62, says, "My wife died last week. She died peacefully though. Thank God for small mercies." He feels:
5. A hospitalized patient, age 35, says, "I really don't like to complain, but I wish you wouldn't ask me if I want my bedpan when I have visitors." She feels:
6. A physician says, "What's the matter with her anyway? I rescheduled this patient's appointment and gave up part of my lunch hour to meet her. You'd think she'd have the courtesy to phone if she's not coming!" He feels:

### IDENTIFYING FEELINGS AND CONTENT

1. A hospital patient, age 30, says, "Hey, are there any quiet rooms in this hospital? That patient in the bed next to me was in and out of bed all night. He was noisy and I hardly got any sleep!"  
You feel:  
Because:
2. A female patient, age 47, says, "Do I really need this x-ray? I've heard that too many x-rays can be very dangerous, and I had a chest x-ray only 6 months ago."  
You feel:  
Because:
3. A female patient, age 75, says, "Oh, I feel much better. The medication really helped. You don't know how wonderful it is not to have that pain anymore."  
You feel:  
Because:
4. An expectant father says, "Our first child was retarded. I'd like to have another child, but . . . what if he or she turns out to be retarded as well?"  
You feel:  
Because:

## TECHNIQUES USED IN ACTIVE LISTENING

DIRECTIONS: Match the comments made by the nurse with the therapeutic technique listed:

- |  |                                       |
|--|---------------------------------------|
| A. Encouraging Evaluation              | F. Placing events in time or sequence |
| B. Helping express thoughts & feelings | G. Exploring                          |
| C. Reflecting feelings                 | H. Problem Solving                    |
| D. Stating observations                | I. General Lead (Acceptance)          |
| E. Encouraging comparison              |                                       |

- Situation 1: Patient: "I'm so confused! Everything is happening at once! The labor pains, the water breaking, and diarrhea, too!"  
Nurse: "Can you tell me which of these events happened first?" \_\_\_\_\_
- Situation 2: Patient: "My husband just does not understand me; he never listens."  
Nurse: "Oh?" \_\_\_\_\_
- Situation 3: Patient: "(Behavior) Is lying in bed, face toward the wall. He is grimacing and clutching his right side."  
Nurse: "You seem to be in pain." \_\_\_\_\_
- Situation 4: Patient: "I don't understand this. I seemed to bounce back so much faster the last time I was in the hospital." \_\_\_\_\_  
Nurse: "Can you think of what was different about that hospitalization and now?" \_\_\_\_\_
- Situation 5: Patient: (Behavior) The visitors have all left and the patient is sitting very quietly in the corner of the room.  
Nurse: "How are you feeling now that everyone is gone?" \_\_\_\_\_
- Situation 6: Patient: "I feel so lost and lonely."  
Nurse: "Can you tell me more about that?" \_\_\_\_\_
- Situation 7: Patient Situation: This is the second day after a difficult delivery of a 9 pound baby girl.  
Nurse: "How are you feeling about your progress, now that your labor and delivery are over?" \_\_\_\_\_
- Situation 8: Patient: "What will I do if the test comes out positive?"  
Nurse: "You are worried about the test results . . ." \_\_\_\_\_
- Situation 9: Patient: "I wish my son would come to see me, but I don't think he will."  
Nurse: "What do you think you could do to make that happen?"  
\_\_\_\_\_

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### Exercise 1 in Open-Ended Questions

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Judge each of the following questions. Is it open-ended or closed-ended? When would it be appropriate to ask?

Is 4 o'clock a good time for us to meet?

Do you come here often?

Is the pain in the arm or shoulder?

Is your daughter well?

Doctor, do you think we should ambulate Mr. Jones?

Do you take aspirin for it?

Tell me about your health history.

What are you doing for the headache?

How have you been?

How has your daughter been?

Doctor, what should we do for Mr. Jones?

When can we meet?

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### Exercise 2 in Open-Ended Questions

---

For each of the statements on the left side of the page, think of a more open-ended way to phrase the question.

#### Nurse's Question

#### Open-Ended Alternative

Where is the pain, when does it hurt,  
how bad is it?

Have you been ill this week?

Do you have family, brothers, sisters?

You look blue—are you depressed?

Did you have a good week?

OHLONE COLLEGE  
NURSING 301

FOCUS: Giving and Receiving Feedback

**CLASS #3**

REQUIRED PREPARATION

1. Read Handouts (Syllabus)
2. Read Alfaro-LeFevre, Ch. 6, pp. 206-220, 226-233.

STUDENT OBJECTIVES:

1. Describe 5 appropriate responses to dealing with complaints.
1. Identify strategies for receiving both constructive and non-constructive criticism.
2. Identify strategies for giving constructive feedback.
3. List 6 types of mistakes, how to prevent them, and how to handle them should they occur.
4. Examine several factors which may influence feedback, both negative and positive.
5. Practice giving and receiving feedback in a group situation.
6. Describe verbal and non-verbal characteristics of assertive, non-assertive, and aggressive behavior.

OHLONE COLLEGE  
NURSING 301

GIVING AND RECEIVING FEEDBACK- Class 3

"Feedback" is a way of helping another person to consider changing his behavior. It is communication to a person (or a group) which gives that person indication about how he affects others.

Some criteria for useful feedback:

1. It is descriptive rather than evaluative. By describing one's own reaction, it leaves the individual free to use it or not to use it as he sees fit. By avoiding evaluative language, it reduces the need for the individual to react defensively.
2. It is specific rather than general... To be told that one is "dominating" will probably not be as useful as to be told that "just now when we were deciding the issue you did not listen to what others said, and I felt forced to accept your arguments or face attack from you."
3. It takes into account the needs of both the receiver and the giver of feedback. Feedback can be destructive when it serves only one's own needs and fails to consider the needs of the person on the receiving end.
4. It is directed toward behavior which the receiver can do something about. Frustration is only increased when a person is reminded of some shortcoming over which he has no control.
5. It is solicited, rather than imposed. Feedback is most useful when the receiver himself has formulated the kind of question which those observing him can answer.
6. It is well-timed. In general, feedback is most useful at the earliest opportunity after the given behavior (depending, of course on the person's readiness to hear it, support available from others, etc.).
7. It is checked to ensure clear communication. One way of doing this is to have the receiver try to rephrase the feedback he has received to see if it corresponds to what the sender has in mind.
8. When feedback is given in a training group, both giver and receiver have opportunity to check with others in the group the accuracy of the feedback. Is this one man's impression or an impression shared by others?

Feedback, then, is a way of giving help; it is a corrective mechanism for the individual who wants to learn how well his behavior matches his intentions, and it is a means for establishing one's identity -- for answering Who am I?

## KNOWING WHAT TO SAY OR DO

### Giving Positive Feedback

- Recognize someone for things done right and done well.
- Accentuate the positive!

You can show appreciation for work well done in a great variety of ways. Here are some examples:

- Courtesy – sincere thank yous
- Praise – describe specific behaviors
- Verbal expressions – “Good job,” “Excellent idea,” “Terrific,” “You are improving,” “This is the best yet” (Traditional; may be considered evaluative.)
- Nonverbal expressions – eye contact, smiling, nodding agreement, pat on the back, signaling okay, thumbs up, clapping hands
- Empathetic listening
- Taking actions:
  - Ask an employee for advice.
  - Ask an employee to demonstrate the correct performance or procedure.
  - Ask an employee to serve as chairperson of a committee.
  - Compliment the work of another person publicly.
  - Display an employee’s work.
  - Recognize the work of an employee at a staff meeting.
  - Ask an employee to explain a complex procedure.
  - Establish a bulletin board – “Good News of the Day.”

### Giving Constructive Feedback

1. Stick to facts: describe recent behavior factually  
Avoid interpretations or inferences – “you’re really disorganized”  
Avoid evaluations – “That was good/bad”  
Avoid labels – “sensitive,” “paranoid,” “touchy”  
Describe behavior and let other person draw conclusion
2. Give details: be specific, clear, and exact
3. Be realistic:
  - Focus on behavior, not personality, attitudes, or personal characteristics.
  - Direct feedback toward behavior a person can do something about.
4. Consider timing:
  - Give feedback in a private setting as soon as possible after the event.
  - No garbage dumping.
5. Check for accuracy:
  - Was the message clear?
  - Was the message given, the message received?
6. Note that agreement by both parties before the conversation ends is not necessary.

OHLONE COLLEGE  
NURSING 301

FOCUS: Barriers to Effective Communication  
Communicating with the Angry, Demanding or Manipulative Patient  
**Class 4**

REQUIRE PREPARATION:

1. Read Elkin, Perry & Potter, Chapter 2, Skills 2.5, 2/6.
2. Flores, N. (2008, May). Dealing with an angry patient. *Nursing 2008*, 30-31. (See instructions on web Ct how to access article).
3. Pagana, K. D. (2009, July). Mind your manners...multiculturally. *Advance for Nurses*. 24-29. Available on web ct.

STUDENT OBJECTIVES:

1. List the risk factors for aggression in a patient, including age-related changes.
2. Recognize how cultural differences can create communication barriers.
3. Identify the signs and symptoms of the three stages of aggressive behavior.
4. Identify communication techniques that may be useful in diffusing each stage of aggression.
5. List 5 safety tips nurses can use with a potentially violent patient.
6. Discuss therapeutic communication strategies to use with the demanding or manipulative patient.

OHLONE COLLEGE  
NURSING 301

FOCUS: Non Therapeutic Techniques  
**Class 4**

\* Bring syllabus non-therapeutic techniques to class.

REQUIRED PREPARATION:

1. Read Potter and Perry, Fundamentals of Nursing. Chapter 24 (pp 355-356).
2. Read syllabus pp. 46-49 (non-therapeutic techniques).
3. Schenk, P. W. (2008, Mar). 'Just breathe normally': Word choices that trigger nocebo responses in patients. *American Journal of Nursing*, (108)3, 52-57. (on web ct)

STUDENT OBJECTIVES:

1. Differentiate between therapeutic and non-therapeutic communication.
2. Propose methods for changing the following non-therapeutic communication techniques into therapeutic techniques:

false reassurance  
giving advice  
judgmental statements  
giving unnecessary approval  
expressing undue disapproval  
agreeing  
disagreeing  
being too strongly opinionated  
asking for approval  
multiple questions  
over use of closed questions  
leading statements  
blaming  
why questions  
you statements  
testing  
defending  
placating  
patronizing  
moralizing

3. Define placebo communication.
4. List 5 placebo word choices to avoid in communicating with patients.

OHLONE COLLEGE

TECHNIQUES OF THERAPEUTIC COMMUNICATION

NOTE: For brevity and readability, the patient will be referred to as "he" and the nurse will be referred to as "she."

TECHNIQUE	DEFINITION	EXAMPLE
1. Clarification of role	Informs patient of role and purpose	"My name is... I am a student nurse from Ohlone College and I will be here all day to help in your care."
2. Giving recognition.	The nurse can show that she recognizes the patient as a person, as an individual by greeting the patient by name indicating awareness of change, or noting efforts the patient has made. Such recognition does not imply that one thing is good and its opposite bad.	"Good afternoon, Mrs. Brown." "I see you've combed your hair this morning." "I notice you have a new dress on today"
3. Offering self.	When the patient is not ready to communicate verbally with another person, or unable to make himself understood, the nurse can offer her availability. This offer must be made unconditionally. The patient should not feel he must give in order to receive.	"I'll sit with you awhile." "I'll stay with you during the exam." "I have a few minutes I can spend with you."
4. General Lead (Acceptance)	Using a general lead indicates the nurse has heard and has followed the trend of thought and encourages the patient to continue. Communication is occurring and the nurse is a participant rather than an observer. Words, facial expression, tone of voice and inflection, and the posture of the nurse must convey acceptance.	"Yes" and nod "Uh hmm" "I follow what you are saying" "Go on." "Please continue."
5. Giving broad openings.	This allows the patient to set the direction of the conversation and express himself. The nurse indicates that she is listening and interested in what will be said next. This can be accomplished verbally, or non-verbally, by nodding or through facial expressions which demonstrate attentiveness and concern.	"Is there something bothering you this morning?"

TECHNIQUE	DEFINITION	EXAMPLE
6. Placing events in time or sequence	Putting events in their proper sequence helps both the nurse and the patient see them in perspective. At times it will become obvious to the patient that previously accepted cause-and-effect relationships could not exist.	<p>“What did you do after that?”</p> <p>“At what time did this occur?”</p> <p>“When did this happen?”</p>
7. Sharing observations	The nurse shares her observations of the patient’s behavior during communication, including any inconsistencies in verbal and nonverbal cues. Focus on the patient’s physical or apparent emotional state. When the nurse voices her perceptions, she offers the patient something to which he can respond when ready. This encourages mutual understanding of the behavior or feeling through discussion.	<p>"You look uncomfortable."</p> <p>"You are biting your nails."</p> <p>"You seem to be trembling."</p> <p>"I notice that you're..."</p>
8. Clarification/clarifying	Clarifying helps to make meaning clear and to avoid misunderstanding. If the nurse is to understand the patient, she must come to see things as they seem to him. The patient should feel free to describe his perceptions to the nurse. When possible these should be described to the nurse as they are occurring. This may include clarification of ambiguous terms as some words have different meanings to different people.	<p>"Tell me if I heard you correctly..."</p> <p>Are you using this word to " say..."</p> <p>"I'm not sure that I follow."</p> <p>"Tell me if my understanding agrees with yours."</p>
9. Encouraging comparison	Comparing ideas or experiences or interpersonal relationships brings out many recurring themes. Seeing the similarities helps the patient become aware of the continuity of his life, and noting differences helps him to evaluate the influence of each person or event individually. It is rarely helpful for the nurse to introduce experiences from her own life as comparisons. Often this results in discussion focused on the needs and problems of the nurse.	<p>"Was the problem similar to..."</p> <p>"How does your roommate remind you of your sister?"</p> <p>"Have you had a similar experience?"</p> <p>"In what ways do you see this hospitalization as similar (different) to your last time here."</p>
10. Restating the main idea expressed (Paraphrasing)	Restatement of what the patient has said in your own words gives evidence to the patient that he has communicated effectively. The patient is encouraged to continue. Or, if he has been misunderstood, he can reword or restate his thoughts to make them more clear.	<p>Patient: "I can't sleep. I stay awake all night."</p> <p>Nurse: "You have difficulty sleeping?"</p>

TECHNIQUE	DEFINITION	EXAMPLE
11. Selective Reflection of Content	All of part of the patient's statement is repeated or slightly rephrased to encourage him to go on. Reflecting can be obvious and should be used sparingly, for the patient is likely to become annoyed if his statements are continually repeated to him. Reflecting is another way of encouraging the patient to continue, but one which may also lead him to expand on words reflected.	Patient: "Everyone here ignores me." Nurse: "Ignores you?"  Patient: "Do you think I should tell the doctor?" Nurse: "Do you think you should?"
12. Reflection of feelings (Acknowledging patient's feelings)	A nurse can relate to a patient that she is aware of how a patient feels. It is used to obtain the feeling response and not to exchange information. Helps the patient to focus and explore his own feelings.	"I realize you are uncomfortable." "You must feel alone." "I see that makes you upset."
13. Helping patient express thoughts and feelings	A patient's behavior at times may indicate his feelings when verbally he is expressing nothing. This technique helps the patient to know his feelings are understood and accepted.	Patient's behavior: Walking around room, slamming objects down, no eye contact; no verbalization. Nurse: "Mr. C., your behavior is showing me you are angry. Can we talk about anger?" "What are your feelings?" "What do you feel right now?"
14. Exploring	Many patients deal only superficially with each topic they bring up, as if testing to see whether the nurse is interested enough to look further. Once a theme or trend is identified, it should be explored as fully as possible. The nurse should refrain from probing or prying and should respect the patient's wishes if he chooses not to elaborate.	"Tell me more about that." "What else happened?" "Describe that more fully."
15. Giving information	The nurse may be able to provide the patient with specific information which will answer questions and help him better evaluate his situation. By providing information the nurse can do much to establish and atmosphere of helpfulness and trust in her relationship with the patient.	"Visiting hours are..." "This testing mat"

TECHNIQUE	DEFINITION	EXAMPLE
16. Eliciting further description	The nurse is seeking further information on a previously described subject.	Patient: "I have a car." Nurse: "What color is it?"  Patient: "I am hearing a noise in my head." Nurse: "What type of noise is it?"
17. Verbalizing the implied	To put into words what has been implied or said only indirectly tends to make the discussion less obscure, to clarify the conversation, and to show that you are listening, interested, and accept what he says. the nurse should be as direct as she can be without being blunt. This technique helps the nurse verify her impression and helps the patient become more fully aware of his feelings.	"Have you ever told your wife how you feel?" "Have you asked your boss for a raise?" "Is it your feeling that no one understands?"
18. Encouraging evaluation	The nurse can help the patient to appraise the quality of his experience, to consider people and events in relation to his own and others values, and to evaluate the way in which people affect him personally as well as understand how he affects others.	"What are your feelings about...?" "Does this contribute to your discomfort?" "What are your feelings in regard to...?" "Do you feel stronger today than...?"
19. Suggesting collaboration	Often to share and work together with the patient for his benefit; offer to do things with, not for or to him. Encourage him to participate in identifying and appraising problems and involve him as an active partner in treatment.	"Perhaps you and I can discuss and discover what produces your anxiety."
20. Problem solving	Ask the patient to consider examples of behavior likely to be appropriate in future situations. He can then plan how to handle future problems or how to carry out necessary self care.	"What could you do to let your anger out harmlessly?" "Next time this comes up, what might you do to handle it?" "Next time what will you do different?"

TECHNIQUE	DEFINITION	EXAMPLE
21. Reassuring	When a patient who has expressed apprehension is told, "everything will be all right", he is likely to feel the nurse is not interested in his problem. When there are facts that are reassuring, the nurse can give genuine reassurance by communicating them to the patient. A less direct, but basic reassurance is given as the nurse communicates to the patient understanding, acceptance, and interest.	Patient: "I can't do this any longer." Nurse: "I think you can do it Mrs. B." Patient: "I'm frightened." Nurse: "I'll stay with you during the procedure and you can hold onto my hand."
22. Open-ended Questions	Any question or implied question that gives the patient a wide range of possible responses.	"Tell me about yourself." Patient: "I have a pain in my leg." Nurse: "Describe your pain."
23. Closed-ended Questions	Any question or implied question that limits the possible response to usually one or two words, such as a "yes" or "no."	Patient: "I have five children" Nurse: "How old are your children?"
24. "I" messages: Helping patient strengthen self identification	Always use you, I and we in proper context. Refer to patient as a separate person with an identity.	Incorrect: "We can take a bath now." Correct: "You can take a bath now."
25. Focusing on a specific problem	A nurse can focus the conversation on a specific problem to obtain more details. The nurse may understand the patient's message but realizes that it is non-specific or vague, and finds it necessary to bring the conversation back to the problem.	Patient: "My husband is away on a business trip. Isn't it a nice day?" Nurse: "Tell me about your husband's business."
26. Silence	Silence allows the patient to dialogue internally and to process information. It also allows time to search for words to describe feelings or situations. The nurse can use this time to observe the patient's non-verbal cues.	

TECHNIQUE	DEFINITION	EXAMPLE
27. Validating	The nurse checks to determine if the patient's need has or has not been met.	"Are you feeling better now?"
28. Summarizing  Therapeutic Techniques for the Psychiatric Patient (#28, 29, 30)	Bring together important points of discussion and give particular emphasis to progress made toward better understanding. Summarizing encourages both nurse and patient to part company with the same ideas in mind, provides a sense of closure at the end of discussion, and promotes a grasp of the significance of what was said. Patient has sense nurse has understood what was said and has chance to review information and add any missing pieces.	"What you've said is..." "You're telling me that..." "Have I got this straight?" "We have been discussing..."
29. Presenting reality	The nurse presents what is real to a patient who is misinterpreting reality. It is done in such a way as not to argue with or belittle the patient.	"I see no one with you." "I am your nurse, not your sister." "There are no bugs on your wall."
30. Voicing doubt	Expressing doubt is another means of responding to distortions in reality. Such expression helps the patient to become aware that others do not necessarily see a situation in the same manner he does. The nurse does not agree or disagree, but at the same time does not allow misconceptions to pass uncommented on.	"Really?" "That's unusual." "That's hard to believe."
31. Attempting to understand	Often what a patient says, when taken literally, seems meaningless or far removed from reality. To understand the nurse must concentrate on what the patient might be feeling in order to express himself as he does.	Patient: "I'm dead." Nurse: "Are you suggesting that you feel lifeless?" OR "Is it that life seems without meaning?" Patient: "I'm way out on the ocean." Nurse: "It must be lonely." OR "You seem to feel deserted."

OHLONE COLLEGE  
NURSING

NON-THERAPEUTIC TECHNIQUES OF COMMUNICATION

TECHNIQUE	DEFINITION	EXAMPLE
1. False Reassurance (Using reassuring clichés)	Reassuring clichés are often given automatically, or they may be used when a person has difficulty knowing what to say. They block communication because they tend to convey to the patient that the nurse feels he is worrying needlessly, or that she is not interested in, or does not understand his problems. It minimizes the significance of the patient's feelings.	"Everything will be all right" "You don't need to worry." "You'll be fine."
2. Giving advice  Judgmental Non-Therapeutic Techniques (#3, 4, 5, 6, 7)	By telling the patient what he should do, the nurse imposes her own opinions and solutions on him rather than helping him to explore his ideas so that he can arrive at his own conclusions.	"What you should do is..." "Why don't you..."
3. Giving unnecessary approval	Stating that something the patient does or feels is particularly good, implies that the opposite is bad and limits freedom of the patient to think, speak, or act in ways that may displease you. This tends to focus conversation the nurse's values rather than the patient's and implies that the nurse's concept of right or wrong will be used in judging the patient's behavior.	"That's good" "I'm glad that you...." "Let's not discuss that." "I don't want to hear about that."
4. Expressing undue disapproval	Denouncing another's behavior or ideas, implies that you have the right to pass judgment on his thoughts and feelings and that he must please you. Such a negative value judgment may intimidate or anger the patient and indicates that his feelings or actions have not been accepted. It implies that the patient must meet the nurse's expectations or standards.	"You should stop worrying like this." "You shouldn't do that."
5. Agreeing	When the nurse introduces her own opinions or values into the conversation, it can prevent the patient from expressing himself freely.	"I agree with you." "You must be right."
6. Disagreeing	By contradicting a patient, the nurse indicates to him that what he has said has not been accepted. This may cause him to feel angry, threatened, or defensive and he may refrain from further interaction on the subject.	"You're wrong." "That's not true."

TECHNIQUE	DEFINITION	EXAMPLE
7. Being strongly opinionated	Being strongly opinionated in any aspect of your conversation creates a barrier, since you do not allow for a different response. It takes decision making away from the patient, inhibits spontaneity, stalls problem-solving and creates doubt.	"I think you would look better in a dress." "I wish you would grow up."
8. Ask for approval	Seeking approval from a patient is inappropriate behavior for the nurse. This places the patient in a situation of having to compare the nurse and creates competition where there should be none.	"Isn't that the best back rub you've ever had?" "I'm the best nurse you've ever had, right?"
9. Using multiple persistent pointed questions	Probing places the patient on the defensive and makes him feel manipulated and valued only for what he can give. Over use of closed-ended questions.	Now tell me about..." "Tell me your life history." "Ever had any operations?" "How long ago?"
10. Leading Statements	Communication that indirectly "puts words in a client's mouth."	"You're tired because you're depressed, right?"
11. Blaming	Communication style characterized by low self-worth and disagreement. A blaming stance is symbolized by standing with one hand on the hip, the other arm extended with a pointed finger.	"You always..." "It's your fault."
12. Asking why (Challenging)	When the patient cannot provide a reason for his thoughts, feelings, and behavior, explanations force him to invent "reasons, to give partial answers, to expand delusions, or to rationalize since he feels "on the spot". "Why" questions are viewed as accusations and can cause resentment, insecurity, and mistrust.	"Why are you here?" If you are dead, then why are you breathing?"
13. "You" statements	"You" statements allow speaker to disown comments that may be difficult to express. Usually are accusatory, evaluative, or judgmental, and provoke defensive behavior.	"You smoke too much." "You're not doing your best." "You're always late."
14. Requesting explanation - demanding proof	The nurse is asking the patient to provide the reasons for his thoughts, feelings, behavior and events. This method encourages the patient to invent reasons.	"Why did you do that?" "Give me a reason for your behavior."
15. Testing	By testing the patient, the nurse is demanding that the patient have insight into his lack of insight. This method of communication only meets the nurses needs, not the patient. Patient may test nurse to check to see if nurse is truly interested or sincere.	"What day is this?" "do you still think you are dead?"

TECHNIQUE	DEFINITION	EXAMPLE
16 Defending	When the nurse becomes defensive in responding to a patient's criticisms, she in effect tells him that his negative comments are unfounded, and implies that he has no right to express such opinions or feelings.	Your doctor is quite capable" "This hospital is well- equipped." "No one here would lie to you"
17. Belittling feelings	Although the nurse is trying to show the patient that she understands, statements which equate the patient's feelings with those felt by herself or others imply that his feelings are not unusual, thereby denying the importance they have for him.	"I know just how you feel." "Everyone gets depressed at times." "I understand how you feel."
18. Stereotyping—Making stereotyped comments	By using social clichés or trite phrases, the nurse may lead the patient to reply in a like manner, thus keeping the conversation at a superficial level. It inhibits uniqueness and oversimplifies the situation.	"How are you feeling?" "Isn't it a beautiful day?"
19. Inappropriate socializing	Socializing with a patient confuses the relationship the nurse is trying to develop. The patient may misinterpret that he is a part of the nurse's life outside the hospital.	"I had a great date last night." "This nursing program at Ohlone is really tough."
20. Offering choice when none available	When there are no choices in a situation, the statement should be made in such a way that the patient understands there are none.	"Would you like to take your medicine now?" "It's bedtime. Would you like to turn out your light now?" "Here's some pills for you Mr. Jones, o.k.?"
21. Using Incongruent Communication (Double-bind)	Incongruence between verbal and nonverbal behavior confuses communication. The patient does not know whether to listen to the verbal communication or to try to interpret the nonverbal.	"It's no bother." (frowning) "I'm angry." (smiling)
22. Breaking useful silence	Patients need time to process information. Allow them time to think about what has been said and to formulate their responses.	Beginning to talk when the client seems to be thinking over what has just been said.
23. Changing topic inappropriately	Changing topic often occurs when topic is uncomfortable to the nurse or the nurse does not know what to say. This denies the existence of the problem and protects the feelings of the nurse. It takes the lead in conversation away from the patient and blocks what he wants to discuss.	Patient: "I'm going to die." Nurse: "Did your wife come in today?"

TECHNIQUE	DEFINITION	EXAMPLE
24. Placating	Incongruent communication style in which the communicator automatically agrees, takes the blame for everything and puts self one-down to all others.	"I'm sorry. It's all my fault."
25. Patronizing	Any communication that "talks down" to the client while attempting to be comforting; often used with children and elderly.	Using baby talk when talking with the elderly, "Oh, you look so cute."
26. Moralizing	A form of judging the client in which the client is implied to be guilty of violating the nurse's code.	"How can you smoke at your age?"
27. Rationalization	A defense mechanism in which the communicator makes up inaccurate excuses or "reasons" to justify behavior	"Oh, well, that's probably because..." "It's not important because..." "Everyone feels a little..."
28. Parroting	Continually using reflecting or repeating parts of the patient's statements.	"I'm concerned about my son." "You're concerned about you're son?" "He's losing weight." "He's losing weight?"
29. Inappropriate use of medical jargon.	Need to communicate with patient in language that he/she can understand.	"You are having multiple syncope episodes. I believe they are a manifestation of T.I.A.'s."
30. Glib, literal responses	Asking questions related only to practical matters cuts off exploration of feelings. Persons often cannot state feelings directly or in a conventional phrasing, but must use symbolism or statements with hidden meaning.	Patient: "I'm a real doll." Nurse: "You think you are a doll?" Patient: "It's a grey day." Nurse: "Yes, we are having bad weather."
31. Indicating the existence of an external source	To suggest the existence of an external source for a patient's behavior provides him with a release of responsibility for his actions. Ambiguously worded questions can lead to this.	"Who told you that?" "What made you do that?"

Ohlone College  
Nursing 301

FOCUS: Nonverbal Communication.  
**Class 4**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Chapter 24 (pp 344-346) and p.779-780

STUDENT OBJECTIVES:

1. Differentiate between verbal and non-verbal communication.
2. Explain why non-verbal communication may be more accurate indication of his/her feelings than the verbal response.
3. Evaluate how the concepts of personal space and territoriality effects the communication process, including cultural differences and how they might affect your communication with patients.
4. Compare and contrast positive and negative uses of silence.
5. Assess a variety of body movements, postures and/or gestures, which hospitalized patients commonly use to communicate feelings of fear, pain, anxiety, isolation, anger or resignation.
6. Illustrate the body language a nurse would use to convey the attitudes of acceptance and caring.
7. Explore the importance of touch to human development and to states of “wellness.”

OHLONE COLLEGE  
NURSING 301

FOCUS: Language Awareness  
Communication with clients of culturally diverse backgrounds or special needs.  
**Class 5**

REQUIRED PREPARATION:

1. Read Potter and Perry. Fundamentals of Nursing, Chapter 9 (pp 117-118), Chapter 24 (pp 344-346; 351-352, 355-357).
2. Complete exercises in syllabus prior to class.
3. Oliva, N. L. (2008, March). When language intervenes: Improving care for patients with limited English proficiency. *American Journal of Nursing*, (108)3, 73-75.

STUDENT OBJECTIVES:

1. Examine how meanings reside in people not words.
2. Distinguish between the denotative and the various connotative meanings of selected words.
3. Examine common problems that arise in the use of words (include contextual, geographic origin, ethnicity and cultural factors, language barrier, and medical jargon).
4. Propose several ways to enhance communication with non-English speaking patients and patients who speak English as a second language.
5. Determine specific communication techniques for the care of the culturally diverse client and the client with special needs (sensory & speech impairments) including the older adult.
6. Illustrate several ways by which one can clarify meanings of words during a conversation to ensure mutuality of understanding.

## EXERCISE: PARAPHRASING

For each of the following statements on the left side of the page, think of how you would paraphrase it. That is, how would you say it in your own words without changing the meaning?

### Patient's Statement

### Nurse's Paraphrase

I'm originally from California, but I've lived in Florida most of my life.

The doctor told me to take one pill three times a day until the pills ran out, but I felt better the next day and stopped.

My child has a 100-degree temperature and has been coughing. What should I do?

I haven't been sleeping well. I get up every morning at 3 a.m. and stay awake looking at the ceiling.

I don't believe all this garbage about smoking. I've smoked a pack a day for 35 years with no problems.

I'd like to lose weight, but you know, the holidays are coming up.

No body in this place gives a damn about you unless you're a private patient.

OHLONE COLLEGE  
NURSING 301

FOCUS: Communicating with the Elderly Client  
**Class 5**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Chapter 14 (**focus on psychosocial aspects**).
2. Read Ebersole, Toward Healthy Aging, Chapter 21 and pp. 624-627 (reminiscence).

SUPPLEMENTAL PREPARATION:

1. Miller, C.A. (2008, March). Communication Difficulties in Hospitalized Older Adults with Dementia, *American Journal of Nursing*, (108)3, 59-66. (on web ct)

STUDENT OBJECTIVES:

1. Evaluate how personal biases and prejudices may affect communication with the elderly.
2. Propose strategies to communicate more effectively with the elderly.
3. Summarize the process of reminiscence, reality orientation, and validation therapy.
4. Demonstrate four nursing actions to promote reminiscence.

Ohlone College  
Nursing 301

FOCUS: Cultural Diversity  
**Class 5**

REQUIRED PREPARATION:

1. Read Potter and Perry, Fundamentals of Nursing, Chapter 9.
2. Read Ebersole, Toward Healthy Aging, Chapter 21.

STUDENT OBJECTIVES:

1. Describe the characteristics of culture.
2. Define the following terms: Ethnicity, Ethnocentrism, Minority, Race, Stereotyping and Cultural competent.
3. Analyze cultural and ethnic factors which influence the health beliefs and behavior of culturally diverse individuals, groups and communities.
4. Identify barriers to providing culturally competent care.
5. Identify nursing skills and competencies required of culturally sensitive nurses.
6. Demonstrate attitudes and communication techniques that promote the nurse's acceptance of others with differing attitudes, values and backgrounds.

OHLONE COLLEGE  
NURSING 301  
PERCEPTIONS – Class 5

A perception is what you see, think you see; hear, think you hear; believe, think you believe; understand, think you understand; in any given situation. It is based on your sensory receptors (whatever you touch, smell, taste, or hear), your past experiences, and the limitations of your own imagination.

While a perception may be reality-based, it need not be. In fact, unless the receiver is aware of the pitfalls of his own subjectivity, a perception is very frequently distorted and inaccurate.

Factors Influencing Perception:

1. Your Past Experience: Expectations of how individuals and groups do behave. What you expect of others in this situation.
2. Self-Concept: Beliefs about kind of person you are or would like to be. What you expect of yourself in this situation. What you think others expect of you in the situation.
3. Attitudes and values: Personal beliefs about the worth, truth, or desirability of any thought, object, or behavior.
4. Expectations: Ways you think people should behave and how things ought to be.
5. Objectives: What are you trying to achieve in this situation? Your present task goals.
6. Senses: Number and functioning ability of senses involved.
7. Role(s): Social, Occupational, Sexual.
8. Culture: Beliefs and practices that are shared by people and passed down from generation to generation.
9. Failure to appreciate ideas or dreams of others: This does not imply agreement with his dreams, but a willingness to accept the fact that he has them.
10. Failure to listen: Preoccupation with other thoughts; or determination to get own ideas across may result in complete blocking out, or distortion of messages.
11. Snap judgments: Tendency to form opinions on first impression.
12. Predisposition: Tendency to draw conclusion before facts are presented (we hear what we want to hear.)
13. Projection: Tendency to attribute to others some of our own motives, faults.
14. Prejudice: Preconceived judgment caused by past experience or teaching.

Ohlone College  
Nursing 301

FOCUS: Critical Thinking  
**Class 6**

REQUIRED PREPARATION:

1. Potter and Perry (2009), ch.15
2. Alfaro-LeFevre, chapters 1 and 2.
2. Complete Student Surveys on Classroom Work and Perceptual Learning Preferences which follow. Interpret your scores before coming to class.

STUDENT OBJECTIVES:

With appropriate reading, study, and classroom discussion the student will:

1. Propose a definition of critical thinking.
2. Relate characteristics of critical thinking.
3. Identify attributes of a critical thinker.
4. Identify your own learning style.
5. Explain the relationship between evidence based practice and critical thinking.
6. Examine how the nurse can use reflection to facilitate critical thinking.
7. Discuss the role of intuition in the process of critical thinking.
8. Describe situational factors and habits that can be barriers for critical thinking.
9. Illustrate how a professional nurse can demonstrate each of the eleven attitudes for critical thinking.
10. Apply specific strategies to improve/promote critical thinking: mind mapping/diagramming, completing case studies, critical reading, questioning/purposeful inquiry and problem solving/priority setting.

# CRITICAL THINKING

## Universal Intellectual Standards

Universal intellectual standards are standards which must be applied to thinking whenever one is interested in checking the quality of one's reasoning about a problem, issue, or situation. To think critically entails having command of these standards.

Below are some questions that can be used to apply them (Paul, R. & Elder, L. 2009. The miniature guide to critical thinking, Foundation for Critical Thinking Press @www.criticalthinking.org)

- CLARITY** Could you elaborate further on that point? Could you have expressed your point of view another way? Could you give me an example?
- ACCURACY** Is that really true? How can we check that?
- PRECISION** Could you be more specific? Could you give me more details?
- RELEVANCE** How is that connected to the question? How does that bear on the issue?
- DEPTH** What are some of the complexities of the question? What factors make this a difficult problem?
- LOGICAL** Does this really make sense? Does what you say follow from the evidence?
- BREADTH** Have you considered another point of view to expand your grasp of the arguments for and against the position(s) you have taken?
- FAIR** Are we considering all relevant viewpoints in good faith? Are we distorting some information to maintain a biased perspective? Are we more concerned about individual interests than the common good?
- SIGNIFICANCE** Is this the most important problem to consider? Which of these facts are most important?

## STUDENT SURVEY: CLASSROOM WORK

In your high school and/or college classes, how often did your studies involve small group work?

Never \_\_\_\_\_ Rarely \_\_\_\_\_ Frequently \_\_\_\_\_

How would you describe your experiences working in small groups?

Mostly Positive \_\_\_\_\_ Just OK \_\_\_\_\_ Mostly Negative \_\_\_\_\_

Directions: This survey has been designed to help you and your teacher better understand the way you usually prefer to work on assignments in class. Please read each statement; then based on your educational experiences, decide whether you mostly agree or disagree with each statement.

	<b>Agree</b>	<b>Disagree</b>
1. When I work by myself on assignments (instead of with a partner or small group), I usually do a better job.	_____	_____
2. When I work on assignments by myself, I often feel frustrated or bored.	_____	_____
3. When I work by myself on assignments I usually concentrate better and learn more.	_____	_____
4. I enjoy having opportunities to share opinions and experiences, compare answers, and solve problems with classmates.	_____	_____
5. I prefer working on assignments in class with a single partner rather than with a group of classmates.	_____	_____
6. Most of the time, I prefer to work by myself in class rather than with a partner or a small group.	_____	_____
7. When I work with a partner or a small group in class instead of by myself, I often feel frustrated or like I am wasting time.	_____	_____
8. When I work with a partner or a small group in class, I usually learn more and do a better job on the assignment.	_____	_____
9. Most of the time, I would prefer to work in class with a single partner rather than by myself.	_____	_____
10. Most of the time, I would prefer to work with a group rather than with a single partner or by myself.	_____	_____

11. I am more comfortable working in groups when I can select the group of classmates with whom I will be working. \_\_\_\_\_
12. Usually, I prefer my teacher to select the group of classmates with whom I will be working. \_\_\_\_\_
13. I prefer working in groups when there is a mixture of students from different backgrounds. \_\_\_\_\_
14. I prefer working in groups when my teacher assigns a specific role to each group member. \_\_\_\_\_
15. I prefer working in groups when the teacher lets us figure out for ourselves which group member roles and responsibilities we each want. \_\_\_\_\_
16. Usually, I find working in a group to be a waste of time. \_\_\_\_\_
17. Usually, I find working in a group to be more interesting and productive than working alone in class. \_\_\_\_\_
18. I hope we will not do a lot of group work in this class. \_\_\_\_\_
19. I hope we will have regular opportunities in this class to work with a partner or with a small group. \_\_\_\_\_
20. I mainly want my teacher to give us classroom assignments that we can work on by ourselves. \_\_\_\_\_

Directions: Give yourself one **(1) point if you agree** with the preceding questionnaire items and **0 points if you disagree**. Next, add the points under each heading.

Independent Work Style

- 1. \_\_\_\_\_
- 3. \_\_\_\_\_
- 5. \_\_\_\_\_
- 7. \_\_\_\_\_
- 9. \_\_\_\_\_
- 11. \_\_\_\_\_
- 13. \_\_\_\_\_
- 15. \_\_\_\_\_
- 17. \_\_\_\_\_
- 19. \_\_\_\_\_
- Total \_\_\_\_\_

Collaborative Work Style

- 2. \_\_\_\_\_
- 4. \_\_\_\_\_
- 6. \_\_\_\_\_
- 8. \_\_\_\_\_
- 10. \_\_\_\_\_
- 12. \_\_\_\_\_
- 14. \_\_\_\_\_
- 16. \_\_\_\_\_
- 18. \_\_\_\_\_
- 20. \_\_\_\_\_
- Total \_\_\_\_\_

Interpretation of Scores:

The column with the greatest total indicates the way you usually prefer to work in class.

Ohlone College  
Nursing Process

FOCUS: Adaptation Nursing Theory & Process.  
**Class 6 & 7**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Chapters 16,17,18,19 and 20. Use textbook as an adjunct to material in syllabus.
2. Complete Adaptation Nursing Theory and Nursing Process Homework prior to class.
3. Bring Nursing Diagnosis book to class.

STUDENT OBJECTIVES:

1. Describe the characteristics of a profession.
2. Relate the 4 components of nursing's metaparadigm.
3. Define the following concepts according to the Adaptation Nursing Theory: Model, Man, Stressors, Adaptation, Adaptive Response and Ineffective Response.
4. Explain the following adaptive modes: Physiologic Mode, Self-Concept Mode, Role Mastery/Interdependence Mode.
5. List the assessment areas for all modes: Seven problem areas of the Physiologic, Areas of assessment in the Psycho/Social modes.
6. Describe the five steps of the nursing process.
7. Define the rationale for use of a nursing process.
8. Explain how critical thinking skills are used when implementing the nursing process.
9. State the purpose of the Nursing Care Plan and explain each of the categories.
10. Describe the activities involved in nursing assessment: Data Collection, objective and subjective; Analysis of behaviors as adaptive and ineffective.
11. Describe methods of data collection.
12. Identify the criteria for a well-stated nursing diagnosis "related to" and goal.

13. Differentiate between nursing diagnosis, medical diagnosis and collaborative problems.
14. Differentiate between nursing diagnosis and a nursing intervention.
15. Identify how the “related to” is utilized in formulating nursing interventions.
16. State the difference between dependent, independent and interdependent nursing interventions.
17. Describe the process and criteria of selecting short-term goals.
18. Explain the basis for evaluation in the nursing process and how it applies to modification of the nursing care plan.

# NURSING PROCESS ACTIVITIES

## A. Assessment

1. Take the following narrative and identify subjective and objective data. Mr. Kantor is lying on his side, grimacing and rubbing his abdomen, and complaining of pain. His vital signs are as follows: BP 140/100, P 120, R 22. He is pale, diaphoretic, and his skin is warm to touch. Oral temperature is 301°F.
2. Upon entering Mrs. Smith's room you find ten bottles of medication on her bedside stand. None of the bottles appear to have ever been opened. What would your assessment include?)

## B. Nursing Diagnosis

1. These two nursing diagnoses are worded incorrectly. What is wrong?
  - 1) High risk of infective airway clearance r/t pneumonia
  - 2) Body disturbance ineffective r/t anorexia.
2. A client comes to the emergency room with a hand laceration resulting from an accidental injury. During the health history the client says she is in situational crisis. She is presently experiencing anorexia, poor concentration, neck and back pain, and is having difficulty sleeping. She also says she is working 32 hours per week and attending college. Her husband recently lost his job, which is causing financial and marital strain. Plus, she is having trouble finding reliable child care for her two young children. Develop nursing diagnoses related to this situation.

## C. Goal/Expected Outcomes

1. From the following list of goals, select the short-term goals.
  - a. Client stops smoking within two months.
  - b. Client's lungs are free of adventitious sounds in 48 hours.
  - c. Client is able to independently care for ostomy by discharge.
  - d. Client observes incision on second postoperative day.
  - e. Client is able to perform all activities of daily living.
2. Determine a specific, client-centered outcome for the following nursing diagnosis.  
Risk for impaired skin integrity related to age, obesity, and prolonged bed rest.

#### D. Nursing Interventions

1. Correctly write the following incorrect nursing interventions.
  - a. Irrigate nasogastric.
  - b. Suction client.
  - c. Change client's dressing.

#### E. Evaluation

1. Mrs. Wells is a 40-year-old woman whose presenting symptoms included acute low back pain that radiated down the left leg, with numbness in the left lateral calf. On a scale of 1 to 10, the client verbalized pain to be at a severity of 9. The client was unable to walk without limping. Pain was aggravated whenever the client sat. Lying in a supine position minimized the discomfort. A nursing diagnosis of *decreased physical mobility related to pain* was made with the goal of "client will gain freedom of back movement without pain within 4 weeks." Identify expected outcomes to be incorporated into the plan of care. What evaluative measures would you use to judge the client's success in meeting outcomes?
2. Write a response to the following:

"It is more important for nurses to have expert assessment skills than to know how to evaluate care."

Patients want resolution of \_\_\_\_\_ must be able to \_\_\_\_\_.

## NURSING ADAPTATION MODEL: Theory

Philosophy may be defined as a set of beliefs that directs our actions. It may include facts, theories, and attitudes, and is usually goal-directed. Sometimes we act without knowing or recognizing the beliefs that guide our actions. A responsible nurse must be aware of the beliefs that guide her practice of nursing.

It is, therefore, important for each of us to first examine our own philosophy toward man, health, illness and nursing.

What is your philosophy or man? Of health? Of illness? Of nursing?

Take a few minutes to jot down your set of beliefs.

Review the philosophy of the Ohlone College Nursing Faculty.

The Roy Adaptation Model provides the theoretical base for adaptation nursing.

A model is a description or representation used to help visualize something that cannot be directly observed. (i.e., model home). It logically presents the situation and provides structure. A nursing model is a representation of the major concepts of nursing and how these relate to one another.

The Roy Adaptation Model was developed by Sister Callista Roy while she was a graduate student in the School of Nursing at the University of California at Los Angeles. Her first publication of this model appeared in 1970. Now the Roy Adaptation Model is one of the most highly developed and widely used models. The Ohlone College Nursing Program has adopted this model with some revisions. A description of the Ohlone College Adaptation Nursing Model is presented below.

The essential concepts of a nursing model include:

1. Person: a description of the person or groups receiving nursing care
2. Health
3. Environment
4. Nursing: goal and nursing activities

### CONCEPT OF MAN

Man is a bio-psycho-social being in constant interaction with a changing environment.

Man is "holistic" - In our nursing courses, we will study parts of man separately--that is the physical problems, psychological problems and social problems.

Actually, man is a whole being--all parts interacting as man adapts to a changing environment. The dynamic interaction makes the whole man greater than the sum of his parts.

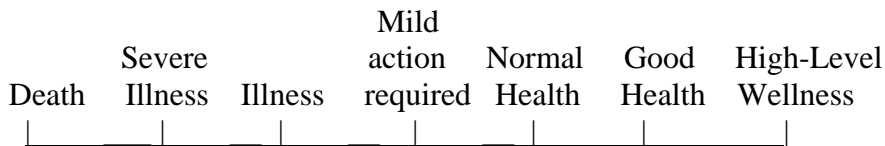
Man is an "adaptive system." A person's behavior is influenced both by the environment, that is, the world within and around the person, and by the person's ability to adapt or deal with that world.

## CONCEPT OF HEALTH

Health is a state of optimum adaptation which includes physical, mental and social well-being and not just the absence of disease.

Health is a state and a process of being and becoming an integrated and whole person. A whole person is one who functions at the optimal level in relation to his/her capabilities.

No one ever achieves the ideal state just described. At any given time, a person's health or state of adaptation varies along a continuum that ranges from severe illness to high level wellness.



HEALTH - ILLNESS CONTINUUM

## CONCEPT OF ENVIRONMENT

Environment is defined as all internal and external conditions, circumstances, and influences surrounding and affecting the development and behavior of persons or groups.

According to the Adaptation Nursing Model, the changing environment causes the person to respond, either in an adaptive or ineffective manner.

Environmental changes may be called stressors to which a person needs to respond to or adapt. For human beings, life is continually changing. It is never the same. Anything that happens can be defined as change or a stressor, i.e., passage of time, aging, conversations, relationships with people, illness. The rate of change is increasing, i.e., expansion of technology and scientific knowledge. Adaptation is adjusting to a changing and stressful world. It is a positive response an individual makes to cope with changes in his internal (within the body) and external environment. The goal of nursing is to promote positive adaptation in situations of health and illness. An example of an adaptive response to changing environment is the patient who reorders his life priorities after suffering a near fatal heart attack. He finds that altering his life style can provide a more meaningful and satisfying life for himself and his family.

A person's ability to adapt depends on:

1. The type and amount of change and/or
2. The state (condition) of the person at the time of the change.

For example, a person providing for a family may adapt when promotion is not received. If that same person is fired, severe depression and loss of self-esteem may occur if adaptation is not adequate.

We are always exposed to the viruses which cause colds. If healthy, we positively adapt and remain well. If "under stress," overly tired, have a poor diet or have another illness, we may be unable to adapt and get a cold.

The nurse first assesses the patient's physiological, and psychosocial adaptation level. In other words, she assesses the way a person responds physically, psychologically, and socially to environmental (internal and external) changes.

There are three ways or "modes" in which a person adapts to or responds to environmental changes to meet his needs. These adaptation modes are interrelated. Each may affect the other. We study each mode separately for the sake of understanding. But man, as a whole being, is a synthesis of all modes.

The three modes are

1. Physiologic Mode
2. Self-Concept Mode
3. Role Function and/or Interdependence Mode

The Physiologic Mode is concerned with the integrity of the physiologic being. It includes attention to needs in the following areas:

1. Respiration
2. Circulation
3. Ingestion and elimination
4. Fluids and electrolytes
5. Neuro/sensation
6. Endocrine/protective
7. Exercise and rest

The self-concept mode is concerned with psychological well-being -- the need to know and become compatible with oneself. Self-concept is the mental image one has of oneself. There are two major components to the self -- the physical self and the personal self. The physical self is concerned with how a person perceives and feels about his body. The personal self is concerned with a person's value system and how well s/he lives up to that value system.

Overall, the self-concept mode deals with how a person uses self to meet his/her needs. To understand self-concept is to understand the meaning of "who I am."

The interdependence mode and role function modes are concerned with social well-being.

The interdependence mode has two major components -- significant others and support systems. Significant others are person(s), animal(s), and/or object(s) with whom the relationship is of primary importance at this time, i.e., parents, family, spouse, pets, social affiliations.

Support systems are person(s), group(s), animal(s), object(s) of secondary importance which affirm or support the individual, i.e., health care system, doctors, nurses, church, club.

The definition of significant others or support systems is based on its importance to the individual and on whether or not it promotes an adaptive response in the individual.

Overall, the interdependence mode deals with a person's perception of the support received from the environment, the satisfaction of his/her needs with the help of others, and the ability to establish an in-depth interaction with another person.

The Role Function mode is concerned with how well a person fulfills a variety of roles. Role is defined as the pattern of behavior expected of all persons occupying a given position in society. Roles must be compatible with one's self-concept. You need to know who you are in relationship to others so you can act. Roles exist only in relationship to other roles. Thus a role must have complimentary role, i.e., mother-son, teacher-student.

An individual can occupy more than one role at a time and different roles at different times. Roles have varying levels of importance. They are classified as primary, secondary and tertiary roles. Primary role is the one you are born into and is directly related to a person's level of development, i.e., sex, age. Secondary roles are the major roles played in the course of a lifetime. They are assumed to complete the tasks associated with each developmental stage and are of much importance to the individual, i.e., daughter, student, wife, mother, teacher. Tertiary roles are temporary roles that may augment some of the secondary roles. They usually have only moderate significance to the individual, i.e., PTA member, cub scout leader, father as a football coach, patient in hospital (sick role).

After the nurse assesses the patient's adaptation level or behavior in each of the modes, she then determines if each of those behaviors is an adaptive response or an ineffective response.

An adaptive response is a behavior that maintains the integrity of the individual; that is, it maintains an individual's wellness and s/he remains healthy and in control of the environment. It also decreases the amount of energy needed to cope with the given situation and increases energy for other human processes. It is a normal response for a particular patient in a particular situation.

An ineffective response is a behavior that does not maintain integrity and is disruptive of the person. This response does not contribute to adaptation. It is unhealthy and may lead to further illness or prevent the person from getting well.

For example, if a person's clothes catch on fire, an adaptive response would be to roll on the ground to extinguish the flames. An ineffective response would be to panic and run, thus fanning the flames and increasing the burn.

## CONCEPT OF NURSING

The Adaptation Nursing Model provides a basis for the development of nursing science and a guideline for nursing practice.

The goal of Nursing is to promote man's positive adaptation in situations of health and illness. In other words, the focus is to increase a person's adaptive responses and to decrease his ineffective responses in the physical and psycho/social adaptive modes, thereby, contributing to health, quality of life, and dying with dignity.

To accomplish this, a problem-solving methodology is used called the nursing process. The nursing process is an organized, systematic method of giving individualized nursing care that focuses on the unique human response of a person to an actual or potential alteration in health. This process delineates the specific activities which distinguish nursing from other disciplines.

The nurse must make assessments to define the patient's level of adaptation. To do this, she assesses the patient's behavior; that is, how the person is behaving as an adaptive system in the physical and psychosocial modes. Next she determines if the behavior is an adaptive or ineffective response. Based on this assessment, the nurse selects the nursing diagnoses and assesses the causes of the behavior or health problem(s). Patient goals are set to reinforce adaptive behaviors or to alter or assist the patient to change ineffective behaviors. Goals are the expected patient outcome. Nursing interventions are selected based on the causes of the behavior and help the patient achieve the stated goal. The final step is to evaluate whether or not the patient goal was met and make any modifications needed.

## SUMMARY

In summary, the Nursing Adaptation Model provides the theoretical base for adaptation nursing. It describes man as a bio-psycho-social being in constant interaction with a changing environment. It defines adaptation as man's positive response to a changing environment and delineates three modes or ways that man adapts. It maintains that the goal of nursing is to promote man's positive adaptation in situations of health and illness.

## GLOSSARY

ADAPTATION	<ol style="list-style-type: none"><li>1. Man's ability to respond positively to a changing environment.</li><li>2. Responses or changes that occur in an individual as a reaction to stressors.</li></ol>
ADAPTATION MODES	<ol style="list-style-type: none"><li>1. <b>PHYSIOLOGIC</b> - Physical Integrity; The nurse assesses the way a person responds physically to stimuli from the environment. The physiologic areas include: respiration, circulation, ingestion and elimination, fluids and electrolytes, neuro/sensation, endocrine/protective, exercise and rest.</li><li>2. <b>INTERDEPENDENCE</b> - Social Integrity; A comfortable balance with others, feeling adequate and secure in relationships with other people, and being loved and supported. The nurse assesses the quality of interaction between a person and another person, animal, or object.</li><li>3. <b>ROLE MASTERY</b> - Social integrity; the nurse assesses how well a person fulfills a variety of roles. Role is a pattern of behavior expected of all persons occupying a given position in society. Accomplishment of sick role is focused on in the hospitalized patient.</li><li>4. <b>SELF-CONCEPT</b> - Physic Integrity; The composite of beliefs and feelings that one holds about oneself at a given time, formed from perceptions of other's reactions, and directing one's behavior. The nurse assesses the physical self and personal self.</li></ol>
BEHAVIOR	Any response to internal or external environmental changes that can be observed, measured, or reported subjectively.
BEHAVIORAL OBJECTIVE	A goal or a desired outcome expressed in terms of observable behavior or performance.
CLIENT	The person receiving nursing care. The client may be healthy or ill.
CONSUMER	One who uses a service or commodity. Health care consumer is one who uses health care services.
CRITERIA	Standards of measurement.
ENVIRONMENT	All internal and external conditions, circumstances, and influences surrounding, and affecting the development and behavior of persons or groups.

HEALTH	<ol style="list-style-type: none"> <li>1. State of optimum adaptation which includes physical, mental, and social well-being and not just the absence of disease.</li> <li>2. State and process of being and becoming an integrated and whole person.</li> </ol>
HEALTH - ILLNESS CONTINUUM	State of health and illness that fluctuate along a continuum.
HIGH LEVEL WELLNESS	A state of health that promotes functioning at the optimal level in relation to the individual's capabilities.
ILLNESS	An imbalance that occurs when a person is unsuccessful in adapting to complex interactions of physical, emotional, and social stressors.
NEED	A necessity or a requirement for living; something people require to maintain homeostasis.
NURSING-ADAPTATION	<p>An approach to nursing which views man as a bio-psychosocial being with modes or ways of adapting to changing environment.</p> <p>The nurse acts to promote man's adaptation in situations of health and illness. The patient is assisted to his/her highest level of wellness.</p>
NURSING CARE PLAN	A tool used by the nurse to prescribe the nursing care necessary for each individual client.
NURSING DIAGNOSIS	Actual or Potential health problems which nurses, by virtue of their education and experience, are capable and licensed to treat (Gordon). The judgment or conclusion that occurs as a result of nursing assessment (Gebbie).
NURSING INTERVENTION	<p>Nursing orders to manipulate the cause (the "related to") to help the patient achieve stated goal.</p> <ol style="list-style-type: none"> <li>1. DEPENDENT: Nursing actions which require a physician's order to be executed. (Delegated care)</li> <li>2. INDEPENDENT: Nursing action that can be performed without a physician's order. Are encompassed by nursing licensure and law. (Autonomous nursing function)</li> <li>3. INTERDEPENDENT: Nursing actions that can be legally performed only under direction of licensed, qualified professional (i.e., physician). (Both delegated and autonomous functions)</li> </ol>

NURSING PROCESS	<ol style="list-style-type: none"> <li>1. A problem-solving procedure used by the nurse to assess (gather data), identify nursing diagnoses and patient goals, select and implement nursing interventions, and evaluate the results of care aimed at promoting health, quality of life, and dying with dignity.</li> <li>2. An organized, systematic method of giving <u>individualized</u> nursing care that focuses on the <u>unique human response</u> of a person to an actual or potential alteration in health.</li> </ol>
RESPONSE	Reaction to environmental changes.
ADAPTIVE RESPONSE	Behavior that maintains the integrity of the individual. It is a normal response for a particular patient in a particular situation.
INEFFECTIVE RESPONSE	Behavior that disrupts the integrity of the individual; responses that do not contribute to adaptation.
PROBLEM	Unmet need or anything that interferes with a persons ability to meet his or her needs.
PROBLEM-SOLVING	Process that enables the nurse to scientifically identify a patient's needs and to plan, implement, and evaluate care through the use of critical thinking.

## EXPECTATIONS FOR NURSING CARE PLANS

ASSESSMENTS	<ol style="list-style-type: none"><li>1. The ongoing and flexible process by which the nurse determines patients' physiological and psychosocial level of adaptation.</li><li>2. The collection of data from many sources, which are then classified, analyzed and summarized to determine the patients' problems or needs.</li><li>3. Use Assessment tool for the seven problem areas in the physiologic mode and the psycho/social modes. Pertinent Assessments refers to "actual and present health status."</li></ol>
NURSING DIAGNOSIS	Actual or Potential health problems which nurses, by virtue of their education and experience, are capable and licensed to treat (Gordon). The judgment or conclusion that occurs as a result of nursing assessment (Gebbie).
RELATED TO	Refers to cause--the etiological and contributing factors which a nurse can change. Medical Diagnosis is secondary to the related to.
EXPECTED OUTCOMES	Statement of expected patient outcome; short-term patient behavioral goals (for time of patient care).  The change in patient behavior seen when the problem identified in the nursing diagnoses is lessened or resolved.  Must be observable and measurable.
INTERVENTIONS	Nursing orders to manipulate the cause ("the related to"). These should be independent, interdependent, or dependent.
EVALUATION	A judgment of whether or not the expected outcome (goal) was achieved. Include modifications and reassessment of care plan, i.e., changing or eliminating previous nursing diagnoses, expected outcomes, and interventions based on new patient data. Include objective and subjective data to support your conclusions.

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ADAPTATION NURSING CARE PLAN

The adaptation nursing process is a problem-solving approach used to provide nursing care for patients in all settings. The process is used with every patient. The total process is summarized in the paragraphs which follow.

**STEP 1: Assessment of Patient Behaviors**

The ongoing and flexible process by which the nurse determines the patient's physiological, psychological, and social level of adaptation through assessment and data collection. This includes a description of the patient's responses to changes (internal or external) in his environment. These responses can be reported objectively (observed, measured) or subjectively (as stated by patient). Use assessment tool provided in the syllabus as a guide.

Examples: 1. Small, hard, dry stool, straining at stool, patient states he "feels pressure in his rectum," this is the only stool he has had in seven days.  
2. Patient states he has "incisional pain," clutches incisional site with a grimace on face; his muscles are tense; and he clenches his fists. He is 12 hours post-operative.

**STEP 2: Judgment of Behaviors as Adaptive or Ineffective**

A nursing judgment about whether a behavior is adaptive or ineffective is based on the following general criteria:

Adaptive: -maintains integrity of individual  
-normal for that particular patient in that particular situation  
-want to continue behavior  
-perceived by patient as adaptive

Ineffective: - does not promote integrity of individual  
- is a useless waste of energy  
- prevents patient from responding to other stimuli and using his energies for getting well.

Examples: All behaviors listed in example in Step I may be considered "ineffective."

**STEP 3: Identification of Nursing Diagnosis**

The Nursing Diagnosis is a statement of an actual or potential health problem which nurses, by virtue of their education and experience, are capable and licensed to treat (Gordon).

The judgment or conclusion that occurs as a result of nursing assessment (Gebbie). The simplest way to write a nursing diagnosis is to identify an actual or potential health problem and select the most appropriate nursing diagnosis from the Official Nursing Diagnosis List.

Example: 1. Constipation.  
2. Pain.

To be useful clinically, nursing diagnoses need to be specific. Thus, quantifying or qualifying adjectives may be needed to identify areas, stages, or levels of a particular problem. This leads to identification of the "related to."

STEP 4: Identification of the "related to" (cause)- the etiologic and contributing factors which a nurse can change.

The "related to"

Identify the main cause of the ineffective assessments and identify nursing diagnosis. NOTE: The nurse must be able to change or influence this cause. Whenever possible the nurse validates this assessment of cause with the patient.

- Examples:
1. Constipation R/T Low roughage diet; low fluid intake; decreased activity.
  2. Abdominal Pain R/T Improper positioning, tight dressing making incisional pain worse.
  3. Sleep Pattern disturbance R/T constant auditory stimuli (company and TV)

Contributing Factors or Causes: may be written on NCP as secondary to (2°)

These are usually medical diagnosis and also must be validated by the nurse.

- Example:
1. Impaired communication R/T cerebral impairment 2° CVA
  2. Altered peripheral tissue perfusion R/T interruption of arterial flow 2° Buerger's Disease

Hypothesis

Suspected but not clearly defined or proven factors or causes. Often based on the theory or previous experience. At the time, the nurse is unable to validate this assumption. May include such things as beliefs, attitudes, experiences, or traits.

Example: Italian background of the client who is complaining of pain.

STEP 5: Expected Outcomes

A statement of the expected patient outcome, short-term patient behavioral goals. The change in patient behavior seen when the problem identified in the nursing diagnosis is lessened or resolved. The expected outcome should include date or time schedules where appropriate. Expected outcomes must be observable or measurable.

- Examples:
1. Patient will have soft, formed stools every day by 9-20.
  2. Patient will verbalize decrease in pain within 45 minutes of administration of pain medication.

STEP 6: Intervention - Selection of Nursing Action

Nursing interventions are those actions the nurse plans to do to help the patient achieve the expected outcomes. Selection of nursing interventions is based on the factors causing the patient's problem or potential problem. The nurse acts to change or reinforce the identified factors or causes of the problem, thereby helping the patient achieve the expected outcomes.

Nursing actions must be specific and individualized. They should be independent, interdependent, or dependent.

- Examples:
- 1a. Assess patient's dietary likes and dislikes; explain the importance of eating high roughage foods to prevent constipation; give patient written list of foods high in roughage.
  - 1b. Offer fluids every hour to a total intake of 1000cc in 8 hrs.
  - 2a. Provide comfort measures, e.g., back rub, change of position.
  - 2b. Encourage relaxation exercises.
  - 2c. Assist patient to evaluate drug regimen

## STEP 7: Evaluation

A judgment of whether or not the expected outcome was achieved. The nurse assesses whether or not the patient manifested the behaviors stated in the expected outcome. Include objective and subjective data to support your conclusions.

Examples:

1. Patient now has a soft, formed stool everyday.
2. Patient verbalizes incisional pain relief 30 minutes after receiving Demerol.

If the goal was not met or a modification is needed, reassess the patient and plan of care. To begin, return to the first step of the nursing process. Look more closely at behaviors that continue to be ineffective and re-assess the causes. Delete as a priority of nursing concern, behaviors that have become adaptive, with no threat of returning to an ineffective state. For behaviors that are still ineffective, re-assesses the nursing diagnosis and causes, to see if goal and nursing interventions should be modified.

<u>Assessments</u>	Nursing Diagnosis (Issue of Nursing Care)	Related To(Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (cause-directed actions)	<u>Evaluation/ Modification</u>
<ul style="list-style-type: none"> <li>- small, hard, dry stool</li> <li>- straining at stool</li> <li>- Pt. states he "feels pressure in rectum"</li> </ul>	constipation	<ul style="list-style-type: none"> <li>Low-roughage diet and low fluid intake</li> <li>Decreased activity</li> <li>Disturbance of routine time for bowel evacuation</li> </ul>	The client will have soft, formed stools qd by 10/20	<ul style="list-style-type: none"> <li>Explain importance of high-roughage foods to prevent constipation.</li> <li>Give pt. written list of foods high in roughage.</li> <li>Offer fluids every hour to a total intake of 1000cc in 8 hours.</li> <li>Position change every hour during waking hours and every 2 hours at night.</li> <li>Placed on bedpan after breakfast for 15-20 minutes daily.</li> </ul>	<ul style="list-style-type: none"> <li>Goal met. Patient now has soft formed stool every day.</li> <li>Patient states he likes to drink prune juice every a.m. but does not like bran cereals.</li> <li>Drank 980cc on this shift and position is changed each hour.</li> </ul>

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FACTORS AFFECTING ACCURATE DATA COLLECTION

DATUM/A:	Collection of all factual information about the patient. It is a specific and description rather than an interpretation. It may be objective or subjective and can be described as constant (date of birth) or variable (blood pressure).
OBJECTIVE DATA:	Concrete, observable, measurable information, i.e., vital signs, laboratory studies, and changes in physical appearance or behavior, act of crying.  A behavior which is observed by one person and could be noted by any other observer and tested using an acceptable standard. It is concise and describes signs or behaviors without drawing conclusions or making interpretations.
SUBJECTIVE DATA:	What the patient actually states—his feelings and perceptions, i.e., I feel so nervous, my stomach is burning, pain, itching. Can be verified only by personal experience.
INFERENCE (JUDGMENTS & CONCLUSIONS):	How someone perceives or interprets a given piece of data. Correct inferences are dependent on the skill and knowledge of the nurse. Inferences must be validated (patient very afraid)
ASSUMPTION:	Act of taking for granted, or supposing without proof that a thing is true; supposition.
PERCEPTION:	What you see, think you see; hear, think you hear; believe; understand; think you understand; in any given situation. It is based on your sensory receptors, your past experiences, and the limitations of your own imagination.
VALUE:	A preference based on a conception of what is desirable; represents inner convictions of what is right and wrong, good or bad.

## YOUR KEY TO CHOOSING APPROPRIATE NURSING DIAGNOSES

### RESPIRATION

Activity intolerance  
Activity intolerance, risk for  
Airway clearance, ineffective  
Aspiration, high risk for  
Breathing pattern, ineffective  
Gas exchange, impaired  
Suffocation, risk for  
Ventilation, inability to sustain spontaneous  
Ventilatory weaning process, dysfunctional (DVWR)

### CIRCULATION

Cardiac output, decreased  
Peripheral neurovascular dysfunction, risk for  
Tissue perfusion, altered (specify type) (renal, cerebral, cardiopulmonary, gastrointestinal, peripheral)

### INGESTION AND ELIMINATION

Nutrition, altered: less than body requirements  
Nutrition, altered: more than body requirements  
Nutrition, altered: risk for more than body requirements  
Bowel elimination, altered  
Breastfeeding, ineffective  
Breastfeeding, interrupted  
Infant feeding pattern, ineffective  
Oral mucous membranes, altered  
Swallowing, impaired  
Constipation  
Constipation, colonic  
Constipation, perceived  
Dentition, altered  
Diarrhea  
Bowel elimination, altered  
Bowel incontinence  
Urinary elimination, altered patterns  
Urinary incontinence, functional  
Urinary incontinence, reflex  
Urinary incontinence, stress  
Urinary incontinence, total  
Urinary incontinence, urge  
Urinary retention

### FLUIDS AND ELECTROLYTES

Fluid volume deficit (1 or 2)  
Fluid volume deficit, risk for  
Fluid volume excess

### NEURO/SENSATION

Autonomic Dysreflexia  
Autonomic Dysreflexia, Risk for  
Comfort, altered  
Communication, impaired verbal  
Confusion, acute  
Confusion, chronic  
Energy field disturbance  
Environment interpretational syndrome, impaired  
Intracranial Adaptive Capacity, Decreased  
Pain  
Pain, chronic  
Sensory/Perceptual alterations (specify) (visual, auditory, kinesthetic, gustatory, tactile, olfactory)  
Swallowing impairment  
Thought processes, altered  
Unilateral neglect

### ENDOCRINE/PROTECTIVE

Body temperature, altered, risk for  
Hyperthermia  
Hypothermia  
Infection, risk for  
Injury, risk for  
Latex, Allergy  
Latex, Allergy, risk for  
Nausea  
Perioperative positioning injury, risk for  
Poisoning, risk for  
Protection, altered  
Skin integrity, impaired  
Skin integrity, impaired, risk for  
Thermoregulation, ineffective  
Tissue integrity, impaired  
Trauma, risk for

### EXERCISE AND REST

Activity Intolerance  
Disuse syndrome, risk for  
Diversional activity deficit  
Falls, Risk for  
Fatigue  
Mobility, impaired physical  
Mobility, impaired wheelchair  
Sedentary Lifestyle  
Self-care deficit, bathing/hygiene  
Self-care deficit, dressing/grooming  
Self-care deficit, feeding  
Self-care deficit, toileting  
Sleep deprivation  
Sleep pattern disturbance  
Transfer ability, impaired  
Unilateral Neglect  
Walking, impaired

## SELF-CONCEPT

Anxiety  
Anxiety, death  
Body image disturbance  
Fear  
Hopelessness  
Loneliness, risk for  
Personal identity disturbance  
Post-Trauma Syndrome, risk for  
Powerlessness  
Self-concept, disturbance in  
Self-esteem disturbance  
Self-esteem, chronic low  
Self-esteem, situational low  
Self-Mutilation, risk for  
Spiritual distress (distress of the human spirit)

## ROLE FUNCTION/INTERDEPENDENCE

Adjustment, impaired  
Caregiver role strain  
Caregiver role strain, risk for  
Decisional conflict (specify)  
Development, risk for altered  
Denial, ineffective  
Family processes, altered  
Family process, altered: alcoholism  
Grieving, anticipatory  
Grieving, dysfunctional  
Infant behavior, disorganized  
Infant behavior, risk for disorganized  
Infant behavior, potential for enhanced organization  
Parental role conflict  
Parenting, altered  
Parenting, altered, risk for  
Parent-Infant attachment, altered, risk for  
Religiosity, Impaired  
Religiosity, Readiness for enhanced  
Role performance, altered  
Social interaction, impaired  
Social isolation  
Spiritual well being, potential for enhanced  
Violence, risk for: self-directed or directed at others

## DIAGNOSES IN ANY PSYCHOSOCIAL MODE.

(Depending on individual problem)

Sexual dysfunction  
Sexuality patterns, altered  
Rape-trauma syndrome  
Rape-trauma syndrome: compound reaction  
Rape-trauma syndrome: silent reaction  
Coping/stress  
Coping, community: potential for enhanced  
Coping, defensive  
Coping, ineffective individual  
Coping, ineffective community  
Coping, family: potential for growth  
Coping, ineffective family: compromised  
Coping, ineffective family: disabling  
Post trauma response  
Relocation stress syndrome  
Management of therapeutic regimen, effective: individual  
Management of therapeutic regimen, ineffective:  
individual  
Management of therapeutic regimen, ineffective:  
community  
Management of therapeutic regimen, ineffective: family

## TEACHING-LEARNING

Growth, risk for altered  
Growth and development, altered  
Health maintenance, altered  
Health-seeking behaviors (specify)  
Home maintenance management, impaired  
Knowledge deficit (specify)  
Management of therapeutic regimen, ineffective  
Noncompliance (specify)

## **2007-2008 NANDA APPROVED NURSING DIAGNOSES**

Activity Intolerance, Risk for	Health-Seeking Behaviors (Specify)	Self-Concept, Readiness for Enhanced
Airway Clearance, Ineffective	Home Maintenance, Impaired	Self-Esteem, Chronic Low
Anxiety	Hope, Readiness for Enhanced	Self-Esteem, Situational Low
Anxiety, Death	Hopelessness	Self-Esteem, Risk for Situational Low
Aspiration, Risk for	Human Dignity, Risk for Compromised	Self-Mutilation
Attachment, Parent/Infant/Child, Risk for Impaired	Hyperthermia	Self-Mutilation, Risk for
Autonomic Dysreflexia	Hypothermia	Sensory Perception, Disturbed (Specify: Auditory, Gustatory, Kinesthetic, Olfactory Tactile, Visual)
Autonomic Dysreflexia, Risk for	Immunization Status, Readiness for Enhanced	Sexual Dysfunction
Blood Glucose, Risk for Unstable	Infant Behavior, Disorganized	Sexuality Pattern, Ineffective
Body Image, Disturbed	Infant Behavior: Disorganized, Risk for	Skin Integrity, Impaired
Body Temperature: Imbalanced, Risk for	Infant Behavior: Organized, Readiness for Enhanced	Skin Integrity, Risk for Impaired
Bowel Incontinence	Infant Feeding Pattern, Ineffective	Sleep Deprivation
Breastfeeding, Effective	Infection, Risk for	Sleep, Readiness for Enhanced
Breastfeeding, Ineffective	Injury, Risk for	Social Interaction, Impaired
Breastfeeding, Interrupted	Insomnia	Social Isolation
Breathing Pattern, Ineffective	Intracranial Adaptive Capacity, Decreased	Sorrow, Chronic
Cardiac Output, Decreased	Knowledge, Deficient (Specify)	Spiritual Distress
Caregiver Role Strain	Knowledge (Specify), Readiness for Enhanced	Spiritual Distress, Risk for
Caregiver Role Strain, Risk for	Latex Allergy Response	Spiritual Well-Being, Readiness for Enhanced
Comfort, Readiness for Enhanced	Latex Allergy Response, Risk for	Spontaneous Ventilation, Impaired
Communication: Impaired, Verbal	Liver Function, Impaired, Risk for	Stress, Overload
Communication, Readiness for Enhanced	Loneliness, Risk for	Sudden Infant Death Syndrome, Risk for
Confusion, Acute	Memory, Impaired	Suffocation, Risk for
Confusion, Acute, Risk for	Mobility: Bed, Impaired	Suicide, Risk for
Confusion, Chronic	Mobility: Physical, Impaired	Surgical Recovery, Delayed
Constipation	Mobility: Wheelchair, Impaired	Swallowing, Impaired
Constipation, Perceived	Moral Distress	Therapeutic Regimen Management: Community, Ineffective
Constipation, Risk for	Nausea	Therapeutic Regimen Management, Effective
Contamination	Neurovascular Dysfunction: Peripheral, Risk for	Therapeutic Regimen Management: Family, Ineffective
Contamination, Risk for	Noncompliance (Specify)	Therapeutic Regimen Management, Ineffective
Coping: Community, Ineffective	Nutrition, Imbalanced: Less than Body Requirements	Therapeutic Regimen Management, Readiness for Enhanced
Coping: Community, Readiness for Enhanced	Nutrition, Imbalanced: More than Body Requirements	Thermoregulation, Ineffective
Coping, Defensive	Nutrition, Imbalanced: More than Body Requirements, Risk for	Thought Processes, Disturbed
Coping: Family, Compromised	Nutrition, Readiness for Enhanced	Tissue Integrity, Impaired
Coping: Family, Disabled	Oral Mucous Membrane, Impaired	Tissue Perfusion, Ineffective (Specify: Cerebral, Cardiopulmonary, Gastrointestinal, Renal)
Coping: Family, Readiness for Enhanced	Pain, Acute	Tissue Perfusion, Ineffective, Peripheral
Coping (Individual), Readiness for Enhanced	Pain, Chronic	Transfer Ability, Impaired
Coping, Ineffective	Parenting, Impaired	Trauma, Risk for
Decisional Conflict	Parenting, Readiness for Enhanced	Unilateral Neglect
Decision Making, Readiness for Enhanced	Parenting, Risk for Impaired	Urinary Elimination, Impaired
Denial, Ineffective	Perioperative Positioning Injury, Risk for	Urinary Elimination, Readiness for Enhanced
Dentition, Impaired	Personal Identity, Disturbed	Urinary Incontinence, Functional
Development: Delayed, Risk for	Poisoning, Risk for	Urinary Incontinence, Overflow
Diarrhea	Post-Trauma Syndrome	Urinary Incontinence, Reflex
Disuse Syndrome, Risk for	Post-Trauma Syndrome, Risk for	Urinary Incontinence, Stress
Diversional Activity, Deficient	Power, Readiness for Enhanced	Urinary Incontinence, Total
Energy Field, Disturbed	Powerlessness	Urinary Incontinence, Urge
Environmental Interpretation Syndrome, Impaired	Powerlessness, Risk for	Urinary Incontinence, Risk for Urge
Failure to Thrive, Adult	Protection, Ineffective	Urinary Retention
Falls, Risk for	Rape-Trauma Syndrome	Ventilatory Weaning Response, Dysfunctional
Family Processes, Dysfunctional: Alcoholism	Rape-Trauma Syndrome: Compound Reaction	Violence: Other-Directed, Risk for
Family Processes, Interrupted	Rape-Trauma Syndrome: Silent Reaction	Violence: Self-Directed, Risk for
Family Processes, Readiness for Enhanced	Religiosity, Impaired	Walking, Impaired
Fatigue	Religiosity, Readiness for Enhanced	Wandering
Fear	Religiosity, Risk for Impaired	
Fluid Balance, Readiness for Enhanced	Relocation Stress Syndrome	
Fluid Volume, Deficient	Relocation Stress Syndrome, Risk for	
Fluid Volume, Deficient, Risk for	Role Conflict, Parental	
Fluid Volume, Excess	Role Performance, Ineffective	
Fluid Volume, Imbalanced, Risk for	Sedentary Lifestyle	
Gas Exchange, Impaired	Self-Care, Readiness for Enhanced	
Grieving	Self-Care Deficit: Bathing/Hygiene	
Grieving, Complicated	Self-Care Deficit: Dressing/Grooming	
Grieving, Risk for Complicated	Self-Care Deficit: Feeding	
Growth, Disproportionate, Risk for	Self-Care Deficit: Toileting	
Growth and Development, Delayed		
Health Behavior, Risk-Prone		
Health Maintenance, Ineffective		

ADAPTATION NURSING THEORY AND PROCESS  
HOMEWORK

1. A statement of the patient's health problem, which is a summary of adaptive and ineffective assessments is called a nursing \_\_\_\_\_.
2. The five steps of the nursing process, using the Adaptation model are:  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.
3. Data that cannot be observed or measured, but are experienced and reported by the patient are \_\_\_\_\_ data.
4. In the interdependence mode, the person or object of most importance to the individual is known as the \_\_\_\_\_ other.
5. An organized systematic method of giving individualized nursing care that focuses on the unique human response of a person to an actual or potential health problem is called the \_\_\_\_\_ process.
6. The primary source of data collection about a patient is the \_\_\_\_\_.
7. A biopsychosocial being in constant interaction with the environment is also known as \_\_\_\_\_.
8. When selecting nursing interventions that are individualized to the patient, the nurse knows the most important factor to change is the \_\_\_\_\_, or cause.
9. The adaptation mode that has to do with psychic integrity is the \_\_\_\_\_ mode.
10. A tool used by the nurse to prescribe nursing care necessary for each individual patient is the \_\_\_\_\_.
11. A conclusion that a nurse reaches as a result of interpreting data, and which must be validated is known as a/an \_\_\_\_\_.
12. The physical and personal self are components of the \_\_\_\_\_ mode.
13. A 62-year-old Mexican woman is a grandmother to eight children. This is an example of a \_\_\_\_\_ role.
14. When the nurse gathers data and assesses the patient, the nurse decides if each assessment is adaptive or \_\_\_\_\_.
15. The nurse who is following a direct order by a physician to give a medication is performing a \_\_\_\_\_ nursing action.

16. What is the most important factor to consider in selecting nursing interventions?  
\_\_\_\_\_
17. Age is an example of a \_\_\_\_\_ role.
18. An \_\_\_\_\_ response is normal for a patient at a particular time.
19. The \_\_\_\_\_ is concerned with a person's value system and how well s/he lives up to that value system.
20. Persons of secondary importance in supporting an individual are called \_\_\_\_\_.
21. A patient hospitalized for an acute illness is classified as being in a sick role or \_\_\_\_\_ role.
22. Physical integrity of a patient is assessed in the \_\_\_\_\_ mode.
23. A nurse who inserts a Foley catheter per physician's order is performing a \_\_\_\_\_ nursing intervention.
24. A nurse who administers a PRN dose of morphine to help alleviate a patient's post-op pain is performing a \_\_\_\_\_ nursing intervention.
25. Health problems which nurses are capable and licensed to treat are called \_\_\_\_\_.
26. The first step of the nursing process is \_\_\_\_\_.
27. Evaluation is a judgment of whether or not the \_\_\_\_\_ was achieved.

## Adaptation Case Study

You are assigned to care for Mrs. Koi, a 48-year-old woman, who is admitted for a lumbar laminectomy today. Her surgery is scheduled for 4:00 p.m. this afternoon. After report, you enter her room and find her pacing back and forth and wringing her hands. She appears distracted and in some distress. She looks at you and says, “Oh, Nurse! I’m glad you’re here. I’ve never gone to surgery before. How do I know if I’ll ever wake up? How do I know I won’t die? Will I be able to dream? Will I be aware of anything? How will I know if I die? How can I trust the doctor? How can I trust the nurses to do the right thing at the right time?”

What would you do first?

Develop a nursing care plan for this patient.

Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term Patient Behavioral Goals)	Nurse Interventions (Cause-directed Actions)	Evaluation/ Modification

OHLONE COLLEGE  
N 301

FOCUS: Circulation: Nursing Assessments and Interventions

**Class 8**

REQUIRED PREPARATION:

1. Potter & Perry, pp. 520-528, 598-609
2. Jarvis, Ch. 19 Review Ch 20
3. Preusser, pp. 5-9

STUDENT OBJECTIVES:

1. Identify factors which influence patient assessments related to circulatory functions.
2. List influencing factors that can alter the pulse rate.
3. List important nursing considerations in assessing regular vs. irregular pulse and blood pressure.
4. Name and describe the location of six points at which pulses can be assessed and compared to the opposite side.
5. Describe the significance of the following heart sounds and the anatomic landmarks at which each sound is heard best: S1, S2, S3 and S4.
6. Identify specific changes in circulatory function across the life span, especially related to the elderly.
7. Discuss ethnic and cultural variations of the circulatory system.
8. Apply nursing assessments of cardiovascular structure and function based on the circulatory assessment tool.
9. Identify standard nursing diagnoses regarding circulation.
10. Define and describe the following terms:

systole	bradycardia
diastole	auscultatory gap
systolic pressure	pulse pressure
diastolic pressure	point of maximal impulse (P.M.I.)
pulse deficit	hypotension, hypertension
tachycardia	
11. Prepare case study on hypertension (Preusser pps. 5-9)

OHLONE COLLEGE  
NURSING 301  
CIRCULATION: ASSESSMENT AND INTERVENTIONS

I. Introduction: (Review only)

Circulation and respiration work together

Parts of Circulatory System: Heart as a pump, arteries, arterioles, capillaries, venules, veins

Stimulation: electrical impulse within the heart begins in the R atrium at the S.A. node

also influenced by nervous system: sympathetic: speeds rate;  
parasympathetic: slows rate

Systole: contraction of ventricles (L is strongest and most important for general circulation)

Diastole: resting and filling of ventricles with blood

Heart pumps about 5 liters/min. rate of about 70 beats/min.

**PULSE**

When L ventricle contracts, pushes blood out into already full aorta, causing a "fluid wave": felt at the periphery

$CO = S.V. \times HR$  (pulse beat per minute)  
5 L/min

Shock: S.V. is decreased so R is increased

Athletes: S.V. is increased efficient and R decreased

So pulse is one objective way to assess the C.V. system

2nd way is to assess heart sounds with stethoscope, listening to the valves

3rd way is Blood Pressure

**BLOOD PRESSURE**

Arterial pressure can be measured indirectly

"force exerted by the blood against any unit area of the vessel wall"

How much force (pressure) it takes to send mercury up a column in millimeters

**SYSTOLIC** pressure (highest #) greatest amount of pressure that the arteries feel  
b/o the contraction of L ventricle

**DIASTOLIC** pressure (lowest #) elastic recoil pressure, constantly present in arterial walls; the walls maintain a constant "tension" or **RESISTANCE (R)**

**PULSE PRESSURE**

Difference between systolic and diastolic pressure e.g.

120/80 P.P. = 40 mm Hg.

significant 180/90, wider P.P. 90 mm Hg, feel bounding pulse if 105/90

P.P. = 15 mm Hg, weak pulse,

sympathetic "clamping down" vasoconstriction

## II. Age-Related Findings in the Elderly

- With age, heart size tends to decrease
- Cardiac output declines 30% to 40% related to decreased size, heart rate, and myocardial contractility results in decreased blood flow to organs.
- Physiological changes, such as thickening of the endocardium and decreased elasticity lead to cardiac irritability, delayed recovery from myocardial infarctions, and reduced response to stress (i.e., reduced return to baseline after activity)
  
- Arterial and venous walls become less efficient as they become more dilated, prominent, tortuous and calcified.
- Increased systolic and diastolic BP occurs related to increased peripheral vascular resistance
- S4 is common, may be associated with decreased left ventricular compliance.

## III. Ethnic And Cultural Variations

### BP

- African-American tend to have higher blood pressures than Caucasians (4 times more common)  
Possible causes are thought to be related to differences in renin activity and regulation of angiotensin II  
In heat related situations, tend to retain sodium and chloride in heart-related situations
- Filipino-Americans have an increased incidence of hypertension

### Varicosities

- African-Americans have fewer varicosities than Caucasians due to greater number of venous valves

### Risk Factors

#### DM

- Varies greatly among cultural groups
- American Indians and Native Alaskans have an incidence ten times that of the general population
- Hispanics have a rate three times of the general population
- African-Americans have a rate 33% higher than whites
- Asian-Americans have a lower incidence

#### Obesity

- Increase in obesity in Native Americans can be parallel to increase in diabetes
- Mexican-American women's obesity maybe related to lower-than-average physical activity
- African-American women tend to be more obese than their Caucasian counterparts

#### Smoking

- 43% of Mexican-American men smoke, the highest percentages in the population

## TOOL FOR ASSESSMENT OF THE PHYSIOLOGIC MODE CIRCULATION

- A. History
  - 1. Previous circulatory problems
  - 2. Risk Factors: Family history, smoking, diet, activity, etc.
  - 3. Medications affecting BP, circulation
  - 4. Diagnostic Tests, monitors: EKG, CVP, serum electrolytes, other
- B. General Observations
  - 1. Patient statements:
    - a. Pain in legs after walking
    - b. Dyspnea on exertion (D.O.E.), undue fatigue
  - 2. Pain: epigastric or chest, radiation to arm, jaw, shoulder, back  
Precipitating factors
  - 3. Response of vital signs to activity, stress (Pulse and BP)
- C. Peripheral Vascular
  - 1. Inspection
    - a. Warmth and color of skin, lips, nailbeds
    - b. Edema--pretibial, ankle, hand, periorbital  
Degree
    - c. Legs--varicosities, ulcers
      - 1) Homan's sign
      - 2) Calf tenderness, redness, swelling
  - 2. Palpation
    - a. Pulses
      - 1) Rate
      - 2) Quality (thready, weak, strong, bounding)
      - 3) Rhythm (regular, irregular, paired beats)
      - 4) Types:
        - a) Radial
        - b) Pulse deficit (apical - radial)
        - c) Others: temporal, ulnar, brachial, femoral, popliteal, post tibial, dorsalis pedis--compare sides.
    - b. Blood Pressure
      - 1) Systolic, Diastolic
      - 2) Lying, sitting, standing
      - 3) Discrepancies between extremities
- D. Heart
  - 1. Inspection
    - a. P.M.I., heaves
  - 2. Palpation
    - a. P.M.I.
    - b. Carotid pulse
  - 3. Auscultation
    - a. Apical pulse
      - 1) Rate
      - 2) Rhythm
    - b. Heart Sounds (S<sub>1</sub> and S<sub>2</sub>)
    - c. Extra Sounds S<sub>3</sub>, S<sub>4</sub>, murmurs, rubs

OHLONE COLLEGE  
NURSING 301

FOCUS: Nursing Care of the Hypertensive Patient  
**Class 8**

REQUIRED PREPARATION:

1. Ignatavicius (2010) *Medical-surgical nursing*, 796-804.
2. Lilley, (2007) *Pharmacology & the nursing process*, Ch. 24 and 25.
3. Ebersole (2008) *Toward Healthy Aging*, pp. 71

STUDENT OBJECTIVES:

1. Physiologically define hypertension and its stages.
2. Identify the common risk factors for hypertension.
3. Compare and contrast essential and secondary hypertension.
4. Identify normal changes of aging which affect blood pressure.
5. Assess the clinical symptoms of hypertension.
6. Discuss the "Step Protocol" utilized for HTN control.
7. Research how hydrochlorothiazide works in the body to lower blood pressure
8. Evaluate the importance of adequate hypertension treatment in light of potential complications.
9. Predict factors which frequently contribute to non-adherence in the hypertensive patient
10. Identify five nonpharmacologic lifestyle modifications which can help to lower blood pressure.
11. Identify primary and secondary prevention measures that could be undertaken to help prevent and manage this silent disease and minimize its many complications.

OHLONE COLLEGE  
N301

FOCUS: Respiration - Nursing Assessments and Interventions

**Class 8 and 9**

REQUIRED PREPARATION:

1. Potter & Perry, pp. 528-535, 592-598
2. Jarvis Review Ch. 1, 5 and 18
3. Preusser, B. pp. 135-138

STUDENT OBJECTIVES:

1. Identify factors which influence patient assessments related to respiratory function.
2. List factors which may affect rate, rhythm and depth of respiration
3. Describe the anatomic location of the lung borders: apex, base, lateral and posterior.
4. Discuss the anatomy of both lungs as they are positioned in the chest.
5. Describe characteristics and location of three types of normal breath sounds: vesicular, bronchovesicular, bronchial.
6. Describe the characteristics and etiology of four types of adventitious lung sounds: crackle, wheeze, rhonchi, pleural friction rub.
7. Explain the following physical examination techniques in assessment of the respiratory patient: inspection, palpation, percussion and auscultation.
8. Discuss three abnormal types of breathing which indicate serious medical conditions. (Cheyne-Stokes, Biot's, Kussmaul).
9. Identify the specific changes in respiratory assessment across the life span, especially related to the elderly.
10. Discuss nursing interventions that may be used to improve a patient's respiratory response.
11. Apply nursing assessments of respiratory structure and function based on the respiratory assessment tool.
12. Discuss ethnic and cultural variations of the lungs and respiratory system.
13. Identify standard nursing diagnoses for respiration.
14. Prepare case study Preusser pps. 135-138.

**DEFINE EACH OF THE  
FOLLOWING TERMS:**

external respiration  
internal respiration  
signs (objective)  
symptoms (subjective)

alveoli  
bronchial tree  
bronchioles  
stridor  
sigh

apnea  
eupnea  
tachypnea  
bradypnea

hyperpnea, hyperventilation  
orthopnea  
dyspnea  
hypoxia  
hypoxemia  
hyper or hypo-carbia

pallor  
cyanosis

tidal volume

excursion  
barrel chest

scoliosis  
lordosis  
kyphosis

hemoptysis  
fremitus

NURSING 301  
RESPIRATORY PHYSIOLOGY OVERVIEW

I. Introduction

Mechanics of Breathing (Review)

Gases move from areas of higher pressure to lower pressure

During inspiration:

Diaphragm contracts and flattens down

Chest wall moves up and out, reduces pressure in alveoli below atmosphere--pulls in air (negative pressure)

Gas is exchanged O<sub>2</sub> for CO<sub>2</sub>

Intrapleural pressure always negative

Visceral and parietal pleura have a "suction" which holds the pleural cavity together as chest expands and contracts. Small amount of fluid causes pleura to adhere

During expiration--passive

Diaphragm relaxes--pushes back up toward chest and chest gets

smaller--air in lungs is compressed so pressure is now higher than atmosphere, so it goes out (But not all of it!!)

Normal amount one breathes in--or out--is called the tidal volume, and normally, in an adult, it is about 500 ml.

Every once in a while, one takes a "sigh," or yawns, to take in an increased volume.

Controls:

Respiratory Center in brainstem--involuntary control

Usual stimulus is hypercarbia increases CO<sub>2</sub> except in COPD

Other stimuli:

Stretch receptors in lungs--keep lung from hyperinflating

Chemoreceptors in blood, note change in pH, CO<sub>2</sub>, O<sub>2</sub>

Presso or baro receptors--in blood vessels note changed pressure

Proprioceptors--movement increases respiration.

Also, can voluntarily take in deep breath or change pattern

External Respiration--act of breathing

Ventilation

Distribution

O<sub>2</sub> and CO<sub>2</sub> diffuse across membrane in alveoli

Perfusion--blood passes thru lungs past alveoli where exchange takes place

Internal Respiration--at cellular level

O<sub>2</sub> is released by Hgb. to cells for metabolism HgbO<sub>2</sub> oxyhgb

CO<sub>2</sub> diffuses out of cells, carried by blood to lungs

## II. Factors Which Influence Respiration

- |  |   |
|--|---|
| A. Exercise or immobility<br>Smoking<br>Heat (fever), humidity<br>Moods: anxiety<br>fear<br>"fight or flight"<br>depression (frequent sighs)<br>hysteria | Thick secretions<br>Mouth breathing<br>Pain<br>Ineffective cough<br>Medications |
|--|---|

Altitude  
Obesity  
Allergens  
Musculoskeletal Abnormalities

### B. Other Medical Conditions

Brain trauma  
Hypertension  
Congestive heart failure  
Other heart disease or injury  
Anemia  
Respiratory obstruction, acute or chronic  
Respiratory infections: pneumonia, bronchitis, T.B., etc.

## III. Age Related Findings in the Elder

- With aging, vital capacity is reduced
- Thoracic cavity is broadened due to loss of muscle strength in the thorax and diaphragm; and skeletal changes
- Decrease amount of alveolar space for gas exchange due to alveoli becoming less elastic and more fibrinous
- D.O.E. is common due to ↓ alveolar gas exchange
- Mucous membranes become dry and less able to clear secretions, resulting in predisposition to bacterial growth and respiratory infection.

## IV. Ethnic and Cultural Variations

### Chest capacity and Pulmonary Function

- Caucasians have the largest thoracic cavities and American Indians the smallest.
- These normal variations affect the amount of air exchange and are reflected in pulmonary function studies of tidal volume and forced expiratory capacity

### Lung Maturity

- African-American infants lungs mature one week earlier than other cultural groups, thus experiencing a decreased incidence of respiratory distress syndrome.

### Common Lung Diseases

- Strikes different cultural groups disproportionately
- TB

- Increased incidence in American Indians
- Lung Cancer
- A health threat to all, especially due to second-hand smoke
- Increased incidences in African-American men and Pacific Islanders
- Lower incidences in American Indians and Alaska Natives
- Smoking patterns of various cultural groups and gender groups explain most, although, not all differences

V. Nursing Interventions: Independent

Maintaining the patency of the airway

Often breathing will be impaired by staying in one position too long

Position for maximum chest expansion, ambulation if possible implement measures that promote comfort (manipulates pain stimulus, causes shallow breathing, splinting)

Deep breathing and coughing (T.C.D.B.) to remove secretions helps to sit, splint incisions when present

Elevate head of bed

Provide adequate hydration--moist mucous membranes, thin secretions

Decrease anxiety and activity, use active listening, allay fears

Monitor L.O.C., confusion--report if abnormal

Assess need for O<sub>2</sub>--administer if PRN order

Explain the device, its purpose--can be frightening

**NO SMOKING!!**

Oral hygiene (foul sputum, dry mouth) decreased appetite

Organize care to minimize strain

Update respiratory assessment PRN

Suctioning

VI. Standard Nursing Diagnoses

High risk for Aspiration

Ineffective airway clearance

Ineffective breathing pattern

Impaired gas exchange

High risk for suffocation

Dysfunctional ventilatory weaning process

TOOL FOR ASSESSMENT OF THE PHYSIOLOGIC MODE  
RESPIRATION

- A. History
  - 1. Exposure to pollutants, inhalants
    - a. Smoking (packs per day)
    - b. Second hand smoke
    - c. Air or factory pollution
  - 2. Medications (affecting respiration rate, bronchioles)
    - a. Narcotics
    - b. Tranquilizers or muscle relaxants
    - c. Bronchodilators, decongestants, antihistamines
    - d. Allergies to meds.
  - 3. Diagnostic Tests
    - a. Chest X-ray
    - b. Lab (sputum culture, C.B.C., others)
- B. General Observations
  - 1. Patient statements ("I feel short of breath") (Air hunger)
  - 2. Level of anxiety, mood R/T breathing
  - 3. Pain--with breathing (splinting)
  - 4. Orientation--level of consciousness
  - 5. Activity tolerance
- C. Physical Assessment
  - 1. Inspection
    - a. Patency of Airway
    - b. Trachea midline
    - c. Respiration rate, rhythm, depth and ease
    - d. Cough--patterns, type, productive, character (color, viscosity, odor, hemoptysis)
    - e. Color (skin, nails, lips)
    - f. Clubbing of fingers, toes
    - g. Posture + symmetry of thorax (kyphosis, scoliosis, lordosis, uneven shoulders, retraction or bulging of interspaces, slope of ribs, barrel chest)
    - h. Accessory Muscles--S.C.M., scalene, nostrils, abdominal
  - 2. Palpation
    - a. Excursion, symmetry
    - b. Fremitus
  - 3. Percussion
    - a. Resonance, flatness, dullness, hyperresonance, tympany
  - 4. Auscultation
    - a. Without stethoscope: stridor, stertor, wheezes
    - b. With stethoscope, type of breath sounds: vesicular, bronchovesicular, bronchial
    - c. Adventitious sounds: rales, rhonchi, wheeze, pleural friction rub
- D. Supportive Devices
  - 1. O<sub>2</sub> per cannula, mask, other--use and effectiveness
  - 2. Nebulizers, aerosols, I.P.P.B., ventilator
  - 3. Tracheostomy

Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (Cause-directed actions)	Evaluation/ Modification
<p><b><u>RESPIRATION</u></b>  <b>History:</b> C.O.P.D., Asthma, T.B., cough, hemoptysis,  wt. loss, night sweats, fever  Age: _____ Gender: _____</p> <p>Religion:</p> <p>Ethnicity:</p> <p>Smoking: packs ___ yrs ___ 2nd hand _____  Substance abuse (marijuana, cocaine)</p> <p>Environmental risks:  Allergies to pollen, dust, airborne irritants</p> <p>Family hx for CA, TB:</p> <p><b>Meds Affecting Resp:</b></p> <p><b>Dx. tests:</b></p> <p><b>Gen. Observations:</b></p> <p>Pt. statements:</p> <p>Activity tol.:</p> <p><b><u>Physical Assessment</u></b></p> <p>resp. rate _____ rhythm _____ depth/ease _____  Pulse oximetry _____  cough/sputum freq _____ prod _____  color (skin, nails, lips) _____ clubbing _____  access. muscle used to breathe:  splinting:  excursion/symmetry:  Breath sds: normal or adventitious  Location</p> <p><b>Supportive devices:</b>  O<sub>2</sub>/spirometry/other:</p> <p>Describe effectiveness:</p>					

OHLONE COLLEGE  
N301

**FOCUS: Pneumonia- Nursing Assessments and Interventions**  
**Class 9**

**REQUIRED PREPARATION:**

1. Ignatavicius, pp. 659-666
2. Jarvis, p. 475

**STUDENT OBJECTIVES:**

1. Explain the pathophysiology of pneumonia including the three means of pathogenic entry into the lungs.
2. Differentiate between community acquired, nosocomial and opportunistic pneumonia.
3. Describe the clinical manifestations of the patient with bacterial pneumonia.
4. Describe how the elder patient with pneumonia may present.
5. Identify the laboratory and diagnostic tests utilized to help establish the diagnosis of pneumonia.
6. Explain the usual medical and nursing care for the patient with pneumonia.

OHLONE COLLEGE  
NURSING 301

**FOCUS:** Endocrine-Protective: Nursing Assessments and Interventions with Alterations in Immunity, Skin and Tissue Integrity, and Thermoregulation  
**Class 9**

**REQUIRED PREPARATION:**

1. Potter & Perry, pp. 504-520, 566-574, 645-648, 1284-1286, 1290-1292.  
Ch. 30
2. Jarvis Ch. 12
3. Lilley, Harrington, & Snyder. 149-150, 683, 701-707
4. Ebersole, pps. 66-68, 83

**STUDENT OBJECTIVES:**

1. Define the terms listed on the vocabulary list.
2. Differentiate the body's physiologic responses to external stressors: (inflammatory adaptive response vs. the immunologic adaptive response)
3. Explain the difference between active and passive immunity.
4. Compare and contrast immune serum globulin with vaccine.
5. Explain the normal immunologic changes of aging.
6. List important functions of skin, hair, and nails.
7. Discuss effects of aging on the skin, hair, nails.
8. Discuss ethnic influences on the skin, hair, nails.
9. Identify factors which may impair the integrity of the skin, hair, and nails.
10. Describe the control systems that regulate body temperature.
11. Identify the physiological mechanisms for heat production, heat conservation, and heat loss.
12. State the normal range of body temperature in Celsius and Fahrenheit.
13. Identify factors which affect thermoregulation.
14. Describe the normal physiological changes in the body with aging that place the elder at risk for both hypothermia and hyperthermia.
15. Describe the assessments in an individual with a fever or hyperpyrexia.
16. List nursing interventions for a patient undergoing hypothermia or experiencing hyperpyrexia.

17. **DESCRIBE THE ACTION, SIDE EFFECTS, AND TOXIC EFFECTS OF THE ANTIPYRETIC DRUGS: A.S.A., ACETAMINOPHEN, IBUPROFEN AND SIMILAR N.S.A.I.D.S.**
18. List important assessments, nursing diagnoses in regards to the skin, hair, and nails.
19. Identify standard nursing diagnosis in the area of endocrine - protective.
20. Define the following terms:
  - Radiation
  - Convection
  - Evaporation
  - Conduction
  - Basal metabolism
  - Antipyretic
  - Circadian rhythm
  - Diaphoresis
  - Febrile
  - Hyperpyrexia
  - Hyperthermia
  - Hypothermia
  - Pyrexia
  - Pyrogen
  - Vasoconstriction
  - Vasodilation
  - Histamine
  - Hyperemia
  - Phagocytosis
  - Macrophage
  - Exudate:
    - serous
    - sanguineous
    - purulent
    - catarrhal
    - fibrinous

## TOOL FOR ASSESSMENT OF THE PHYSIOLOGIC MODE

### ENDOCRINE/PROTECTIVE

- A. Resistance to Infection
  - 1. Presence of infection or wound
  - 2. Exposure to infection
  - 3. General appearance and vigor (nutritional status)
  - 4. Immune mechanisms
    - a. Immunizations
    - b. Previous infections
    - c. Plasma proteins
    - d. White blood count
- B. Temperature
  - 1. Subjective Data
    - a. Exposure to temperature extremes
    - b. History of body temp. extremes
    - c. Physical needs
  - 2. Objective Data
    - a. Vital signs
    - b. Range of temperature
    - c. Pattern of alteration
    - d. Relationship to environment
    - e. Illness, injuries
    - f. Factors affecting temperature
    - g. Skin assessment
- C. Skin
  - 1. Color and turgor
  - 2. Intactness (wounds, incisions, rashes)
  - 3. Character of lesions
  - 4. Areas of ischemia
  - 5. Odor and excretions
  - 6. Hair and nails
  - 7. Factors predisposing to breakdown--body prominences, incontinence, age, habits  
of personal hygiene
- D. Hormonal Activity--Lab Tests
  - 1. Thyroid
  - 2. Steroids
  - 3. Insulin (blood glucose)
  - 4. Sex hormones

Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (Cause-directed actions)	Evaluation/ Modification
<p><b><u>ENDOCRINE/ PROTECTIVE</u></b></p> <p><b>History:</b> HIV, CA, PVD, DM, smoking, drugs Age: _____ Gender: _____</p> <p><b>Risk factors:</b> urinary/bowel: continent _____ - incontinent _____ activity _____ hygiene _____ nutrition _____ cultural _____ socioeconomic influences _____</p> <p><b>Meds</b></p> <p><b>Dx tests:</b></p> <p><b><u>Physical Assessment</u></b></p> <p>Gen. Appear/hygiene _____ Temperature: _____</p> <p><b>Skin:</b> Color _____ turgor _____ Temp. _____ dry/moist _____ Lesions/wds: (describe) _____</p> <p>Drains _____ drsgs _____ Hair/beard _____ Scalp _____</p> <p><b>Protective devices:</b> Mattress/Bed _____ Heel _____ Elbow _____ Foot cradle _____ Eggcrate/other _____</p> <p><b>Therapeutic Devices:</b> Heat _____ Cold _____</p>					

OHLONE COLLEGE  
NURSING 301

FOCUS: CHAIN OF INFECTION AND NURSING INTERVENTIONS

**Class 9**

READING ASSIGNMENT: Potter and Perry, pps. 641-645

STUDENT OBJECTIVES:

1. Identify the six links in the chain of infection.
2. Describe factors contributing to the virulence or aggressiveness of an organism.
3. List three common reservoirs for infectious organisms.
4. Define nosocomial infection.
5. Describe five types of modes of transmission of pathogens.
6. Explain factors which increase susceptibility to infection in the host.
7. Describe seven nursing interventions to maximize host defenses and prevent transmission of pathogens.

OHLONE COLLEGE  
Nursing 301

FOCUS: Neuro/Sensation: Nursing Assessments and Interventions  
**Class 10**

REQUIRED PREPARATION:

1. Potter & Perry, Review pp.631-638, Ch 49.
2. Jarvis Ch 23
3. Ebersole, ch. 14

STUDENT OBJECTIVES:

1. Describe sensory deprivation and its possible effects on infants and adults.
2. List factors that may alter a patient's sensory input or cause the patient to be High Risk for altered sensory perception
3. Describe normal changes of aging related to vision which can alter perception
4. Describe normal changes of aging related to hearing which can alter perception.
5. Discuss the effects of aging on neurological assessment.
6. Explain the significance of the Glasgow Coma Scale.
7. Assess the level of consciousness of a patient using the Glasgow Coma Scale.
8. Conduct a basic cranial nerve assessment.
9. Describe your approach and the normal expected findings of pupillary assessment.
10. Describe the significance of testing both the superficial and deep tendon reflexes.
11. Perform evaluation of the corneal, gag, abdominal, cremasteric and plantar reflexes
12. Explain the proper technique you use to test and evaluate the muscle stretch or deep tendon reflexes.
13. Describe the more commonly occurring visual and auditory problems that may occur in the adult.
14. Identify nursing diagnoses in the neuro/sensation area.

NEURO/SENSATION ASSESSMENT  
NURSING 301

- I. Sensory/Perceptual Alterations
  - A. Sensoristasis: need for sensory stimulation
  - B. Sensory input from the "5 senses"
  - C. Internal "senses": kinesthetic, visceral
  - D. Sensory impairments: develop other senses to higher degree
  - E. Sudden loss of a sense: more disorganization
  - F. Behaviors seen in Sensory Deprivation
    - 1. Boredom
    - 2. Inactivity
    - 3. Slowness of thought
    - 4. Daydreaming
    - 5. Increased amount of sleep
    - 6. Thought disorganization
    - 7. Anxiety, panic, hallucinations
  - G. Behaviors seen in Sensory Overload:
  - H. Nursing Diagnosis: Actual or Potential sensory perceptual alterations. Related to:
    - Isolation
    - Eye patches, blindness
    - Decreased hearing (H.O.H.)
    - Language barrier
    - Brain tumor, lesion, hemorrhage
    - Narcotics, other meds
  - I. Specific nursing interventions
    - 1. Deaf or hearing impaired patients
    - 2. Impaired vision, or patched eyes
    - 3. Confused, Disoriented Patients

## NEURO/SENSATION ASSESSMENT AND THE OLDER ADULT

- The conduction of nerve impulses and responses decrease by 10% between the ages of 30-60.
- From about the age of 50, the number of brain cells decreases by about 1%.
- A systemic or neurologic disorder can cause a decline in intelligence, vocabulary, memory.
- Normal changes include decline in muscle bulk (especially in the hands); tremors; deviation from normal gait.
- Some loss of reflexes and sensations occurs.
- Knee jerk; ankle jerk; light touch.

## ETHNIC AND CULTURAL VARIATIONS

- Structure and function of neurological system is consistent across racial lines.
- Stroke is the third leading cause of death in the U.S. and cultural differences are noted among various ethnic groups in morbidity and mortality.
- African-American men are at a risk for stroke.
- Depression and suicide is much higher among young American Indians/Alaskan natives than any other group.

**GLASGOW COMA SCALE**

Category of Response	Appropriate Stimulus	Response	Score		
Eyes open (4)	Approach to bedside Verbal command	Spontaneous response	4		
		Opening of eyes to name or command	3		
	Pain (pressure on proximal nail bed)	Lack of opening of eyes to previous stimuli but opening to pain	2		
		Lack of opening of eyes to any stimulus	1		
		Untestable	U		
Best verbal response (5)	Verbal questioning with maximum arousal	Appropriate orientation, conversant, correct identification of self, place, year, and month	5		
		Confusion, conversant, but disorientation in one or more spheres	4		
		Inappropriate or disorganized use of words (e.g., cursing), lack of sustained conversation	3		
		Incomprehensible words, sounds (e.g., moaning)	2		
		Lack of sound, even with painful stimuli	1		
		Untestable	U		
		Best motor response (6)	Verbal command (e.g., "raise your arm, hold up two fingers") Pain (pressure on proximal nail bed)	Obedience of command	6
				Localization of pain, lack of obedience but presence of attempts to remove offending stimulus	5
				Flexion withdrawal, flexion of arm in response to pain without abnormal flexion posture	4
				Abnormal flexion, flexing of arm at elbow and pronation, making a fist	3
Abnormal extension, extension of arm at elbow usually with adduction and internal rotation of arm at shoulder	2				
		Lack of response Untestable	1 U		
TOTAL: 15					

Ohlone College  
Nursing 301

FOCUS: Neuro/Sensation: Pain Assessment  
**Class 10**

REQUIRED PREPARATION:

1. Potter & Perry, Ch. 43, pps 1056-1073 to acute care management only.
2. Ignatavicius & Workman (2010) In chapter 5 read the following pages: 35-37, 40 (chart only), 41-44, 55-57 (Nonpharmacologic Interventions through Other Complementary and Alternative Therapies only).

STUDENT OBJECTIVES

1. Discuss geriatric considerations regarding pain assessment
2. Describe factors which influence the pain experience including culture.
3. Describe the methods of assessing pain and evaluating pain relief.
4. Discuss the role of nonpharmacological management in the relief of pain.
5. Explain how attitudes and behaviors of health care workers can influence both pain assessment and pain management.

## NEURO/SENSATION ASSESSMENT

- A. History
  - 1. Previous neurological deficits: C.V.A., trauma, paralysis, epilepsy, others
  - 2. Medications (affecting nervous system)
    - a. C.N.S. depressants, stimulants
    - b. Anticonvulsants, antiinflammatory, etc.
  - 3. Diagnostic Tests: EEG, C.T. scan, myelogram, skull x-ray
- B. General Observations
  - 1. Level of consciousness: Alert, semiconscious, comatose
    - a. Orientation to Person, Place, Time (x 3)
    - b. Barriers to orientation (Language, aphasia, lack of aids, such as glasses, hearing)
  - 2. Affect and mental status
    - a. General mood: Depressed, Animated
    - b. Facial Expression
      - 1) Symmetry of nasolabial folds, eyelids, mouth (cranial nerves: motor)
  - 3. Gait and coordination (Motor)
  - 4. Muscular strength and symmetry (grips)
  - 5. Sensation: touch, temp., vibration, pain
  - 6. Speech: any impairments, aphasia, dysarthria (Motor)
  - 7. Pain
    - a. Site
    - b. Character
    - c. Circumstances
      - 1) Causes
      - 2) Relief
- C. Cranial Nerves I--XII as indicated, but especially:
  - 1. Vision
    - a. Visual acuity (distinguishing objects at specific distance--Snellen chart)
    - b. Field of vision
    - c. Known deficits (presbyopia, myopia, hyperopia, astigmatism, color blindness, blindness)
    - d. Corrective devices
    - e. Unusual sensations (halos around lights, flashing lights, diplopia, blind spots, floaters)
  - 2. Hearing
    - a. Ability to distinguish sounds
    - b. Known deficits (conductive or sensorineural, presbycusis)
    - c. Corrective device
    - d. Unusual sensations (tinnitus, dizziness, pain)
  - 3. Taste and smell: changes due to age, physical impairment
- D. Reflexes (only as indicated)--noted in history
  - 1. Deep tendon reflexes (DTR's)
  - 2. Superficial: abdominal, cremasteric, plantar (Babinski)
  - 3. Infantile automatism
- E. Central Neuro Check includes
  - 1. Level of consciousness (Oriented X 3)
  - 2. Reaction of Pupils (PERRL, sometimes A: accommodation)
  - 3. Muscular strength and symmetry (hand grips)
  - 4. Vital signs: BP and P



Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (Cause-directed actions)	Evaluation/ Modification
<p><b><u>NEURO/SENSATION</u></b>  <b>History:</b> C.V.A., paralysis, head/spinal cord injury, HTN,  headache, seizures, alterations in sensation,  tremors, dizziness, substance abuse/use  Religious/cultural influence—drugs, foods  Age: _____ Gender: _____</p> <p><b>Meds:</b>  analgesics, antipsychotics, antidepressants, sedatives,  hypnotics</p> <p><b>Dx. Tests:</b></p> <p><b>Gen. Observations:</b></p> <p>Mental status:  Oriented _____ L.O.C. _____  Mood/affect _____  Glasgow scale _____  <i>Explain if Glasgow is &lt;math&gt;\leq 15&lt;/math&gt;:</i></p> <p>Barriers to orientation _____  Memory (L.T/S.T) _____  Motor/sensation _____  Numbness/tingling _____  Gait/coordination _____  Grip strength equal? _____  Vision hearing _____  Corrective devices _____</p> <p><b><u>Physical Assessment</u></b> (Neuro ck)  V.S. _____ PERRLA _____  Grips _____  Reflexes (as indicated):</p> <p><b><u>Pain Assessment</u></b></p> <p>Pt. description:  Site _____ quality _____  Source _____ intensity (1-10) _____  How relieved _____  Acceptable pain level _____</p>					

OHLONE COLLEGE  
NURSING 301

FOCUS: Ingestion and Elimination: Nursing Assessments and Interventions in Altered Nutrition  
**Class 11**

REQUIRED PREPARATION:

1. Potter & Perry, pp. 1085-1111, 1125-1128
2. Lilly, Harrington, & Snyder Ch 54 & 55 (read about nutritional supplements **excluding nasogastric and parenteral nutrition**).
3. Jarvis, Ch 11
4. Ebersole. Ch. 9

STUDENT OBJECTIVES:

1. Review independently the basic functions of major nutrients, vitamins and minerals.
2. Discuss the "Basic Four" food guide and the Food Guide Pyramid as means for assessing the nutritional patterns of clients.
  - a. Evaluate a patient diet and judge its adequacy in terms of the basic four and the Pyramid.
  - b. State the changes in the number of servings needed for adults, elderly.
3. Describe recommendations for a healthy diet using the Pyramid
  - a. Complete My Pyramid Exercise in WebCT
  - b. Bring to class for discussion
4. Define and describe the following diets: Regular, Soft, Full Liquid, Clear Liquid, A.D.A., N.A.S., Mechanical Soft, Progress as Tolerated, Low Residue, Sodium Restricted, Pureed.
5. Identify factors for assessing the nutritional status of patients:
  - a. Physical signs
  - b. Energy level
4. Discuss cultural influences of a healthy diet.
5. Identify standard nursing diagnoses related to's and goals, for patients with problems of ingestion and nursing interventions which may be needed.
6. Assess the nutritional status of a geriatric client, identifying unique needs that occur with aging.

OHLONE COLLEGE  
NURSING 301

FOCUS: Ingestion and Elimination: Nursing Assessments and Interventions in Altered Fecal Elimination  
**Class 11**

REQUIRED PREPARATION:

1. Potter & Perry, Ch 46 (delete skills and bowel diversions)
2. Lilly, Harrington, & Snyder Ch. 52.
3. Jarvis Ch 21
4. Ebersole. Ch. 7 (pp. 120-135)

STUDENT OBJECTIVES:

1. Review independently the processes of stool formation and defecation.
2. Describe the nursing assessment of the lower intestinal tract.
3. Identify nursing diagnoses of patients with alterations of fecal elimination.
  - a. Constipation
  - b. Diarrhea
  - c. Incontinence
  - d. Flatulence
  - e. Fecal Impaction
4. Discuss factors which influence elimination.
5. Discuss how the effects of aging influence fecal elimination.

6. Define in simple terms, the following vocabulary words:

ammonia

BRAT diet

cathartic

chyme

creatinine

duodenocolic reflex

eructation

feces

flatulence

flatus

gastrocolic reflex

glucosuria

hematemesis

hematuria

hemorrhoid

lactose intolerance

laxative

masticate

nocturia

paralytic ileus

peristalsis

proteinuria

regurgitation

simethicone

urea

uric acid

OHLONE COLLEGE  
NURSING 301

FOCUS: Ingestion and Elimination: Nursing Assessments and Interventions in Altered Urinary Elimination

**Class 11**

REQUIRED PREPARATION:

1. Potter and Perry, Ch 45 (delete the skills of inserting catheters)
2. Ebersole. Ch. 7 (pp. 120-135)

STUDENT OBJECTIVES:

1. Review independently the process of urine formation and elimination.
2. Identify factors that affect urinary habits and patterns.
3. List normal and abnormal findings in a routine urinalysis
  - a. color
  - b. appearance
  - c. specific gravity
  - d. pH
  - e. protein
  - f. blood
  - g. glucose
  - h. ketone bodies
4. Identify common problems experienced by patients with urinary system dysfunction.
5. Compare types of incontinence and its incidence in the geriatric population
6. List methods used to assess kidney and bladder function.
7. Identify nursing diagnoses of patients with alterations in urinary elimination.
8. State examples of clinical manifestations of an urinary tract infection (UTI) that may occur in the geriatric population.
9. Define the following terms:  
Retention  
Incontinence  
Cystitis  
Frequency  
Urgency  
Dysuria  
Polyuria  
Nocturia  
Oliguria  
Residual Urine  
Stasis

OHLONE COLLEGE  
NURSING 301

I. Urine—Kidney Function

Regulates fluids, electrolytes, acid-base balance, osmotic pressure

Eliminates waste

Kidneys weigh only .5% of total body weight. About 1500 to 1600 ml of urine is excreted in a 24 hr. period.

A. Factors Affecting Urination

- Psychological--the power of suggestion
- Toilet training and Culture
- Personal habits--reading
- Fluid intake-stimulants to void
- Meds
- Muscle tone
- Surgery
- Neuro impairment
- Other--hormones, pregnancy, age (toilet training)

B. Assessment:

Lab. Values and Diagnostic Tests (X-rays, etc.)

- Color: Pale, straw color to amber
  - Meds or physiologic changes may cause urine to be other colors
- Appearance: Clear
- Specific Gravity (the density or "heaviness" of urine as compared to water, which has been given the value, 1.0)
  - Urine is 1.010 to 1.025
  - Demonstrates the ability of the kidneys to concentrate the urine
- pH--varies from acid to alkaline for lots of reasons about 4.5 to 7.5, or 4.6-8 as in your syllabus
- RBC's--should be absent if +, bladder infection, or perhaps higher up in the urinary tract
- WBC's--none--if +, infection as above
- Protein--neg.--if +, not filtering out plasma proteins
- Sugar--neg.--if +, possible Diabetes, or problem with low threshold for glucose
- Ketone bodies (acetone)--neg.--if +, possible Diabetes, or starvation--breakdown of stored protein
- Bacteria--negative--if +, either infection or contaminated
- Casts--None

Other serum tests: such as B.U.N., K.U.B., I.V.P., creatinine

Usual Patterns Should not void more than every 1 1/2 hours or less than every 12 hours.

Changes due to illness, stress, surgery, trauma

Artificial orifice or catheter device

Pain

Urgency

Incontinence--stress, cough, bouncing, sneezing

Fever

Bladder percussion--dull with distention

palpation--detect "firmness" above symphysis pubis

Patient should produce 30-50cc of urine per hour!!

if less than 25cc, consider shock, kidney failure, dehydration

### C. Common Problems

#### 1. Cystitis—more common in women

Causes: Irritation, poor hygiene, catheters

Symptoms: Burning, urgency, frequency, blood in urine

Ascending infections: fever, chills, n + v, flank pain

Nursing Interventions:

Increase fluid intake--keeps urine dilute

Void every 2 hours throughout day, 1 or 2 X's at noc.

Alter pH--cranberry juice, Vit. C., acid ash diet

If on antibiotics for already present infection, may need alkaline urine for medication to work effectively.

Diet includes: meats, eggs, cheese, whole grains, cranberries, prunes, plums

Avoid: most vegies, other fruits than above, pickles, nuts, soda, baking powder, carbonated beverages.

#### 2. Urinary Retention

Causes: Obstruction, fecal impaction, poor fluid intake, stress

Nursing Interventions:

Patient teaching!

FIRST try relaxation, positioning, take to B.R., power of suggestion!

May need an order for cholinergic drug, such as Urecholine

LAST RESORT: catheterize (need an order)

#### 3. Urinary Incontinence

Causes: Drugs, alcohol (ETOH), U.T.I., neurological impairment

"Giving up"--no one answered the call light

Nursing Interventions:

Good skin care

Maintain fluid intake

Offer bedpan or commode more often

Urinal in place for males

Pelvic exercises Bladder training

**Table 44-5 Urinary Incontinence and Treatment Options**

Description/Causes	Symptoms	Interventions
<b>Functional</b>		
Involuntary, unpredictable passage of urine in a client with intact urinary and nervous system Change in environment: sensory, cognitive, or mobility deficits	Urge to void that causes loss of urine before reaching appropriate receptacle. The client with cognitive changes may have forgotten what to do.	Habit training Environmental alterations Scheduled toileting Condom catheter (men) Protective undergarments
<b>Overflow</b>		
Voluntary or involuntary loss of a small amount of urine (20-30 ml) from an overdistended bladder Hypotonic or underactive detrusor secondary to drugs, fecal impaction, diabetes, spinal cord injury; men—prostate enlargement; women—severe uterine prolapse	Symptoms may vary from dribbling of a few drops of urine to larger amounts with urgency and frequency.	Intermittent catheterization Surgery Indwelling or condom catheter Credé's method
<b>Reflex</b>		
Involuntary loss of urine occurring at somewhat predictable intervals; large or small volume Spinal cord dysfunction (either inhibition of cerebral awareness or impairment of the reflex arc)	Unawareness of bladder filling, lack of urge to void, uninhibited bladder spasm contraction	Anticholinergic medications Surgery Intermittent catheterization Indwelling or condom catheter Estrogen replacement Credé's method
<b>Stress</b>		
Leakage of small volumes of urine caused by sudden increase in intraabdominal pressure Coughing, laughing, sneezing, or lifting with a full bladder; obesity; full uterus in third trimester; incompetent bladder outlet; weak pelvic musculature	Loss of urine with increased intraabdominal pressure, urinary urgency and frequency	Pelvic floor exercises (Kegel) Surgery Artificial sphincter Biofeedback Scheduled toileting Electrical stimulation Lifestyle modifications (e.g., weight reduction, smoking cessation)
<b>Urge</b>		
Involuntary passage of urine after a strong sense of urgency to void Decreased bladder capacity; irritation of bladder stretch receptors; alcohol or caffeine ingestion; increased fluid intake; infection	Urinary urgency, often with frequency (more often than every 2 hours); bladder spasm or contraction; voiding in either small amounts (<100 ml) or large amounts (>500 ml)	Anticholinergic medications Bladder retraining Scheduled toileting Treatment of UTI or vaginitis Biofeedback Electrical stimulation Lifestyle modifications (e.g., selected dietary and fluid modifications)

Data from Ackley BJ, Ludwig GB: *Nursing diagnosis handbook: a guide to planning care*, St. Louis, 1997, Mosby; Wyman JF: Treatment of urinary incontinence in men and older women, *Am J Nurs* 103(3 suppl): 26, 2003.

(Potter, Patricia A. Potter. *Fundamentals of Nursing, 6th Edition*. Elsevier, 2004.).

TOOL FOR ASSESSMENT OF THE PHYSIOLOGIC MODE  
INGESTION AND ELIMINATION

A. History

1. Dietary Habits
  - a. Usual eating habits (basic four, RDA)
  - b. Appetite
  - c. Changes related to health problem
  - d. Person responsible to prepare food at home
  - e. Present Diet
2. Adequacy of Diet
  - a. Height, weight, gain-loss pattern
  - b. General appearance and vigor
3. Attitudes toward Eating
  - a. Importance of food to feeling of well-being
  - b. Religious dietary restrictions
  - c. Symbolic meaning of food - reward, punishment, love
4. Factors in Ingestion
  - a. State of consciousness
  - b. State of mouth (mucous membranes, moistness, breath odor)
  - c. State of teeth and gums (enough to chew)
  - d. Ability to swallow
  - e. Intestinal motility (bowel sounds)
5. Digestion
  - a. Ease of digestion (indigestion or heartburn)
  - b. Nausea, vomiting
  - c. Eructation or flatus
  - d. Medications affecting digestion or metabolism
6. Non-oral means of feeding
  - a. Parenteral fluids; hyperalimentation
  - b. Nasogastric tube; gastrostomy
7. Normal Patterns of Elimination
  - a. Frequency
  - b. Amount
  - c. Color and consistency of stool; color and character of urine
  - d. Last B.M.
8. Aids to elimination normally used
  - a. Habit patterns
  - b. Beverages or foods
  - c. Laxatives or enemas
9. Changes due to Health Problem
  - a. Character of urine (unusual lab values)
  - b. Character of stool (color, consistency, unusual lab values)

10. Method of Elimination
  - a. Bedpan, toilet, urinal
  - b. Artificial orifices (colostomy, ileostomy, ureterostomy)
11. Special Problems
  - a. Incontinence (urine or stool)
  - b. Urinary retention
  - c. Constipation (fecal impaction)
  - d. Diarrhea

B. Abdominal Assessment

1. Inspection
  - a. Skin: rashes, scars, lesions
  - b. Size, swelling, girth
  - c. Peristalsis (abnormal)
2. Auscultation
  - a. Bowel sounds: frequency--present, hyperactive, hypoactive, absent
  - b. Bruits
3. Percussion
  - a. Fluid
  - b. Masses (full bladder)
  - c. Gas (tympany)
4. Palpation
  - a. tenderness
  - b. masses

C. Rectal Assessment (if indicated) for fecal impaction

Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (Cause-directed actions)	Evaluation/ Modification
<p><b>INGESTION/ ELIMINATION</b></p> <p><b>History:</b> GI/GU, AIDS, CA eating disorders, obesity, renal disease, liver, pancrease, gallbladder, substance abuse, hemorrhoids Age: _____ Gender: _____</p> <p><b>Meds:</b></p> <p><b>Risk factors:</b> Physical activity, diet</p> <p><b>Diet:</b> _____ Changes _____ ht/wt: Current _____ Last 6 mo: _____ <i>Calculate BMI:</i> _____ Diet _____ Cultural Influence, Religious Influence, Socioeconomic factors Usual changes related to current diagnosis</p> <p><b>Changes/Restrictions:</b> Appetite _____ NPO _____ Anorexia _____ Nausea/vomiting _____ Heartburn/indigestion _____ Belching/flatus _____ Chewing/swallowing _____ Dentures/teeth _____ Mucous mem./gums _____ NG/GT Tube _____ PPN/TPN _____</p> <p><b>B.M.:</b> usual pattern: Last _____ Describe color/consist _____ Laxatives/enema use _____ Ostomies _____</p> <p><b>Urine:</b> Amt./pattern _____ Color/clarity _____ Continent ____ Incont ____ Supra pubic, Continent ____ Incont ____ Foley cath ____ patent ____ briefs ____</p> <p><b>Abdominal Assessment</b> Skin _____ Girth _____ Distended/flat _____</p> <p><b>Bowel sds:</b> Present _____</p> <p><b>Percussion:</b> Tympany ____ Dull ____</p> <p><b>Palpation:</b> Tender ____ masses _____</p>					

Ohlone College  
N301

FOCUS: Antibiotic Resistant Organisms, Blood Borne Pathogens

**Class 12**

REQUIRED PREPARATION:

Potter and Perry, pps 643, 647, 660-668

Objectives:

1. Describe how a healthcare worker might be potentially exposed to a blood-borne pathogen.
2. Identify three prevention strategies for health care workers to minimize transmission of blood-borne pathogens.
3. Describe factors affecting the risk of transmission once exposed to blood borne pathogens.
4. Explain the OSHA bloodborne pathogens standard.
5. Identify the primary components of “Standard Precautions.”
6. Locate personal protective equipment (PPE) in your clinical setting and use appropriately.
7. Discuss ways that bacteria make themselves resistant to antibiotics.
8. Discuss factors/practices contributing to drug resistance in the United States and the world.
9. Identify actions you can take as an individual and as a health care provider to help prevent the spread of resistant strains.
10. Explain the specific precautions required to help prevent spread of MRSA and VRE.

## ANTIBIOTIC RESISTANT ORGANISMS

**VRE:** Vancomycin-resistant enterococcus

- Enterococcus nl in stomach, intestines, female genital tract
- Once RX with penicillin or ampicillin, then gentamicin, then vancomycin—all resistant
- Risk: immunosuppressed, hx of taking vancomycin, 3<sup>rd</sup> generation cephalosporins, or antibiotics targeted at anaerobic bacteria (i.e. Clostridium difficile), pt with Foleys or CVPs, elderly with prolonged or repeated hospital adm.
- Spread: Direct contact with infected or colonized individual  
Colonized—no s & s of infection yet VRE can be isolated from stool, etc.  
Capable of living for weeks on surfaces, i.e., overbed table
- RX: Standard precautions, contact isolation until culture-negative or discharged, several antibiotic drug combinations or no drug Rx (wait for nl bacteria to repopulate and replace VRE)

**MRSA:** methicillin-resistant Staphylococcus aureus

- S. aureus nl on skin, mucous membranes, upper respiratory, intestinal, and genitourinary tracts.
- In 1941, all staph was susceptible to penicillin; today 90% are penicillin-resistant; 27% methicillin resistant, also resist cephalosporins, aminoglycosides, erythromycin, tetracycline, clindamycin.
- Risk: Immunosuppressed, burns, intubated, CVPs, surgical wound, dermatitis, prosthetic devices, heart valves, post-op wound infections, prolonged hospital stays, extended therapy with multiple or broad-spectrum antibiotics, close proximity to those colonized or infected with MRSA, acute endocarditis, bacteremia, cervicitis, meningitis, pericarditis, pneumonia.
- Spread: Direct contact with infected or colonized individual; transmitted mainly on health care workers' **hands**; most frequent site of colonization is the anterior nares—40% of adults and children become transient nasal carriers; other colonized sites include groin, axilla, gut
- RX: standard precautions, contact isolation—transmission based precautions, Vancomycin

**Hand washing with soap is key. Check your facility re: alcohol based hand cleansers.**

MRSA can survive on health care workers' hands for up to 3 hours.

Dedicated equipment, use gloves, gown, and mask in pt room ONLY!

Single room, prudence when dealing with body fluids (colostomy, draining wound, etc.)

Education of patient, family, and visitors; continued vigilance against the spread of these organisms.

Encourage MDs to limit the indiscriminate use of antibiotics.

**VISA:** S. aureus intermediately resistant to vancomycin—discovered in 1996 in Japan. last summer isolated in Michigan and New Jersey. Virtually no antibiotic to treat this microbe.

OHLONE COLLEGE  
NURSING 301

FOCUS: Wound Healing, Pressure Ulcer Assessment and Prevention

**Class 12**

REQUIRED PREPARATION:

1. Potter and Perry, ch. 48, pp. 1278-1305
2. Ignatavicius and Workman (2010). Chapter 27, pp. 484-493 (on p. 493 chart 27-4 only)

STUDENT OBJECTIVES:

After appropriate reading, study, and classroom discussion the student will:

1. Define terms commonly used to describe wounds.

abrasion

contusion

incision

ischemia

laceration

puncture

stab

2. Identify the three phases of wound healing.

3. Describe at least three processes that take place at each phase of wound healing.

Thought Question: How does partial thickness wound repair differ from full-thickness wound repair?

4. Differentiate the three different ways in which wounds heal: primary, secondary and tertiary intention.

5. Define the term pressure ulcer.

6. Differentiate characteristics of stage I, stage II, stage III, and stage IV pressure ulcers.

7. Compare and contrast normal reactive hyperemia with nonblanching erythema and

identify other related skin assessment indicators in the dark-skinned individual.

8. Explain seven risk factors for pressure ulcer formation.
9. Describe three normal age related changes that increase risk of pressure ulcer formation.
10. Identify three lab/diagnostic tests that may help identify the body's capability for wound healing or the presence of infection.
11. Describe the Braden scale and demonstrate how it is used in assessment of skin integrity.
12. Describe how you would perform a thorough wound assessment and document your findings.
13. Describe the following wound related terms: tunneling, undermining, slough, eschar.
14. Describe factors which affect wound healing.
15. Discuss principles of wound care to promote wound healing.
16. Relate actions you can take as the nurse to reduce the risk for impaired skin integrity and promote healing in your patients.

OHLONE COLLEGE  
NURSING 301

FOCUS: Principles of Fluids and Electrolytes

**Class 12**

REQUIRED PREPARATION:

1. Ignatavicius (2010) ch. 13 pp. 170-198
2. Potter and Perry, p. 992
3. Ebersole, p.74-75

STUDENT OBJECTIVES: At the completion of this unit, the student will be able to:

1. Describe how fluids and electrolytes are distributed in the body.
2. Identify the primary functions and normal ranges of the following electrolytes in the body: sodium, chloride, potassium and calcium.
3. Discuss concepts of fluid movement in the body; diffusion, osmosis, filtration and active transport.
4. Discuss the body organ systems and hormonal control of fluid and electrolyte balance.
5. Identify the primary function and normal ranges of the following electrolytes in the body: Na, CL, K, Ca.
6. Identify individuals at greatest risk for fluid and electrolyte imbalance with emphasis on the normal changes of aging.
7. Define the terms, isotonic, hypotonic and hypertonic.
8. Give one example of a hypotonic, isotonic and hypertonic intravenous solution and state when it would be used.

Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (Cause-directed actions)	Evaluation/ Modification
<p><b><u>FLUIDS AND ELECTROLYTES</u></b></p> <p><b>History:</b> CA, CHF, DM, Dehydration, renal failure.  Fluid imbalances-renal, c.v., g.i.:  age ___ cultural influences ___ Gender: ___  religious influences  diet</p> <p>Risk factors: fever _____  Vomiting ___ diarrhea ___  Diaphoresis ___  Fistulas ___ burns ___</p> <p><b>Meds</b></p> <p>Wt. changes r/t fluids _____  24° I &amp; O trend _____ Current I &amp; O _____</p> <p><b>Dx. Tests:</b></p> <p><b><u>Physical Assessment</u></b></p> <p>Mucous membranes:  Dry _____ moist _____</p> <p>Report of thirst _____</p> <p>Skin turgor:</p> <p>Neck veins:  Flat _____ distended _____</p> <p>Edema: (2 mm:1+ - 8 mm:4+)  Pitting ___ dependent ___</p> <p>Periph. veins:  Slow filling _____ full _____</p> <p>I.V. Fluids hypotonic, hypertonic, isotonic</p>					

OHLONE COLLEGE  
NURSING 301

FOCUS: Exercise and Rest: Nursing Assessments and Interventions  
**Class 13**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Chapter 42, 37, 38 (p 819-832)
2. Bring Adaptation Nursing Diagnosis List
3. Bring Nursing Diagnosis textbook to class.
4. Ebersole, ch. 15, pps. 380-385 only

STUDENT OBJECTIVES

1. List assessment factors affecting exercise, rest, and sleep.
2. List four purposes of exercise.
3. Identify positive effects of exercise.
4. Identify indices used to assess activity tolerance and the times they should be measured.
5. Identify maturational changes that impact mobility and safety.
6. Develop a plan to minimize the risk of falling in the geriatric population.
7. Discuss common reasons for restraining patients.
8. Propose fall risk reduction strategies and restraint alternatives nurses can use to promote the least restrictive environment for patients especially the elderly.
9. Identify normal changes of aging which affect mobility and sleep.
10. Name the two distinct types of sleep activity and compare the physiologic manifestations of each.
11. Describe the physical and mental assessments associated with sleep deprivation, or insufficient sleep.
12. Describe nursing interventions designed to promote normal rest and sleep patterns, and also exercise.
13. Identify nursing diagnoses relevant to problems of exercise and rest.
14. Define terms in the Rest and Sleep, Exercise vocabulary lists.



## EXERCISE AND REST

### A. Musculoskeletal Status

1. General movement (coordination, ease, stability; deliberate and purposeful; moves independently)
2. Muscle strength, tone, and mass (all extremities, trunk abdomen; symmetry; change due to health problem; grips equal)
3. Range of motion all joints (no limitations or degree of limitation)
4. Posture/alignment
5. Handedness
6. Deformities (intactness of extremities, prosthetic devices)
7. Abnormal innervation to muscles (paralysis, weakness)

### B. Mobility

1. Medical restrictions of activity (bedrest, etc.)
2. Method of ambulation (unassisted, crutches, cane, walker, wheelchair)
3. Gait (mode of walking, coordination, stability)
4. Endurance (amount of activity tolerated)

### C. Assessment of Activities of Daily Living (ADL)

	ADAPTIVE	ASSISTED
Eating	Self	Assist with preparation of food Assist in eating
Dressing	Self	Assist in dressing
Bathing	Self	Bed bath or partial Needs help with tub or shower
Grooming	Self	Needs assistance
Elimination	Voluntary control	Needs assistance with drugs or enemas
Ambulation	Self Stable/normal gait	Needs help or special devices

### D. Sleep

1. Normal sleep patterns (number of hours, time, feelings of being rested)
2. Alterations due to health problems
3. Aids used for sleep (beverages, familiar objects)
4. Medications

OHLONE COLLEGE

NURSING 301

**FOCUS:** Nursing Care of the Patient with Degenerative Joint Disease  
**Class 13**

**REQUIRED PREPARATION:**

Ignatavicius (2010), ch. 20, pps. 322-328 up to but not including surgical management.

**STUDENT OBJECTIVES:**

1. Describe the pathophysiology, clinical manifestations, therapeutic management, and nursing care of osteoarthritis.
2. Describe the sequence of events leading to joint destruction in osteoarthritis.
3. Compare osteoarthritis with inflammatory joint disease related to clinical manifestations, nursing care, and prognosis.
4. Identify the nursing role in the conservative management of arthritis.
5. Identify common medications used to treat osteoarthritis and possible complications.

OHLONE COLLEGE  
NURSING 301

FOCUS: Problems of Immobility and Bedrest  
**Class 14**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Chapter 47.

STUDENT OBJECTIVES:

1. Discuss the differences between bedrest and immobility.
2. Identify changes in physiological and psychosocial function associated with immobility.
3. Identify groups most at risk for complications of immobility
4. Describe nursing assessments associated with hazards of immobility.
5. Identify nursing diagnoses relevant to problems of immobility.
6. Describe nursing interventions designed to reduce hazards of immobility.
7. Recognizes the impact of patient's nutritional status on the immobile patient.
8. Understands the effect of pain on the patient's mobility.

Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (Cause-directed actions)	Evaluation Modification
<p><b><u>EXERCISE &amp; REST</u></b></p> <p><b>History:</b></p> <p>Medical Restrictions: Bedrest _____ Other _____</p> <p><b>Gen. Observations:</b></p> <p>R.O.M. active ____ passive _____</p> <p>Limitations _____</p> <p>Extremity elevation _____</p> <p>Activity tolerance _____</p> <p>Muscle strength/tone/mass _____</p> <p>Body alignment/posture _____</p> <p>Turn q _____ hrs</p> <p>Movements/coordination _____</p> <p>Ambulation _____</p> <p>Assistive devices _____</p> <p>Use of aids (walker, cane, etc) _____</p> <p><b>Safety precautions:</b></p> <p><b>Performance of ADLs:</b></p> <p>Eating _____</p> <p>Dressing _____ bathing _____</p> <p>Grooming _____ other _____</p> <p><b><u>Assessment of Rest/Sleep</u></b></p> <p>Usual pattern _____ hrs.</p> <p>Alterations due to hospitalization: Sleep aids: meds/other _____</p>					

OHLONE COLLEGE  
NURSING 301

FOCUS: Homeostasis, Stress, and Adaptation –

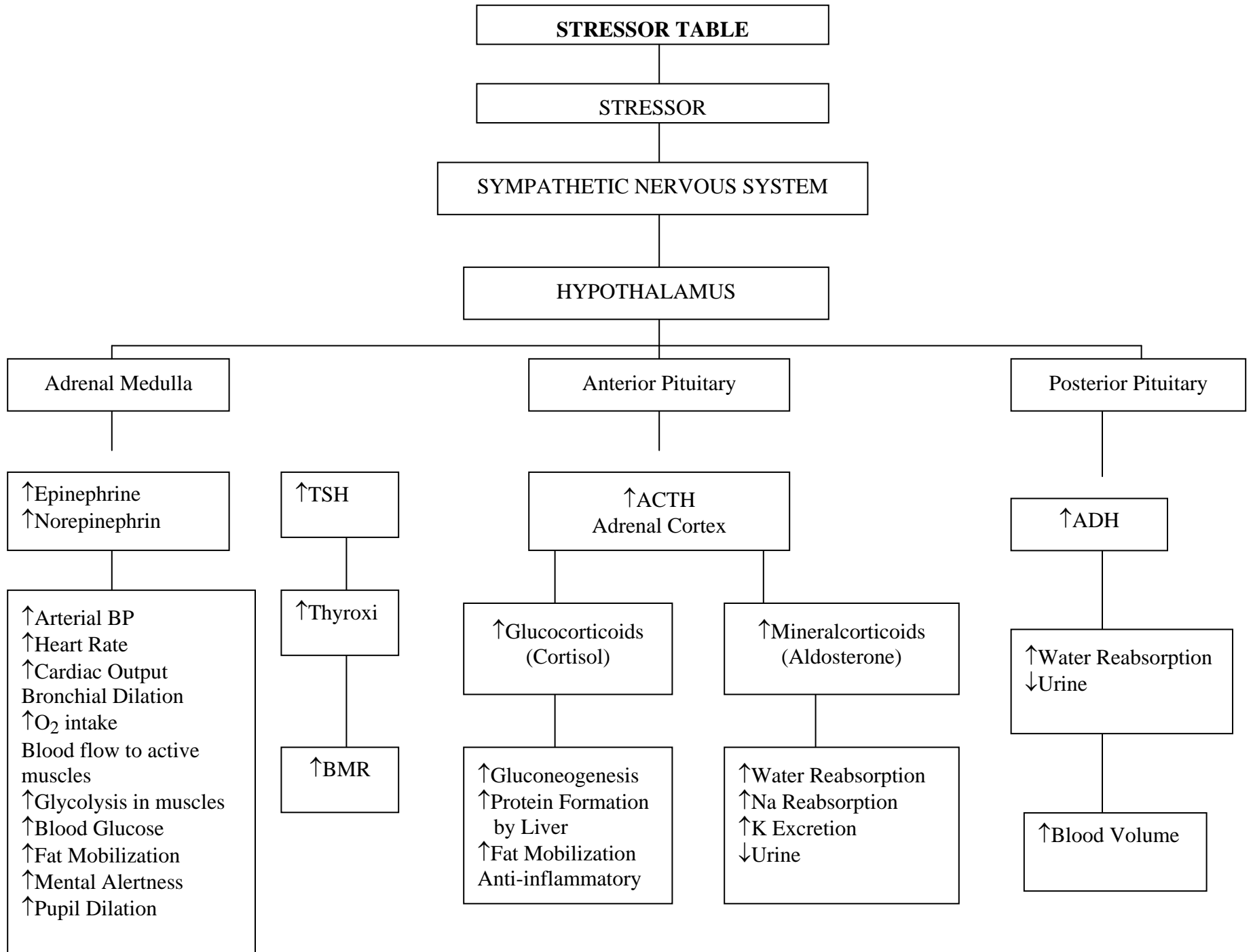
**Class 14**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of nursing, Chapter 31.
2. View Video VID 789; Managing the Stress Response.
3. Complete defense mechanism and stress worksheet prior to class.

STUDENT OBJECTIVES:

1. Define homeostasis, stress, and stressors.
2. Assess variables influencing the degree to which stressors affect individuals and how culture might impact the variable.
3. Describe the concept of physiological and psychosocial adaptation according to the Roy Adaptation Nursing Model.
4. Describe the physiology of the stress response.
5. Assess the physiologic and psychological signs and symptoms of stress in oneself.
6. Describe the psychological responses to stress and plan interventions to minimize psychological stress.
7. Identify and give examples of the ego defense mechanisms.
8. Assess stressors to which hospitalized patients are exposed and plan nursing interventions to minimize them.
9. List stressors to which nurses are exposed and plan interventions to minimize them for each other.



## PHYSICAL

- \_\_\_ increased or decreased appetite
- \_\_\_ headaches
- \_\_\_ tension
- \_\_\_ fatigue
- \_\_\_ insomnia
- \_\_\_ weight change - more than 10 lbs.
- \_\_\_ muscle & joint aches
- \_\_\_ pounding heart
- \_\_\_ accident prone
- \_\_\_ teeth grinding
- \_\_\_ rash
- \_\_\_ restlessness
- \_\_\_ foot-tapping, leg movement
- \_\_\_ clenched fists
- \_\_\_ finger-drumming
- \_\_\_ nail biting
- \_\_\_ increased alcohol, drug, tobacco use
- \_\_\_ elevated blood pressure
- \_\_\_ tightness in chest, chest pain
- \_\_\_ tight shoulders
- \_\_\_ neck pain
- \_\_\_ breathing difficulty
- \_\_\_ exhaustion
- \_\_\_ digestive upsets: nausea, diarrhea, vomiting, ulcers, colitis, stomach aches, constipation, flatus
- \_\_\_ vague somatic complaints, minor ailments
- \_\_\_ backaches
- \_\_\_ frequent or prolonged colds or flu
- \_\_\_ urinary frequency
- \_\_\_ sweaty palms, perspire excessively
- \_\_\_ dry mouth
- \_\_\_ feel flushed
- \_\_\_ dysmenorrhea & frigidity in woman
- \_\_\_ impotence in men
- \_\_\_ nervous twitch

## COGNITIVE

- \_\_\_ forgetfulness
- \_\_\_ dull senses
- \_\_\_ poor concentration
- \_\_\_ low productivity
- \_\_\_ negative attitude
- \_\_\_ confusion
- \_\_\_ lethargy
- \_\_\_ whirling mind
- \_\_\_ no new ideas
- \_\_\_ boredom
- \_\_\_ spacing out - increased fantasy life, day dreaming
- \_\_\_ negative self-talk
- \_\_\_ preoccupation
- \_\_\_ blocking
- \_\_\_ past - rather than present oriented
- \_\_\_ decreased creativity
- \_\_\_ mentally lazy
- \_\_\_ disorganized
- \_\_\_ increased errors
- \_\_\_ increased speed of talking

## BEHAVIORAL

- \_\_\_ decreased exercise
- \_\_\_ sleeping pills
- \_\_\_ increased smoking
- \_\_\_ increased drug use (caffeine)
- \_\_\_ difficulty sitting still
- \_\_\_ increased fat intake
- \_\_\_ easily startled
- \_\_\_ increased sugar intake
- \_\_\_ increased alcohol

## EMOTIONAL

- anxiety
- frustration
- the "blues"
- mood swings
- bad temper, anger
- nightmares
- cries easily
- irritability
- "no one cares"
- depression
- nervous laugh
- worrying
- easily discouraged
- little joy
- overreacting
- hostility
- jealousy
- withdrawn
- apathetic
- blaming others
- less personal involvement from others
- cynical
- job dissatisfaction

## SPIRITUAL

- emptiness
- loss of meaning
- doubt
- unforgiving
- martyrdom
- looking for magic
- loss of direction
- needing to "prove" self
- cynicism
- apathy

## RELATIONAL

- isolation
- intolerance
- resentment
- loneliness
- lashing out
- hiding
- claming up
- lowered sex drive
- nagging
- distrust
- fewer contacts with friends
- lack of intimacy
- using people

## **Coping Mechanisms to Stress/Anxiety**

- 1.) *Compensation*: Making up for deficit or inadequacy by excelling in another
- 2.) *Conversion*: An attempt to deny or relieve emotions by changing them into physical symptoms.
- 3.) *Denial*: Refuse to acknowledge that which causes emotional pain.
- 4.) *Displacement*: Transfer emotions associated with an idea, object or person to another.
- 5.) *Identification*: An individual thinks, feels or acts like another person or group who are significant to him.
- 6.) *Projection*: Attribute own thoughts, feeling and actions to the external environment.
- 7.) *Rationalization*: Finding a more plausible reason for behavior than real one.
- 8.) *Reaction Formation*: Denying unacceptable aspects of personality by developing the extreme opposite kind of behavior.
- 9.) *Regression*: Return to earlier, more comforting but less mature ways of behaving.
- 10.) *Repression*: Exclude from awareness unpleasant or unwanted experiences, emotions, ideas
- 11.) *Sublimation*: Direct unacceptable impulses into constructive channels.
- 12.) *Suppression*: Conscious decision to not deal with an issue and postpone it, using unrealistic rationale as the reason.

## DEFENSE MECHANISM WORKSHEET

DIRECTIONS: Match the description of a situation with a defense mechanism.

DENIAL

REACTION FORMATION

DISPLACEMENT

PROJECTION

CONVERSION

IDENTIFICATION

RATIONALIZATION

COMPENSATION

REPRESSION

SUBLIMATION

SUPPRESSION

REGRESSION

1. A man who is paralyzed and in a wheelchair works as a volunteer in the hospital. He delivers flowers to patients. \_\_\_\_\_
2. Mr. Jones cannot remember that the doctor told him his condition is terminal. \_\_\_\_\_
3. The nursing student says, "I've got two weeks before my next test, so I will study later."
4. A young girl has a positive experience with her nurse while on the pediatric ward and decides she wants to become a nurse. \_\_\_\_\_
5. A young mother, when told she is expecting twins, suddenly becomes blind. \_\_\_\_\_
6. A teenage boy who has a violent temper, takes karate lessons. \_\_\_\_\_
7. The patient that is angry with his doctor yells at the nurse who is making his bed. \_\_\_\_\_
8. Mr. Smith who has emphysema from smoking says, "I want to quit smoking, but my wife smokes too, so it wouldn't make any difference with all that smoke in the house."  
\_\_\_\_\_
9. Miss Brown, age 22, has temper tantrums when she doesn't get her own way. \_\_\_\_\_
10. John Baswsett who is admitted for a "heart attack," says, "There's nothing wrong with me, just a little indigestion." \_\_\_\_\_
11. A day nurse who is known for not getting along well with others complains about an evening shift nurse, who is unfriendly. \_\_\_\_\_
12. A nurse who dislikes the physician she is working with carries on a lengthy, social conversation with him. \_\_\_\_\_

OHLONE COLLEGE  
NURSING 301

FOCUS: Psychosocial Modes: Nursing Assessment and Interventions in Self-Concept, Role Function, and Interdependence.

**Class 15**

REQUIRED PREPARATION:

1. Read Potter & Perry, Fundamentals of Nursing, Chapter 11 (p 139-140); Chapter 27, 29.
2. Bring Nursing Diagnosis textbook and Nursing Diagnosis sheet (p 79-80) to class.
3. Ebersole, pps. 33-40, 84-85, 625-627
4. Complete worksheets and read syllabus handouts.

STUDENT OBJECTIVES:

1. Define and describe the components of self-concept.
2. Describe the effects of Erickson's psychosocial tasks on self-concept.
3. Recognize adult developmental stages by the description of tasks, according to Erickson.
4. Describe aspects essential to assessing stressors and coping strategies.
5. Identify assessments suggestive of ineffective self-concept.
6. Identify common problems or nursing diagnoses related to each component of self-concept.
7. Identify nursing diagnoses related to problems of self-concept.
8. Recognizing essentials involved in planning and implementing nursing interventions, to maintain, promote and restore a person's self-concept and self-esteem.
9. Briefly discuss three psychosocial theories of aging and describe ways to enhance the self-esteem of older adults.
10. Describe how reminiscence and life review can be used by the nurse to help meet the psychosocial and spiritual needs of the elder.
11. Describe the developmental nature of Role Function.

OBJECTIVES: (con't)

12. Define:
  - a. Primary role
  - b. Secondary role
  - c. Tertiary role
13. Discuss the significance of role changes in terms of secondary and tertiary roles across the life span. (Who has the least/most roles?)
14. Discuss identification of "related to's" and the general focus of interventions in the Role Function Mode.
15. Identify standard nursing diagnoses that are used in Role Function.
16. Identify common behavior changes in sick persons.
17. Describe the effects of illness on family members' roles and functions.
18. Define the following:
  - a. Interdependence
  - b. Significant other
  - c. Support system
19. Describe the major tasks involved in achieving interdependence.
20. Describe how illness and hospitalization might effect the interdependence balance between a patient and his/her significant others and support systems.
21. Discuss assessment factors and the focus of interventions in the Interdependence Mode.
22. Identify standard nursing diagnoses that are used in the Interdependence Mode.
23. Define spirituality.
24. Describe the approach and components of a moral and spiritual assessment.
25. Discuss the unique spiritual needs of the elder.

## INTRODUCTION

There are three psychosocial modes. The Self-Concept Mode focuses specifically on the psychological and spiritual aspects of the person. The basic need underlying the Self-Concept Mode is psychic integrity - the need to know who one is so that one can exist with a sense of unity.

The Role Function (Mastery) Mode is one of two social modes and focuses on the roles the person occupies in society. The basic need underlying the Role Function Mode is social integrity - the need to know who one is in relation to others so that one can act.

The Interdependence Mode is the second social mode and focuses on interactions related to the giving and receiving of love, respect and nurturance. The basic need of this role is called affectional adequacy - the feeling of security in nurturing relationships.

## SELF-CONCEPT

The Roy Adaptation Model views the Self-Concept Mode as having two subareas: the physical self and the personal self.

The physical self includes two components: body sensation and body image. Body sensation refers to the ability to feel and to experience oneself as a physical being and its response to changes in health status.

Examples: "I feel sick."  
"I feel exhausted."  
"I feel sensuous."

Body image refers to how one sees one's body and its parts in terms of size, appearance and functioning.

Examples: "I am 15 pounds overweight."  
"My nose is too long."  
"I am fairly attractive."

Body image is influenced by feedback from others as well as cultural and societal values. It is assessed by his/her verbal statements as well as the person's appearance: use of makeup, posture, clothing, artificial limb, etc.

The personal self has three components: self-consistency, self-ideal, and moral-ethical-spiritual self.

Self-consistency is the part that allows people to act and express feelings in fairly stable or predictable patterns as they carry out activities of daily living. They have learned to organize and to cope with usual changes in a predictable way.

This component can be assessed in a person's response to a situation and his or her verbal statements.

Examples: "I don't anticipate any problems with surgery."  
"I feel self-confident about going home."  
"I am worried/anxious about the lab tests."

Self-Ideal refers to what one would like to be or is capable of being or achieving. This aspect incorporates the traits or actions that one admires in others into the image of what one would like to be. It serves as a guide toward achieving goals. Some people may never be able to achieve their self-ideal image. Assessment is based on the person's statements.

Examples:

"I would like to be able to walk without crutches."

"I want to be a concert pianist."

"I want to get A's in every subject."

The Moral-Ethical-Spiritual Self includes one's belief system and an evaluation of who one is. This part of the self-concept learns to tell right from wrong and to set standards for behavior based on values gained from the family, peer groups and others in one's culture. Assessment is based on the person's statements or behaviors.

Examples:

"I believe that abortion is wrong."

"God will take care of me."

"I must have done something bad to deserve this."

The patient is praying silently, using Rosary beads.

### Self-Esteem

Development of the personal self leads to feelings of self-esteem or the overall perception of one's worth. An inverse relationship exists between self-esteem and anxiety. When anxiety is high, one perceives numerous threats or danger to the self. Threats to the self lead to doubts, ineffective coping, and problems associated with low self-esteem.

On the other hand, people with high self-esteem have low levels of anxiety. They are seen as being mentally healthy, having a positive attitude, and being "in control" of their bodies and their lives through good decision making.

Examples:

#### High Self-Esteem

Self-assured; poised  
Effective in solving problems  
Trusting; friendly  
Unselfish  
Happy; sincere  
Productive; active  
Independent  
Realistic view of the world  
Optimistic  
Hopeful

#### Low Self-Esteem

Poor view of self; unsure  
Lack of control; gives way to impulses  
Distrusting; demanding  
Self-centered; egotistic  
Frustrated; angry  
Depression; despair  
Withdrawn; isolated from others  
Negative outlook; pessimistic  
Helpless; dependent upon others  
Rebellious; acting out behavior

## Growth and Development

The eight stages of psychosocial development as described by Erikson provide a framework with implications for Self-Concept. Each stage requires certain developmental tasks and is a building block in organizing self-concept. Failure to accomplish tasks within the stages leads to problems at that time and especially when unpredicted circumstances arise, such as illness.

Exercise: The following is a list of assessments. Identify those that apply to the Self-Concept Mode and the specific sub-areas.

- a. Person states, "I'm so tired." \_\_\_\_\_
- b. Blood pressure is 140/90 mm Hg. \_\_\_\_\_
- c. Woman applied makeup and is wearing an attractive robe. \_\_\_\_\_
- d. Man is unshaven and refuses his bath. \_\_\_\_\_
- e. Woman states, "I really love my husband." \_\_\_\_\_
- f. Man states, "God has helped me through surgery." \_\_\_\_\_
- g. Woman calls her boyfriend every evening. \_\_\_\_\_
- h. Man states, "I'll be back to work on Monday, broken leg or not." \_\_\_\_\_
- i. Woman states, "I feel prepared for labor; I've gone through this before." \_\_\_\_\_

## Nursing Diagnosis

Identifying the stressors and coping strategies (related to's).

See texts for suggestions. Remember, they must be stated in a way that can be changed.

Expected Outcomes (goal)

Nursing Interventions:

Actively listen

Explore previous coping strategies

Identifying areas of strength

Encouraging positive self-evaluation: Positive feedback

Enhancing self-esteem of older adults.

1. Encourage participation in planning care
2. Allow person to have familiar objects.
3. Respect the person's "space" - treat belongings with respect.
4. Actively listen and allow time to verbalize.

## Common Problems in Self-Concept Mode

<p>Body Sensations and Body Image:  Nursing Diagnosis:      Body image disturbance      Anticipatory grieving      Dysfunctional grieving</p>	<p>Feelings of loss of function or body part, or of loss of control, grieving.</p>
<p>Self-Consistency:  Nursing Diagnosis:      Anxiety      Fear      Ineffective coping (and other coping dxs)</p>	<p>(Usual coping mech. aren't working)  Feelings that express anxiety (anger, sadness, fears, depression, worry)</p>
<p>Self-Ideal:  Nursing Diagnosis:      Hopelessness      Powerlessness</p>	<p>Feelings that express powerlessness, helplessness, hopelessness, frustration or anger.</p>
<p>Moral-Ethical-Spiritual Self:  Nursing Diagnosis:      Spiritual distress</p>	<p>Feelings that express guilt or shame.</p>

## ROLE FUNCTION/INTERDEPENDENCE

**Definition:** Role is the pattern of behavior expected in order to occupy a given position in society.  
(a title given by society)

Why do we assess role function?

1. Patients frequently are required to take on temporary roles: sick role, student role
2. Patients or clients may acquire a new permanent role: mother, diabetic
3. Patients may need to change a role: widow, breadwinner

Two basic assumptions:

1. Roles exist only in relationship to each other (reciprocal)  
Cannot be a parent without a child, spouse without a spouse
2. Roles are filled by individuals  
Must have certain perception of yourself--tied with self-concept--compatible with the role

Identify the Roles:

**Primary Role:** Filled as a result of developmental stage: the obvious  
Determines most of your behaviors during a particular period  
of your life (developmental stages)  
Age and sex (what you are) not necessarily how you see yourself!  
Examples: adolescent male, elderly female, generative female  
See Handout: based on Erikson

**Secondary Role:** The major roles played in a certain developmental stage, and certain tasks must be  
accomplished to fulfill these roles: mother, father, brother, peer

Think about the different developmental levels:  
Who has the most roles? The least?

Roles change over the life span  
Chronic illness fits here: diabetic, cancer, paralysis

**Tertiary Roles:** Temporary, usually associated with secondary, but may also be associated with  
primary.

Usually chosen to fulfill a minor task in a developmental stage, such as room  
mother.

Sick Role (not really chosen, but accepted)--when chronic it becomes more  
permanent, so becomes secondary role.  
The patient can choose to take on the sick role.)

Identification of "related to":

Social norms: what is expected? culture, nationality, religion, economics

Relationship to others:

Knowledge of the role:

Influence of other roles the patient holds at the same time

Problem Identification: Nursing Diagnosis

No problem = Role Mastery

See List of Diagnoses

Role Transition/Change: There is not always a conflict, but generally it requires learning and adjustment.

Changes occur with developmental stages--a necessary part of life. Roles develop throughout life, often with some potential problems occurring! Some causes might be lack of knowledge, education, practice or role models.

Interventions in Role Problems:

Role modeling

Teaching

Encouraging family participation

Encouraging verbalization of concerns

Support groups

## INTERDEPENDENCE MODE

### 1. DEFINITION:

Interdependence is:

- A. A comfortable balance with others
- B. Feeling adequate and secure in relationships with other people - i.e., able to "give and take."
- C. Being loved and supported yet able to love and to nurture others as well as oneself.
- D. Belonging: - Affiliated within a given group

### 2. COMPONENTS OF THE MODE:

- A. Significant Other(s): individuals or groups to whom importance is ascribed or inherent in the interaction. (Usually 1 person at a time.)  
Examples: Parent  
Family  
Social affiliation - friend, lover  
(animals and objects may also be included) - dog, "security blanket"
- B. Support Systems: persons, groups, animals, objects who/which  
(Secondary Group) affirm/support the individual irrespective of whether behaviors are adaptive or ineffective.

\*Interaction patterns are learned - they are the means an individual has for learning about himself, about relationships, with others, and the ways of response and expression that are acceptable or unacceptable, that are effective or ineffective in achieving and/or maintaining the major tasks of the mode.

### 3. NEEDS that are met in a functionally interdependent person:

- A. To be trusted and believed, and to trust and believe in others
- B. To be loved, nurtured, and supported; and to love, nurture, and support others
- C. To be understood and to win approval from others, and to understand and approve of the self
- D. To be needed by others and to recognize one's own needs from others

### 4. PURPOSE:

The purpose of interdependence is to be responded to by another and/or to establish an in-depth interaction with another person. It has the characteristics of protection, caring, proximity, physical contact, recognition, praise, and approval.





SUMMARY OF THEORETICAL BASIS OF ROLE DEVELOPMENT

AGE YEARS	DEVELOPMENTAL STAGE	FOCUS OF TASKS OR CRISES	ADAPTIVE OUTCOME	INEFFECTIVE OUTCOME	SOCIAL GOAL	SOCIAL PROCESS
0-1 1/2	Infant: Trust vs. Mistrust	To develop confidence in having needs met To feel physically safe	Optimism about world Trust	Pessimism about world Mistrust	Social development of the individual	Society contributes to the individual
1 1/2 3 1/2	Toddler Autonomy vs. Shame	When needs are consistently met, anticipation of satisfaction occurs. "I am what I imagine I can be." Fantasy play precedes each effort	Autonomy	Autonomy Doubt Sense of uselessness	Social development of the individual	Society contributes to the individual
3 1/2-6	Preschool: Initiative vs. Guilt	"I am what I do."	Initiative	Guilt	Social development of the individual	Society contributes to the individual
6-11	School age: Industry vs. Inferiority	Skills and values expand to include those of the school and neighborhood	Industry	Inferiority	Social development of the individual	Individual begins to contribute to society
11-18	Adolescence Identity vs. Role confusion	To know "who I am" Values become those of the peer group and of leaders To develop the ability to love in terms of intimacy Values are those of fidelity, friendship and cooperation	Identity	Identify diffusion  Alienation	Social development of the individual	Individual relates to society through peer groups
18-35	Young Adult Intimacy vs. Isolation	Establishment as independent individual Building a strong, mutual affectionate bond with (possible) marriage partner and family of spouse To be able to nurture, support and provide for spouse and off-spring	Intimacy	Isolation	Social development of the individual	Individual becomes independent member of society and begins to contribute toward the continuance of society by starting a new family

### SUMMARY OF THEORETICAL BASIS OF ROLE DEVELOPMENT

AGE YEARS	DEVELOPMENTAL STAGE	FOCUS OF TASKS OR CRISES	ADAPTIVE OUTCOME	INEFFECTIVE OUTCOME	SOCIAL GOAL	SOCIAL PROCESS
35-60	Generative Adult Generativity vs. Stagnation	<p>Learning to be inter-dependent with others other than spouse, leaning on another person as well as to succor in time of need and developing leisure-time activities</p> <p>Maintaining a strong and mutually satisfying marriage relationship</p> <p>Assisting in the establishment and guidance of the next generation</p> <p>Meeting the new needs of affection of one's own aging parents &amp; parents of spouse</p>	Generativity	Stagnation	Implementing and maintaining norms of society	Individual becomes involved with the survival of society through own efforts and the guidance of the next generation
60 years and on	Mature Adult Ego Integrity vs. Despair	<p>Accepting the help needed from others as dependency needs increase</p> <p>Facing loss of spouse and developing sources to meet needs of affection.</p> <p>Learning new roles with one's own children and grandchildren as their roles change</p> <p>Finding or preserving satisfying relationships outside of the family</p>	Ego Integrity	Despair	Maintaining Society	Individual becomes able to incorporate becoming a follower, again, sometimes in the sense of being a consultant, as well as to continue to lead

#### ASSESSMENT OF ROLE FUNCTION

There are certain demographic data that are pertinent to all four of the adaptive modes. Factors such as age, sex, culture, and others should be identified before attempting to use the nursing process as specified by the Roy Adaptation Model. This information may be obtained from the person, the family, friends, or a hospital chart or records of some kind. Role data are gathered in much the same fashion, with the exception that some of the information, especially expressive role behaviors, must come from the patient himself.

In first-level assessment, determine the person's primary role by identifying age, sex, and developmental stage as noted. Using the same chart, project in your own mind some of the secondary and tertiary roles that this individual may occupy. For example, if your client is a 25-year-old female, her developmental stage is young adult. You would expect her to occupy roles that would help her achieve her goal of intimacy. These might include a student, a professional, a spouse, a mother, a nonprofessional tennis player, a good friend, or a book club member.

Assessments	Nursing Diagnosis	Related To	Expected Outcomes	Nurse Interventions	Evaluation
<p><b><u>ROLE FUNCTION/ INTERDEPENDENCE</u></b></p> <p>Primary: Age/Sex/Race Development stage:</p> <p>Secondary: Tasks Performing:</p> <p>Tertiary: Sick role stage Response</p> <p>Significant Other: Interactions</p> <p>Support Systems: Interactions</p> <p><b><u>SELF-CONCEPT</u></b></p> <p>Physical Self: Body Image:</p> <p>Personal Self: Usual coping mech: Current coping: Ideal: Moral/Ethical/Spiritual:</p> <p>Self-Esteem:</p>					

GUIDE FOR ASSESSMENT OF THE  
ROLE FUNCTION MODE/INTERDEPENDENCE MODE

- I. Identify Roles
- A. Define the patient's primary role as it relates to his/her developmental level (e.g., adolescent male, young adult female, generative adult male, elderly female)
    - 1. Age
    - 2. Sex
  - B. Define secondary role(s), tasks associated with developmental stage  
Example: Son, daughter, wife, mother, father, sister, peer (chronic illness fits here, such as Diabetic)
  - C. Define tertiary role(s) Temporary, usually "chosen," may be related to 1° or 2° roles to fulfill minor task in developmental stage.  
Example: Team sponsor, fund raiser, stamp collector -and- "sick role" - hospitalized patient.
  - D. Assess Stages of Sick Role
    - 1. Symptom Experience Stage
    - 2. Assumption of Sick Role
    - 3. Medical Care Contact Stage
    - 4. Dependent Patient role stage
    - 5. Recovery or Rehab Stage
  - E.
    - 1. Assess "Related to" that causes stress on family: finances, relocation
    - 2. Assess Developmental Causes: marriage, child bearing, child rearing, adolescence, new members, loss of spouse, arrival of grandparent
    - 3. Assess Situation Causes: illness, hospitalization, separation
- II. Identify Interdependence
- A. Define the patient's significant other:
    - Who or what (i.e., spouse, lover, friend, dog, neighbor)
    - Perceptions of the relationship
      - Observe non-verbal behavior
      - Note statements made suggesting nurturing, compatibility, importance of the relationship
      - Do behaviors suggest warmth, acceptance, affection? -OR distaste, rejection, conflict?
  - B. List support systems
    - Who or what; (i.e., family, church group, neighbors, club)
    - Importance/Acceptance of the support system
    - Adequacy of support system
      - Does the patient use the support system? Share Needs? Ask for and give support?
- III. Identify adaptive responses to Role Function and Interdependence or problems using standard nursing diagnoses.

## PSYCHOSOCIAL CASE STUDY

Agnes Duffy is a 68-year-old Caucasian female who was hospitalized yesterday with a fracture of her right wrist. Mrs. Duffy is right handed. She has been confined to a wheelchair for the past several years, after experiencing polio, which resulted in the atrophy of her leg muscles and consequent weakness.

Yesterday, she fell while attempting to move from her bed to her wheelchair without the assistance of her husband, Ralph. Ralph has been Agnes' devoted companion for the past 45 years, and up until his retirement three years ago, revolved his work schedule around his wife's needs at home. He does most of the cooking and housework himself, but Agnes is usually able to do some of the lighter work around the house.

They have a daughter, Daphne, who is 42 years old and has three children. She is divorced and lives in the same town, but due to her work schedule, visits her parents infrequently. She visited her mother last evening and brought flowers. The Duffys are members of a Methodist church, and Agnes belongs to the Ladies' Guild. There is a get well-card on her table from them.

Today as you begin to care for Agnes, she begins to cry and says, "I feel so discouraged. I'm such a burden to everyone. We were going to go on a trip next month, but now look at me! My hair's a mess, I can't even brush my teeth—I can't do anything for myself. Why did this have to happen to me now? I feel like God is punishing me for something!"

Ralph catches you in the hall and is very upset. "This is just not like her. I know she is in pain, but usually she is such an 'up' person. She is a careful dresser, and likes to get her hair done once a week—I don't even recognize her like this!"



OHLONE COLLEGE  
NURSING 301

FOCUS: Principles of Pharmacology (part I)

**Class 16**

REQUIRED PREPARATION:

1. Lilly, Harrington, & Snyder: Chapter 2, and chapter 4 pps. 47-51 only.

STUDENT OBJECTIVES: At the completion of the unit, the student will be able to:

1. Describe the development of federal standards for safe and effective drugs.(on your own)
2. Describe pharmacokinetics and define the four processes that make up pharmacokinetic events; absorption, distribution, metabolism and elimination.
3. Describe factors affecting the absorption, distribution, metabolism and excretion of drugs.
4. Identify normal changes of aging that may affect the absorption, distribution, metabolism and excretion of drugs.
- 5 Explain how absorption is affected by the route of administration.
6. Explain the purpose and nursing implications of enteric coated tablets.
7. Explain the concept of drug half life.
8. Briefly describe the pharmacodynamics and mechanism of drug action.
9. Differentiate between a drug's generic, trade, and chemical name.
10. Define the following terms:

Drug onset    Drug Peak    Drug Duration

Pharmacodynamics

Therapeutic Effect

Mechanism of Action:

-Receptor Interaction

-Enzyme Interaction

-Nonspecific Interactions

Pharmacotherapeutics

-Tolerance and Dependence

-Drug Interactions

- Incompatibility

-Adverse Drug Reaction

-Medication Error

-Idiosyncratic Reaction

OHLONE COLLEGE  
NURSING 301

INTRODUCTION TO PHARMACOLOGY

I. DRUG REGULATIONS AND CONTROLS:

1. Drug Standards:

- a. Federal Food and Drug Administration (FDA) sets standards for drugs, approves new drug applications (tested on animals first); can recall drugs and remove them from the market.
- b. 1906—Pure Food and Drug Act—protected public from adulterated or mislabeling of drugs.
- c. 1938—Food, Drug and Cosmetic Act of 1938—drugs must be pure and unadulterated with accurate drug labels—dosage and warning. Required drugs be proven safe before being marketed.
- d. 1952—Durkam-Humphrey
- e. 1962—Kefauver-Harris amendment empowered FDA to regulate testing of drugs in humans (after Thalidomide). Required drugs be proven effective, as well as safe before being marketed.
- f. 1970—Controlled Substance Act: Provided research into and prevention of drug abuse and drug dependence; provided for treatment and rehabilitation of drug dependent persons; and strengthened existing law enforcement authority in the field of drug abuse.

II. DRUG ACTION: Pharmacodynamics

- a. Receptor Theory: Interaction of a drug with a target cell at the cell receptor site. The effect of the drug is seen after the interaction, a biological effect  
The drug with the greatest affinity for “fit” will elicit the greatest response from the tissue or cell.
- b. Enzyme Interaction: for the drug to alter the physiological response, it must inhibit the action of the specific enzyme. The drug “fools” the enzyme into binding to itself instead of the target cell.  
Example: Angiotensin-converting enzyme (ACE) causes an enzymatic reaction that results in the production of angiotensin II, which is a potent vasoconstrictor. “FOOLS” ACE into binding to itself rather than to angiotensin preventing the formation of angiotensin II and helps to reduce BP.
- c. Nonspecific Interactions: cell membranes, cellular processes and metabolic processes are the main site of action. Drugs physically interfere or chemically alter cellular processes. (e.g., cause cells to starve or die due to lack of energy or causes cells to lysis.)

### III. FOUR GENERAL PROCESSES BY WHICH DRUGS ARE HANDLED IN BODY: (Pharmacokinetics)

In order for the drug to work, it has to move from its entry point to site of action, and then move to the organs that break them down and eliminate them.

1. Absorption: what happens to the drug from the time it enters the body until it enters the circulation.
  - a. Requirements:
    - 1) the drug must dissolve, go into solution (water soluble);
    - 2) the drug must be able to cross into the cells (across the cell membranes) (lipid soluble).
  - b. Affected by Route of Administration:
    - 1) P.O. is the slowest.
    - 2) SQ/IM - SQ has a slower onset of action and has less absorption than IM. IM rate of absorption is about 10-30 minutes.
    - 3) IV - Fastest - administered directly into bloodstream thus no absorption is required; peak level of concentration is attained.  
DANGEROUS!! - It has a narrow margin of error!!
    - 4) Skin/mucous membranes.
2. Distribution: Drugs usually combine with plasma proteins (albumin) and are then transported thru circulation. Some drug molecules are bound to the protein, others are "free" - pharmacologically active. Drug-protein complex is not active. As free drug is used, more drug can be separated from the protein to replace what is lost. Many drug solutions are stored in tissues until needed.
  - Binding sites
  - Blood-Brain barrier
  - Placenta barrier
3. Metabolism (Biotransformation): Changing a drug into a non-active (water soluble) substance for elimination.

Enzymes in the liver change the drug so that it is easily eliminated thru urine. Most drug metabolism occurs in the liver, but metabolism can also occur in renal tissues, blood plasma, lungs, intestinal mucosa.

Problems with liver damage - cannot detoxify drugs.
4. Excretion: Kidney is the most important organ for drug elimination. Drugs are also excreted in bile, feces, milk, exhaled air.
  - a. Biologic half life - time period in which peak drug level is reduced by 1/2 through metabolism or elimination. A drug with a short half life may be administered several times a day. A drug with a long half life may take a long time for all of the drug to be eliminated (weeks to months) but may need a certain level to be therapeutic.
  - b. Cumulation can occur when:
    - metabolism or excretion is delayed
    - age: very young (immature organs); very old (organ impairment)
    - damaged liver or kidney

#### IV. FACTORS AFFECTING DRUG ACTION:

1. Dose:
  - a. therapeutic dose - amount of drug needed to produce desired therapeutic effect.
  - b. Toxic level - too much drug in body due to overdose or ineffective metabolism or excretion.
  
2. Individual Variables:
  - a. Age - infant vs. elderly
  - b. Sex - Pregnancy: affect fetus (teratogenicity)  
breast feeding
  - c. Pathology of circulatory system, liver, kidneys, thyroid metabolism; nutrition and fluid status affects absorption and distribution
  - d. Time of administration: circadian rhythms  
I.V. antibiotics given around the clock to maintain blood level.
  - e. Body weight
  - f. Attitudes and expectations

#### V. DRUG NOMENCLATURE: 3 types of names describe the same drug.

1. Chemical Name: describes the molecular or structural formula.
  
2. Generic Name: official name; in lower case letters; less expensive. Used in U.S. Pharmacopeia (USP)--standards for single drugs and National Formulary (NF)--standards for drug compounds.
  
3. Trade Name: capitalized, has Registered trade mark (R); drugs are patented for 17 years; no two drug companies can give the same name to the same drug, so there may be several names per drug. M.D. may prefer a certain preparation made by a certain drug company; extracts may vary, additives change things, etc.

Usually, the companies think of names, that imply their action or classification to give you a clue. It's confusing--and names vary from country to country--desirable to have an International nomenclature of drugs.