TEXAS A&M UNIVERSITY - CORPUS CHRISTI  
College of Nursing and Health Sciences  
NURS 3628-001 CRN: 10956 Nursing Care of Adults I  
Summer Semester 2015  

Faculty:  Karen LaNasa, (Course Coordinator) MSN, RN, OCN  
Clinical Faculty:  Diana Keeler MSN, RN  
Karen Peck MSN, RN  
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Fax:  361-825-3491  
Credits:  6 credit hours  
Prerequisites:  All first semester Junior level courses  

Course Description: Introduces the student to the use of the nursing process in the care of adults with chronic or non-complex illness. Uses a systems approach to discuss the effects of illness on individual and family and to examine the disruption of growth and development patterns across the lifespan from young adult to senior years. The course includes clinical laboratory to allow the student the opportunity to apply theoretical concepts to clinical practice in diverse adult populations. Prerequisites: All first semester junior level courses.  

Course Objectives With Examples of Outcome Criteria:  
At the completion of Nursing Care of Adults I, the student will be able to:  

1. Examine applicable nursing and non-nursing theories related to growth and development and transcultural nursing.  
2. Give examples of relevant and recent research findings, particularly as they relate to nursing care of patients with disorders of physiological systems.  
   a. Discuss research topics that could improve the care of clients and their families.  
   b. Seek opportunities to acquire and apply new knowledge to practice.  
3. Describe ethical and legal principles impacting health care across the age/health continua, including informed consent, diminished autonomy, individual freedom of choice, and confidentiality.  
4. Analyze the use of the nursing process with individuals experiencing illness.  
   a. Utilize critical thinking skills to assess adults and families responses to specific illnesses.  
   b. Utilize the data collection process based upon Gordon’s functional health patterns to derive nursing diagnoses appropriate to the client and family.  
   c. Describe appropriate nursing and medical interventions for health challenges common to adults.  
   d. Demonstrate appropriate therapeutic nursing interventions to assist clients and
to attain, maintain, or regain optimal health.
e. Demonstrate safe, technically competent care of adults with common medical/surgical health challenges.

5. Discuss patient teaching plans for selected physiological disorders.
6. Identify concepts related to the disruption of growth and development patterns across the lifespan.
7. Demonstrate responsibility for own learning at levels consistent with course and professional expectations.
   a. Demonstrate professional role behavior.
   b. Demonstrate accountability for own behavior in implementation of nursing care.
   c. Demonstrate collaborative skills with members of the interdisciplinary health care team in planning, coordinating, providing and evaluating patient care.

8. Describe caring behaviors to be utilized while providing nursing care to clients from diverse populations.

**Required Textbooks:**


**On-line purchase of 2 HESI exams ** Cost is about $30 each )additional information will be provided in class)

Evolve Online Case Studies

**Recommended textbooks:**


**Learning Experiences and Teaching Methods:**
Course objectives may be met through individual study using suggested resources, active involvement in classroom activities, and formal and/or informal exchange of information/ideas with classmates and colleagues regarding specific topics to include utilization of critical thinking skills. Teaching methods include lecture, seminar, discussion, small group work, independent study, computer-assisted instruction, audio-visual aids and the assignments listed below. While the professor will provide guidance and consultation, the student is responsible for identification of learning needs, self-direction, seeking consultation and demonstration of course objectives.

Students are expected to act in a professional manner and are accountable for their behaviors and learning.

**Student Class Responsibilities**

1. This is a web-assisted course and lecture/learning materials may be found on the course website.
2. Students are expected to respect the learning rights of all others in the classroom. Individual conversations, chatting online, text messaging, arriving to class late, sleeping during class, working on online assignments, playing computer games, surfing the internet and studying for another class during classroom time are unacceptable behaviors. Students who demonstrate these behaviors may be asked to leave class.
3. Cell phones and pagers are to be turned off or put on vibrate for the duration of the class; they must be off for examinations.
4. No children are allowed in class at any time.
5. Students are expected to complete all required reading prior to each class. As a 6-credit course, it is expected that students will spend 8-12 hours of independent study and preparation each week in addition to class time. Preparation for class includes assigned reading, review of appropriate anatomy, physiology, and pathophysiology, and review of assessment of appropriate body systems. **Students are held accountable for content from previous and concurrent courses. Questions related to content from previous or concurrent coursework may appear on quizzes or examinations.**
6. It is the student’s responsibility to obtain handouts, lecture notes, and information from announcements in the event a class is missed.
7. Taping of lectures is permitted in this course. Clinical examples cannot be recorded due to patient confidentiality and HIPAA regulations.

**Class Policies**

**Grading Policy**
Completion of NURS 3628 requires the successful completion of both the clinical and theoretical components of the course.

In order to pass Nursing 3628, the student must achieve the following:

- **Exam 1**: 20%
- **Exam 2**: 20%
- **Exam 3**: 20%
- **Comprehensive Final Exam**: 20%
- **Evolve Case Studies (3) + Learning Modules**: 5%
- **In-Class Medication Quizzes (4) + Math Quiz**: 10% (Top 3 quiz marks will be utilized)
- **Participation Grade**: 5%

**Total**: 100%

A combined average of 75% on the 4 course exams is required in order for the other 25% of the course grade to be considered. **Students who do not achieve a 74.5% exam average will receive a D or F for the course based on their exam average.** In calculating the final course grade only the final overall course grade will be rounded.

A grade of “pass” of the Clinical Evaluation Tool used for the clinical component of the course.

Completion of all required clinical paperwork, including concept mapping and additional assignments required by clinical faculty.

**Grading scale for Texas A&M University-Corpus Christi, College of Nursing & Health Sciences is:**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>A</td>
<td>89.5 - 100</td>
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<tr>
<td>B</td>
<td>82.5 - 89.4</td>
</tr>
<tr>
<td>C</td>
<td>74.5 - 82.4</td>
</tr>
<tr>
<td>D</td>
<td>67 - 74.4</td>
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<tr>
<td>F</td>
<td>Below 67</td>
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**Attendance Policy:**
The class roll list will be circulated in each class. Students are expected to sign in if they are present. Absences from more than 3 classes may result in a reduction in class grade of one level, for example, from an A to a B. Each class period is worth 4 hours of lecture, persons leaving or asked to leave prior to the end of class, or at any time during class, will be counted absent for that hour of class. Although there are no excused class absences except for official university business, persons who are ill should be courteous to classmates and not attend class.

**Late Work & Make-up Examinations:**
No late work is accepted. No exceptions. No make-up examinations will be administered. Exams will be given only on the day and time scheduled. If one scheduled exam is missed due to unforeseen circumstance, the score earned on the HESI final exam will count as 40%. In order to be considered excused the Professor must have received an email via Blackboard stating circumstance prior to the start of the exam scheduled time. For the missed exam, the student will have a zero recorded until they successfully complete the final exam. An unexcused absence for ANY exam will result in a zero for that exam. Exam average must be a 75 or higher to pass this course.

**Examination Guidelines:**

1. Students must achieve a combined average of 75% on all exams to pass the course.
2. The final exam is comprehensive.
3. Students are held accountable for content from previous and concurrent courses. Questions related to content from previous or concurrent coursework may appear on quizzes or examinations.
4. All exam dates and times are printed on the course schedule.
5. Exam dates, times and locations are subject to change.
6. Students who are late for exams will not be allowed to test and the grade will be counted as a missed exam (Please see Late Work & Make-up Examinations).
7. No examination or test material is to leave the classroom.
8. Any student determined by faculty to have cheated on the exam will receive a score of zero for that exam and may be subject to failure from the course and dismissal from the nursing program.
9. Exams will be given only on the date and time scheduled. For each exam:
   - Cell phones, PDAs and beepers are not allowed during exams and must be turned off.
   - All books, bags, notebooks, and purses will be left at the front of or outside the room.
   - A brief examination blueprint will be provided on Blackboard.
   - Medication math problems will be included on each exam. Calculators may be used and will be provided on the computer exam interface.
   - Exam dates, times, and locations are subject to change.
10. Course faculty will review the exam and the grades will be posted on Blackboard. Those students scoring below 75 on any exam are encouraged to make an appointment with the faculty/course coordinator to review their exam and address their concerns.
11. All students will complete Test Taking Assignment via Blackboard indicating they have read and will adhere to the Test Taking Policies and Procedures for NURS 3628. Failure to follow these policies may result in failure of the exam and/or failure of NURS 3628.

**Academic Integrity/Plagiarism**
University students are expected to conduct themselves in accordance with the highest standards of academic honesty. Academic misconduct for which a student is subject to a penalty includes any and all forms of cheating, such as illicit possession of examinations or examination materials, forgery, collusion, or plagiarism.

http://falcon.tamucc.edu/~students/JAffairs/ja_code_of_conduct_article3.htm

Nurses bear enormous responsibilities and ethical behavior is essential. Unethical behavior may result in patient harm or death. Ethical Behavior, including honesty and confidentiality, is an expected professional behavior in the classroom or clinical setting. Refer to the College of Nursing policy for definitions of these expected behaviors (see the College of Nursing Student Handbook, Policies and Regulations, Academic Honesty and Professional Integrity Policy).

At the university level of the student’s education, honesty and integrity are expected in all approaches to learning. In order to maintain academic honesty and integrity two primary areas must be addressed.

**Plagiarism** (exemplified by but not restricted to):
- The offering of any work done by another as your own work.
- Using quotations or the paraphrase of a quote within your work without citing the source.
- Using a paper for one course that was prepared for another course without both instructors’ knowledge and permission.
- Collaborating with others on an assignment/quiz/exam without the instructor’s permission.

**Academic Honesty** (exemplified by but not restricted to):
- Providing your fair share of input and effort for all group work that is required in a course.
- Refraining from changing answers on in-class quizzes prior to turning in for grading.
- Preparing for every class that you attend. This includes careful reading of assignments, being prepared to participate in discussions and completing any mini-assignments.
- Preparing the answers for take home exams using the appropriate materials but without the assistance of any other person or persons (this means NO GROUP TESTING for individual assignments)
- Refraining from giving, receiving, or downloading exam or quiz information unless authorized by the instructor.
- Refraining from using any materials during exams or quizzes that have not been approved by the instructor.
- Refraining from consulting with others (including but not limited to instant messages, texts, or emails) during exams or classroom activities unless explicitly authorized to do so by the instructor.
In this class, academic misconduct or complicity in an act of academic misconduct on an assignment or test will result in a student receiving a score of zero for that component of the course and the student may be subject to failure from the course and dismissal from the nursing program.

**Dropping a Class**

I hope that you never find it necessary to drop this or any other class. However, events can sometimes occur that make dropping a course necessary or wise. Please consult with Professor Buckner before you decide to drop to be sure it is the best thing to do. Should dropping the course be the best course of action, you must initiate the process to drop the course by going to the Student Services Center and filling out a course drop form. Just stopping attendance and participation WILL NOT automatically result in your being dropped from the class. Faculty cannot drop you from a course. **Friday, June 20, 2014 is the last day to drop a class with an automatic grade of “W” this term.**

**Grade Appeals**

Information regarding Student Grade Appeals can be found in the CONHS Student Handbook. A student who believes that he or she has not been held to appropriate academic standards as outlined in the class syllabus, equitable evaluation procedures, or appropriate grading, may appeal the final grade given in the course. The burden of proof is upon the student to demonstrate the appropriateness of the appeal. A student with a complaint about a grade is encouraged to first discuss the matter with the instructor. For assistance and/or guidance in the grade appeal process, students may contact the Office of Student Affairs.

**Disabilities Accommodations**

The Americans with Disabilities Act (ADA) is a federal anti-discrimination statute that provides comprehensive civil rights protection for persons with disabilities. Among other things, this legislation requires that all students with disabilities be guaranteed a learning environment that provides for reasonable accommodation of their disabilities. If you believe you have a disability requiring an accommodation, please call or visit Disability Services at (361) 825-5816 in Driftwood 101.

If you are a returning veteran and are experiencing cognitive and/or physical access issues in the classroom or on campus, please contact the Disability Services office for assistance at (361) 825-5816. Veterans and active duty military personnel with special circumstances (eg: deployment, drill requirements, disabilities) are welcome and encouraged to communicate these, in advance if possible, to the course coordinator.

**Military:**

“Active duty military personnel, military spouses, and veterans with special
circumstances (e.g. deployment, drill requirements, disabilities) are welcome and encouraged to communicate these, in advance if possible, to the course and clinical instructor.”

**Pregnancy:**

If you are pregnant or become pregnant during the semester, please notify the course coordinator for possible necessary accommodation.

You will need to email Samuel.Ramirez@tamucc.edu directly to honor the University support by formally including it in the system.

**Class Cancellation:**

In the event that a class is canceled, class falls on a holiday or the campus is closed, the student is expected to do the readings and complete the objectives for that day. The content will still be included on course examinations.

**Website Information:**

This is a web-supported course. All course and class materials will be on the web and accessed through Blackboard. The URL for Blackboard is http://islandonline.tamucc.edu

You will be oriented to the website during the first day of class. Class slides and notes may be obtained from the site. A discussion list, announcements, e-mail access as well as class information will be contained on this site. Grades will be posted to this site. It is recommended that students check the site at least daily. Students are responsible for the information on the website.

**Student course evaluations**

The faculty of the College of Nursing and Health Sciences places great value on evaluative input from students. Evaluation of courses, instructors and clinical facilities provides the College with important data, which is used to strengthen the program. Data is analyzed as to trends and themes and is important to curriculum and sequencing decisions. All evaluations for courses are posted online. The online mechanism allows us the opportunity to tabulate and store information in order to analyze trends within the curriculum. Please be assured that this information is secured and not released until after grades are submitted. In order to garner reliability and validity, the College must have representative data from the student population. That representation based on the literature has been set at 70%.

All nursing courses require a 70% return of evaluations from the entire class before final grades are released. The College is anticipating that students will thoughtfully participate in the evaluation process, which will assist the faculty with the growth of the specific tracks within the CONHS. A link to evaluations will be available on Blackboard toward the end of
Assignments

Learning module assignments and Evolve Apply case studies may not be submitted late. Students will receive a score of zero for learning module assignments and case studies not completed by 11:55 p.m. the date they are due. Additional homework may be assigned at the discretion of the faculty.

Case Study Analysis

Medical-Surgical case studies from the Evolve Apply website (https://evolve.elsevier.com/staticPages/s_index.html) have been selected by the faculty for student analysis. Case study grades will be registered on the Evolve HESI website, but it is strongly recommended you print your score sheet. The most recent highest score for the case study, within the due date and time, will be the grade recorded; you may repeat the case study for a higher grade as desired, but will only have two attempts. The two attempts will then be averaged together for the achieved grade. Scores/assignments submitted after 11:59 p.m. on the date due will not be accepted. Case study grades count toward the assignment average. Case Study Due Dates are listed in the course schedule.

You may refer to the Evolve Comprehensive review manual, your textbooks, and class notes to complete the case studies. Case studies are individual assignments. It is expected that you will complete the assignment on your own. Please review the academic integrity section above.

Please ensure that you are enrolled in the correct cohort for the “Evolve Apply: Complete RN Online Case Studies section or your score cannot be accepted (Should be the cohort Semester on admission). You will need to utilize the access code you were provided in class and then go to the website: http://evolve.elsevier.com/staticPages/s_enroll.html enter the course code that you will be provided in class; and follow the directions to register. All case studies are located under Course Documents—Evolve Apply—Medical-Surgical.

Learning Module Assignments

Scores/assignments submitted after 11:59 pm on the date due will not be accepted. All learning module assignments count toward the assignment grade. Learning Module Due Dates are listed in the course schedule.

Math Module for Safe Dosage Calculations:
Available on Blackboard. There is a math tutorial for your review. An in class dosage calculation quiz will be completed in lab the first week of your clinical rotation. The grade on the first dosage calculation quiz will be counted as an assignment and averaged into the 10% of the mark making up the assignment portion of the grade. Students will NOT be able to pass medications in the clinical setting until they achieve 95% or
higher on a medication calculation exam. Students will have a maximum of 3 opportunities within the first 3 weeks of the clinical portion of the course to pass a medication calculation exam with a grade of 95% or higher. Failure to achieve a grade of 95% or better will result in a student failing NURS 3628 as students will be unable to successfully meet clinical objectives related to medication administration.

**Blood Administration Module:**
Available on Blackboard. There are reading assignments and an online quiz. There is no time limit for taking the quiz, but you can only access the quiz one time and questions will be presented one at a time and cannot be revisited. Be sure each answer is saved before moving on; skipped questions cannot be counted toward the quiz grade. This is to be completed as an individual assignment.

**Fluid and Electrolyte/CVAD/TPN Module:**
Available on Blackboard. There are several reading assignments and an online quiz. The majority of the questions are about fluids and electrolytes. There is no time limit for taking the quiz, but you can only access the quiz one time and questions will be presented one at a time and cannot be revisited. Be sure each answer is saved before moving on; skipped questions cannot be counted toward the quiz grade. This is to be completed as an individual assignment.

**In-Class Medication Quizzes:**
During the course of the semester 4 medication quizzes will be given in class covering knowledge and application-level medication questions relevant to the topics being studied. The comprehensive quiz grade may be used to drop the lowest quiz grade. These quizzes will be worth 10% of the overall course grade. Students not present or arriving late will not be allowed in the classroom once the quiz has been handed out and will receive a quiz grade of “zero.”

- Quiz #1 Perioperative Care and Diabetes, and Pulmonary Disorders
- Quiz #2 Musculoskeletal Health Challenges, Immune Disorders/Infections/STDs, Renal and Hematological
- Quiz #3 Cardiovascular Health Challenges and Neurological/Sensory
- Quiz #4 Comprehensive Drug Quiz
INFORMATION RELATED TO CLINICAL ACTIVITIES

Students in a professional nursing program must function within the legal, moral, and ethical standards of the profession. These standards guide practice. The following is a guide for your clinical preparation and performance. It alerts you to the major areas for which you will be held accountable. Please see the clinical evaluation tool, located on the College of Nursing & Health Sciences website (http://conhs.tamucc.edu/nursingstuhandbook/index.htm) under Nursing Undergraduate Curriculum for clinical objectives. While the professor will provide guidance, supervision and consultation, the student is responsible for identification of learning needs, self-direction, seeking consultation and demonstration of course and clinical objectives.

It is the responsibility of the student to be sure that all health records, immunizations, CPR certification and Hospital Orientation are current and on file. These are required by the University, the college, and the clinical facilities to insure the health of students and patients. Students who do not have Hospital Orientation, current immunizations, CPR certification, liability insurance, background checks, and urine drug screening on file will not be permitted to attend clinical until their file is up to date. **The student will receive a clinical warning for every day clinical is missed related to the above, thus putting themselves at risk for failing due to clinically-related absences.**

**Overall**

1. Clinical is graded Pass/Fail. If the student fails the clinical component, the entire course must be repeated.
2. Clinical attendance is mandatory. Loss of time in the clinical setting for whatever reason could place a student in jeopardy of not meeting the course objectives. If an absence from the clinical site is absolutely necessary, the student must notify his/her clinical instructor at least one hour before the clinical day begins. In the majority of cases, an absence will be counted as a clinical warning, but each situation will be evaluated with your clinical instructor having the final say. If you are sent home for any reason, it is counted as an absence.
3. There are several infractions that might lead to a student being given a clinical warning for the day, including but not limited to:
   - Absences
   - Tardiness
   - Illness
   - Violation of dress code (either in hospital or during data collection)
   - Incomplete health immunization records
   - Expired CPR certification
   - Failure to turn in care plan when due
   - Incomplete hospital orientation on Blackboard
   - Lack of preparation
4. Accumulating three (3) warnings in a 135 hour clinical course will lead to failure of the clinical rotation and therefore, failure of the entire course.
5. Other offenses, which depending on severity, may lead to immediate failure of the course, including but are not limited to:
   - No call, no show for clinical day
   - Unsafe or unprofessional practices or behaviors
   - HIPAA violations
   - Inability to pass required clinical assignments
   - Falsification of records

6. Based on student learning needs, pattern of unprofessional behavior, and nature of precipitating event(s), the faculty will determine the appropriate amount of time and clinical assignments needed to assess student growth. Faculty may require additional assignments and clinical work to ensure students have met clinical objectives. Students are expected to comply with any additional assignments or clinical hours assigned.

7. Students are required to achieve a minimum score of 75 on two completed sets of paperwork, which includes the clinical preparation tool, nursing database, laboratory values worksheet, medications, pathophysiology tree, data clustering and diagnoses formation, and self-evaluation. Additional care plans and other assignments may be assigned at the discretion of the clinical instructor and also must be satisfactorily completed.

8. Students are also required to satisfactorily complete the Clinical OR Questions (to be turned in to the clinical instructor the week of the student’s observation day in the OR or when stipulated). Students earn the privilege of attending clinical in specialty areas; faculty may opt not to send students to specialty areas based on individual student learning needs.

General Considerations

1. Prior to clinical, and as necessary during clinical practice, refer to the guidelines governing prevention of transmission of infectious disease. Review the CDC’s Infection Control in Healthcare Settings: http://www.cdc.gov/ncidod/dhqp/index.html

2. Application of material presented in pre-requisite, co-requisite, and NURS 3628 to the clinical setting is a minimal expectation. Any time you do not understand or cannot correlate something, ask for help. It is far better to ask for assistance than to confess ignorance when asked by your instructor.

3. Patient confidentiality is to be maintained at all times as a critical element of clinical behavior; failure to do so may result in failure of the course. Examples of violating confidentiality includes talking about patient matters in social non-professional situations, removing confidential materials from agency premises, misplacing clinical paperwork, revealing client/patient names to non-professional or professional non related persons, and including patient names and identifying information on clinical paperwork.

4. Students are responsible for the care of the patient during clinical hours. If you leave the unit for any reason, you must assure coverage for your patients. You must report off to the clinical instructor and staff nurse responsible when leaving the floor and when leaving for the day.

5. Cell phones are not to be utilized for personal use in the clinical area.

6. All students will be required to complete a simulation experience during their rotation. The simulation may or may not be on a scheduled clinical day.

Preparation
Specific preparation for clinical rotations may vary according to the clinical site and/or faculty.
However, the following are general expectations from the course faculty:

1. Students should be able to describe client history, including assessment data, as obtained from the chart for the client(s) assigned to them. Students should also be able to discuss the pathophysiology of the client’s underlying health problem in addition to the plan of care, which will include (a) expected findings, (b) medical management, (c) possible complications, (d) medications, and (e) nursing management. This will be accomplished as the student completes the “Nursing Data Base: Clinical Preparation Tool”, the “Clinical Medication Sheet”, the “Clinical Lab Values” sheet, and the Pathophysiology Flow sheet (see syllabus for example). All of the above must be completed prior to the clinical day to be considered safe practice. Lack of preparation by the student is considered unsafe practice and will result in a clinical warning and dismissal from the clinical area for the day.

2. The “Nursing Data Base: Physical Assessment” will be completed at the beginning of the clinical day. Students may NOT provide any kind of care or assessment prior to the clinical day. These preparations will continue until the student has completed the clinical rotation; completion of the required number of care plans/concept maps DOES NOT release the student from the responsibility of preparation.

3. Students should present a professional image. When going to the nursing unit for pre-clinical assessment, the student must wear a lab coat with name badge in clear view. Jeans, sweat suits, and shorts are not acceptable attire at any time in the clinical setting.

Clinical Paperwork
1. Students are required to complete the Clinical Preparation Tool, Laboratory Value Worksheet, Medication Worksheet, and Pathophysiology Tree every week prior to the clinical day.
2. The Nursing Data Base: Physical Examination must be done every week while in clinical.
3. A problem list & Diagnoses Formation Tool must be done every week until the student receives two passing grades of 75. The grading evaluation tool and weekly self-evaluation must be submitted with each care plan. The clinical instructor reserves the right to require additional material to ascertain student accomplishment of learning objectives.
4. The Weekly Self Evaluation Log is done every week and should include an evaluation of your progress in meeting your learning goals. Identify “how you would do things differently” based on your experience. Include what the week was like for you. Identify what you were the most proud of accomplishing. Share any needs or concerns with your instructor.
5. Students have the possibility to rotate through the operating room and possibly day surgery during Nursing Care of Adults I. There is an OR experience assignment that is to be completed and submitted to your clinical instructor following the experience. The assignment is located on Blackboard. Faculty reserve the right to delay or cancel rotations to specialty areas.
6. Due dates for submission of clinical paperwork will be decided and announced by the clinical faculty. Late clinical paperwork may not be accepted and may result in clinical failure for the entire week (two days).

Clinical Uniform
Information about the required clinical uniform is located on the CONHS website in the Student handbook. http://conhs.tamucc.edu/assets/Student_Handbook_Uniform_Policy_2012.pdf
## Clinical Unit Orientation

<table>
<thead>
<tr>
<th>Item</th>
<th>Where located &amp; Phone number where indicated</th>
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<tbody>
<tr>
<td>Bathrooms: Staff and Visitors</td>
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<tr>
<td>Cafeteria</td>
<td></td>
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<tr>
<td>Refrigerators (for meds, pt foods, staff lunches)</td>
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<tr>
<td>Report Room/ Where to put your stuff</td>
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<tr>
<td>Orient self to a patient room</td>
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<tr>
<td>IV Solutions supplies (access codes to rooms)</td>
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<tr>
<td>IV poles/pumps and how to work the IV pump</td>
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<tr>
<td>How to obtain meds from pharmacy, including phone number</td>
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<td>Syringes and needles/needleless system</td>
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<tr>
<td>Patients meds (access codes to rooms)</td>
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<tr>
<td>Medication Administration Record (MAR)</td>
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<td>Insulin</td>
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<td>Thermometers</td>
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<td>BP cuffs</td>
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<td>Pulse oximeters</td>
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<tr>
<td>Supplies: Foley catheters, tape, 4x4, tegaderm, angiocaths, isolation supplies/ warning signs (PPE) (access codes to rooms)</td>
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<tr>
<td>Urinals and bedpans</td>
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<tr>
<td>Specimen containers (all types)</td>
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<td>How to charge supplies</td>
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<td>Linen/ Linen disposal</td>
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<td>Clean/Dirty utility rooms and what goes in them.</td>
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<td>Assignment sheet: Students and staff</td>
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<td>Charts</td>
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<td>Patient care plans</td>
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<td>I&amp;O records/ Vitals</td>
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<td>Scales</td>
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<td>Crash cart/Defibrillator</td>
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<td>Codes (what colors and what they mean). How to initiate one.</td>
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<td>How to call telemetry</td>
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<td>Glucometer docking stations and supplies</td>
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<td>Fire extinguishers – where and how many</td>
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<td>How to use call light system</td>
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<td>Unit phone number</td>
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<td>How to page overhead</td>
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<td>How to page the supervisor</td>
<td></td>
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<tr>
<td>How to contact the instructor</td>
<td></td>
</tr>
<tr>
<td>Lab</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
</tr>
<tr>
<td>ER</td>
<td></td>
</tr>
<tr>
<td>OR/OPSU</td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td>PT/OT</td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td></td>
</tr>
</tbody>
</table>
Clinical Preparation Tool

Student Name________________________________ Date ________________
Date of Patient admission_________ Patient Initials ________ Patient Age _____ Code
Status ________ Sex: M __  F __  Marital status: S __  M __  S __  D __  Living with SO __
Unit/room number _____ Initial VS: BP ______ P _____ R _____ T _____

Reason for Patient Admission (Chief complaint and History of present illness)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Medical Diagnoses
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Hospital Course (summary of what has happened to your patient since admission)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Laboratory Values Sheets + Current Medications + Pathophysiology Tree + This Form

= Short Careplan**
Interpretation and Analysis of Laboratory Values

Laboratory values are a reflection of the health status of your patient. These values may tell you if the patient is responding to therapeutic interventions, is having an adverse reaction to a therapeutic intervention, or compensation for either a therapeutic intervention or a disease process. Lab data may also confirm or rule out a specific disease process. **Assessment and interpretation** of laboratory values are an essential part of data collection and demonstrates your synthesis and critical thinking skills in relation to the care you provide your patient.

Hematology and chemistry values should be assessed on every patient. Additional lab values relevant to your patient’s specific diagnosis must be part of your data collection. In order to assist you in your interpretation and analysis of lab data, the following guidelines are suggested:

1. Collect lab data in a systematic manner. A lab worksheet is provided to assist you in data collection. You may, however, need to use the back of your worksheet or an additional sheet of paper to adequately address all lab values for your patient. One lab value, analyzed in isolation, may lead to erroneous conclusions and inappropriate actions. Look at the trends of the lab values by collecting at least three days of values. The most recent three days are the most appropriate.
2. Compare the lab values to the normal values listed.
3. If the lab value is within normal limits, indicate “WNL” on the worksheet. If the value is abnormal, indicate if it is above the norm (elevated or H) or below the norm (↓ or L).
4. Consult your laboratory text to assist you in analyzing why the abnormality has occurred in THIS patient. **DO NOT list all the possible reasons why the lab value could be abnormal; your clinical instructor wants to know why it is abnormal in this particular patient in this particular circumstance.**
   a. Consider why the lab was drawn for the patient.
   b. Look at the reason for hospitalization, complications, and therapeutic interventions.
   c. Does your patient have a pre-existing condition that would contribute to the abnormality?
   d. Has your patient had a surgery or other procedure that would lead to the abnormality?
   e. Is your patient receiving any medications that could account for the abnormality?
   f. Are there reciprocal changes in other lab values?
5. Taking all of the above into account, **make an educated assumption as to why you think the lab value is abnormal for your patient.** Write that assumption on the worksheet and include it in your pathophysiology tree.
# Laboratory Values Worksheet

**Student Name _________________________ Date ___________ Pt. Initials _____**

<table>
<thead>
<tr>
<th>Lab Test</th>
<th>Normal Value</th>
<th>Admission/ Data Collect</th>
<th>Clinical Day 1</th>
<th>Clinical Day 2</th>
<th>Implications/ANALYSIS Cite causes for THIS patient’s lab values</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBC</td>
<td>4.5 – 10 µl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC</td>
<td>M 4.6-6.0 mil/µl F 4.0-5.0 mil/µl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hgb</td>
<td>M 13.5-17 g/dl F 12-15 g/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hct</td>
<td>M 40-54% F 36-46%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Platelets</td>
<td>150-400 µl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PT</td>
<td>11-15 seconds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTT</td>
<td>25-40 seconds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INR</td>
<td>Ther: x2.0-3.0 Valve: x2.5-3.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sed Rate</td>
<td>0 – 20 mm/hr</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Na</td>
<td>135 – 145 mEq/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>3.5 – 5.3 mEq/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td>70 – 110 mg/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cl</td>
<td>95 – 105 mEq/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Test</td>
<td>Normal Value</td>
<td>Admission/ Data Collect</td>
<td>Clinical Day 1</td>
<td>Clinical Day 2</td>
<td>Implications/Analysis</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------</td>
<td>-------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>CO2</td>
<td>22 – 30 mEq/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUN</td>
<td>5 – 25 mg/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td>0.5 – 1.5 mg/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium</td>
<td>9 – 11 mg/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnesium</td>
<td>1.8 – 3.0 mg/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phosphorus</td>
<td>2.5 – 4.5 mg/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albumin</td>
<td>3.5 – 5.0 g/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilirubin (Total)</td>
<td>0.1 – 1.2 mg/dl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alkaline Phosphatase</td>
<td>42 – 136 U/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactic acid dehydrogenase (LDH)</td>
<td>100 – 190 IU/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST</td>
<td>0 – 35 U/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALT</td>
<td>10-35 U/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipase</td>
<td>20 – 180 U/l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Troponin T</td>
<td>&lt; 0.2 - &lt; 1.0 mg/ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natriuretic peptides</td>
<td>ANP 20-77 pg/ml BNP &lt; 100 pg/ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Creatinine phosphokinase (CK)**

- **CK:** M: 30-180 IU/l
| **MM** | **F: 25-250 IU/l** |
| **BB** | **MM = 94-100%** |
| **MB** | **BB = 0%** |
|        | **MB = 0 – 6%**   |

Glycosylated hemoglobin

- Non DM: 2-5%
- DM control 2.5-6%

Finger Sticks

(Include the date/times for each shift)

Arterial Blood Gases

- pH: 7.35-7.45
- PaO2: 80-100 mmHg
- PaCO2: 35-45 mmHg
- HCO3: 24-28 mEq/l

Urine Tests

- WBC: 3-4
- RBC: 1-2
- Glucose: Negative
- Ketones: Negative
- PH: 4.5-8.0
- Protein: Negative
- Specific gravity: 1.005-1.030


**Summarize the SIGNIFICANCE of these tests in your own words as if you were describing the results to your patient.**

Additional lab tests:

Cultures:

Radiology reports:
Medications:  *(Include scheduled meds, all pain meds and PRN meds given in the last 24 hours)*

<table>
<thead>
<tr>
<th>Generic/Trade name</th>
<th>Classification</th>
<th>Mechanism of Action</th>
<th>Dosage and Route</th>
<th>Is this a Safe Dose?</th>
<th>Drug/food Interactions</th>
<th>Side Effects / Adverse Reactions</th>
<th>Lab / VS needed prior to administration</th>
<th>Nursing Considerations and Patient Teaching</th>
<th>Why is this patient taking this?</th>
<th>Is it effective? How do you know? Provide the evidence.</th>
</tr>
</thead>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Why is this patient taking this?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
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</tr>
<tr>
<td>Is it effective? How do you know? Provide the evidence.</td>
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<td>Drug/food Interactions</td>
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<tr>
<td>Side Effects / Adverse Reactions</td>
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<tr>
<td>Lab / VS needed prior to administration</td>
</tr>
<tr>
<td>Nursing Considerations and Patient Teaching</td>
</tr>
<tr>
<td>Why is this patient taking this?</td>
</tr>
<tr>
<td>Is it effective? How do you know? Provide the evidence.</td>
</tr>
</tbody>
</table>
Is it effective? How do you know? Provide the evidence.

Pathophysiology Tree

“Patho-flow diagramming helps students to develop a systematic method for processing information required for clinical decision-making” (Reynolds, 1994, p. 334). The pathophysiology flow chart is a visual, graphic representation that illustrates the physiological and pathophysiological basis of the medical diagnoses/clinical problems and behaviors experienced by your patient. “The diagram sequence incorporates signs and symptoms, clinical manifestations, and assessment data specific data specific to each step of the cascade of pathophysiology events” (Reynolds, 1994, p. 333). The flow chart also demonstrates the interrelationship between multiple clinical problems/diagnoses of the patient (i.e., HTN, NIDDM, renal failure, dialysis). Medical conditions, other than the one responsible for the patient’s hospitalization (i.e., IDDM/CAD/ COPD) are to be taken into consideration when appropriate and be represented on the chart.

You will be asked to construct a patho flow chart on each patient assigned to you. In constructing the flow chart, consider how the disease process/clinical problem affects the anatomical and physiological processes of the body. How are the cells -> tissues -> organs -> systems affected? What is the physiological basis for the symptoms experienced by this patient? Continually ask yourself “WHY?” something occurs – why does the patient have this symptom? Why is there a dysfunction in the body system? What processes are responsible for the dysfunction? Use Med-Surg and patho textbooks as resources.

The patho flow chart is a dynamic process. Show a logical and rational presentation of your patient’s physiological responses to a pathological problem. **THE PATHO FLOW CHART IS NOT A LIST OR A WRITTEN PARAGRAPH – SEE EXAMPLE ON NEXT PAGE.** The patho flow chart must reflect both the textbook presentation of your patient’s diagnosis as well as your patient’s actual clinical presentation. Indicate in some manner which pathophysiological mechanisms actually represent your patient (highlight, colored ink, asterisks, etc.).

The patho flow tree is one mechanism by which you validate to your clinical instructor your understanding of your patients. It demonstrates the quality of data collection, the ability to analyze and synthesize relevant data to arrive at logical conclusions, and illustrates your thought processes and critical thinking skills.
Pathophysiology Tree for Cellulitis

Pt has Tinea pedis infection

Pt has laceration between toes

Break in Skin Integrity

Infection of tissue by streptococcal or staphylococcal bacteria

Pt has bacterial superinfection

Inflammation of skin and subcutaneous tissue

Pt WBC 17.2

Erythema

Pt had redness of L leg up to thigh

Pain

Pt had pain of L leg up to thigh

Heat

Pt L lower leg warm to touch on

Fever

Pt temp 101.3\(^\circ\) on admit

Edema

Left lower leg very swollen

Lymph-adenopathy

Lymphatic streaks

Erythema -> Pt had redness of L leg up to thigh

Pain -> Pt had pain of L leg up to thigh

Heat -> Pt L lower leg warm to touch on

Fever -> Pt temp 101.3\(^\circ\) on admit

Edema -> Left lower leg very swollen

Erythema, Pain, Heat, Fever originate from Break in Skin Integrity

Break in Skin Integrity -> Inflammation of skin and subcutaneous tissue

Inflammation of skin and subcutaneous tissue -> Erythema, Pain, Heat, Fever

Erythema, Pain, Heat, Fever -> Immobility, Septicemia, Multiorgan failure, Septic shock

Immobility -> Pt unable to bear weight on L leg

Septicemia -> Spread of infection to blood stream

Multiorgan failure -> Septic shock

Pt unable to bear weight on L leg -> Immobility

Spread of infection to blood stream -> Septicemia

Septicemia -> Multiorgan failure

Multiorgan failure -> Septic shock

Inflammation of skin and subcutaneous tissue -> Edema

Edema -> Increased metabolic rate, Decreased tissue perfusion

Increased metabolic rate -> Increased cardiac

Decreased tissue perfusion -> Tissue

Pt was tachycardic on admission -> Septic shock

Septic shock -> Gangrene

Gangrene -> Multiorgan failure, Septic shock

Multiorgan failure, Septic shock -> Septic shock
Nursing Data Base: Physical Examination

Current Date: ____________  Client Initials: _________  Primary ethnicity: ____________

Complete all information below. Add comments as needed.

Admitted from (check all appropriate boxes):

- Home (alone):
- Home (family/friend):
- Homeless:
- LTC:
- ER:
- Other:

Mode of arrival (check all appropriate boxes):

- Ambulance:
- Car (self):
- Car (relative or other):
- Wheelchair:
- Stretcher:
- Other:

Past medical and surgical history:

_________________________________________________________

_________________________________________________________

---------------------------------------------

Developmental Stage (Erickson) and relevance to patient. How does the client’s age in years and developmental stage match?

_________________________________________________________

_________________________________________________________

---------------------------------------------

Needs Assessment (Maslow) and relevance to patient:

_________________________________________________________

_________________________________________________________

---------------------------------------------
**Health Maintenance-Perception Pattern**

<table>
<thead>
<tr>
<th>TOBACCO</th>
<th>□ None □ Quit (date): __________ □ Pipe □ Cigar □ Cigarettes Pack/Day _____ Pack/Years _____ (calculate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALCOHOL</td>
<td>□ None □ Type ___________________________ Amount __________________ per day/week/month</td>
</tr>
<tr>
<td></td>
<td>Age consumption began: _______________________ Does client think that he/she has a problem with alcohol consumption? □ No □ Yes</td>
</tr>
<tr>
<td>ILLICIT DRUGS</td>
<td>□ No □ Yes Describe use: ________________________________________________________________</td>
</tr>
<tr>
<td>BARRIERS TO PRESCRIPTION MEDICATION COMPLIANCE: □ None □ Type ___________________________</td>
<td></td>
</tr>
<tr>
<td>USE OF OTC MEDICATIONS OR HERBAL SUPPLEMENTS: □ None □ Type ___________________________</td>
<td></td>
</tr>
<tr>
<td>ALLERGIES: □ No □ Yes To: □ Drugs □ Food □ Tape □ Dyes □ Iodine □ Other</td>
<td></td>
</tr>
<tr>
<td>Name of allergen(s): ____________________________ Reaction: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Name of allergen(s): ____________________________ Reaction: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Name of allergen(s): ____________________________ Reaction: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Name of allergen(s): ____________________________ Reaction: ____________________________</td>
<td></td>
</tr>
<tr>
<td>FALL RISK: __________ Describe: ___________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>INFECTION RISKS: ______________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>SEASONAL FLU IMMUNIZATION: □ No □ Yes □ NA LAST TETANUS INJECTION: ___________________________</td>
<td></td>
</tr>
<tr>
<td>PNEUMOCOCCAL VACCINE □ No □ Yes □ NA OTHER: __ Year if known ____________________________</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Activity-Exercise Pattern</td>
<td>Cardiovascular System</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Objective Data</strong></td>
<td><strong>Subjective Data</strong></td>
</tr>
<tr>
<td>□ WNL □ No</td>
<td></td>
</tr>
</tbody>
</table>

**Supporting Data:**

- BP ____________________ □ Left □ Right Temp ____________
- Apical Pulse: ___________ Radial Pulse: _______________
- Pedal Pulses (amplitude):
  - R ____________________ L ____________________
- Peripheral Pulses *name/describe*:
- Cap Refill ____________ Neck Veins:

**Edema** □ None □ Yes □ Pitting

- Loc ____________________ □ Pitting (1,2,3+)
- Loc ____________________ □ Pitting (1,2,3+)

□ SCDs □ TED Hose

- Heart Sounds Ausc ____________
- Heart Rhythm: ____________________
  - (reg or irreg)
- Tele Rate/Rhythm: ________________

**IV Site(s):** □ Patent, no redness, no edema

- Type/Size: ____________ Location ____________

**Fluid Restriction** □ None □ Yes ______ mL per day

**Cardiac response to activity** ____________________________________________________

<table>
<thead>
<tr>
<th>Respiratory System</th>
<th>Objective Data</th>
<th>Subjective Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ WNL □ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Supporting Data:**

- RR ____________________ Pattern: ____________
- O2 Sats ____________________ O2 Use: ____________
- Aids to Respiration: ________________
- Cough: □ None □ Yes
  - Describe ____________________
- Sputum (describe) ____________________

**Lung Sounds:**

- Upper RL ____________________
- Middle RL ____________________
- Lower RL ____________________
- Upper LL ____________________
- Lower LL ____________________

**Respiratory response to activity** ____________________________________________________
<table>
<thead>
<tr>
<th>Musculoskeletal System</th>
<th>Objective Data</th>
<th>Subjective Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ WNL □ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Supporting Data:**

- Full ROM: □ Yes □ No
- ROM: (List joints that are limited with degree/description)

- Balance/Gate: □ Steady □ Unsteady
- Hand Grips: □ Equal □ Strong
- □ Weak/Paralysis R □ L
- Lower Extremity: □ Equal □ Strong
- □ Weak R/L □ Paralysis R/L

**Posture**

**Musculoskeletal response to activity**

<table>
<thead>
<tr>
<th>Eating/Dressing</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = Independent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>1 = Assistive Device</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing/Grooming</td>
<td>2 = Assistance from Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>3 = Assistance from Person and Equip</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Mobility</td>
<td>4 = Dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assitive Devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stair Climbing</td>
<td>□ None □ Wheelchair □ Walker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td>□ Bedside Commode □ Cane</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking</td>
<td>□ Splint/Brace □ Crutches</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>□ Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal System</th>
<th>Objective Data</th>
<th>Subjective Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ WNL □ No</td>
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</tbody>
</table>

**Supporting Data:**

- Bowel Sounds: (desc)
- Abdomen: Inspection
  - Palpation:
  - Percussion:
- Ostomy: □ None □ Yes
- Appliance: □ None □ Yes (type)
- Change pattern
  - Who cares for ostomy?
- GI Tubes:
### Nutritional/Metabolic Pattern

- **Objective Data**
  - WNL □
  - □ No
  - □ N/A

**Supporting Data:**

- **Appetite**
  - Diet________ Restrictions______________________
  - Does Pt. Understand? □ Yes □ No □ N/A

- **Diet Supplements:**
  - □ None □ Yes __________________________

- **Taste Intact?**
  - □ Yes □ No □ Nausea

- **Ht________**
  - **Wt________**
  - **BMI________**
  - **IBW________**

- **Wt change past 6 mo:** ____________ lb. (-/+)

- **Dysphagia?**
  - □ None □ Solids □ Liquids

- **Thicket used** ______________

- **Feeding Tube:**
  - □ None □ Yes __________

- **Dentures:**
  - □ None □ Upper (□ partial/□ full)
  - □ Lower (□ partial/□ full)

- **Dentures on hand?** □ Yes □ No □ N/A

- **Describe abnormalities:** ___________________________

### Integumentary System

- **Objective Data**
  - □ WNL □ No

**Supporting Data:**

- **Color:** ____________________________

- **Pale □ Cyanotic □ Ashen □ Jaundice**

- **Turgor:** ____________________________

- **Temp (desc)**______________________

- **Edema:** □ None □ Yes □ Pitting

- **Desc/Loc_______________________ (1,2,3+)**

- **Lesions:** □ None □ Yes

- **Describe/Loc____________________***

- **Bruises:** □ None □ Yes

- **Describe/Loc____________________***

- **Pruritus:** □ None □ Yes

- **Describe/Loc____________________***

- **Decubitus:** □ None □ Yes

- **Stage/Location____________________***

- **Dressing_______________________**

- **Drainage_______________________**

- **Braden Scale:**
  - **Score:** ____________________________
  - **Risk Level:** ____________________________

(Use Tool to Calculate Score)

### Fluid Restriction

- □ None □ Yes ____________________________mL
## Elimination Pattern

<table>
<thead>
<tr>
<th>Objective Data</th>
<th>Subjective Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bowel habits:</strong> # BMs/day: ___________________________</td>
<td>(hospital)</td>
</tr>
<tr>
<td>Bowel pattern/character-home – change? ___________________________</td>
<td></td>
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<tr>
<td>Date of last BM: ___________________________</td>
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<tr>
<td>Constipation: □Yes □No</td>
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<tr>
<td>Diarrhea: □Yes □No</td>
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<tr>
<td>Stool Incontinence: □Yes □No</td>
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</tr>
</tbody>
</table>

**I&O:** Intake for YOUR shift: ___________________________ ml
- Output for YOUR shift: ___________________________ ml
- Intake previous 24 hours: ___________________________ ml
- Output previous 24 hours: ___________________________ ml

**Balance:** ___________________________

## Bladder habits:

<table>
<thead>
<tr>
<th>Objective Data</th>
<th>Subjective Data</th>
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</thead>
<tbody>
<tr>
<td><strong>#voidings/day:</strong> ___________________________</td>
<td></td>
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<tr>
<td>Urinary pattern - home - change? ___________________________</td>
<td></td>
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<tr>
<td>□Frequency □Dysuria</td>
<td></td>
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<tr>
<td>□Nocturia ___________________________</td>
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<tr>
<td>□Urgency □Hematuria □Retention ___________________________</td>
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<tr>
<td>□Difficulty voiding ___________________________</td>
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<tr>
<td><strong>Assistive Devices</strong> □None □Yes ___________________________</td>
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<tr>
<td>□Indwelling catheter □Intermittent catheter</td>
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<tr>
<td>□External Catheter □Briefs □Bedside Commode □Penile Implant</td>
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<tr>
<td><strong>Incontinence</strong> □None □Yes Type ___________________________</td>
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<tr>
<td>□Total □Daytime □Nighttime</td>
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</tbody>
</table>

**Urine appearance:**
- Describe: ___________________________
- Clear: □Yes □No
- Odor: □Yes □No

## Cognitive-Perceptual Pattern

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<tr>
<th>Objective Data</th>
<th>Subjective Data</th>
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<td>□ WNL □ No</td>
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</table>

**Supporting Data:**
- Mental Status: □Alert □Receptive Aphasia □Poor historian
- □Oriented: ___________________________ □Confused □Combative □Unresponsive
- Speech: □Normal □Slurred □Garbled □Expressive Aphasia
- Spoken Language: ___________________________

**Interpreter:** ___________________________

**Ability to read English:** □Yes □No
**Ability to communicate:** □Yes □No
**Ability to comprehend:** □Yes □No

**Interactive Skills:**
- Describe: ___________________________

**Anxiety:** □None □Yes □Mild □Moderate □Severe □Panic

**Hearing:**
- Impaired □Yes □No (□R □L)
- Deaf (□R □L)
- Hearing Aid (□R □L)
- Tinnitus

**Vision:**
- Impaired □Yes □No (□R □L)
- Eyeglasses □Contact Lens
- Blind (□R □L)
- Prosthesis (□R □L)

**Pupils (describe):**
- Right: ___________________________ Left: ___________________________

**Reactive to light:**
- Left: □Yes □No Specify: ___________________________
- Right: □Yes □No Specify: ___________________________
- □Clear □Draining □Reddened

**Vertigo:** □None □Yes

**Desc:** ___________________________

## Pain

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<tr>
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<th>Subjective Data</th>
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</thead>
</table>

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Revised 04/16/2014
**Value-Belief Pattern**

| □ WNL □ No |
| Supporting Data. |
| Religion: ☐ Roman Catholic ☐ Protestant ☐ Jewish ☐ Other: ____________________________ |
| Religious restrictions: ____________________________ |
| Request chaplain visitations at this time: ☐ Yes ☐ No |
| Other comments relating to pattern: ____________________________ |

---

**Sleep-Rest Pattern**

| □ WNL □ No |
| Supporting Data: |
| Habits: Hours/night: ____________________________ |
| AM nap: ____________________________ PM nap: ____________________________ |
| Feels rested after sleep: Y____ N_____ |
| Problems: None: ____________________________ |
| Early waking: _______ Insomnia: _______ |
| Nightmares: ____________________________ |

---

**Coping/Stress/Tolerance Self-perception Self-Concept Pattern**

| □ WNL □ No |
| Supporting Data. |
| Major concerns regarding hospitalization or illness (financial, self care) |
| Major loss/change in past year: □ None □ Yes |
| Other comments relating to pattern: ____________________________ |
### Sexuality – Reproductive Pattern

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</tr>
</thead>
<tbody>
<tr>
<td>□ WNL □ No</td>
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</tbody>
</table>

*Supporting Data:*
- **LMP:** ______________________
- **Menstruation/Hormonal Problems:**
  - □ None □ Yes Describe__________________________
- **Last Pap Smear (>70 NA):** ______________________
- **Monthly self-breast exam:** □ Y □ N____________
- **Last Prostate exam:** ________________________
- **Monthly Self Testicular Exam:** □ Y □ N

*Sexual Concerns:* □ No □ Yes ______________________

### Role-Relational Pattern

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>□ WNL □ No</td>
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</table>

*Supporting Data:*
- **Occupation:** ________________________________
  - □ Employed □ ST disability □ LT disability
  - □ Unemployed □ Retired from __________________

### Discharge Planning

Lives alone: _____ With: ____________________________ No known residence:

Does client anticipate discharge: Y _____ N____

Where: __________________________________________

Community resources or Referrals needed: Home Health/Hospice:_____ Adult day care:_____
Senior center: ____ Church group: _____ Meals on wheels:_____ Home Health Agency:_____
Other ______

Support group: (Identify)

________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________

Anticipated problems post discharge. ____________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________
Recommendations (Consider teaching, services and equipment)
The following pages include NANDA Nursing Diagnosis List 2012 – 2014 with Domains 1-12.

You must identify and highlight each nursing diagnosis a different color that are appropriate for your patient. Then select the top 3 priority nursing diagnoses.

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<thead>
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<th>Objective Data Clusters (Including relevant medications and diagnostic tests)</th>
<th>Nursing Diagnoses Relevant to Data Clustering</th>
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<tr>
<td>Domain 1</td>
<td></td>
<td></td>
<td>- Deficient diversional activity</td>
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<tr>
<td>1. Health Awareness</td>
<td></td>
<td></td>
<td>- Sedentary lifestyle</td>
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<tr>
<td>2: Health Management</td>
<td></td>
<td></td>
<td>- Deficient community health</td>
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<td>- Risk-prone health behavior (specify)</td>
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<td>- Ineffective health maintenance (specify)</td>
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<td>- Readiness for enhanced immunization status</td>
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<td>- Ineffective protection (specify)</td>
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<td>- Ineffective self-health management</td>
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<td>- Readiness for enhanced self-health management</td>
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<td></td>
<td>- Ineffective family therapeutic regimen Management (specify)</td>
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<td>- Health-seeking behaviors (specify)</td>
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<td>- Ineffective Health maintenance (specify)</td>
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<td>- Ineffective Therapeutic regimen management (specify)</td>
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<td>- Risk for ineffective Therapeutic regimen management (specify)</td>
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<td>- Readiness for enhanced Therapeutic regimen management</td>
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<tr>
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<td>- Effective Therapeutic regimen management (specify)</td>
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<td>- Health-Management Deficit (specify)</td>
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<td>- Risk for Health-Management Deficit (specify)</td>
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<tr>
<td><strong>Domain 2 – Nutrition</strong></td>
<td></td>
<td></td>
<td>- Imbalanced Nutrition: more than body requirements</td>
</tr>
<tr>
<td>1. Ingestion</td>
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<td>- Risk for imbalanced Nutrition: more than body requirements</td>
</tr>
<tr>
<td>2. Digestion</td>
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<td>- Imbalanced Nutrition: less than body requirements</td>
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<tr>
<td>3. Absorption</td>
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<td>- Readiness for enhanced Nutrition</td>
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<tr>
<td>4. Metabolism</td>
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<td>- Impaired Swallowing</td>
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<tr>
<td>5. Hydration</td>
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<td>- Risk for Electrolyte imbalance</td>
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<td>- Risk for imbalanced Fluid volume</td>
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<td>- Risk for deficient Fluid volume</td>
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<td>- Deficient Fluid volume</td>
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<td>- Excess Fluid volume</td>
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<td>- Readiness for enhanced Fluid balance</td>
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<td>- Risk for unstable blood glucose level</td>
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<td>- Risk for Impaired Liver function</td>
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<td>- Insufficient breast milk</td>
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<td>- Ineffective Infant feeding pattern</td>
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<td>- Neonatal jaundice</td>
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<td>- Risk for neonatal jaundice</td>
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<td><strong>Domain3: Elimination &amp; Exchange</strong></td>
<td></td>
<td></td>
<td>- Constipation</td>
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<tr>
<td>1. Urinary System</td>
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<td>- Perceived Constipation</td>
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<td>3. Integumentary System</td>
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<td>- Diarrhea</td>
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<td>- Dysfunctional gastrointestinal motility</td>
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<td>- Risk for dysfunctional GI motility</td>
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<td>- Bowel incontinence</td>
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<th>Nursing Diagnoses Relevant to Data Clustering</th>
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<tr>
<td>4. Pulmonary System</td>
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<td>Functional urinary incontinence</td>
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<td>Overflow urinary Incontinence</td>
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<td>Reflex urinary incontinence</td>
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<td>Stress urinary incontinence</td>
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<td>Urge urinary incontinence</td>
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<td>Risk for Urge urinary incontinence</td>
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<td>Impaired urinary elimination</td>
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<td>Urinary retention</td>
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<td>Readiness for enhanced Urinary elimination</td>
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<tr>
<td>Domain 4: Activity-Rest</td>
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</tr>
<tr>
<td>1. Sleep/Rest</td>
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<td>2. Activity/Exercise</td>
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<td>3. Energy/Balance</td>
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<td>4. Cardiovascular/</td>
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<td>Risk for Disuse syndrome</td>
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<td>5. Self-care</td>
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<td>Impaired bed mobility</td>
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<td>Impaired physical mobility</td>
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<td>Ineffective Breathing pattern</td>
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<td>Decreased Cardiac Output</td>
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<td>Risk for ineffective gastrointestinal</td>
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<td>Perfusion</td>
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<td>Risk for ineffective renal perfusion</td>
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<td>Ineffective peripheral tissue perfusion</td>
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<td>Risk for decreased cardiac tissue Perfusion</td>
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<td>- Dysfunctional ventilatory weaning response</td>
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<td>- Impaired home maintenance</td>
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<td>- Readiness for enhanced self-care</td>
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<td>- Bathing self-care deficit</td>
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<td>- Toileting self-care deficit</td>
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<td>- Self neglect</td>
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</tbody>
</table>
| **Domain 5:** Perception/Cognition | | | - Uncompensated Sensory Loss (specify type/degree)  
- Sensory Overload  
- Sensory Deprivation  
- Unilateral neglect  
- Deficient Knowledge  
- Readiness for enhanced Knowledge  
- Disturbed Thought processes  
- Attention-Concentration Deficit  
- Acute confusion  
- Chronic confusion  
- Risk for Acute Confusion  
- Impaired Memory  
- Impaired Environmental interpretation syndrome  
- Ineffective impulse control  
- Uncompensated Memory Loss  
- Risk for Cognitive Impairment  
- Decisional Conflict (specify)  
- Impaired verbal communication  
- Readiness for enhanced communication |
<p>| 1. Attention | | | |
| 2. Orientation | | | |
| 3. Sensation/Perception/Cognition | | | |
| 4. Communication | | | |</p>
<table>
<thead>
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<tbody>
<tr>
<td><strong>Domain 6: Self-Perception</strong></td>
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<tr>
<td>1. Self-Concept</td>
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<td>Hopelessness</td>
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<tr>
<td>2. Self-Esteem</td>
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<td>3. Body Image</td>
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<td>Readiness for enhanced self-control</td>
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<td>Risk for situational low self-esteem</td>
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<td>Disturbed Body image</td>
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<td>2. Family Relationship</td>
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<td>3. Role Performance</td>
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<td>Impaired skin integrity</td>
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<td>Delayed surgical recovery</td>
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<td>Risk for adverse reaction to iodinated contrast media</td>
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### Functional Health Pattern

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<th>Nursing Diagnoses Relevant to Data Clustering</th>
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<td>- Latex allergy response</td>
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<td>- Risk for latex allergy response</td>
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<td>- Risk for imbalanced body temperature</td>
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<td>- Hypothermia</td>
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<td>- Ineffective thermoregulation</td>
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</tbody>
</table>

#### Domain 12: Comfort

1. Physical
2. Environmental
3. Social

|                          |                                                                                | - Impaired comfort                           |
|                          |                                                                                | - Readiness for enhanced comfort             |
|                          |                                                                                | - Nausea                                     |
|                          |                                                                                | - Acute pain (specify location)              |
|                          |                                                                                | - Chronic pain (specify location)            |
|                          |                                                                                | - Impaired comfort                           |
|                          |                                                                                | - Readiness for enhanced comfort             |
|                          |                                                                                | - Social isolation                           |

From your analysis of the data clustered identify the top 3 **PRIORITY** nursing diagnoses for this patient WHEN YOU CARED FOR THEM? **Write the nursing diagnoses in NANDA format.** Provide **rationale** below for why you’ve prioritized them in this way.
**CLINICAL DECISION MAKING MODEL: PLANNING, INTERVENTION, EVALUATION**

NURSING DIAGNOSIS PRIORITY #1: ____________________________ related to ____________________________ as evidenced by ____________________________

CLIENT OUTCOMES: SHORT-TERM GOAL (Realistic/Measureable): ____________________________

LONG-TERM GOAL (Realistic/Measureable):

<table>
<thead>
<tr>
<th>PRIORITY Nursing Intervention (action)</th>
<th>Rationale (why do this)</th>
<th>Evaluation (did it help the client meet the goal?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions should relate to Goals</td>
<td>Evidence-based rationale with reference.</td>
<td>Describe how the intervention was effective.</td>
</tr>
<tr>
<td>Give a minimum of 3-4 List in order of Priority</td>
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</table>

WERE CLIENT OUTCOMES MET? Yes_______ No________ Partially__________ (Explain how you know) ____________________________

IFI GOAL WAS NOT MET, WHAT COULD BE DONE DIFFERENTLY?

________________________________________________________

Revised 04/16/2014
NURSING DIAGNOSIS **PRIORITY #2**: _________________ related to _________________ as evidenced by _________________

CLIENT OUTCOMES: SHORT-TERM GOAL (Realistic/Measurable): _________________

LONG-TERM GOAL (Realistic/Measureable):

<table>
<thead>
<tr>
<th><strong>PRIORITY</strong> Nursing Intervention (action)</th>
<th>Rationale (why do this)</th>
<th>Evaluation (did it help the client meet the goal?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give a minimum of 3-4</td>
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WERE CLIENT OUTCOMES MET? Yes ______ No ______ Partially _______ (Explain how you know) ________________

IF GOAL WAS NOT MET, WHAT COULD BE DONE DIFFERENTLY?

____________________________________________________________________________________________
____________________________________________________________________________________________________________
**CARE PLAN EVALUATION FORM**

**Assessment and Data Clustering**
Data Assessment and Functional Health Pattern reflect actual patient status;
Objective and Subjective data identified as taught in class
Conclusions drawn are data dependent  
10

**Lab and Diagnostic Data:**
All lab and diagnostics documented
Cites **IMPLICATION:** why lab drawn for patient
Cites **ANALYSIS:** causes for patient values
Relates to client  
10

**Medication:**
Classification
Safe Dose Nursing Responsibilities/ Teaching
Mechanism of action Drug/Food Interactions
Use Side Effect/ Major Adverse Reactions
Why this patient is ordered this medication Effectiveness evaluated  
10

**Pathophysiology Tree:**
Describes course of medical condition through death
Provides Risk Factors for diagnosis
Highlights signs/symptoms for current patient  
10

**Problem List:**
High Risk Actual
Problems identified come from assessment data
All problems are noted that assessment data shows
Rationale for selecting highest priority diagnoses  
10

**Nursing Diagnostic Statement:**
Stated in nursing terms (NANDA format)
“Related to” is pathophysiologically based
Supported by Objective Data
Supported by Subjective Data  
10

**Goals and Outcomes:**
Relate to Problem Long and Short Term Goals Identified
States desired patient outcome criteria
Realistic time frame and for the Patient Measurable  
10

**Carative Factors/Interventions:**
Contain what, how much, where, when, who to do
Related to goals and outcomes
Could be completed by another nurse for the client  
10

**Evidenced –Based Rationale:**
Based on Valid Theory; States nursing action modifications to accomplish
the desired outcome(s) and why the interventions are being done
**IN-TEXT CITATION MUST BE PRESENT**  
5

**References/Format:**
References (page and source) within document where appropriate
Separate reference page.  APA Format,  
5

**Evaluation:**
States how goals and outcomes were met or not met
Recommended changes related to interventions
Based on outcome criteria  
10

**TOTAL:**  
100

Revised 04/16/2014
WEEKLY CLINICAL EVALUATION FORM

Student: ________________________________

Dates of Clinical: ______________________

Evaluation of Clinical Experience:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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Self Evaluation (Objectives & Goals met/unmet):
______________________________________________________________________________
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