

INTRODUCTION TO PROFESSIONAL NURSING COURSE SYLLABUS HYBRID NUR 2000LHY

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GENERAL CLASS & COURSE INFORMATION

Course number: NUR 2000L Class Reference Number: Multiple Term: Fall 2012

Course title: Introduction to Professional Nursing Credit/Contact hours: 1 Credit

Course Description: This course must be taken prior to entering the nursing program. This course is designed as a transitional course for the LPN, Paramedic or transfer student who is becoming a professional nurse. This course encompasses the area of role definition; providing/managing care of individuals and groups utilizing goal attainment to reach an optimum state of health and wellness.

Course Learning Outcomes: As a result of taking this course, the student will be able to:

1	Explain King's theory of Goal Attainment with Dossey's Principles of Holism as a theoretical framework for nursing practice.
2	Utilize the nursing process to demonstrate critical thinking in planning for and providing holistic nursing care to clients in relation to the human response patterns to health challenges as evidenced by completion of a Daily Holistic Assessment Tool (DHAT).
3	Demonstrate principles of therapeutic communication appropriate to clients, families, health team members, and professional nursing through completion of an Interpersonal Recording (IPR) videotaped interview with analysis employed techniques for effectiveness.
4	Demonstrate an understanding of the impact of human responses to health challenges in goal attainment by utilizing a comprehensive holistic assessment tool (CHAT) to assess an elder in the community.
5	Display components of professional/personal growth and life-long learning as evidenced by a class presentation utilizing the dynamic principles of Teaching/Learning.
6	Compare and contrast health as it relates to maintaining wellness of self, the individual and family in the ever-changing health care delivery system.
7	Analyze current wellness practices and create a plan for improvement applying the principles of nutrition, multiculturalism, and the influence of generational health practices, as evidenced by satisfactory completion of the wellness paper.
8	Articulate leadership expectations of the professional nurse.
9	Describe ethical and legal concepts relevant to the practice of professional nursing.

Course Outline for NUR2000LHY - INTRO PROFES NURSING

Class Schedule: Will be available on the first day of class and will be posted on the web site by the instructor.



Textbooks information: Textbooks are listed as Required and Recommended.

Required:

- Wilkinson J & Treas, L. (2010) Fundamentals of Nursing, 2nd Ed. FA Davis ISBN 13-978-0-8036-2354-5
- 2. Skills Video: Fundamentals of Nursing ISBN 13-978-0-8036-2403-0
- 3. (2011) *Student Success for Health Professionals Made Incredibly Easy*.2nd Ed. Baltimore: Lippincott Williams & Wilkins. ISBN 10 1609137841 ISBN 13 978-1609137847
- 4. Ackley, Betty J. and Ladwig, Gail B.; Nursing Diagnosis Handbook: A Guide to Planning Care, 9th ed., 2008, Mosby, St. Louis, Missouri, ISBN 978-032307150-5
- 5. Palm Beach State College NUR 2000LHY Syllabus is posted online.
- 6. The Essential Nursing Resources Webpage is mandatory reading as published on assigned Blackboard course or component.

Recommended:

- Smeltzer, S., et al., (2009) <u>Brunner & Suddarth's Textbook of Medical Surgical Nursing</u>, (12thed), Philadelphia:Lippincott, Williams, & Wilkins. ISBN-10: 1-58255-994-5 ISBN-13: 978-1-58255-994-0 (2 volume set)
- 2. Wilson, B. et. al. (2013) Pearson Nurse's Drug Guide ISBN 9780132964890

You may purchase your textbook(s) at any one of Palm Beach State College's campus bookstores or online.

The Electronic <u>Essential Nursing Resources</u> can be found online. A Video list is recommended & available in <u>MTIS</u> (Media Technology and Instructional Services) located on the first floor of the LLRC.

Web Content Information: <u>This course has an Internet Component</u> which is on the Weblink: https://palmbeachstate.blackboard.com

To pass the course, you must be able to access this web site.

It is the student's responsibility to have accessed this site no later than the semester start date. The web site has a security system which requires a *Sign on* and a *Password*. Only registered students will be able to access the course. On-line students are not permitted to attend 'live lecture classes'.

To login to the course web site:

User Name & Password: Use your PantherWeb logon information.

Your Palm Beach State College Student ID Number can be found on the back of your student ID card. If you do not have a student ID card, you can obtain one in the bookstore at Lake Worth campus. For obtaining a student ID card on other campuses, check with each campus directly.



What do I do if I forget my password or need assistance with Blackboard?

<u>E-mail the Blackboard administrator</u>. You can also email the Palm Beach State College <u>Student Help</u> <u>Desk</u> or contact them by phone at (561)868-4000. Be sure you have the following information available:

- your full name
- your Palm Beach State College Student ID number
- course with the reference number
- details of the assistance needed and any error messages

The Student Help Desk Hours of Operation are posted on the following web page:

On hours and days that the Help Desk is closed, the student may leave a voice message or an e-mail and the issue will be addressed the next business day.

"Netiquette Rule" requirements: Refer to the web site for network application. The faculty expectation is for student adherence to the same standards of behavior online that you follow in real life.

PROFESSOR'S CONTACT INFORMATION

Deborah Copeland, RN, MSN

Professor I
AH 206 (561) 868-3431
Lake Worth campus
Email

Leslie Kent MSN, RN, CEN

Professor I AH201 (561) 868-3436 Lake Worth campus Email

Faculty Office Hours are Posted on Faculty Web Pages and Outside Office

CLASS REQUIREMENTS

Assignments: NUR 2000LHY will have 4 major papers; a presentation; a cumulative final exam; and a class participation grade. See grading scale for details. All students are encouraged to participate fully in online activities. All readings, discussions, AV material, and posted files are testable material. In order to complete this course satisfactorily all papers, presentations and exams must be completed.

Late Assignment Policy: Assignments and presentations are due by the assigned deadlines as noted on the course schedule. Any exception to the deadline **must** be approved in **advance** by the instructor. Late papers will not have the opportunity to be redone if unsatisfactory.

Nursing Department Grading Scale and Policy

90 - 100 = A 83 - 89 = B

75 - 82 = C

Below 75 = F

The minimum score to pass the course is 75%.

Tests, Papers and Final Examination - Your course grade will be determined by the following:

Daily Holistic Assessment Tool (DHAT)	=	15%
Comprehensive Holistic Assessment Tool (CHAT)	=	15%
Interpersonal Recording (IPR)	=	10%
Wellness Assessment Paper	=	15%
Presentation of Issues of Professional Practice	=	15%
Final Exam	=	20%
Participation (Wellness; Discussion; Internet)	=	10%
Total		100%

Make-up Exam Policy: The final exam must be taken at the assigned time in AH 208. Any make-up exam must be approved in advance by the instructor.

Please see Nursing Handbook for standard Nursing policy related to Essay Make-up Exams.

DISTANCE LEARNING CLASS INFORMATION

This course is taken by attending a classroom on campus for 50% of the scheduled classes and via the Internet for the remaining scheduled classes. Before you decide to take the course under these conditions, it is recommended that you:

- take the following assessments to determine if distance learning is best for you:
 - 1. Should I take a distance learning class?
 - 2. Do I have enough time to take a distance learning class?
 - 3. Do I have the technical skills and knowledge to learn online?
- read the <u>Distance Learning Frequently Answered Questions</u> page which include instructions for logging onto Blackboard, computer requirements, and basic computer skills students must have prior to enrolling a distance learning class.
- read the syllabus description below carefully.
- contact the professor by e-mail or by phone if you have any questions.

Computer Requirements

If you choose to take this course, you must have access to a computer that meets the <u>basic computer</u> requirements

Computer Competency Component: Each student will, to the satisfaction of the instructor, demonstrate a fundamental understanding of basic computer operations through various instructor-determined exercises and/or assignments. All assignments must be submitted as attachments via the Assignment Tool in .doc or .rtf format.

Specific Testing Requirements: The **Comprehensive Final Exam must be taken on campus** at the scheduled date and time in a designated Computer Testing Lab on the course assigned campus location.

SLC Computer Lab

If students do not have access to a computer at home, the SLC Computer Lab at a Palm Beach State College campus can be used to complete course assignments. Visit the <u>SLC Computer Lab</u> web page for location and hours.



IT IS RECOMMENDED THAT THE STUDENT TAKING THIS COURSE AS A *PURE INTERNET* COURSE <u>NOT</u> BE A NOVICE COMPUTER USER. THE STUDENT SHOULD KNOW HOW TO USE A MOUSE, NAVIGATE THE INTERNET, AND SEND/RECEIVE E-MAIL WITH ATTACHMENTS. VISIT THE FOLLOWING WEB PAGE FOR MORE INFORMATION REGARDING MINIMUM COMPUTER SKILLS STUDENTS MUST HAVE PRIOR TO ENROLLING IN AN ONLINE COURSE — HTTPS://PALMBEACHSTATE.BLACKBOARD.COM

CLASS POLICIES AND METHODOLOGY

Attendance: Professors are required to take attendance. **Students are expected to access the course web site daily.** Students who are actively involved in their learning are more successful. Students are expected to complete all class work; scheduled tests; and participate in structured class discussions.

ALL students are expected to attend all scheduled tests, classes, and clinical/labs. In the event of an absence due to extenuating circumstances, the student is expected to notify the appropriate faculty member.

Electronic Device Use: The use of Hand-held devices that are iPOD capable are encouraged to facilitate downloadable information as learning strategies and study tools. Cell phones are prohibited in the campus Testing Centers.

<u>Email Policy</u>: All students have access to a college email account. It is the responsibility of the student to activate this account in order to be kept current with college, program and course information. College email should be checked daily. This course has email within the course. Course email should be used for all course-related communications with faculty.

Faculty will contact students via college and course email, so be certain to check these email accounts daily for any updates or changes to coursework.

Equipment & Supplies: Required text books; access to a computer with active Internet service; word processing and printing capabilities are essential to be successful in this class. Students are also required to have a Syllabus; pen; pencil; paper; and a CD/memory stick.

Professor's Expectations: Students will follow these Strategies for Success:

- 1 Read in advance and come to class prepared.
- 2 Attend all Classes
- 3 Utilize resources currently available:
 - a. Media & Instructional Technology Services (MTIS)
 - b. Student Learning Center (SLC), If reading comprehension is a problem for you explore the resources in TC 210 such as: the video on how to read a textbook, and the bank of computer programs that cover Math, English, Reading, and Study Skills.
 - c. Nursing Skills Lab
- 4 Study groups: form a group for serious study time. Make rules that all students must come prepared. This is not a social gathering.
- Visual learners: Take notes & recopy notes. Take notes as you read your text and then merge the notes together!
- 6 Auditory learners: tape lectures; listen again, and discuss material with your peers.
- 7 Do not procrastinate when it comes to studying and/or reading.



- 8 Explore the reference text: *Test Success* by Nugent & Vitale. This book is an excellent guide on how to read test questions; how to choose the "best" answer; etc. Available in the Palm Beach State College bookstore. There is a copy on the 3rd floor of the LLRC, at the Reference Desk.
- 9 Look at the "big picture." Answer these questions:
 - Do you have the commitment to succeed?
 - How many hours are you working?
 - What are your other life commitments?
 - Are you neglecting your wellness plan?
 - Have you studied effectively?
 - Have you spent quality time with your loved ones?
- 10 Remember that the faculty is here to assist and support you. Please feel free to come to us for any further direction.

YOU CAN DO IT!!!

Methods of Instruction:

8 Student group work Selected reading 9 Journal Articles 2 Lectures Demonstrations 3 10 Study Guides 4 Discussions 11 Interactive Educational Activities 5 Audiovisuals 12 Internet – Blackboard Learning System 13 Student Lead Presentation Interactive video software programs 7 Computer-Assisted Instruction 14 Critical Thinking Exercises

Classroom Strategies

- A. Class Discussion
- B. Media Presentations: Video, PowerPoint
- C. Group Presentations/Case Scenarios
- D. Critical Thinking Exercises

Evaluation Methods

- A. Group/Individual Activities
- B. Critical Thinking Assignments
- C. Class Attendance/Participation
- D. Periodic Exams, Final Examination

All students enrolled in a Nursing course must maintain compliance with the policies and procedures published in the Nursing Student Handbook in addition to those established for the general college population by Palm Beach State College.

Please refer to the following documents:

- Palm Beach State College Student Handbook:
- Palm Beach State College Nursing Student Handbook:
- PantherWeb Student Information:

COLLEGE POLICIES AND WEB INFORMATION

Academic Dishonesty

Academic dishonesty includes the following actions, as well as other similar conduct aimed at making false representation with respect to the student's academic performance:

(1) Cheating on an exam, (2) Collaborating with others on work to be presented, if contrary to the stated rules of the course, (3) Submitting, if contrary to the rules of the course, work previously submitted in another course, (4) Knowingly and intentionally assisting another student in any of the above actions,



including assistance in an arrangement whereby work, classroom performance, examination, or other activity is submitted or performed by a person other that the student under whose name the work is submitted or performed, (5) Plagiarism.

Please refer to the Palm Beach State College Student Handbook

Classroom Etiquette and Student Behavior Guidelines

Students will demonstrate respect for professors and fellow students. Behavior that is disruptive to a positive learning environment reported by the professor will result in a warning on the first instance; the second instance might result in expulsion from the course or campus.

Computer Competency Component

Each student will, to the satisfaction of the professor, demonstrate a fundamental understanding of basic computer operations through various professor-determined exercises and/or assignments.

Disability Support Services

Students with disabilities are advised, in compliance with federal and state laws, that accommodations and services are available through the office of <u>Disability Support Services</u> (DSS). It is the student's responsibility to contact <u>Disabled Student Services Advisors</u> and to submit appropriate documentation prior to receiving services.

Eating, Drinking and Smoking

Eating and drinking are confined to areas designated on the campus. Smoking is not permitted in any College building and only in areas designated at each campus.

Student Responsibility Policy

When a student attends the College, s/he becomes subject to its jurisdiction. Students are expected to conduct themselves in a responsible manner, in all areas of campus life. By enrolling, they pledge to obey the rules and regulations of the College and are responsible for observing all College policies and procedures as published in the student handbook, the College catalog and other College publications. The student will be responsible for preparing for class, participating in class, and completing assignments on time.

Palm Beach State College Websites of Interest

Withdrawal Policy for Individual Courses: It is the responsibility of the student to note the last day of withdrawal from class and to use the PantherWeb system or visit a campus Registrar's office to withdraw. An official withdrawal entitles the student to a grade of "W" in the class.

DEPARTMENT CONTACT INFORMATION

Kellie Bassell, MSN, EdS, RN

Nursing Program Director AH 110 (561) 868-3412 Fax (561) 868-3452 Email



GETTING STARTED

- 1. Make sure you have all the computer system requirements as listed in the Computer Requirements section of this syllabus.
- 2. The professor will communicate with you through Blackboard or your PALM BEACH STATE COLLEGE-issued email address only.
- 3. Obtain course materials. The textbook(s) can be purchased at the PALM BEACH STATE COLLEGE campus bookstore or <u>online</u>.
- 4. Log onto the course web site <u>BlackBoard Learn eLearning Campus</u>. Use your PantherWeb logon information.
- 5. Explore the different parts of the web page. Be sure you print the syllabus, course calendar, and assignment sheet so that you know what is expected of you during the semester.
- 6. Read the instructor's *Welcome* message on the discussion board and post a reply to it introducing yourself to the class.
- 7. Print the course worksheets and content outlines that follow this section of the syllabus.
- 8. Begin completing your assignments as listed on the course calendar and/or class schedule.

Have fun!

Disclaimer

Changes may be made to the syllabus at any time during the term by announcement of the professor. It is the responsibility of the student to make any adjustments as announced.

COURSE CONTENT OUTLINES

UNIT I: COURSE ORIENTATION

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
 Describe the purpose of and requirements for NUR 2000L. Describe the transition process into the role of the student. 	 A. Orientation to course 1. General information 2. Learning Outcomes for course 3. Course requirements a. Written assignments b. Participation 	Review NUR 2000L Syllabus Review Nursing Student Handbook Establish Student Portfolio Take Online Tour of Library Review Essential Nursing Resource Page Wellness Activity Class Discussion Topic: Role Transition Write Personal Definition of Nursing

UNIT II: INTRODUCTION TO PROFESSIONAL NURSING

UNIT II: INTRODUCTION TO PROFESSIONAL NURSING			
OBJECTIVES	<u> </u>	CONTENT	LEARNING ACTIVITIES
The Student will:	A.	Historical Overview	Required:
Compare and contrast the nursing profession as an art and as a science.		 Societal influences in development of nursing practice Contributors to nursing as a profession. 	Read Palm Beach State College Nursing Student Handbook
Describe the historical evolution of nursing as a profession.	В.	 Impact of technological age on advancing nursing as a practice and profession. Theoretical Frameworks of Professional Nursing 	A. Review Palm Beach State College Curriculum, Framework
3. Explain the role of theoretical frameworks as they apply to nursing as a profession.		Practice 1. Role of theory in the professional practice of	Review Website: www.dosseydossey.com/barbara/default.html
Identify the major concepts of King's Theory of Goal Attainment.		nursing.2. Major contributors to development of nursing theory.	On Reserve (3 rd Floor) Dossey: Core Curriculum for Holistic Nursing Chapters 9 & 10 - pp. 66-80
5. Discuss methods of application for King's Theory of Goal Attainment for clients across the life span.		a. Imogene King's Theory of Goal Attainmentb. Dossey's Theoretical Approach to Holistic	Complete Wellness Activity
Identify key concepts of holistic nursing practice methods for application across the life span.		Nursing. 3. Palm Beach State College a. Philosophy	
7. Describe trends in nursing education.		b. Conceptual Framework	
Explain the basis for conducting research in nursing.		c. Overview of the 5 concepts(1) The 5 concepts(a) Oxygenation	
9. Discuss the contributions of formal education and research in the development of nursing practice as a profession.		(b) Cellular Integrity(c) Regulation(d) Mobility	
10. Describe the five (5) concepts of the PALM BEACH STATE COLLEGE Nursing Conceptual Framework from a holistic wellness perspective.		 (e) Perceptual/Sensory/Cognition (2) Health Promotion, Health Maintenance, and Disease Prevention and their application to the 5 concepts across the 	
11. Utilize the five (5) concepts of the PALM BEACH STATE COLLEGE Nursing Conceptual Framework while applying the Nursing Process to health promotion, health maintenance, and disease prevention across the life span.	C.	life span. Nursing Education and Research 1. Role of formal education in the practice of nursing as a profession. a. Methods of obtaining current nursing education. 2. Role of Research a. Nursing Practice	
		b. Nursing as a Profession	

UNIT III: MAINTAINING WELLNESS

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
The student will: 1. Differentiate health, illness & wellness as they relate to health promotion and disease prevention.	A. Health promotion and disease prevention throughout the life span. 1. Healthy people 2010 initiative 2. Nurse's role 3. Personal Wellness Plan	Required: Access Healthy People 2020 website. Complete Personal Wellness Assessment/Plan Paper
2. Discuss the nurse's role in Health Promotion	B. Health, Wellness, Illness	Complete Discussion Topic: Wellness
 Compare various models of health. Identify factors affecting health status, beliefs and practices. 	 Concepts of health and well-being Concepts of health and well-being Health Personal definitions of health 	Complete Wellness Activity
5. Describe factors affecting health care adherence	c) Wellness and well-being	
6. Differentiate illness from disease and acute illness from chronic illness.	 Models of health and wellness Variables influencing health status, beliefs, and practices 	
7. Describe effects of illness on individuals' and family members' roles and functions.	a) Internal variablesb) External variables	
8. Distinguish the various services, which collectively make up the Health Care Delivery System (H.C.D.S.) and the role of the nurse therein.	 4. Health belief models a) Health locus of control model 5. Health care adherence 6. Illness and disease 	
9. Identify major factors, which influence health care.	a) Illness behaviors	
10. Discuss current challenges in the H.C.D.S.	b) Effects of illness	
11. List current trends & issues, which affect H.C.D.S.		

UNIT IV: CRITICAL THINKING

The Student will: 1. Discuss the skills and attitudes of critical thinking. 2. Discuss the relationships among the nursing process, critical thinking, the problem solving process and the decision-making process. Discuss the relationships among the nursing process and the decision-making process. A. Critical Thinking	OBJECTIVES	CONTENT	LEARNING ACTIVITIES
	 The Student will: Discuss the skills and attitudes of critical thinking. Discuss the relationships among the nursing process, critical thinking, the problem solving 	A. Critical Thinking 1. Skills in critical thinking 2. Attitudes that foster critical thinking a. Independence of thought b. Fair-mindedness c. Insight into egocentricity and sociocentricity d. Intellectual humility e. Intellectual courage f. Integrity g. Perseverance h. Confidence in reason i. Curiosity 3. Standards of critical thinking 4. Applying critical thinking to nursing practice a. Problem solving 1) Trial and error 2) Intuition 3) Research process and scientific/modified scientific method b. Decision making 5. Developing critical-thinking attitudes and skills a. Self-assessment b. Tolerating dissonance and ambiguity c. Seeking situations where good thinking is practiced d. Creating environments that support critical	Required: Define Critical Thinking Complete Discussion Topic: Critical Thinking

UNIT V: NURSING PROCCESS

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
The student will: 1. Describe the nursing process. 2. Differentiate between subjective & objective data during the assessment phase of nursing process. 3. Discuss the unique characteristics of subjective data. 4. Create nursing diagnoses for identified client needs. 5. Describe the process of planning individualized nursing care. 6. Compose correctly worded expected outcomes or goals. 7. Discuss interventions included on a nursing care plan. 8. Describe the implementation of a nursing care plan. 9. Describe the evaluation of a nursing care plan. 10. Utilize the five (5) concepts of the Palm Beach State College Nursing Conceptual Framework while applying the Nursing Process to health promotion, health maintenance and disease prevention across the lifespan.	A. Nursing process 1. Definition and purposes 2. Phases of the process 3. Interrelatedness of phases B. The Significance of Nursing Process 1. Impact on nursing practice 2. Standard of care – JCAHO, facility review 3. Care plans, Standards of care, Critical pathways C. Assessment phase 1. Purpose of Assessment a. Establish a database to identify overall state of health 2. Types of Assessment a. Comprehensive (admission) b. Focused – limited scope c. Ongoing – recurring assessment for specific problems 3. Data Collection a. Subjective – patient self-report b. Objective – can be measured, compared to a norm c. Other Sources – family, staff, medical records, literature 4. Methods of Data Collection a. Observation b. Interview c. Health History d. Physical Examination e. Lab and Diagnostic Data 5. Data Organization a. Functional Health Patterns	Required: Define Nursing process steps Define Nursing diagnosis Define NANDA Define Outcome Criteria Participate in Group discussion Complete Daily Holistic Assessment Tool (DHAT) Complete Comprehensive Holistic Assessment Tool (CHAT) with an elder Complete Self Directed Attitude Assessment of the Aging Process (SDAAAP). Learning Guide: Nursing Process Learning Guide: Physical Assessment



UNIT V: NURSING PROCESS (CONTINUED)

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
05523.1725	6. Assessment activities	22, 11, 12, 10, 12, 17, 120
	a. Collection of data	
	b. Validation of data	
	D. Subjective data	
	Individual characteristics	
	2. Developmental	
	3. Personal, interpersonal & social system transactions	
	4. The interview process	
	E. Nursing diagnosis phase	
	Definition & purposes	
	Organization of assessment data	
	a. NANDA common language – improves	
	communication and understanding of client	
	problems	
	3. Analysis of data	
	a. (P) Problem	
	b. (E) Etiology	
	c. (S) Signs & symptoms	
	4. Statement of nursing diagnosis	
	a. Actual	
	b. Potential	
	5. Compare and Contrast Nursing and Medical Diagnoses	
	a. Methods of Documentation	
	1. Narrative	
	2. Problem-Oriented Medical Record	
	3. Computerized Charting	
	F. Planning phase	
	Priority setting	
	2. Goal-setting	
	a. Short term	
	b. Long term	
	3. Expected outcomes	
	a. Realistic & achievable	
	b. Measurable, observable & behavioral	
	c. Client – centered	
	d. Time designated	
	e. Mutually set	
	4. Planning nursing care	

UNIT V: NURSING PROCESS (CONTINUED)

	UNIT V: NORSING PROCESS (CONTINUED)	
OBJECTIVES	CONTENT	LEARNING ACTIVITIES
	a. Priority setting	
	b. Sources of interventions	
	1. Dependent	
	2. Independent	
	3. Interdependent	
	c. Rationale for interventions	
	d. Specificity of interventions	
	G. The implementation phase	
	1. Action Phase – giving the care needed to affect the	
	change in client condition	
	Types of Nursing Care Delivery Systems	
	a. Primary	
	b. Functional	
	c. Team	
	3. Roles within the health care team	
	a. Teamwork	
	b. Delegation	
	H The evaluation phase	
	Results are compared to outcome criteria from	
	Planning Stage.	
	a. Positive – goal attainment	
	b. Partially met goals	
	c. Negative – unmet goals	
	2. Quality Assurance	
	a. Peer Review	
	3. Revision of Care Plan	
	I Documentation	
	Medical Records Components used by purso	
	a. Components used by nurseb. Nurse's Progress Notes	
	Nurse's Progress Notes Verbal Reporting	
	2. Verbai Neporting	

UNIT V: TEACHING/LEARNING PROCESS

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
The student will:	A. Teaching	Paguirod:
1. Describe key elements of the teaching-learning	 Teaching clients and their families 	Required:
process.	2. Teaching in the community	Teaching Plan on assigned Well Elder.
Compare and contrast teaching-learning	3. Teaching health personnel	Complete Self Learning Style Assessment
environments across the life span.	B. Learning	Complete Sen Learning Style 763633ment
3. Identify the professional responsibilities of client	Learning Theories	
teaching.	a. Behaviorism	
4. Integrate the application of the nursing process to	b. Cognitivism	
the teaching-learning process.	c. Humanism	
5. Identify and apply guidelines for effective client	2. Using Learning Theories	
teaching.	3. Factors affecting learning	
6. Discuss the implications of culture on the teaching-	a. Motivation	
learning process.	b. Readiness	
7. Develop a teaching plan utilizing the nursing	c. Active involvement	
process.	d. Relevance	
	e. Feedback	
	f. Nonjudgmental support	
	g. Simple to complex h. Repetition	
	n. Repetition i. Timing	
	j. Environment	
	k. Emotions	
	I. Physiologic events	
	m. Cultural aspects	
	n. Psychomotor ability	
	C. Nurse as Educator	

UNIT VI: COMMUNICATION

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
	A. Therapeutic Relationship	LEARNING ACTIVITIES
The Student will:	B. Communication Process	Required:
1. Discuss key elements of therapeutic relationship.	1. Components	Review Therapeutic Communication, Videos (Located
2. Discuss key elements of the communication process.	2. Factors influencing	under Web links)
3. Compare and contrast methods of communication.	C. Methods of Communication Process	a. Basic Components of Communication
4. Describe the different types of communication and	1. Verbal 2. Nonverbal	b. Opening, Questioning and Using Silence
the impact of utilization.	D. Types of Communication	
5. Recognize the professional nurse's role in and	1. Therapeutic	c. Responding and Closing
impact of utilizing the communication process.	A. Elements of	Discussion Topic: Communication
6. Identify types of crises and describe nurses' role in crisis intervention.	B. Barriers to 2. Non-therapeutic	Complete Interpersonal Process Recording (IPR) with one client.
7. Recognize key elements of psychological responses to physical illness.	E. Professional ResponsibilityA. Patient InteractionsB. Interdisciplinary Interactions	Learning Guide: Therapeutic Communication
8. Identify the elements of assertive communication.	F. Communication With Special Populations Crisis	
 Compare and contrast different documentation methods: source-oriented and problem-oriented medical records, PIE, focus charting, charting by exception, computerized records, and the case management model. 	Intervention Physically III G. Medical Records 1. Components used by nurse 2. Nurse's Progress Notes a. Methods of Documentation	
 Identify and discuss guidelines for effective recording that meets legal and ethical standards. 	(1) Narrative(2) Problem-Oriented Medical Record(3) PIE	
11. Identify essential guidelines for reporting client data.	(4) Focus	
12. Identify abbreviations and symbols commonly used for charting.	(5) Charting by exception (6) Computerized Charting	
13. Explain how various forms in the client are used to document steps of the nursing process (assessment, diagnosis, planning, implementation, and evaluation).	H. Verbal Reporting I. Interpersonal Process Recording (I.P.R.)	
14. Compare and contrast the documentation needed for clients in acute care, home health care, and long-term care settings.		



UNIT VII: PROFESSIONALISM

ODJECTIVEC	CONTENT	LEADNING ACTIVITIES
OBJECTIVES	CONTENT	LEARNING ACTIVITIES
The Student will:	A. Roles and Responsibilities1. The role of the professional nurse includes	Required:
1. Identify the role of the professional nurse.	application of the nursing process, advocacy for	Discussion Topic: Compare definitions of Nursing from
 Identify the scope of practice between LPN and RN in the Nurse Practice Act. Identify and discuss the responsibilities and 	patients, and management of care. B. Legal and Ethical Issues 1. Read and discuss the Nurse Practice Act. 2. ANA Standards of Care	ANA and Board of Nursing Review Florida Nurse Practice Act. Wellness Activity
accountability of the professional nurse in the practice setting.	 3. Legal Responsibilities of Students C. Personal Professional Growth 1. Discuss the scope of practice for the RN 	Review Ethical Agreement sign and place in student portfolio.
4. Discuss the responsibility of teaching by the RN.	2. Differentiate job from profession	Complete Presentation on Professionalism topic.
 Discuss the responsibility of teaching by the RN. Describe the characteristics of tasks appropriate to delegate to unlicensed and licensed assistive personnel. List the five rights of delegation. 	 2. Differentiate job from profession 3. Profession includes a. Education b. Theory c. Service d. Autonomy D. Accountability and Leadership E. Health Team Collaboration F. The Transition Process 1. Identifying personal goals 2. Overcoming barriers and fears 3. Strategies for success G. Political Action H. Delegation Unlicensed Assistive Personnel Licensed Assistive Personnel I. S Rights of Delegation Right task Right circumstances Right person Right direction and communication Right supervision and evaluation 	Complete Presentation on Professionalism topic.



UNIT VIII: ASPECTS OF HOLISTIC CARE

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
ODJECTIVES		
 Discuss how values, beliefs, culture, spirituality, sexuality, self-concept, and developmental stage affects the nurse/client relationship. 	 A. Cultural: 1. Concepts of Culture 2. Influence of Culture on health 3. Application to Nursing Care 4. World Religions & Health Implications 5. Transcultural Nursing 	Required: Discussion: Personal cultural heritage and its impact on your life. View Video: Patient Diversity (Found under web links).
 Define and provide examples of the following culture, subculture, customs, beliefs, attitudes, and values. 	6. Vulnerable populationsB. Spiritual:1. Characteristics	Wellness Activity: Complete Self-Assessment of Sexual Knowledge and Attitudes - SASKA
 Discuss the impact of culture on health beliefs and health behaviors 	2. Application of Nursing CareC. Sexuality:1. Sexual Nature of Individuals	Attitudes SASIM
4. Demonstrate sensitivity to the cultures, values, and practices of others.	2. Human Sexual Response3. Attitudes Toward Sexuality	
 Identify nursing strategies that offer culturally sensitive care. 	 4. Application to Nursing Care D. Self-Concept: Identity, Body Image, Self-Esteem & Role Performance Development of Self-Concept Factors Affecting Self-Concept Application to Nursing Care	

UNIT IX: TRANSITION PROCESS

OBJECTIVES	CONTENT	LEARNING ACTIVITIES
The Student will: 1. Describe the transition process into the role of the professional nurse. 2. Discuss strategies for success.	A. Transition to Role 1. Identifying personal goals 2. Overcoming barriers and fears 3. Strategies for Success 4. Time Management	Required: Located under Web links: Review: Successful Note taking

INTERNET RESOURCES FOR NURSING PROFESSIONALS

- Agency for Health Care Research and Quality: http://www.ahcpr.gov/
- American Academy of Hospice & Palliative Medicine: http://www.aahpm.org
- American Holistic Nursing Association: http://ahna.org
- American Journal of Nursing: http://www.nursingworld.org/ajn/
- American Medical Association: http://www.ama-assn.org/
- American Pain Society: http://www.ampainsoc.org
- ANA: http://www.ana.org
- Centers for Disease Control: http://www.cdc.gov/
- Florida Department of Health Business and Professional Regulation: http://fcn.state.fl.us/dbpr/
- National Institutes of Health: http://www.health.nih.gov
- Hospice & Palliative Nurse's Association: http://www.HPNA.org
- Medscape: http://www.medscape.com/
- Nursing Center: http://www.nursingcenter.com/journals
- United States National Library of Medicine: http://www.nlm.nih.gov/
- Oncolink: http://www.oncolink.upenn.edu/
- American Association for the History of Nursing: http://www.aahn.org

GUIDELINES FOR WRITTEN ASSIGNMENTS

- Wellness Assessment
- DHAT
- CHAT
- IPR
- Presentation

CRITERIA FOR WELLNESS PAPER

Purpose: To deepen your understanding of health patterns as they relate to you and your family. The goals of this paper are to enhance your personal well being and nursing practice.

The paper is to be typed (word processed) and double-spaced, using APA format. Please include a reference page, as well as an Appendix for Internet Resource URL sites. Also include the Evaluation Form For Wellness Paper. There will be $\underline{6}$ parts to the paper. They are as follows:

- 1. Write a personal statement on "What being healthy means to me."
- 2. Describe your family's health patterns as follows:
 - A. Place of birth
 - B. Cultural background
 - C. State of health
 - D. Health care practices for your family including maternal and paternal grandparents, mother and father, yourself, spouse, children, siblings.
 - E. What patterns emerge from the above?
 - F. Discuss any concerns/issues you may have.
 - G. Have you changed any of your health practices due to your family pattern?
- 3. Describe your own practices of health promotion/disease prevention (HP/DP) in the following areas:
 - A. Physical activity and fitness.
 - B. Nutrition include cancer prevention strategies.
 - C. Use of tobacco, alcohol and other drugs.
 - D. Safety in home (abusive toxic substances/drug safety potential, guns secure). Safety in car (seatbelts, where children sit).
 - E. Environment (lead, radon, allergens).
 - F. Food.
 - G. Stress reduction.
 - H. STD's.
 - I. Immunizations.
 - J. SBE = Self Breast Exam, mammogram, pap, testicular exam, PSA, rectal.
 - K. Physician (cholesterol, B/P, DM) assessments.
 - L. Alternative Therapies
 - M. Support.
 - N. Other.
- 4. Develop your own long-term personal wellness plan using the nursing process. (This plan will be an active wellness plan throughout the nursing program.)
- 5. Do an Internet search to find at least 2 resources that would be valuable for you to use. Include a copy of these in the Appendix of your paper and the reference section of your paper. Be sure to have URL (Uniform Resource Locater) e.g. http://www.palmbeachstate.edu.
- 6. The reference page has to include at least 2 resources from book and/or professional journal along with 2 Internet search resources.
- 7. Refer to the <u>Evaluation Form For Wellness Paper</u> for specific evaluated criteria.



EVALUATION FORM FOR WELLNESS PAPER

STUDENTS NAME:	DATE:

Actual	Possible	Focus
Points	Points	Tocus
		I. Organization
	3	A. Neatly typed
	8	B. APA format
	<u>15</u>	C. Spelling/grammar
	26	
		II. Body of Paper
	4	A. Statement of "Meaning of Health"
	8	B. Description of health care practices of 3 generations - including place
		of birth, cultural background, state of health
	8	C. Analysis of family patterns
	8	D. Discussion of concerns/issues
	<u>4</u>	E. Discussion of any change in your own health care practices related to
	32	concerns/issues
		III. Description of Health Promotion and Disease Prevention (Ensure)
		A. Physical Activity/Fitness
		B. Nutrition (vitamins/cancer prevention heart healthy strategies)
		C. use of alcohol, tobacco, drugs
		D. Safety
		▶ home
		toxic substances/drugs
		securing firearms
		• pool
		abuse potential
		safe sitters (child and elder)
		working fire extinguishers
		storm and fire emergency plans
		► car
		• car seats
		where children sit
		• road rage
		► workplace
		• hazards
		E. Environment
		► allergens
		water supply
		F. Food handling
		G. Stress reduction
		H. STD awareness
		I. Immunizations
		J. Cancer Screenings
		self breast exam
		► testicular exam

1	1		
		▶ pap smear	
		▶ occult stool	
		► rectal exam	
		► skin/tongue lesions	
		K. Yearly health care provider visits▶ B/P▶ 11811	
		► H&H ► cholesterol	
		 blood sugars Use of alternative modalities - herbs, massage, yoga, acupuncture, tai chi, etc. 	
		M. Personal support system	
	16	N. Other	
	10	N. Other	
		IV. Personal Wellness Plan	
		A. One NANDA self-diagnosis	
		B. Two goals (must be specific, measurable, realistic)	
		C. Minimally five interventions	
		D. Evaluation	
	20		
		V. References and Internet Search	
		A. Must minimally include 2 books and/or professional journal articles	
		plus 2 Internet resources with copies of the first page identifying the	
		URL site.	
	6		
Total	Total		
Actual	Possible		
Points	Points	75 points are required for a passing grade of SATISFACTORY.	
	100		

Faculty Comments:

DAILY HOLISTIC ASSESSMENT TOOL (DHAT)

GUIDELINES FOR DAILY HOLISTIC ASSESSMENT TOOL (DHAT)

Date of birth: Do not need to fill in

Culture Needs: Identify the ethnic background for your patient.

Admitting Diagnosis: Indicate what your patient was admitted for

Secondary Diagnosis: Underlying health history

Pathophysiology: List and define any medical history. Use a reference to define.

Health Challenges: Subjective - indicate what the patient said to you.

Objective - indicate what you see or can measure

Circumference, birth weight, and gestational age: N/A.

Lifespan: Indicate whether patient is an adolescent, early adulthood, middle adulthood or later

adulthood.

Stage of Growth and Development According to Erickson: Indicate the anticipated stage of growth and

development.

Actual Stage of Growth and Development: Select one appropriate for the individual and explain why

client is in this stage.

Family Rate/Issues: Identify roles that this individual takes on within the family and identify any issues

that are currently present or created by this hospitalization.

Allergies: List food, drug, chemicals and/or environmental.

SENSORY/PERCEPTION/COGNITION

L.O.C.: Identify whether the patient is awake, alert, lethargic.

Pupils: Assess pupils reaction to light.

Level of Orientation: Check as appropriate for your patient.

Hearing Aid: Check if your patient has a hearing aid, which ear(s). Write no if your patient does not

have one.

Hard of Hearing: Check item if patient is hard of hearing, if not, write no.

Glasses/Contacts: Circle item if patient has either one or both. If patient has neither write none.

Mood: Fill in appropriate blank with yes or no.

Course Syllabus – Distance Learning (Online)

Substance Abuse: *Identify how many packs or number of cigarettes per day. If patient does not smoke, write none. "Rx drugs: Write in yes or no. *ETOH: write in yes or no. *Illicit drugs: write in yes or no. *Any yes answer should be followed up on back with further explanation and details.

History of abuse, memory & judgment/anxiety Level: Fill in the appropriate blank with yes or no.

MOBILITY

Activity Tolerance/Limitations: Identify any issues affecting mobility. Indicate how patient is tolerating activity.

Functional Ability: Indicate ability utilizing numbers.

Assistive Needs: Indicate ability utilizing numbers.

Fall Risk: Indicate yes or no.

OXYGENATION

Respirations

Pattern & Rate: Identify the pattern of response and rate. Examples: even, labored, rapid.

Breath Sounds: Identify sounds as well as location of your assessment, i.e., clear bilaterally, rales right base, rhonchi, crackles, wheezing.

Oxygen Therapy: What type of oxygen therapy and how many liters.

Oxygen Saturation: Indicate percent if assessed or state not assessed.

TX's: Respiratory treatments. If your patient is receiving treatment indicate what type and how often, otherwise write no.

CARDIOVASCULAR

Heart Sounds: Check that you heard normal heart sounds.

PMI: If in appropriate location, check yes.

Murmur: Did you hear a murmur? Indicate yes or no.

Pulse Deficit: check yes or no in appropriate space.

Apical Rate: Write in actual rate and circle either regular or irregular.

Fetal Heart Rate: N/A if patient is not pregnant.

Capillary Refill: Circle either brisk or slow and indicate the time in seconds for refill.

Homans: Indicate whether your patient has a positive or negative human sign on the right and left side.

Peripheral Pulses: Check your patients pedal pulses. Indicate whether they are present and the quality of the pulses.



Course Syllabus – Distance Learning (Online)

CELLULAR INTEGRITY

Skin Temperature: Assess your patient and check appropriate area.

Edema: If present circle and indicate location in space. Mark no if not present.

Wound: Indicate whether your patient has a laceration, or abdominal incision.

Drainage/Discharge: Using the REEDA method, assess your patients wound, then answer questions appropriately. Indicate yes or no for drainage. *Color: indicate if present and what color. *Odor: indicate yes or no.

Site/Wound Care: Indicate what you are doing for the stated wound, i.e.; pericare, topicals, sitz bath.

REGULATION

Nutrition: Mark adequate or poor based on your assessment and the patient's nutritional status.

Therapeutic: Indicate type of diet.

Elimination Pattern: Indicate your patient's pattern and check appropriate box.

LBM: Indicate date of last BM.

Bowel Sounds: Circle presents or absent. Indicate location.

Urinary: Identify patients voiding pattern. State if catheter is present.

Fluid Restriction: Indicate yes or no.

Intake/Output: Record totals for your shift.

Formula/Type: N/A

Intravenous Fluid: Indicate type of fluid infusing and rate. Identify site location and if a Saline Lock or MAP is in place

PRIORITY NURSING DIAGNOSIS

A total of **three nursing diagnoses** will be identified with each DHAT. One should be a psychosocial issue. The student will develop 3 complete nursing plans of care to be submitted the next clinical day.



Course Syllabus – Distance Learning (Online)

Evaluation of Daily Holistic Assessment Tool (DHAT) & Care plan

	<u>% Possible</u>	<u>% Earned</u>
Assessment	10%	
Med sheet(s)	15%	
Lab sheet(s)	15%	
Care Plan #1	20%	
Care Plan #2	20%	
Care Plan #3	<u>20%</u>	
TOTAL	100%	

Student Name:	Date:
	Adult Daily Holistic Assessment Tool (DHAT)
Client Initials Age	DOB Gender Date
WT HT	Admission Date: Allergies
Admission Diagnosis / Current	Diagnosis:
Pathophysiology (textbook ref	erence):
Initial Assessment	Time:
Vital Signs	T P RR B/P
Sensory / Perception / Cognition	1
LOC / Visual or auditory deficits	†awake †alert †oriented †asleep † confused †obtunded †none specify:
Mood	†appropriate †depressed †anxious †angry †euphoric †labile
Behavior	†cooperative †uncooperative †apprehensive †agitated †lethargic
Speech / Primary language	clear †appropriate †inappropriate †aphasia †impaired hearing Primary language:
Pupils	(L)mm †brisk †sluggish †nonreactive (R)mm †brisk †sluggish †nonreactive PERRLA
Pain	Score: location: description: medicated Y* N
Growth & Development (Erikson) Stage	(Actual Stage) AEB
* Alteration in S/P/C	none present R/T
Cellular Integrity:	
Skin temperature / moisture	jwarm jcool jcold jdry jmoist jdiaphoretic
Color / turgor	†pink †pale †cyanotic †mottled †jaundiced †elastic †tenting
Edema	none present location pitting +1 +2 +3 +4
Mucous membranes	†pink †pale †moist †dry †lesions
Rash / lesion / wound	†none † present site describelocation
* Alteration in Skin Integrity	none present R/T
Oxygenation:	
Respiratory: Effort	junlabored jdyspneic jnasal flaring jabdominal jstridor jgrunting jretractions Regular irregular
Lung sounds	RUL RML RLL LUL LLL Clear Decreased Absent Rales Rhonchi Wheezes

Student Name:	Date:	
O ₂ therapy / O ₂ saturation	none O_2 therapy lpm / % NC Mask Oxyhood saturation level %	
Cough / Respiratory Treatments	nonproductive productive tx's tx's	
* Impaired Gas Exchange	none present R/T	
Cardiovascular: Apical	regular irregular \$1 \$2 PMI Murmur	
Extremities: Capillary refill / peripheral pulses	<pre>< >seconds {0 - 3} R/L brachial R/L radial R/L dorsal pedalis R/L posterior tibial other</pre>	
Monitors	none specify:	
*Alteration in tissue perfusion	none present R/T	
Regulation:		
Abdomen / LBM Diet	soft ifirm irigid idistended iround iflat itenderness / LBM icontinent incontinent	
Bowel sounds	RLQ RUQ LUQ + present -absent ++hyperactive +/-hypoactive	
NG / GT	none specify	
*Alteration in nutrition	none present R/T size †gravity †suction	
GU	no problems foley dysuria hematuria frequency continent incontinent LMP	
Intravenous Fluids	none specify/solution & rate	
* Alteration in elimination	none For shift: total in total outpresent R/T	
Mobility:		
Muscle tone / strength / Range Of Motion	†strength equal bilaterally UE and LE †weakness (specify) †Full Range Of Motion †limitations:	
Gait / fall risk	steady junsteady jpre-ambulatory jparalysis /describe	
Functional ability	independent itotal assistance irequires assistance (explain)	
Casts / Assistance devices	none specify	
*Alteration in Mobility	none present R/T	
* for abnormal findings, see additional notes		
SN signature:		
STATE AND PRIORITIZE 3 NURSING DIAGNOSES		

Student Name:	Date:	
NURSES NOTES:		
SN Signature		

LAB WORK AND DIAGNOSTIC TESTS

TEST	RESULTS	NORMALS	DATES	REASON FOR TEST	NURSING SIGNIFICANCE

MEDICATION SHEET

PATIENT ALLERGIES DATE: STUDENT:

TRADE/GENERIC NAME CLASSIFICATION	SPECIFIC INDICATIONS/ REASON GIVEN TO YOUR CLIENT	MECHANISM OF ACTION	PATIENT DOSE/ROUTE/SAFE DOSAGE RANGE (AGE SPECIFIC)	MAJOR SIDE EFFECTS	DRUG/DRUG OR DRUG/DIET INTERACTIONS AND CONTRAINDICATIONS	CLIENT SPECIFIC NURSING IMPLICATIONS
TRADE: GENERIC: CLASSIFICATION:						
TRADE: GENERIC: CLASSIFICATION:						
TRADE: GENERIC: CLASSIFICATION:						

CLIENT INITIALS: DATE:	NURSING CARE PLAN	HU	JMAN PATTERN:	
NURSING DIAGNOSIS:	PRIORITY CONCEPT:	□ Exchanging	□ Valuing	□ Perceiving
RT:	☐ Oxy ☐ Reg ☐ Cell Integ	□ Communicating	□ Choosing	☐ Knowing
AEB:	☐ Mob ☐ S/P/C	☐ Relating	☐ Moving	☐ Feeling

Assessment	Planning Goal Desired Outcome (Specific/Measurable)	Implementation Nursing Interventions	Rationale Reason for Interventions	Evaluation	Goal I	Met?*
Pertinent Data:	Patient Will:	Nurse Will:	Why:	What Happened:	Yes	No
Subjective: (What did client say – use direct quotations)						
Objective: (What did you see/hear/smell/feel – list findings)						

^{*}If the client goal was/was not met briefly describe why and what steps would be taken next:

COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (CHAT)

FOCUS: THE WELL ELDER

STUDENT CLINICAL EXPERIENCE USING THE COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (CHAT) WITH A ELDER

General Guidelines:

- 1. Follow an individual who is 65 years of age or older.
- 2. Make a visit(s) lasting 60 minutes utilizing guidelines related to a specified area of focus.
- 3. Summarize the visit using the "Summary of Visit with Elder" form.
- 4. Contact faculty for problems that arise or whenever assistance is needed.
- 5. Develop a teaching plan based on your nursing health history.

Preparation Activities:

- 1. Review on Head to Toe Physical Assessment for obtaining a nursing health history.
- 2. Self-assessment on own time.
 - A. How would you describe you health?
 - B. Where do you place yourself on the wellness-illness continuum?
 - C. How do you promote wellness in yourself?
 - D. Is there anything that interferes with you being healthy?

Student Learning Experience:

- 1. Conduct and record a nursing health history using the Palm Beach State College Nursing Comprehensive Holistic Assessment Tool. (C.H.A.T.) Remember to include completed Daily Holistic Assessment Tool.
- 2. Complete Nutritional Assessment.
- 3. Prepare a teaching plan based on the elders learning needs.
- 4. Develop two nursing care plans.

Learning Guides:

Palm Beach State College Comprehensive Holistic Assessment Tool (C.H.A.T.) Teaching Care Plan

Discussion Guidelines:

- 1. How does your elder perceive his/her health?
- 2. How do you perceive your elder's health?
- 3. Where do you think your elder is on the wellness-illness continuum?
- 4. Identify factors that promote wellness in your elder.
- 5. Identify anything that interferes with your elder's health and well-being.



THE AGED FAMILY DEVELOPMENTAL TASKS

The following developmental tasks are to be achieved by the aging couple as a family as well as by the aging person alone:

- 1. Decide where and how to live out the remaining years.
- 2. Continue a supportive, close, warm relationship with the spouse or significant other, including a satisfying sexual relationship.
- 3. Find a satisfactory home or living arrangement and establish a safe, comfortable household routine to fit health and economic status.
- 4. Adjust living standards to retirement income; supplement retirement income if possible with remunerative activity.
- 5. Maintain maximum level of health; care of self physically and emotionally by getting regular health examinations and needed medical or dental care, eating an adequate diet, and maintaining personal hygiene.
- 6. Maintain contact with children, grandchildren, and other living relatives, finding emotional satisfaction with them.
- 7. Maintain interest in people outside the family, and in social, civic, and political responsibility.
- 8. Pursue new interests and maintain former activities in order to gain status, recognition, and a feeling of being needed.
- 9. Find meaning in life after retirement and in facing inevitable illness and death of oneself and spouse as well as other loved ones.
- 10. Work out a significant philosophy of life, finding comfort in a philosophy or religion.
- 11. Adjust to the death of spouse and other loved ones.



EVALUATION OF COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (CHAT)

	% Possible	<u>% Earned</u>
CHAT form	10%	
Nutritional forms	10%	
Med sheet(s)	10%	
Lab sheet(s)	10%	
Care Plan #1	20%	
Care Plan #2	20%	
Teaching Plan	<u>20%</u>	
TOTAL	100%	

Admission	Assessment: Con	nprehensive Ho	listic Assessment To	ol (CHAT)
Client Initials:	DOB:	Age:	Wt:	
Diagnosis:				
**attach daily assessm				
Patient Admission Info	rmation:			
I. PERCEPTUAL / SENS	SORY / COGNITION			
Communicating: patte	ern involving sending me	ssages		
Name preferred:		S	ex: Age:	Date:
Informant: Patient Patient Patient Patient Patient	arent Spouse Other	A	dmitted from: Home ED	OR Other
At time of interview pa	atient is: alert appropri	ate relaxed agitate	d anxious tearful sleepy	other
Primary language:		I	nterpreter needed:	
Relating: pattern invol	lving established bonds			
Role: marital status, c	children, parents, siblings	5:		
	xual / emotional abuse:			
instally of priyateary se				
Are you in a relationsh	ip in which you or your c	child have been hurt	or threatened?	
Are you in a relationsh	ip in which you or your c	child have been hurt		
Are you in a relationsh In the past year, has so	ip in which you or your comeone close to you hit,	child have been hurt kicked, punched, sla	or threatened? pped, or shoved you or your	child?
Are you in a relationsh In the past year, has so Occupation / Education	ip in which you or your comeone close to you hit,	child have been hurt kicked, punched, sla	or threatened? pped, or shoved you or your	child?
Are you in a relationsh In the past year, has so Occupation / Education	ip in which you or your comeone close to you hit,	child have been hurt kicked, punched, sla	or threatened? pped, or shoved you or your	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer	ip in which you or your on the properties of the	child have been hurt kicked, punched, sla sibilities (school, wo	or threatened? pped, or shoved you or your	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer Socialization / support	ip in which you or your comeone close to you hit, nal experience:rn related to role respon	child have been hurt kicked, punched, sla sibilities (school, wo	or threatened? pped, or shoved you or your	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer Socialization / support Valuing: pattern involves	ip in which you or your or meone close to you hit, nal experience:rn related to role responsystems:ving spiritual growth	child have been hurt kicked, punched, sla sibilities (school, wo	or threatened? pped, or shoved you or your rk, financial, caregiver):	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concersocialization / support Valuing: pattern involved Religious preference:	ip in which you or your comeone close to you hit, nal experience: rn related to role respon systems: ving spiritual growth	child have been hurt kicked, punched, sla sibilities (school, wo	or threatened? pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer Socialization / support Valuing: pattern involv Religious preference: _ Cultural preferences /	ip in which you or your or meone close to you hit, nal experience: rn related to role responsystems: ving spiritual growth needs:	child have been hurt kicked, punched, sla sibilities (school, wo	or threatened? pped, or shoved you or your rk, financial, caregiver):	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concersocialization / support Valuing: pattern involve Religious preferences / Knowing: pattern invo	ip in which you or your comeone close to you hit, nal experience: rn related to role respon systems: ving spiritual growth	child have been hurt kicked, punched, sla sibilities (school, wo	or threatened? pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concersocialization / support Valuing: pattern involve Religious preferences / Knowing: pattern involve Medical History:	ip in which you or your or meone close to you hit, mal experience:	child have been hurt kicked, punched, sla sibilities (school, wo	pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concersocialization / support Valuing: pattern involve Religious preferences / Knowing: pattern involve Medical History:	ip in which you or your or meone close to you hit, mal experience:	child have been hurt kicked, punched, sla sibilities (school, wo	or threatened? pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concersocialization / support Valuing: pattern involve Religious preferences / Knowing: pattern involve Medical History:	ip in which you or your or meone close to you hit, mal experience:	child have been hurt kicked, punched, sla sibilities (school, wo	pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer Socialization / support Valuing: pattern involv Religious preference: _ Cultural preferences / Knowing: pattern invo Medical History: Chief complaint:	ip in which you or your or meone close to you hit, mal experience:	shild have been hurt kicked, punched, sla sibilities (school, wo	pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer Socialization / support Valuing: pattern involv Religious preference: _ Cultural preferences / Knowing: pattern invo Medical History: Chief complaint:	ip in which you or your or meone close to you hit, mal experience:	shild have been hurt kicked, punched, sla sibilities (school, wo	pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer Socialization / support Valuing: pattern involv Religious preference: _ Cultural preferences / Knowing: pattern invo Medical History: Chief complaint:	ip in which you or your comeone close to you hit, mal experience:	shild have been hurt kicked, punched, sla sibilities (school, wo	pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer Socialization / support Valuing: pattern involv Religious preference: _ Cultural preferences / Knowing: pattern invo Medical History: Chief complaint: Previous / Ongoing Hea	ip in which you or your or meone close to you hit, mal experience:	shild have been hurt kicked, punched, sla sibilities (school, wo	pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?
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Are you in a relationsh In the past year, has so Occupation / Education Patient / parent concer Socialization / support Valuing: pattern involv Religious preference: _ Cultural preferences / Knowing: pattern invo Medical History: Chief complaint: Previous / Ongoing Hea	ip in which you or your comeone close to you hit, nal experience: rn related to role respon systems: ving spiritual growth needs: olving the means associate alth problems (symptom	shild have been hurt kicked, punched, slassibilities (school, wo	pped, or shoved you or your rk, financial, caregiver): piritual needs:	child?

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Student Name:		Date:				
Infectious Disease Exposure: None		·				
List all medications in use (prescription, OTC, herbals) – see attached medication sheet						
	List all allergies (medications, food, environment and reaction)					
Medication / Food / Environment Reaction						
Risk factors: (smoking, family histo	ory, etc.):					
Substance use: Alcohol (type)		drinks/day Cigarettes:				
per day						
		Rx drug use:				
Readiness to learn (ready, willing,	and able):					
Comprehension: Ability to grasp c	oncepts and respond to	questions: HIGH MEDIUM LOW				
Motivational Level: asks questions	s eager to learn anxion	us uninterested uncooperative disinterested				
denies need for education						
Memory: No problem Limited sh	nort term memory Limi	ted long term memory				
Learning Barriers: None Language	e Cultural / Religious	Emotional Hearing Vision Dexterity				
Describe:						
Feeling: pattern involving the subj						
Comfort / Pain: (is patient in pain:	? Chronic? Acute? Who	at methods relieve pain, provide comfort?):				
Emotional Integrity: /lonely.cad	doprossed angry iou):					
emotional integrity. (lonely, sau, t	uepresseu, angry, joy)					
Perceiving: pattern involving the re	eception of information	:				
Sensory Perception: (Able to recei	ive information via all se	enses? Deficits noted?):				
Visual:	Contacts:	Eyeglasses:				
		Hearing Aids:				
Choosing: pattern involving the se						
Coping / Stress Management Meas	sures:					
Support systems:						



Student Name:		Date:	
II. MOBILITY			
Moving: pattern involving activity			
See daily assessment for physical assessment com	iponent		
Functional ability: (independent, if not specify def	ficits and needs):		
Assistive devices required:			
Orthopedic equipment:			
Physical Therapy:			
Age related hazards of mobility:			
Fall Risk:			
Recreation / Play:			
Self care:			
III. OXYGENATION			
See daily assessment for physical assessment com	nonent		
Home nebulizer / O_2 / CR monitor:	•		
IV. CELLULAR INTEGRITY			
See daily assessment for physical assessment com	iponent		
Skin integrity risk factors: none obesity inconting	nent urine/feces emacia	ated immobility pre	maturity altered LOC
altered sensation breakdown present Home tre	eatment plan:		·
V. REGULATION			
Exchanging: pattern involving mutual giving and i	receivina		
See daily assessment for physical assessment com	_		
	•		
Recent weight loss or gain:			
Suck quality: Loose teeth:			
Sleep patterns: Sexual preference: _			mc·
LMP: Menarche (age): Me			
Reproductive History: # of pregnancies:			
Testes: TSE: Circumcised:			
restes rst circumcised.	FIC	DIEI113	
Additional Comments:			
		<u></u>	



Student Name:	 Date:
Discharge Plan:	

SUMMARY OF VISIT WITH ELDER

			Due:
You	ur Name:		No. of Visits:
Pla	ce of meeting:		
Tin	ne:		
Eld	er's age:	Sex:	
1.	How does your elder describe his/her health?		
2.	How do you perceive your elder's health?		
3.	Identify factors that promote wellness in your elder.		
4.	Identify anything that interferes with your elder's hea	lth and well-hei	ng.
••	identify anything that interfered with your cluck stilled	iai ana wen bei	٠٠٠.

NUTRITION SCREENING TOOL

Height:	Weight:	Ideal Boo	ly Weight:	Weight 6 mo. ago:	
How many teeth	:		tatus:		
Date last dental	exam:	Dentures:	Partial:	Complete:	
		Fit:			
Chewing probler	ms:				
Swallowing prob	lems:				
Appetite:					
Use of Vitamins/	'Mineral Supp.:				
Use of Laxatives	:				
Use of Alcohol:					
Does individual h	nave any health p	roblems that affo	ect his/her ability t	to eat or drink?	
Does individual I	nave any problem	s that affect his/	her ability to prep	are food?	
	dual get to the sto blems with transp	, ,		grocery bags, etc.)	
Does individual I running wate refrigeration cooking facil	er ye	es no	o		
COOKING IDEN	itics ye	es no)		

Revised June 2012

24-Hour Diet Recall

"I would like you to tell me everything you ate and drank from the time you got up in the morning until you went to bed at night and what you ate during the night. Include snacks and drinks of all kinds." (Record amount and type of food or drink and time taken.)
Was the 24-hour nutritional intake unusual in any way?
Yes No
If yes, describe how it was unusual.

COMMUNITY RESOURCES NUTRITION

Resource List:

TEACHING PLAN

Include at least one problem on the next page.

- 1. State a knowledge deficit that currently applies to your elder.
- 2. List an objective related to your elder's knowledge deficit.
- 3. Describe how you will meet the above objective.
- 4. Discuss your teaching plan with your clinical group in post conference.

TEACHING CARE PLAN

KNOWLEDGE DEFICIT/ LEARNING NEED	GOAL AND PLAN FOR TEACHING	EVALUATION
	Goal:	
	Plan:	
	- Kan	

LEARNING GUIDE SELF-DIRECTED ATTITUDE ASSESSMENT OF THE AGING PROCESS (SDAAAP)*

1.	A person can be considered old when:
2.	Words that society uses to describe the elderly are:
3.	Growing old means:
4.	Seeing an old person make me feel:
5.	The best thing about getting old is:
6.	The worst thing abut getting old is:
7.	How many elders do you personally know?
8.	What influence have they (see #7) had on you?
9.	Why is "getting old" an issue today?
10.	Most elderly live in

11.	Economically, older people are:
12.	Socially older people are:
13.	Culturally the elderly are:
14.	The spiritual needs of the elderly are:
15.	Health-wise older people are:
16.	Mentally older people are:
17.	Sexually older people are:
18.	What will your greatest challenge as a health care professional be regarding care of the elderly?
19.	What are your own personal goals regarding your aging process?

LEARNING STYLE ASSESSMENT

Learning Styles:

1. Auditory Learner

This student learns from hearing words spoken. When reading, this student vocalizes, moves the lips or throat while reading. In essence reads to self as striving to understand new material. This student is better able to understand and remember words or facts by hearing. Lectures will be particularly effective as well as audiotapes, rote oral practice and group discussions.

2. Visual Learner

This student learns well from seeing words in books, on the chalkboard, charts, movies, videotapes, etc. This student may even write down words that are given, orally, in order to learn by seeing them on paper. This learner will remember and use information better if given a chance to read it.

3. Kinestetic Learner

This student learns best by experience and a combination of stimuli. The manipulation of material along with sight and sound, will make a big difference to this student. He/She will seek to handle, touch, and work with what is to be learned. This student can write fluent essays, care plans and good answers on tests to show what has been learned. He/She may feel less comfortable, perhaps even stupid, when asked to give oral answers. Thoughts are better organized on paper than when given orally. This student will benefit by the opportunity to write reports, keep notebooks and journals for credit, and take written tests for evaluation. This learner will seek to take copious notes and will perform better during evaluations if allowed to write or demonstrate procedures, rather than explain them orally.

Additional Learning Types

Social Learner

This student strives to study with at least one other student and will not get as much accomplished when studying alone. Others' opinions and preferences are valued. Group interaction for this student increases learning and later recognition of facts. This student is very social in class.

Solitary Learner

This student gets more work done alone and thinks best and remembers more when learning alone. This student cares more for his/her own opinions than for the ideas of others. This student should be encouraged to go to the library to study.

Orally Dependent Learner

This student can easily tell you what 95% has been mastered. This student speaks fluently, comfortably, and seems able to say what he/she means. This student may know more than paper/pencil tests show. The student is probably not shy about giving reports or talking to the instructor or classmates. The muscular coordination involved in writing may be difficult for this student. Organizing and putting thoughts on paper may be a slow and tedious task. As a result, written work may appear carelessly done or incomplete.



CRITICAL THINKING EXERCISES

What would you do if	
The learner was profoundly deaf and used sign language?	
The learner was confused. You are to instruct her on the importance of tapering a medication as part of her discharge-teaching plan?	
The learner spoke only a foreign language?	
The learner was fourteen years old?	
The learner was an infant and the mother spoke broken English?	
The learner had motor aphasia, but his receptive aphasia was intact?	
The learner could not read?	
Delegation: Is there any area of teaching a client that can be delegated to unlicensed assistive personnel?	

INTERPERSONAL PROCESS RECORDING (IPR)

GUIDELINES FOR WRITING AN INTERPERSONAL PROCESS RECORDING

OBJECTIVES:

- 1. This IPR is to focus on an actual interaction between student nurse and a patient or the patient's significant other during the clinical experience.
- 2. An IPR is an opportunity for the nurse to evaluate the effectiveness of therapeutic communication skills. This is not a patient teaching or data gathering exercise. Therefore, the focus of this exercise is Therapeutic Communication.

GENERAL INSTRUCTIONS:

- 1. **The introduction** is to be typed in <u>narrative</u> format. The introduction is an essential part of the IPR in order to acquaint the reader with the setting, and circumstances in which the interaction took place. This should include the client's facial expression, voice quality, appropriateness of dress and grooming and room environment. Refer to Criteria and Evaluation Tool for IPR for content.
- 2. The body of the IPR (client verbatim nurse verbatim section), is to be written in the 5-column format found in the syllabus or at the Palm Beach State College Nursing website. Make copies of the format as needed. Verbatim statements of the nurse and the client during the interaction should be documented. Time lapses and silences should be noted, as well as the length of the silence. This section is to be written in an objective fashion, without any interpretations on the part of the student. Refer to Criteria and Evaluation Tool for IPR for directions. The body of the IPR must include at least six responses between client and nurse. A "response" is client and student each talk once. Minimally the client and student must each speak six times.
- 3. **Non-verbal behavior** of nurse and client section is to be used for recording communication and behavior that is not verbalized. Significant gestures, facial expressions, body postures, tones of voice, eye contact, etc., should be noted both the client's and the nurse's. For example, it should be recorded that the voice dropped to a whisper when he spoke about his mother's death. Examples of behavioral "clues" to anxiety should be included.
- 4. **Interpretation of interaction** section includes your ideas as to what was going on in a dynamic sense during the interaction. How did you perceive the client to feel? How did you feel? You should also not any associative looseness and/or flight of ideas, as well as disorders of thinking that were present and defense mechanisms that were employed by the nurse or client. Any shifts in the conversation made by either the client or the nurse should be noted.

Your interpretations should be supported with theoretical knowledge. You should include the phases of the interaction.

5. **Alternative responses** section is one of the most important parts of the IPR and is heavily weighted in terms of evaluation. This section provides the student with an opportunity to look back on the interaction and to formulate responses that might have been more effective than the one used. Although the interaction itself may have been ineffective in achieving the stated goal, it can still be a learning experience, and be a guide for future interactions.

Each alternative response should be accompanied by a rationale (either theoretical or your own logic) as to why it might promote more effective communication. **Every student response must have an alternate or it will be returned to be redone.**

- 6. **The summary** of the IPR is to be typed in <u>narrative</u> form and should relate to the initial goal identified. The student should include the strengths and weaknesses of the interaction as well as writing objectives for client care based on his/her interpretation. The student should include objectives for his or her own improvement. The participation of both the nurse and the client should be evaluated. References should be cited in a bibliography. Refer to Criteria and Evaluation Tool for IPR for content.
- 7. **Bibliography** Any references used should be footnoted and a bibliography attached. Correct APA bibliographical form must be used.
- 8. Credit will be deducted for spelling and grammatical errors. Any paper which does not meet the requirements will be returned to the student to be redone.
- 9. Criteria and Evaluation tool must be submitted with the paper for the instructor to mark for grading.

CRITERIA AND EVALUATION TOOL FOR INTERPERSONAL PROCESS RECORDING (IPR)

Satisfactory	Unsatisfactory	
		1. Introduction includes:
		A. Date of interaction
		B. Duration of interaction
		C. Description of location where interaction took place
		D. Client's initials, age, gender
		 E. Client's personal, interpersonal and social strengths and weaknesses.
		F. Admitting diagnosis and other pertinent medical diagnoses
		G. Initial goal of interaction. State any changes as interaction occurred.
		2. Body of IPR includes:
		A. Exact verbal statements of client and nurse. (At least six responses between client and nurse.)
		B. Non-verbal communications of client and nurse include: affect, speech quality, observations of body language, personal space.
		 C. All verbal and nonverbal communications of the client and nurse are analyzed (interpreted) using appropriate terminology.
		D. State alternate communication techniques for each of the nurse's actual responses utilizing a variety of communication skills.
		E. State rationale for alternate responses.
		3. Summary statements includes:
		A. Whether objectives were met, if not, why not.
		B. Evaluate your therapeutic communication techniques in this interaction.

Satisfactory	Unsatisfactory	
		C. Identify what you learned regarding the clients personal, interpersonal and social systems.
		D. Identify therapeutic communication techniques that you perceive will be helpful for you to use in future interactions.
		E. Assess and identify your personal or interpersonal strengths and weaknesses.
		F. State interactions you plan to utilize to address these needs.
		4. Bibliography of at least two resources used to interpret/analyze interaction and to acquire therapeutic communication techniques.
		5. Submitted on time.
		6. Used appropriate format for introduction, body of IPR with five-column format and summary.

Comments:

BODY OF INTERPERSONAL PROCESS RECORDING (IPR)

Patient Verbatim	Nurse Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

Patient Verbatim	Nurse Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

Patient Verbatim	Nurse Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

Patient Verbatim	Nurse Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

Patient Verbatim	Nurse Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

PRESENTATION

GUIDELINES FOR PRESENTATION

The Presentation is designed to address professional aspects of nursing.

The presentation is worth a maximum total of 15% of the course grade. Depending upon class size, this may either be done as a group activity or done alone. If there is a group, each student in the group will sign a form (Group Participation Form), which indicates participation and contribution.

The topic should address issues of professional nursing. Some ideas are listed below. By all means, feel free to choose a topic not listed, but have it cleared with the instructor before proceeding with your research.

Professionalism

Membership in professional organizations, ethics in nursing, legal aspects of nursing, professional behavior and presentation in the workplace

Career options

Hospice nursing, travel nursing, advanced practice nursing, trauma nursing, etc.

Diversity in nursing

Men in nursing, ethnic diversity in nursing, generational differences among nurses

Workforce issues

The shortage of nurses, ADN versus BSN as entry level to practice, staffing ratios

Include 5 references from the Internet, and from other sources, which will support your information.

For those in the on-campus class:

Dress in a professional manner, as you are speaking to the group. Don't be nervous, these are your peers who you have become familiar with all semester. Remember to speak to the audience, not the presentation up on the screen.

EVALUATION FORM

The Presentation is worth a maximum total of 15% of the course grade. Each student who participates in the group will receive the same percentage total.

Criteria:	Possible Percentage	Actual Percentage:
The topic addressed a professional aspect of nursing	10%	
The presentation delivery was professional	25%	
The presentation used creativity and was interesting.	25%	
The presenter(s) demonstrated knowledge of the topic	25%	
There were 5 references using APA format.	10%	
A copy of the presentation was submitted to the instru	ctor 5%	
Total:	100%	
Comments:		