FUNDAMENTALS OF NURSING I & II
BASIC & ADVANCED SKILLS
COURSE DESCRIPTION


DESCRIPTION: During this course, the student learns the technical procedures used in direct patient care. The course is designed to progress from simple to complex and to enable the student to understand the rationale for various procedures and treatments. The nursing process is introduced as a method of problem solving and foundation for delivery of client care. The student will perform nursing skills and function within the scope of practice from a practical nurse in the long term care setting. In addition, the student will learn basic information about the family unit and family dynamics, problems that may occur in the family structure, and basic gerontologic concepts related to the care of the aging client.

TERMINAL OBJECTIVES: Upon completion of this unit, the student will demonstrate knowledge on written examinations, with a minimum score of 80%. Students will demonstrate the basic nursing skills with 100% accuracy.

GRADE ASSIGNMENT: Theory grade will be determined as follows:
- Tests & Assignments 85%
- Final Exam 15%

Clinical grade will be satisfactory or unsatisfactory based upon evaluation of nursing actions and criteria outlined in clinical syllabus.

HOURS:
- Skills Theory Hours 153 hours that include:
  - AV Aids 13 hours
  - Testing 11 hours
- Integrated Course Hours
  - Growth & Development 18 hours
  - Geriatrics 12 hours
- Total Lab Hours 41 hours
- Clinical Hours 82 hours
- TOTAL 235 hours

Written: 09/90
Reviewed: 09/92, 09/94, 08/03; 03/06; 09/13
Revised: 09/95, 09/96, 09/97, 10/98, 10/99, 12/00, 08/01, 12/02, 12/03, 12/04; 06/07; 06/09; 08/11; 01/15
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms associated with nursing process and decision making.
2. Discuss ways critical thinking is used in nursing.
3. Enumerate the steps of the nursing process.
4. Contrast subjective and objective data.
5. List techniques used to gather data during a physical assessment.
6. Describe how Maslow’s hierarchy of human needs is used to prioritize nursing diagnoses.
7. Describe the four blended skills essential to nursing practice.

PLAN OF LESSON

I. Definition
II. Critical Thinking in Nursing
III. Five Steps of the Nursing Process
   A. Assessment
   B. Diagnosis
   C. Planning
   D. Implementation
   E. Evaluation and Documentation
IV. Role of LPN in Nursing Process
V. Data
   A. Subjective
   B. Objective
VI. Gathering Data
   A. Who
   B. How
VII. Maslow’s Hierarchy
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms associated with documentation.
2. Explain four purposes of written documentation.
3. Discuss confidentiality of patient records.
4. Summarize 12 guidelines for documentation.
5. Compare source-oriented and problem-oriented documentation systems.
6. List the common sections of a source-oriented documentation system.
7. Compare PIE charting and SOAPIER charting formats.
8. Contrast charting by exception and focus charting.
9. Explain how narrative charting is different from all other formats.
10. Enumerate the advantages and disadvantages of computerized charting.

PLAN OF LESSON

I. Terminology
II. Purposes of Documentation
III. Confidentiality
   A. HIPAA
IV. Guidelines for Documentation
V. Methods of Documentation
   A. Problem-Oriented
   B. Source-Oriented
   C. PIE
   D. SOAPIER
   E. Charting by Exception
   F. Focus Charting
   G. Narrative Charting
VI. Computerized Charting
   A. Advantages
   B. Disadvantages
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Identify three primary learning styles.
2. Explain ways to address learning styles during patient teaching.
3. Discuss factors that affect learning.
4. Discuss the importance of reinforcement of patient teaching.
5. Identify two primary purposes of patient teaching.
6. Define the concept of teachable moments.
7. Discuss ways to implement a teaching plan.
10. Describe three ways to evaluate patient teaching.
11. Explain how to teach patients about Internet resources.

PLAN OF LESSON

I. Learning Styles
   A. Auditory
   B. Visual
   C. Kinesthetic
II. Learning Styles with Patient Teaching
III. Barriers
IV. Interpreters
V. Reinforcement
VI. Purposes of Patient Teaching
VII. Teachable Moments
VIII. Teaching Plan
      A. Development
      B. Implementation
      C. Evaluation
IX. Internet Resources

Written: 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Explain areas addressed by National Patient Safety Goals.
2. Describe six factors that contribute to an unsafe patient environment.
3. Discuss the use of fall-assessment scales and restraint alternatives in preventing falls.
4. Describe a situation where restraints would be necessary.
5. Identify requirements for use of restraints and release of restraints.
6. Explain the acronyms RACE and PASS.
7. Describe three types of fires and extinguishers.
8. Determine actions to take when a patient is unresponsive.
9. Discuss the role of nurses in a mass-casualty event.
10. Identify ways to use body mechanics to prevent injury when caring for patients.
11. Explain how lack of rest and substance use or abuse can contribute to unsafe patient care.
12. Describe ways to protect yourself from radiation hazards.
13. Discuss safe handling of chemicals and gases.
14. Identify the purpose of a material safety data sheet.
15. Explain ways to protect yourself from biological hazards.

PLAN OF LESSON

I. National Patient Safety Goals
II. Contributing Factors
III. Falls
   A. Scales
   B. Prevention
IV. Restraints
   A. When Used
   B. Requirements
   C. Laws
V. RACE
VI. PASS
VII. Fire Extinguishers
VIII. Unresponsive Patient
IX. Mass Casualty
X. Substance/Alcohol Abuse
XI. Radiation Hazards
XII. Chemicals/Gases
XIII. MSDS
XIV.
XV.
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define assigned vocabulary.
2. State the purpose for using proper body mechanics.
3. Identify and demonstrate body mechanics for reaching, stooping, pivoting, lifting, pushing, and pulling.

PLAN OF LESSON

I. Vocabulary
II. Purpose of Body Mechanics
   A. Definitions
   B. Demonstration
III. Principles of Body Mechanics
   A. Definitions
   B. Demonstration
IV. Proper Body Mechanics
   A. Assessment
   B. Correct Technique
V. Home Health Considerations
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms related to medical asepsis and infection control.
2. Describe five types of pathogens.
3. Identify selected common illnesses caused by microbes.
4. Illustrate the chain of infection.
5. Differentiate types of infections.
6. Compare primary, secondary, and tertiary defenses against infection.
7. Explain factors that decrease the body’s defenses.
8. Differentiate between the use of standard precautions and transmission-based precautions.
9. Compare medical and surgical asepsis.
10. Describe when and how to use hand hygiene.
11. Detail the use of standard precautions.
12. Compare the purpose and types of transmission-based precautions.
13. Explain ways to meet the emotional needs of patients who are isolated due to communicable disease.

PLAN OF LESSON

I. Vocabulary
II. Types of Pathogens
III. Illnesses
IV. Chain of Infection
V. Types of Infections
VI. Defenses
   A. Primary
   B. Secondary
   C. Tertiary
   D. Factors that Decrease Body’s Defenses
VII. Standard Precautions
VIII. Transmission-Based Precautions
IX. Medical vs. Surgical Asepsis
X. Hand Hygiene
XI. Emotional Needs
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms associated with personal care.
2. Categorize personal-care tasks performed at particular times during the day.
3. Describe the benefits of bathing patients, both for the patient and for the nurse.
4. Explain factors to consider when planning patient care and bathing.
5. Enumerate three categories of personal care.
6. Identify types of baths and their purposes.
7. Contrast back massage with applying lotion to the back.
8. Discuss key aspects of providing oral care to unconscious and conscious patients.
9. Describe assessments to make during oral care, hair care, and nail care.
10. Explain how to remove jewelry from piercings and circumstances that could make removal necessary.
11. Discuss how to remove contact lenses, artificial eyes, and hearing aids.
12. Explain how to clean and insert an ocular prosthesis and hearing aids.
13. Identify ways to minimize noise, odors, and clutter in the patient’s environment.

PLAN OF LESSON

I. Vocabulary
II. Routine Care
   A. AM Care
   B. Afternoon Care
   C. Bedtime Care
III. Benefits of Bathing
IV. Planning Care
V. Categories of Care
VI. Types of Bath and Purpose
VII. Massage
VIII. Oral Care
   A. Conscious
   B. Unconscious
IX. Assessment
X. Piercings
XI. Prosthetics
   A. Removing
   B. Cleaning
XII. Privacy
XIII. Assessment of Patient’s Ability to Dress/Undress Self
   A. Physical Factors
   B. Psychological Factors
XIV. Changing a Hospital Gown
   A. Assessment
   B. Planning
   C. Implementation
   D. Evaluation
   E. Documentation
   F. Modification for IV Equipment
XV. Slippers and Robe
   A. Assessment
   B. Planning
   C. Implementation
   D. Evaluation
XVI. Elastic Stockings
   A. Assessment
   B. Planning
   C. Implementation
   D. Evaluation
XVII. Home Health Considerations

Written: 09/90
Reviewed: 06/92, 06/97, 08/98, 08/00, 12/02; 03/06; 03/09
Revised: 06/94, 08/96; 12/04; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define vocabulary terms as assigned.
2. Identify reasons for making hospital beds according to proper procedure.
3. Identify principles of asepsis in bedmaking.
4. Identify and demonstrate proper body mechanics.
5. Identify the importance of conversation during procedure of bed making.
6. State the purpose of side rails.
7. Identify various bed positions.
8. State and demonstrate the proper procedure for stripping linens from bed.
9. Identify and demonstrate the proper procedure for making an unoccupied bed and state rationale for actions.
10. Identify and demonstrate procedure for making a post-op bed.
11. Identify and demonstrate procedure for making an occupied bed.
12. Identify general guidelines, cleansing, and maintenance of equipment and bed.

PLAN OF LESSON

I. Vocabulary
II. Reasons for Proper Bedmaking
III. Asepsis in Bedmaking
IV. Body Mechanics
   A. Personal
   B. Head of Bed
V. Importance of Rapport with Patient
VI. Side Rails
VII. Stripping the Bed
VIII. Unoccupied Bed
   A. Open Bed
   B. Closed Bed
IX. Post Operative Bed
X. Occupied Bed
XI. Home Health Considerations
Unit: Basic Nursing Skills  
Lesson: 9  
Title: Range of Motion Exercises  
Time: Theory 1 Hour, Lab 1 Hour

Implementation: Burton Ch. 16; Lecture/Class Discussion; Demonstrations; Video  
Evaluation: Application in Patient Care, Demonstrations  
Integrated: N/A

OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define the vocabulary terms.
2. Define range of motion and differentiate between the three types.
3. Identify joints which need ROM.
4. Identify the proper sequence for performing ROM exercises and state ideal time schedule for exercises.
5. Define and demonstrate the following joint movements: flexion, extension, hyperextension, abduction, and adduction.
6. Identify and demonstrate the proper procedure for performing ROM exercises.
7. Indicate what should be charted when ROM exercises are done.

PLAN OF LESSON

I. Vocabulary
II. Range of Motion  
   A. Three Types  
   B. Joints  
   C. Sequence and Timing
III. Procedure for ROM Exercise  
   A. Assessment  
   B. Planning  
   C. Implementation  
   D. Evaluation
IV. Home Health Considerations

Written: 09/90  
Reviewed: 06/92, 06/97, 08/98, 08/00; 03/06; 06/09  
Revised: 06/94, 08/96, 12/02; 12/04; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms associated with moving and positioning patients.
2. Describe the effects of immobility on seven body systems.
3. Enumerate nursing measures to prevent complications of immobility for these body systems.
4. Describe the psychological effects of immobility and nursing measures to prevent psychological complications.
5. Discuss the importance of positioning patients correctly and performing frequent position changes.
6. Identify commonly used patient positions.
7. Describe devices available to increase safety and ease of transferring patients.
9. Contrast types of specialty beds and their purposes.
10. Summarize the importance of assisting a patient to dangle prior to transfer or ambulation.

PLAN OF LESSON

I. Vocabulary
II. Effects of Immobility
III. Preventing Complications
IV. Psychological Effects of Immobility
V. Importance of Positioning
VI. Positions
VII. Assistive Devices
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Identify safety factors to be considered when transferring a patient out of bed.
2. State what assessments should be made prior to transferring a patient out of bed.
3. Identify necessary planning needed before transferring a patient.
4. Identify and demonstrate the following procedures:
   A. Bed to Chair: 1 person maximum to assist.
   B. Bed to Chair: 1 person minimum to assist.
   C. Chair to Chair: 2 person lift.
   D. Bed to Chair: 1 person lift.
   E. Bed to Chair: 2 person lift.
   F. Bed to Chair: Hydraulic lift.
   G. Horizontal Lift: 3-4 persons

PLAN OF LESSON

I. Safety Factors

II. Procedure
   A. Assessment
   B. Planning
   C. Implementation
      1. Bed to Chair
         a. With Gait Belt
         b. With Minimal Assist
         c. 2 Person Lift-Chair to Chair, Bed to Chair
         d. Hydraulic Lift
         e. Horizontal Lift
   D. Evaluation
   E. Charting

III. Home Health Considerations
Unit: Basic Nursing Skills
Lesson: 12
Title: Patient Ambulation, Wheelchairs and Stretchers
Time: Theory 2 Hours, Lab 1 Hour

Implementation: Burton Ch. 27; Lecture/Class Discussion; Demonstrations
Evaluation: Application in Patient Care, Demonstrations
Integrated: N/A

OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Identify and demonstrate the correct procedure for assisting a patient to dangle.
2. Identify and demonstrate the correct procedure for ambulating a patient:
   A. Simple assist
   B. Using a cane
   C. Using a walker
   D. Using crutches
4. Describe and demonstrate the procedure for assisting a patient who is falling.
5. List the steps of the follow up procedure that is completed after a patient has fallen.

PLAN OF LESSON

I. Dangling
   A. Procedure
      1. Assessment
      2. Planning
      3. Implementation
      4. Evaluation
      5. Charting

II. Ambulation
   A. Procedure for:
      1. Simple Assist
      2. Using a Cane
      3. Using a Walker
      4. Using Crutches
   B. Nursing Process as Outlined Above for Each Type of Ambulation

III. Patient Falls
   A. Reasons/Causes
   B. Methods of Prevention
   C. Aiding a Falling Patient
   D. Patient Follow Up Care and Incident Reporting

Written: 09/90
Reviewed: 06/92, 06/97, 08/98, 08/00, 12/02; 03/06; 06/09
Revised: 06/94, 08/96; 12/04; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms related to urinary elimination.
2. Describe normal and abnormal urine output.
3. Discuss characteristics of normal urine and the significance of abnormal characteristics.
4. Explain the causes and complications of urinary retention.
5. Describe the treatment for urinary retention and residual urine.
7. Describe nursing interventions to help manage incontinence.
8. Discuss methods of assessing urine.
9. Explain ways to assist patients with toileting.
10. Discuss the care of patients with an indwelling urinary catheter.
11. Identify types of urinary diversions.
12. Describe the occurrence, risk factors for, and prevention of UTIs.

PLAN OF LESSON

I. Vocabulary
II. Urinary Elimination
III. Characteristics of Urine
IV. Retention
   A. Causes
   B. Complications
   C. Treatment
V. Incontinence
   A. Nursing Interventions
VI. Assessment
VII. Toileting
VIII. Catheters
    A. Purpose
    B. Care
IX. UTIs
    A. Occurrence
    B. Risk Factors
    C. Prevention
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms related to bowel elimination and care.
2. Explain the digestion, absorption, and metabolism of nutrients.
3. Differentiate between normal and abnormal function in digestion and bowel elimination.
4. Differentiate between normal and abnormal characteristics of feces.
5. Explain how different factors affect bowel elimination.
6. Accurately assess bowel elimination problems.
7. Describe interventions that help to prevent and treat bowel elimination problems.
8. Contrast different types of enemas.
10. List signs and symptoms of vagal stimulation.
11. Prioritize nursing actions to perform when vagal stimulation is suspected.

PLAN OF LESSON

I. Vocabulary
II. Review Anatomy
III. GI Functioning
   A. Normal
   B. Abnormal
IV. Characteristics of Feces
V. Factors Affecting Bowel Elimination
VI. Assessment
VII. Nursing Interventions
VIII. Enemas
   A. Types
IX. Complications
X. Treatment
XI. Vagal Stimulation
   A. Signs and Symptoms
   B. Nursing Actions
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Describe possible adverse psychological reaction an adult may have to being fed.
2. State factors which influence eating habits.
3. List assessments which should be made while feeding a patient.
4. Identify nursing responsibilities while feeding a patient.
5. Identify and demonstrate the correct procedure for feeding a patient.
6. Identify and demonstrate correct procedure for between meals and snacks.

PLAN OF LESSON

I. Factors to Consider:
   A. Psychological Overtones
   B. Factors that Influence Eating Habits-
      Food Preferences and Allergies
   C. Assessing the Patient
   D. Nursing Responsibilities

II. Feeding Procedures
   A. Assessment
   B. Planning
   C. Implementation
   D. Evaluation
   E. Charting
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Identify the functions of body fluids.
2. Describe the nurse’s role in maintaining fluid balances.
3. State the average daily fluid requirements for an adult.
4. List the food/fluids on patient’s tray which need to be measured for an accurate I&O.
5. Demonstrate the correct procedure for measuring fluids and recording a patient’s intake.
6. State the average urinary output of an adult in a 24 hour period and minimum hour output.
7. List body fluids which need to be measured at output for a patient on I&O.
8. Demonstrate the correct procedure for measuring a patient’s output fluids.
9. Identify the various I&O records and knowledge of how to correctly use them.
10. Define nasogastric and nasointestinal tubes.
11. Measurement and recording of intake and output per tubes.

PLAN OF LESSON

I. Functions of Body Fluids
II. Nurse’s Role in Fluid Balance
III. Measuring Patient’s I&O
   A. Procedure
      1. Assessment
      2. Planning
      3. Implementation
      4. Evaluation
      5. Charting
         a. Forms
IV. Measurement of Intake and Output per NGT
V. Home Health Considerations

Written: 09/90
Reviewed: 06/92, 06/97, 08/98, 08/00, 12/02; 03/06; 06/09
Revised: 06/94, 08/96; 12/04; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Identify the reasons for taking body temperatures.
2. List factors which should be considered when evaluating a person’s temperature.
3. List and define three classifications of fever.
4. Identify the procedures for taking an oral temperature and state the normal range of temperature per oral method.
5. Demonstrate the correct procedure for taking an oral temperature and record the results.
6. Identify and demonstrate the correct procedure for taking an auxiliary temperature and record the results.
7. List the circumstances which would necessitate taking a rectal temperature.
8. Identify and demonstrate the correct procedure for taking a rectal temperature and recording the results.
9. State the normal range for temperatures taken rectally.
10. Describe and demonstrate the correct method/procedure for cleaning thermometer.

PLAN OF LESSON

I. Body temperature
   A. Importance
   B. Factors that Influence Temperature
   C. Classifications

II. Oral Temperatures
   A. Assessment
   B. Planning
   C. Implementation
   D. Evaluation
   E. Charting

III. Auxiliary Temperature
   A. Nsg. Process A.-E. as identified above

IV. Rectal Temperature
   A. Nsg. Process A.-E. as identified above

V. Cleaning Thermometers

VI. Home Health Considerations

Written: 09/90
Reviewed: 06/92, 06/97, 08/98, 08/00, 12/02; 12/04; 03/06; 06/09
Revised: 06/94, 08/96; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define pulse: radial and apical.
2. List six common pulse sites.
3. State normal range for an adult pulse and list factors that may influence pulse rate.
4. List three factors/observations a nurse must note when taking a pulse and terms commonly used to describe these observations.
5. Identify and demonstrate the correct procedure for taking and recording a radial pulse.
6. Identify and demonstrate the correct procedure for taking a recording an apical pulse.
7. Define respirations, indicating normal respiratory rate for an adult.
8. List three symptoms of low oxygen supply in the body.
9. List and define terms commonly used to describe nurse’s observations of respirations.
10. Identify and demonstrate the correct procedure for taking respirations and recording the results.

PLAN OF LESSON

I. Vocabulary
II. Pulses
   A. Types
   B. Locations
   C. Normal Pulse Rate
   D. Influencing Factors
   E. Observations to be Noted and Charted
III. Procedures
   A. Radial
   B. Apical
      1. Assessment
      2. Planning
      3. Implementation
      4. Evaluation
      5. Charting
IV. Respirations
   A. Definitions
   B. Normal Rate Range
   C. Symptoms of Oxygen Deficiency
   D. Description of Respirations
   E. Procedure
      1. Assessment
      2. Planning
      3. Implementation
      4. Evaluation
      5. Charting
V. Home Health Considerations
Unit: Basic Nursing Skills
Lesson: 19
Title: Blood Pressure
Time: Theory 2 Hours, Lab 3 Hours

Implementation: Burton Ch. 17; Lecture/Class Discussion; Handouts; Demonstrations
Evaluation: Application in Patient Care, Post Test, Demonstrations
Integrated: N/A

OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define blood pressure, systolic and diastolic pressure.
2. Identify factors that may influence a person’s B.P.
3. State the normal range for blood pressure.
4. Describe methods of obtaining patient data regarding blood pressure.
5. Identify equipment used in taking a blood pressure.
6. Identify and demonstrate the correct procedure for taking a patient’s blood pressure and recording the results.

PLAN OF LESSON

I. Definition
II. Blood Pressure
   A. Influencing Factors
   B. Normal Range
   C. Obtaining Patient Data
   D. Equipment
   E. Procedure
      1. Assessment
      2. Planning
      3. Implementation
      4. Evaluation
      5. Charting
III. Home Health Considerations
Unit: Advanced Nursing Skills
Lesson: 1
Title: Nasogastric Tubes
Time: Theory 2 Hours, Lab 1 Hour

OBJECTIVES

Upon completion of this unit, the student will be able to:

1. State the purposes/uses of NGT and nasointestinal tubes.
2. Identify and demonstrate proper procedures for patient preparation and assessment, tube measurement, insertion and placement of tube and how to determine tube placement prior to administering fluids.
3. Measurement and recording of intake and output per tubes.
4. Identify and demonstrate correct procedure for insertion, irrigation, and removal of NGT.
5. Identify and demonstrate correct procedure for administration of feeding per NGT, gastrostomy tube, J-tube, and PEG tube.
6. Define enteral feedings, purposes, and advantages.

Implementation: Burton Ch. 24; Lecture/Class Discussion; Demonstrations
Evaluation: Application in Patient Care, Post Test, Demonstrations
Integrated: N/A

PLAN OF LESSON

I. Nasogastric and Nasointestinal Tubes
   A. Purposes
   B. Types of Tubes
II. Demonstration of Assessment and Procedures
   A. Patient Preparation
   B. Assessment of Patient’s Nostrils
   C. Measurement of tube
   D. Tube Insertion and Placement
   E. Checking Placement
III. NGT
   A. Insertion
   B. Irrigation
   C. Removal
   D. Feedings
      1. Continuous Pump
      2. Intermittent
IV. Feeding Tubes
   A. Gastrostomy Tube
   B. J Tube
   C. PEG Tube
V. Enteral Feedings
   A. Definition
   B. Purpose
   C. Advantages
   D. Disadvantages
VI. Goals
   A. Long Term
   B. Short Term

Written: 09/90
Reviewed: 06/92, 06/97, 08/98, 08/00, 12/02; 03/06; 06/09
Revised: 06/94, 08/06; 12/04; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define assigned vocabulary terms.
2. Identify the reasons for the physical exam and define the four methods used during a physical.
3. State the correct sequence of a physical examination.
4. Identify the two major roles of the nurse in assisting with a physical examination.
5. Identify and demonstrate the correct procedure for assisting with a physical examination.
6. Identify the procedure for assisting with assigned diagnostic and therapeutic procedures.

PLAN OF LESSON

I. Vocabulary
II. Physical Exam
   A. Purpose
   B. Methods
   C. Sequence
   D. Nurse’s Role
   E. Procedure
      1. Assessment
      2. Planning
      3. Implementation
      4. Evaluation
      5. Documentation

III. Diagnostic and Therapeutic Procedures
IV. Home Health Considerations
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms associated with physical assessment.
2. Describe purposes of physical assessment.
3. Differentiate between a comprehensive health assessment, a focused assessment, and an initial head-to-toe shift assessment.
4. Summarize the six techniques used for physical assessment.
5. Distinguish the different components to be examined during an initial head-to-toe shift assessment.
6. Relate each component of assessment to its associated body system(s).
7. Explain the significance of various abnormal assessment findings.
8. Describe adaptations in assessment techniques that are necessary due to the age of the patient.
10. Document the results of an initial head-to-toe assessment.

PLAN OF LESSON

I. Vocabulary
II. Purpose of Physical Assessment
III. Types of Assessments
   A. Comprehensive Health Assessment
   B. Focuses Assessment
   C. Head-to-Toe Shift Assessment
IV. Techniques for Assessment
V. Components of Head-to-Toe
VI. Abnormal Findings
VII. Adapations for Age of Patient
VIII. Sequence of Head-to-Toe Exam
IX. Documentation
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. State basic principles of obtaining any specimens.
2. Identify and demonstrate the correct procedure for obtaining a sputum specimen.
3. State the best time of day to obtain sputum and the rationale.
4. Identify the procedure for obtaining a culture and sensitivity on draining body part.
5. State the procedure for obtaining a 24 hour urine specimen and demonstrate this procedure.
6. Identify the purpose of testing the urine for sugar and acetone.
7. Identify and demonstrate the correct procedure for testing urine and acetone.
8. Identify and demonstrate the correct procedure for obtaining the following specimens:
   A. Routine
   B. Mid Stream
   C. From closed urinary system/catheterized patient
9. Identify and demonstrate the correct procedure for obtaining a stool specimen:
   A. Occult blood
   B. Ova and parasites
   C. C&S

PLAN OF LESSON

I. Basic Principles
   A. Assessment
   B. Planning
   C. Implementation
   D. Evaluation
   E. Documentation

   1. Sputum Specimen
      a. Types

II. Culture and Sensitivities
   A. Nsg. Process
   B. Types

III. Urine Specimens
   A. Types and Purpose of Each
   B. Nsg. Process
      1. 24 hour Urine Collection
         a. Clinitest
         b. Test-tape
         c. Acetest
         d. Keto distix
      2. Test for A/C

IV. Stool Specimens
   A. Assessment
   B. Planning
   C. Implementation
   D. Evaluation
   E. Charting
   F. Procedures

   1. Occult Blood
   2. O&P
   3. C&S

V. Home Health Considerations

Written: 09/90
Reviewed: 06/92, 06/97, 08/98, 08/00, 12/02; 03/06; 06/09
Revised: 06/94, 08/96; 12/04; 06/07; 08/11
Unit: Advanced Nursing Skills  
Lesson: 5  
Title: Care of the Patient Using Oxygen  
Time: Theory 1 Hour

Implementation: Burton Ch. 28; Lecture/Class Discussion; Handout; Demonstrations; Videos  
Evaluation: Application in Patient Care, Post Test  
Integrated: N/A

OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define oxygen  
2. Identify symptoms which may indicate a patient’s need for oxygen therapy.  
3. Identify methods of oxygen administration.  
4. Identify basic nursing care of the patient receiving oxygen.  
5. Identify toxic effects of oxygen.  
6. Describe the safety precautions necessary when administering oxygen.  
7. Define pulse oximetry.  
8. Describe the correct use of a pulse oximeter.

PLAN OF LESSON

I. Oxygen Therapy  
   A. Definition  
   B. Assessment of Patient  
      1. S/S of Insufficiency  
   C. Planning  
      1. Methods  
      2. Equipment  
   D. Implementation of Nursing Care  
   E. Evaluation  
      1. Toxic Effects  
   F. Charting  
   G. Safety Measures  

II. Home Health Considerations

III. Pulse Oximetry  
   A. Oximeter  
   B. Oxygen Saturation

Written: 09/90  
Reviewed: 06/92, 06/97, 08/98, 08/00, 12/02, 03/06; 06/09  
Revised: 06/94, 08/96; 12/04; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define intravenous, parental and infiltration, phlebitis and thrombophlebitis.
2. List purpose of an IV.
3. List major concerns of a patient.
4. Identify various aspects of care for which a patient may need assistance due to an IV.
5. Calculation of IV rates.
6. Identify methods of checking for correct IV infusion.
7. Identify signs of IV infiltration.
8. Identify signs of phlebitis, overhydration and blood transfusion reactions.
9. Identify the student practical nurse’s responsibility in maintaining IV fluids, including charting.
10. State the procedure for discontinuing and IV.

PLAN OF LESSON

I. Vocabulary
II. Purposes of the IV
III. Patient’s perspective/Concerns of IV Therapy
IV. Assessment of Patient’s Needs During IV Therapy
V. Factors of Time, Hour/Minute, Use of IVAC
VI. SPN’s Responsibility
VII. Assessment of Physical Symptoms
VIII. Discontinuing IV
   A. Needle
   B. Catheter
   C. Heparin Lock
IX. Home Health Considerations
Unit: Advanced Nursing Skills
Lesson: 7
Title: Skin Care
Time: Theory 1 Hour

OBJECTIVES

Upon completion of this unit, the student will be able to:

1. State the importance of skin care.
2. Identify the effects of incontinence on the skin and care of the incontinent patient.
3. Identify causes of decubitis ulcers.
4. List and describe methods of preventing and treating decubitus ulcers.
5. Identify skin care measures for patient with various types of ostomies.
6. Describe preventive skin care measures for patients cared for at home.

Implementation: Burton Ch. 26 & 30;
Lecture/Class Discussion; Demonstrations
Display of Skin Care Products; Videos
Evaluation: Application in Patient Care, Post Test, Demonstrations
Integrated: N/A

PLAN OF LESSON

I. Introduction to Skin Care
   A. Principles of Skin Care

II. Incontinence
   A. Assessment
   B. Planning
   C. Implementation of Preventive Care
   D. Evaluation
   E. Documentation

III. Decubitus Ulcers
   A. Assessment of Skin
   B. Planning
   C. Implementation of Care
   D. Evaluation
   E. Documentation

IV. Ostomy Care
   A. Assessment
   B. Planning
   C. Implementation
   D. Evaluation
   E. Documentation

V. Home Health Considerations

Written: 09/90
Reviewed: 06/92, 06/97, 08/98, 08/00, 12/02; 03/06; 06/09
Revised: 06/94, 08/96; 12/04; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms related to applying heat and cold.
2. Contrast the physiological effects of local heat and cold applications.
3. Identify at least four uses for heat therapy.
4. Explain how application of heat can support healing.
5. Detail the nursing assessment to make before, during, and after application of heat therapy.
6. Describe three uses for cold therapy.
7. Compare the methods of heat and cold application.
8. Summarize the nursing assessments pertinent to cold applications.
9. Teach a patient how to make a simple cold pack using only a washcloth and a ziptop baggie.

PLAN OF LESSON

I. Vocabulary
II. Physiological Effects of Heat & Cold
III. Uses of Heat Therapy
IV. Nursing Assessment
   A. Before Therapy
   B. During Therapy
   C. After Therapy
V. Use of Cold Therapy
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define irrigations and state its purpose.
2. State types of techniques which must be used for various types of irrigations.
3. Identify the safety factors involved during irrigations.
4. State the observations which should be made during irrigations and information that needs to be charted.
5. Identify and demonstrate the correct procedure for irrigations.
6. Identify the procedure for irrigating a catheter, continuous and intermittent, and demonstrate this in the lab.
7. Identify and demonstrate the correct technique for irrigating and discontinuing a NG tube.
8. Identify the correct procedure for irrigating a wound.
9. Identify the correct procedure for irrigating a colostomy.
10. Identify the correct procedure for irrigating a vagina.
11. Identify the correct procedure for irrigating a mouth/throat.
12. Identify the correct procedure for irrigating an eye.

PLAN OF LESSON

I. Irrigations
   A. Definition
   B. Purpose
   C. Nsg. Process
      1. Assessment
      2. Planning
      3. Implementation
      4. Evaluation
      5. Charting

II. Irrigation Procedures
   A. General
   B. Types
      1. Catheter
      2. NG Tube
      3. Wound
      4. Colostomy
      5. Vagina
      6. Mouth/Throat
      7. Eye

III. Home Health Considerations
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define vocabulary words.
2. List purposes of bandages and binders.
3. List principles of applying bandages and binders.
4. Identify types and uses of various types of bandages.
5. Identify and demonstrate various methods of applying bandages:
   A. Circular
   B. Spiral
   C. Reverse Spiral
   D. Figure 8
   E. Recurrent Wrap
6. Identify the various types of binders and their uses:
   A. Elasticnet
   B. Abdominal scultetus
   C. T-Binders
   D. Slings
7. Identify and demonstrate the correct procedures for applying the various binders (mentioned above).
8. Demonstrate the correct procedures for applying a wet-to-dry dressing.

PLAN OF LESSON

I. Vocabulary
II. Purposes
III. Principles of Application
IV. Bandages
   A. Types
   B. Methods
   C. Procedures
      1. Assessment
      2. Planning
      3. Implementation
      4. Evaluation
      5. Charting
V. Binders
   A. Types
   B. Uses
   C. Procedures Nursing Process as Above
VI. Wet-to-Dry Dressing
   A. Purpose
   B. Procedure
   C. Nursing Process
VII. Home Health Considerations

Written: 09/90
Reviewed: 06/92, 06/97, 08/98, 08/00; 03/06; 06/09
Revised: 06/94, 08/96, 12/02; 12/04; 06/07; 08/11
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms associated with surgical asepsis.
2. Differentiate between medical asepsis and surgical asepsis.
3. Describe five methods of sterilization.
4. Explain how to tell if supplies are sterile.
5. Enumerate restricted settings in the hospital where aseptic surroundings are maintained.
6. Explain the necessity of developing a sterile conscience.
7. Identify guidelines for using sterile technique while opening sterile supplies, setting up and adding items to the sterile field, opening sterile packs, and working with a sterile field.
8. Determine when to use sterile technique.

PLAN OF LESSON

I. Vocabulary
II. Medical vs. Sterile Asepsis
III. Methods of Sterilization
IV. Restricted Areas in Hospital
V. Principles of Sterile Technique
VI. When to use Sterile Technique
VII. Demonstration
Unit: Advanced Nursing Skills
Lesson: 12
Title: Sterile Dressing
Time: Theory 2 Hours, Lab 1 Hour

Implementation: Burton Ch. 22 & 26; Lecture/Class Discussion; Demonstrations; Videos
Evaluation: Application in Patient Care, Post Test, Demonstrations
Integrated: N/A

OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define vocabulary terms.
2. State observations that should be made about a wound during a dressing change.
3. List materials needed to change a sterile dressing.
4. Identify and demonstrate the correct procedure for changing a sterile dressing.

PLAN OF LESSON

I. Vocabulary
II. Observation of Wounds
III. Procedure for Sterile Dressing Change
   A. Assessment
   B. Planning
   C. Implementation
      1. Set Sterile Field
      2. Open Sterile Packs
      3. Don Sterile Gowns
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define urinary catheterization.
2. Distinguish between straight and retention catheters.
3. Describe and demonstrate proper positioning and draping of patient who is to be catheterized.
4. Describe and demonstrate proper procedure for inserting straight catheter.
5. Describe and demonstrate the proper procedures for removing a retention catheter.
6. Describe and demonstrate proper procedure for applying a condom catheter.
7. Describe and demonstrate procedure for attaching catheter to leg urinary drainage bag.

PLAN OF LESSON

I. Introduction
   A. Define Urinary Catheterization
   B. Purposes
   C. Types of Catheters
      1. Straight
      2. Retention

II. Patient Preparation
   A. Explanation
   B. Positioning
   C. Draping

III. Straight Catheter
   A. Purpose
   B. Procedure
      1. Assessment
      2. Planning
      3. Implementation
         a. Demonstration
      4. Charting

IV. Retention Catheter
   A. Purpose
   B. Procedure Insertion
      1. Assessment
      2. Planning
      3. Implementation
         a. Demonstration of Application and Connection to Leg Drainage Bag
      4. Charting

V. Condom Catheter
   A. Purpose
   B. Procedure Insertion
      1. Assessment
      2. Planning
      3. Implementation
         a. Demonstration of Application and Connection to Leg Drainage Bag
      4. Charting
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. List precautions the nurse should take in handling secretions.
2. Indicate why mouth care is important in patients with increased secretions.
3. Identify observations and charting which the nurse should make regarding sputum.
4. Define mechanical and nasopharyngeal suctioning.
5. Identify the proper procedure suctioning
6. Identify basic guidelines the nurse should use to avoid serious consequences of oxygen removal by suction.
7. Define oropharyngeal suctioning.
8. Indicate the purpose of bulb suctioning and the procedure.
9. Define tracheostomy and list conditions which may indicate its use.
10. Identify general nursing measures and responsibilities in caring for a patient with a tracheostomy.
11. Define trach care and stoma care.
12. Describe and demonstrate the cleaning of inner cannula.
13. Describe and demonstrate the procedure for changing trach ties/straps.
14. Describe and demonstrate the proper procedures for suctioning a tracheostomy.

PLAN OF LESSON

I. Secretions
   A. Precautions in Handling
   B. Importance of Mouth Care
   C. Observations and Charting

II. Suctioning
   A. Nasopharyngeal Suctioning
      1. Definition
      2. Procedure
      3. Precautions
      4. Charting
   B. Oropharyngeal Suctioning
      1. Definition
      2. Procedure
      3. Precautions
      4. Charting
   C. Bulb Syringe Suctioning

III. Tracheostomy Care
   A. Definition
   B. Indications for Use
   C. Types of Tubes
   D. General Nursing Measures
   E. Cleaning of Inner Cannula
   F. Changing Ties
   G. Procedure for Suctioning
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Identify four common patient reactions to admission.
2. Describe nursing interventions for common reactions to admission.
3. Explain the importance of making the patient feel welcome during the admission process.
4. Relate specific ways you can enhance communication in a culturally diverse patient population.
5. List the nurse’s responsibilities during patient admission.
6. Name two populations that are prone to separation anxiety.
7. Discuss the importance of completing an admission orientation checklist.
8. Describe the information that should be included in a discharge summary.
9. Outline the nursing responsibilities during the patient discharge process.
10. Compare the transfer of a patient to another facility to a transfer within the same facility.

PLAN OF LESSON

I. Patient Reactions
II. Nursing Interventions
III. Enhance Communication
   A. Rapport
IV. Nursing Responsibilities
V. Orientation
VI. Discharge Summary
VII. Nursing Responsibility on Discharge
VIII. Transfer
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. State the purpose of consent forms and release forms.
2. Identify the common types of consent and release forms.
3. State who may legally sign consent and release forms.
4. Identify the purpose of an incident report and list the general incidents that are reportable.
5. Indicate who is responsible for completing an incident report.

PLAN OF LESSON

I. Consent and Release Form
   A. Purpose
   B. Types
   C. Legal Signatures

II. Incident Reports
   A. Purpose
   B. Incidents Reportable
   C. Legal Responsibilities
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define intravenous therapy and venipuncture.
2. State reasons why patient may become anxious about IV procedures.
3. Describe the processes used to establish guidelines for nurses to perform infusion therapy.
4. Identify and differentiate between winged or butterfly needles, over-the-needle catheters, administration sets, and intravenous access devices.
5. Differentiate among peripheral, midline, central venous, and implantable access devices used for IV therapy.
6. Differentiate between the meaning of isotonic, hypotonic, and hypertonic solutions.
7. List criteria used for the selection of an IV access site.
8. Describe and demonstrate the correct technique for initiating and maintaining an IV in lab.
9. Discuss the correct baseline patient assessment needed to evaluate the IV therapy.
10. Explain the signs, symptoms, and treatment of complications associated with IV therapy.
11. Explain the importance of sterility in skin preparation for venipuncture.
12. Describe the location for the venipuncture site.
13. Define venipuncture and explain why it is necessary.
14. Explain step-by-step venipuncture technique and demonstrate this in the lab.

PLAN OF LESSON

I. Definitions
   A. Intravenous therapy
   B. Venipuncture
   C. Psychological Implications

II. Processes/Guidelines
   A. Qualified
   B. MD order

III. Equipment
   A. Administration Sets
   B. Infusion Control Devices
      a. Controllers
      b. Pumps
      c. Syringe Pumps
   C. Access Devices
      a. Winged/Butterfly
      b. Over-the-Needle
      c. Heparin or Med Lock
      d. Central Access Device
      e. Implantable Infusion Ports

III. Types of IV Solutions

IV. Selection of Site

V. Techniques
   a. Venipuncture
   b. Initiating IV

VI. Maintenance of IV Therapy
   a. Patient Assessment

VII. Complications
   a. Signs/Symptoms
   b. Treatment
OBJECTIVES

Upon completion of this unit, the student will be able to:

1. Define key terms associated with nursing process and decision making.
2. Discuss ways critical thinking is used in nursing.
3. Enumerate the steps of the nursing process.
4. Contrast subjective and objective data.
5. Explain how to conduct a nursing interview.
6. List techniques used to gather data during a physical assessment.
7. Describe how Maslow’s hierarchy of human needs is used to prioritize nursing diagnoses.
8. Explain how to write correct outcomes statements.
9. Compare types of nursing interventions.
10. Explain the importance of individualized nursing interventions.
11. Enumerate initial intervention steps.
12. List types of nursing care plans.
13. Explain the process for writing a student care plan.
14. Discuss use of concept maps to plan care.

PLAN OF LESSON

I. Vocabulary
II. Critical Thinking
III. Steps of Nursing Process
IV. Role of LPN in Nursing Process
V. Data
   A. Subjective
   B. Objective
VI. Gathering Data
VII. Maslow’s Hierarchy of Human Needs
VIII. NANDA Nursing Diagnoses
IX. Types of Nursing Diagnoses
X. Goals
XI. Outcomes
   A. Measureable
   B. Timeframe
XII. Nursing Interventions
    A. Rationales
XIII. Care Plans
    A. Types
    B. Steps of Writing
XIV. Concept Mapping
XV. Practice/Demonstration