**NUR 214 Assignments**

Students may download and print assignments and many instructors will accept assignments by e-mail.

**CLINICAL OBSERVATION EXPERIENCE**

Clinical observation experiences may be selected as they are available in the clinical facility. The number of experiences in specialty units will not exceed one clinical laboratory session. A report is submitted for each observation attended.

**PURPOSES:**

To provide the student with an opportunity to observe the activities of health care providers in a variety of settings and to explore implications of observations for the student’s personal nursing practice.

**PREPARATION:**

Read the appropriate pages in Lewis, based on which setting the observation will occur.

**CRITERIA:**

1. Describe activities of the health care providers in terms of Professional Behaviors, Communication, Assessment, Clinical Decision Making, Collaboration and Teaching/Learning.

2. Describe the therapeutic nursing interventions you observed.

3. Describe information technology available to support the planning and provision of client care.

4. List 2 examples of specific nursing care you observed and reflect on how those examples will affect your nursing practice.

**ASSIGNMENT AND DUE DATE:**

1. A written report must be submitted to the clinical faculty member, responding to each of the criteria. The due date for the written report will be one week after this clinical experience.

**REQUIRED READING:**

Emergency Department: Lewis, pp. 1845-1867
Medical Intensive Care: Lewis pp. 1758-1795
Interventional Radiology/Special Procedures Unit: Lewis, pp. 384-390 (Anesthesia)
Bone Marrow Transplant Unit: Lewis, pp. 321-322
Cardiac Catheterization Lab/Electrophysiology Lab: Lewis, pp. 770-771, 774, 820-902 (EPS), 878 (Catheter Ablation Therapy)
Respiratory Unit: Lewis, pp. 550-558
Lab Notes: Bring to experience
Cardiology Clinic: Lewis, pp. 768-771
Dialysis Unit: Lewis, pp. 1228-1238
Cardiac Step down: Lewis, pp. 857-858, 1736-1776
Burn Trauma: Lewis, pp. 1758-1795

Rev. 6/05
CLINICAL OBSERVATION EXPERIENCE
Observation _____________________________

Student Name: ___________________ Coassigned Staff: _________________ Date: ____________

1. Describe activities of the health care provider:
   a. Professional Behaviors
   b. Communication
   c. Assessment
   d. Clinical Decision Making
   e. Collaboration
   f. Teaching-Learning

2. If the staff member you observed was a nurse, describe the therapeutic nursing interventions you observed.

3. Describe information technology available to support the planning and provision of client care.

4. Describe at least 2 examples of situations you observed and how they will affect your practice.
CLINICAL OBSERVATION EXPERIENCE
Observation ________________________________

Student Name: __________________ Coassigned Staff: ________________ Date: ___________

1. Describe activities of the health care provider:
   a. Professional Behaviors
   b. Communication
   c. Assessment
   d. Clinical Decision Making
   e. Collaboration
   f. Teaching-Learning

2. If the staff member you observed was a nurse, describe the therapeutic nursing interventions you observed.

3. Describe information technology available to support the planning and provision of client care.

4. Describe at least 2 examples of situations you observed and how they will affect your practice.
EVALUATION OF THE DISCHARGE PLANNING PROCESS FOR A CLIENT

PURPOSE:

To provide the student with an opportunity to review the process used in preparing a client for discharge and to evaluate the process used. A student need not discharge the client to do this assignment.

PREPARATION:

Review Lewis, pp. 76-79, 90

CRITERIA:

1. Give a brief 2-3 sentence summary of the patient.
2. Identify steps taken during the first 24 hours after the client’s admission to plan for discharge.
3. Identify the health team members involved and their roles in this client’s discharge process.
4. Describe the discharge needs identified and which health team member identified the need. Which services are available to meet these needs.
5. Discuss the completeness of documented assessments of learning strengths, capabilities, barriers and educational needs. Discuss any documented patient/family teaching.
6. Discuss any barriers to the client’s ability to access available community resources. Assess the strengths, resources, and needs of clients within the context of their community.
7. Identify the areas of the discharge planning process that have not been addressed or that need modification.
8. Describe information technology available to support the planning and provision of client care.
9. Describe what you have learned and how you will use this knowledge when preparing future clients for discharge in your RN role.
10. Complete Discharge Audit Tool and submit along with responses to the above criteria.

ASSIGNMENT AND DUE DATE:

A written report plus the Discharge Audit Tool must be submitted to the clinical faculty, responding to each of the criteria. The due date for the written report will be one week following this clinical experience.

DISCHARGE AUDIT TOOL

<table>
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<tr>
<th>Y</th>
<th>Description of Form</th>
<th>Actual Name of Form</th>
<th>Form Initiated</th>
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<tr>
<td></td>
<td>First notation of Discharge Planning</td>
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<td></td>
<td>Advanced Directives</td>
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Purpose
To provide the student with the opportunity to combine interviewing and documenting skills in one assignment. The student will, for a selected adult client, complete a health history and perform a health risk assessment and document using a nurse’s progress note format.

Preparation:
1. Read the Assessment Form Before the Experience.
2. Review Lewis, pp. 30-42 (Chapter 3).
3. Please refer to list of common medical abbreviations guide for appropriate terminology.

Criteria:
1. Respond to each item on the Health History.

2. Document current and accurate information on the assignment form.


4. Write a Nurse’s Progress Note incorporating a focused physical assessment based on the client’s priority health problem(s) and including pertinent information from the interview. Assume that other staff may not have access to this information.

**ASSIGNMENT AND DUE DATE:**

One written Health History, Health Risk Assessment and Nurse’s Progress Note will be submitted to the student=s clinical faculty within one week following this clinical experience.
HEALTH HISTORY

Use both client interview and medical record for gathering data.

Student Name: _______________________________  Date: ________________

**GENERAL INFORMATION**

Client Initials: ____  Sex: M  F  Age: ____  DOB: _____________

Health care insurance:

Source(s) of information:

History of present condition/illness/surgery:

Client’s understanding of current condition:

Past health/medical problems:

Medications currently prescribed:

Nonprescription medications used and frequency:

Health maintenance, health promotion practices, healing modalities and home remedies:

History of family health/illness (DM, cancer, HTN, CVA, MI, communicable diseases, emotional illness):
Allergies (include foods, medications, environmental sources, latex, etc.)

<table>
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<tr>
<th>SUBSTANCE</th>
<th>REACTION</th>
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Substance use:
- Number of cigarettes/day:
- Other tobacco/day:
- Number of years smoked:
- Amount of caffeinated beverages/day:
- Amount/type of alcoholic drinks/day:
- Other substances:

**Oxygenation Assessment**

Chest Pain/Palpitations: (frequency precipitating/alleviating factors)

Cough, Sputum or Dyspnea:

Distance client can walk without resting: (Is client limited by SOB, claudication, fatigue, angina)

Number of pillows do you sleep with at night:

Nocturia:

**Rest/Sleep/Comfort Assessment**

Hours worked/day:

Hours of sleep/night:

Rest periods/naps: Yes   No   Describe:
Measures to aid sleep (include medications):

Sleep problems:

Pain, discomfort: If yes, describe (include if acute or chronic in nature):

Type and amount of activity/exercise:

Gait:

Muscle Strength:

Musculoskeletal discomfort or limitation:

Assistive Devices:

Ability to care for self:

Nutrition Assessment

24 hour recall of “typical” day.

<table>
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<tr>
<th>INTAKE</th>
<th>BREAKFAST</th>
<th>LUNCH</th>
<th>DINNER</th>
<th>SNACKS</th>
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<td>Food</td>
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<tr>
<td>Fluid</td>
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<td>Usual times of meals at home</td>
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</tbody>
</table>
Dietary restrictions/dislikes/difficulty:

Appetite:

Recent weight and/or appetite changes:

Ability to feed self: Dentition:

Symptoms (nausea, vomiting, pain, emesis, bleeding):

**Bowel Elimination Assessment**

Typical bowel elimination pattern:

Appearance of stool:

Continence:

Symptoms (diarrhea, blood, hemorrhoids, pain):

**Urinary Elimination Assessment**

Typical daily voiding pattern:

Appearance of urine:

Continence:

Symptoms (dysuria, hematuria, anuria):
Safety and Security Assessment

Hearing:  Sight:  Aids:

Orientation to:  Person:  Place:  Time:

Environmental history (exposure to domestic/occupational/recreational substances; noise, chemicals, infectious agents; financial concerns)

Higher Level Needs

Educational Level:

Occupation:

Ability to speak and understand:

Type and Place of Residence:

Student: Yes  No  Employed: Yes  No  Retired: Yes  No

Religion

Present emotional state:

Usual emotional state:

Symptoms (anxiety, stress, depression, grief):
Love and Belonging

Primary support:

Family composition:  (do not write down names)
    Household members= relationships

Symptoms (adequacy of relationships and social support, domestic violence):

Sexuality (partner, STD exposure and protection, contraception):

Recognition/Esteem

Hobbies:

Volunteer work:

Other pertinent data:
HEALTH RISK ASSESSMENT

Based on the data gathered in the Health History, identify:

1. Risk behavior(s): ____________________________________________________________

2. Probable consequences of continuing this behavior for this client: __________________

3. Circle the client’s stage of readiness for change of this risk behavior, using the information contained in the chronic illness conference guide.


   Support this stage selection with client information (e.g. client statements or client activities r/t the risk behavior):

   _______________________________________________________

   _______________________________________________________

   _______________________________________________________

4. Recommended Plan of Action: ________________________________________________

   EXAMPLE

   1. Risk behavior(s): sedentary lifestyle, high sodium, high fat diet, cigarette smoking

   2. Probable consequences of continuation of this behavior for this client: hypertension, coronary artery disease, MI, CVA, cancer

   3. Circle the client’s stage of readiness for change of this risk behavior, using the information contained in the chronic illness conference guide.

      Pre-contemplative / Contemplative / Planning / Action / Maintenance / Relapse

   4. Refer to dietician; teach benefits of regular exercise; provide smoking cessation materials.

   Revised 6/06
MANAGING CARE ASSIGNMENT

PURPOSE:

To provide the student with the opportunity to participate in managing care either within the NUR 214 Clinical Group, or collaboratively in a NUR 111 or NUR 112 Clinical Group, or both.

The student will:

a. prioritize client care.
b. coordinate the implementation of individualized plan of care.
c. facilitate the continuity of care across settings.
d. assign aspects of client care to assistive personnel.
e. supervise and evaluate the activities of assistive personnel.
f. modify client care based on healthcare settings and management systems.
g. assist the client and significant person(s) to access available resources and services.
h. implement nursing strategies to provide cost effective care.
i. demonstrate competence with current technology.

PREPARATION:

Review classroom materials regarding management from NUR 210 and NUR 214. Review instructions with clinical instructor(s). Students may accomplish the objectives in a variety of settings, using various experiences.

CRITERIA:

Planning and Prioritizing Nursing Care for a Group of Clients

1. Identify one outcome of highest priority for each client.
2. List the priority nursing interventions.
3. Establish priorities for the listed nursing interventions.
4. Identify the nursing activities to be assigned/delegated and to whom they will be assigned/delegated.

After implementing the plan:

5. Compare the priorities established with the actual order of implementation of nursing activities.
6. Evaluate the effectiveness of the plan, including the assigning/delegating for the group of clients.
7. Briefly critique your team members. How effectively did your team work together?
8. Evaluate this managing care experience. What were the most positive aspects? What would you change to make this experience more meaningful?

ASSIGNMENT AND DUE DATE:

A written report will be submitted to the clinical faculty one week after the experience. There are a variety of forms provided. Your clinical faculty will inform you of which ones you will need.

Revised 6/06
## Managing Care Assignment
Complete this after report, rounds and discussion with student caring for client.

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Client Initials and Room #</th>
<th>Actual Highest Priority Nursing Diagnosis</th>
<th>Actual Highest Priority Nursing Interventions</th>
<th>Actual Priority of Patient</th>
<th>What care can actually be assigned to UAP?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
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<td>Assess:</td>
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</table>
NUR 214 Course Outline – Fall 2007

Managing Care Assignment

1. Evaluate the effectiveness of the plan, including the assigning/delegating for the group of clients.

2. Describe how you supervised the team. Evaluate your team members. How effectively did your team work together?

3. How would this plan be modified if you were in a different healthcare setting. How would it be modified if a different management system was in place? Compare and contrast the management system you observed with another management system from a different health care setting (e.g. home care, acute care).

4. What strategies could be implemented to provide more cost effective care?

5. Evaluate this managing care experience. What were the most positive aspects? What would you change to make this experience more meaningful?
Collaborative Managing Care Assignment

PURPOSE: The purpose of the Collaborative Managing Care experience is to provide students with the opportunity to explore managing care and develop, implement and evaluate a plan of care for a group of clients within a NUR 111/112 Clinical Group. Primary skills used will include: assigning, delegating, priority setting, role modeling, monitoring and effective communication.

1. One NUR 214 student will be assigned to a group of clients.

2. The NUR 214 student will manage care for the group of clients. This student may or may not provide direct client care. The remaining students will provide the nursing care, including medications, for the client group. The second-year student will meet with the NUR 111 instructor to collect client data, analyze needs for the care of the group of clients and develop a collaborative plan to be implemented during the clinical time.

3. The second-year student will discuss the plan with the instructor of NUR 111 students prior to the experience. This plan will include:
   a. review/discussion of policies and procedures for the assigned agency.
   b. which NUR 111/112 student(s) will administer medications, perform treatments and provide other care for which clients.
   c. rationale for tasks assigned to NUR 111/112 students and a plan for how communication and supervision of the NUR 111/112 students will be handled.
   d. a written assignment will be prepared to give to the NUR 111/112 students on the morning of the clinical experience.

4. The NUR 214 student will keep the MCC instructor and the co-assigned nurse apprised of changes in the plan as the morning progresses in order to assure safe coordination of client care and clarification of roles and responsibilities.

OBJECTIVES:

Collaborative Managing Care experience will:

a. provide the NUR 214 student with an opportunity to explore and implement the role of the nurse as manager of care using practical and current approaches.

b. improve student performance on the Manager of Care section of the NCLEX exam.

c. provide a balanced “real life” experience for students to help decrease reality shock and ease transition into the role of professional nurse.

d. enhance student confidence with leadership skills.
## Collaborative Managing Care Assignment
### Criteria And Implementation

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>OPTIONS FOR IMPLEMENTATION</th>
</tr>
</thead>
</table>
| Works cooperatively with others to achieve client outcomes for a group of clients | Provides an update of plan of care to students after shift report.  
Develops comprehensive nursing priority worksheet for a group of clients.  
Communicates client changes to clinical instructor, first year students, and clinical staff. |
| Prioritizes client care | Articulates plan of care to instructor and students  
Assists students to prioritize care.  
Collaborates with clinical instructor to adjust nursing intervention based on clients’ needs and skill set of student.  
Continuously demonstrates assessment and evaluation of plan of care. |
| Assign aspects of care to assistive personnel | Assist clinical instructor with development of student assignment based on skill set and learning need.  
Obtains shift report on clinical unit.  
Assist clinical instructor with coordination of break assignments for students to ensure continuity of client care. |
| Supervises and evaluates the activities of assistive personnel | Rounds on clients and students to verify completion of TNIs and assist PRN.  
Verifies assessments are completed and documented.  
Verifies charting is completed.  
Is available to students as a resource for problem solving and assistance with completion of assignment.  
Consistently demonstrates effective communication skills.  
Assist clinical instructor with evaluation of student verbal report. |
| Applies theoretical aspects of Assigning and Delegating to Managing Care assignment | Assigns clinical tasks appropriately.  
Acts as a resource for institutional and community resources for clients. |
| Serves as a positive role model within the health care settings and the community at large | Dresses in professional manner according to MCC dress code policy.  
Role models foundational clinical skills such as body mechanics with turning and repositioning, ambulation of patients with a variety of needs, client ADLs, organization of care, etc.  
Contributes to the enhancement of a clinical environment conductive to teaching and learning.  
Assists students with practice of fundamental nursing skills such as assessment of BP & P, wound care using a simulator and physical assessment techniques.  
Has an approachable demeanor. |
NUR 214 Course Outline – Fall 2007

Collaborative Managing Care Assignment
Procedure

Site:

Clinical Day/Time:

1. Meet with the NUR 111/112 faculty before this clinical experience. Please call to set up an appointment. You may choose to meet briefly, work on the materials at home and return them or you may choose to meet for a longer period of time and work on the materials in the office and turn them in on the same day. NUR 111/112 students will give you a brief tour of the unit at the beginning of the clinical day.

2. Assist with client selection/student assignment based on client needs and student learning needs.

3. Review plan with faculty.

4. Written assignment sheets will be distributed by the instructor to the NUR 111/112 students prior to the week of the clinical experience.

5. Arrive at (time) to review the plan for the day with the clinical instructor.

6. Participate in pre-conference (time) to assist NUR 111/112 students by answering questions re: individual assignments and review the plan for the day with the students.

7. Obtain report from unit staff (co-assigned nurses) (time).

8. Give report to students.

9. Check charts for new orders; notify faculty and students.

10. Check IV’s (solution, rate, site, tubing).

11. Verify that all client care is completed by (time) and charted.

12. Verify completion of TNIs and assist PRN.
13. Assist with client care/role model appropriate behaviors/actions.

14. Round on clients/students frequently (check client safety).

15. Check with faculty frequently and if problem develops.

16. Assist students to gather needed supplies and organize (drugs., irrigations, etc.).

17. MARs, NP notes, clinical assignments.

18. Verify charting completed (flowsheets, I/Os) by (time) ________.

19. Obtain students’ verbal report while the clinical instructor observes by (time) ______.

20. Give report to co-assigned nurses under supervision of the clinical instructor.

21. Assist NUR 111/112 students with non-invasive skills as time allows.

22. Participate in post-conference (time) ____________.

23. The NUR 111/112 clinical instructor will discuss the experience with you and provide feedback based on the outcome criteria. This feedback will be shared with your NUR 214 clinical instructor.
NUR 214 Course Outline – Fall 2007

NURSING PROCESS ASSIGNMENT (NPA)

PURPOSES:
To apply the nursing process to an adult client care situation.
To establish priorities and demonstrate clinical decision making.

PREPARATION:
Review Lewis, pp. 2-17. Prepare Part 1 prior to experience.

REQUIREMENTS:

- Submits a complete assignment according to the criteria, in ink, one week following the experience.
- Submission of the NPA must include copies of articles based on research and pertinent to the Nursing Diagnoses chosen. The following is a listing of search engines or websites that may be helpful:
  - www.cdc.gov – Center for Disease Control
  - www.martindalecenter.com/nursing.html – interactive resource
  - www.mayoclinic.com

CRITERIA:

Criteria are listed on the checklist at the front of the assignment pages.
### Part 1: Preparation for Clinical

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<tbody>
<tr>
<td>1.</td>
<td>Formulates possible reason(s) for each medication the client receives.</td>
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<tr>
<td>2.</td>
<td>Identify individualized focused assessment with rationale.</td>
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### Part 2: Client Assessment and Nursing Diagnosis

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<tbody>
<tr>
<td>1.</td>
<td>Specifies subjective and objective data to assess each basic need of the client, including a complete system assessment where indicated.</td>
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<tr>
<td>2.</td>
<td>Specifies client’s understanding of health status, discharge planning and health promotion behaviors.</td>
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<tr>
<td>3.</td>
<td>Formulates five individualized nursing diagnoses based on the data in the assessment.</td>
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<tr>
<td>4.</td>
<td>Categorizes each of the five nursing diagnoses as high, medium, or low priority.</td>
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### Part 3: Nursing Care Plan and Evaluation

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<tbody>
<tr>
<td>1.</td>
<td>Select two of the individualized NANDA nursing diagnoses of high priority.</td>
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<tr>
<td>2.</td>
<td>Identifies defining characteristics and sufficient substantiating data for each of the two nursing diagnoses.</td>
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<tr>
<td>3.</td>
<td>Establishes at least two individualized client outcomes for each nursing diagnosis.</td>
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<tr>
<td>4.</td>
<td>Establishes at least four individualized high priority therapeutic nursing interventions to assist the client in achieving the identified outcomes.</td>
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<tr>
<td>5.</td>
<td>Specifies to what degree each outcomes was achieved. (Yes, partially or no)</td>
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<td>6.</td>
<td>Specifies client data which shows the level of outcome achievement.</td>
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<td>7.</td>
<td>Identifies adaptation made to nursing care.</td>
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<td>8.</td>
<td>Determines modifications to client care as indicated by evaluation of outcomes</td>
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<td>9.</td>
<td>Note research based information utilized to support clinical decision making.</td>
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**Professional Behavior:**

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<tr>
<td>1.</td>
<td>Submitted on time.</td>
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<td>2.</td>
<td>Written in ink.</td>
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<tr>
<td>3.</td>
<td>Written legibly.</td>
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</tbody>
</table>
Identify components of a focused assessment for this client with rationale.

<table>
<thead>
<tr>
<th>Focused Assessment (in priority order)</th>
<th>Rationale</th>
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</table>
### General Information

<table>
<thead>
<tr>
<th>Client Initials</th>
<th>Age:</th>
<th>Gender:</th>
</tr>
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</table>

**History of present illness:**

**Allergies:**

**Past medical/surgical history:**

**Current vital signs:**

<table>
<thead>
<tr>
<th>T</th>
<th>P</th>
<th>BP</th>
<th>R</th>
<th>SpO₂</th>
<th>Pain Level</th>
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**Baseline vital signs (ranges):**

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<tr>
<th>T</th>
<th>P</th>
<th>BP</th>
<th>R</th>
<th>SpO₂</th>
<th>Pain level</th>
</tr>
</thead>
</table>

### Data Collection for each Basic Need

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Subjective Data (Subjective information obtained from client)</th>
<th>Objective Data (Assessment findings based on subjective information)</th>
<th>Relevant Laboratory Values &amp; Diagnostic Tests</th>
<th>Relevant Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>OXYGEN (Cardiovascular Assessment)</td>
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</tr>
<tr>
<td>Subjective Data</td>
<td>Objective Data</td>
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<tr>
<td>OXYGEN (Respiratory Assessment)</td>
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<td>Subjective Data</td>
<td>Objective Data</td>
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<tr>
<td>Past Medical History</td>
<td>Data Collection for each Basic Need</td>
<td>Relevant Laboratory Values &amp; Diagnostic Tests</td>
<td>Relevant Medications</td>
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<tr>
<td></td>
<td>Subjective Data (Subjective information obtained from client)</td>
<td>Objective Data (Assessment findings based on subjective information)</td>
<td></td>
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</tr>
<tr>
<td>REST/SLEEP/COMFORT (include Pain and Integument Assessment)</td>
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<tr>
<td>Subjective Data</td>
<td>Objective Data</td>
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<tr>
<td>ACTIVITY (includes Musculoskeletal Assessment)</td>
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<tr>
<td>Subjective Data</td>
<td>Objective Data</td>
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<tr>
<td>FLUIDS AND URINE ELIMINATION (includes IV Site Assessment)</td>
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<tr>
<td>Subjective Data</td>
<td>Objective Data</td>
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<td></td>
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<tr>
<td>NUTRITION (includes Oral Assessment)</td>
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</tbody>
</table>
## Data Collection for each Basic Need

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Subjective Data (Subjective information obtained from client)</th>
<th>Objective Data (Assessment findings based on subjective information)</th>
<th>Relevant Laboratory Values &amp; Diagnostic Tests</th>
<th>Relevant Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subjective Data</td>
<td>Objective Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOWEL ELIMINATION (includes Abdominal Assessment)</td>
<td>Subjective Data</td>
<td>Objective Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAFETY AND SECURITY: Neurological Assessment</td>
<td>Subjective Data</td>
<td>Objective Data</td>
<td></td>
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</tbody>
</table>
## Data Collection for each Basic Need

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Data Collection for each Basic Need</th>
<th>Relevant Laboratory Values &amp; Diagnostic Tests</th>
<th>Relevant Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subjective Data (Subjective information obtained from client)</td>
<td>Objective Data (Assessment findings based on subjective information)</td>
<td></td>
</tr>
</tbody>
</table>

### SAFETY/SECURITY (environmental assessment)

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

### HIGHER LEVEL NEEDS

#### LOVE/BELONGING (includes assessment of client’s interaction with support person(s))

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

#### RECOGNITION/ESTEEM (includes educational level, occupation, etc.)

<table>
<thead>
<tr>
<th></th>
<th>Subjective Data</th>
<th>Objective Data</th>
</tr>
</thead>
</table>
### Data Collection for each Basic Need

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Subjective Data (Subjective information obtained from client)</th>
<th>Objective Data (Assessment findings based on subjective information)</th>
<th>Relevant Laboratory Values &amp; Diagnostic Tests</th>
<th>Relevant Medications</th>
</tr>
</thead>
</table>

#### UNDERSTANDING OF HEALTH STATUS (includes learning strength, capabilities, barriers and educational needs)

- **Subjective Data**
- **Objective Data**

#### DISCHARGE PLANNING NEEDS (includes assessment of ability to access available community resources)

- **Subjective Data**
- **Objective Data**

#### HEALTH PROMOTION BEHAVIORS

- Exercise at home
- Diet at home
- Medications at home (include OTC)
- Tobacco (packs/no. years)
- Caffeine
- Alcohol (type/amount/frequency)
### NUR 214 Course Outline – Fall 2007

#### Data Collection for each Basic Need

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Data Collection for each Basic Need</th>
<th>Relevant Laboratory Values &amp; Diagnostic Tests</th>
<th>Relevant Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subjective Data</td>
<td>Relevant Laboratory Values &amp; Diagnostic Tests</td>
<td>Relevant Medications</td>
</tr>
<tr>
<td></td>
<td>(Subjective information obtained from client)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective Data</td>
<td>Relevant Laboratory Values &amp; Diagnostic Tests</td>
<td>Relevant Medications</td>
</tr>
<tr>
<td></td>
<td>(Assessment findings based on subjective information)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other substances</td>
<td></td>
<td>Relevant Laboratory Values &amp; Diagnostic Tests</td>
<td>Relevant Medications</td>
</tr>
<tr>
<td>Alternative/Complementary Therapies</td>
<td></td>
<td>Relevant Laboratory Values &amp; Diagnostic Tests</td>
<td>Relevant Medications</td>
</tr>
</tbody>
</table>

**OTHER (includes Assessment of Developmental, Socioeconomic, Emotional, Cultural, Religious and Spiritual influences on client’s health.)**

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NUR 214 Nursing Process Assignment

<table>
<thead>
<tr>
<th></th>
<th>Nursing Diagnoses (NANDA) and Related Factor(s)</th>
<th>Priority Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<td>3</td>
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<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defining Characteristics</td>
<td>Substantiating Data</td>
<td>Client Outcomes (At least 2 per diagnosis)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------</td>
<td>---------------------------------------------</td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>
### Nursing Diagnosis #1: Client Outcomes

<table>
<thead>
<tr>
<th>Client Data Showing Outcome Achievement</th>
<th>Adaptations Made to Nursing Care</th>
<th>Modification as indicated by Evaluation of Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Emotional</td>
<td>Should Nursing Care Plan be:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>_____ maintained?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>_____ changed?</td>
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<tr>
<td></td>
<td></td>
<td>_____ discontinued?</td>
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<tr>
<td></td>
<td></td>
<td>Rationale</td>
</tr>
</tbody>
</table>

Describe how the client’s participation in care facilitated/ impaired the achievement of these outcomes:

<table>
<thead>
<tr>
<th>Cultural</th>
<th>Religious</th>
<th>Spiritual</th>
<th>Values/Customs/Habits</th>
</tr>
</thead>
</table>

Specify changes if any

- Nursing Diagnosis
- Outcomes
- Therapeutic Nursing Interventions
### Nursing Diagnosis of High Priority #2

<table>
<thead>
<tr>
<th>Defining Characteristics</th>
<th>Substantiating Data</th>
<th>Client Outcomes (At least 2 per diagnosis)</th>
<th>High Priority Therapeutic Nursing Interventions (At least 4 per diagnosis)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>Nursing Diagnosis #2: Client Outcomes</td>
<td>Client Data Showing Outcome Achievement</td>
<td>Adaptations Made to Nursing Care</td>
<td>Modification as indicated by Evaluation of Outcomes</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>1. Met</td>
<td>Met</td>
<td>Emotional</td>
<td>Should Nursing Care Plan be:</td>
</tr>
<tr>
<td>Partially Met</td>
<td>Partially Met</td>
<td></td>
<td>maintained?</td>
</tr>
<tr>
<td>Unmet</td>
<td>Unmet</td>
<td></td>
<td>changed?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>discontinued?</td>
</tr>
<tr>
<td>2. Met</td>
<td>Met</td>
<td>Cultural</td>
<td>Specify changes if any</td>
</tr>
<tr>
<td>Partially Met</td>
<td>Partially Met</td>
<td>Religioal</td>
<td>Nursing Diagnosis</td>
</tr>
<tr>
<td>Unmet</td>
<td>Unmet</td>
<td>Spiritual</td>
<td>Outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Values/Customs/Habits</td>
<td>Therapeutic Nursing Interventions</td>
</tr>
</tbody>
</table>
Research/Evidence Based Article:

Identify a current nursing based article (less than 6 years old) that presents information that can be utilized at the bedside and implemented in your care plan. This article should present either research or evidence based information that directly relates to your client’s identified nursing diagnosis, outcomes, or therapeutic nursing interventions.

Write a 2-4 paragraph annotated bibliography that includes the following:
- a brief description of the article
- relevance of the information to your client
- any bias or weaknesses in the article
- how you would incorporate this information in your client’s plan of care.

Information concerning how to write an annotated bibliography or APA format can be found at http://www.monroecc.edu/depts/library/

Search for annotated Bibliography or APA format.
PURPOSES:
To provide the student with the opportunity to compare nursing roles, responsibilities and activities in home care settings and acute care settings
To assess the need for client/significant support person(s) teaching in a community setting.

PREPARATION:
Please read the article McCullagh, Marjorie C. (2006). “Home Modification.” American Journal of Nursing 2006. (106)10 – pp. 54-63. This article will be in the 214 Bulletin Board Notebook as well as with your conference instructor.

CRITERIA:
Using information obtained from this experience, respond to each criterion.

1. Describe the roles and responsibilities of the community health nurse as seen during your experience.

2. Describe the activities of your community health nurse in preparation for the home visit, during the home visit and following a home visit. What other preparations might be needed that you did not observe?

3. Describe the actual and/or potential health problems of the clients visited. Assess the client’s ability to access available community resources. Include a brief summary of the actual patient visits with specifics on treatment issues.

4. Identify ways in which the community health nurse did/could promote the health of the client and significant support person(s). Include discussion of how the nurse could serve as a positive role model within the community at large.

5. Describe how the physical and psychosocial environment of the home affects client care. Identify the adaptation of equipment/procedures you encountered during the home visit.

6. Discuss how the community health nurse did/could serve as an advocate for clients’ rights.

7. Describe what the responsibilities of significant support persons could be in the care of the client.

8. Describe how third-party reimbursement did/could affect the care clients may receive.

9. Describe the information technology and the documentation system used to communicate support the planning and provision of client care client data.

10. Compare and contrast the use of the nursing process in the home setting with its use in an acute care agency.

ASSIGNMENT AND DUE DATE:
The student will submit a written report to the clinical faculty member one week after the Community Health Nurse experience that will include response to above criteria.
DEVELOPMENT OF AN INDIVIDUALIZED TEACHING PLAN

PURPOSE:
To provide the student with the opportunity to develop an individualized teaching plan.

The student will:
   a. Develop an individualized teaching plan based on assessed needs.
   b. Provide the client and/or significant support person(s) with the information to make choices regarding health.
   c. Teach the client and/or significant support person(s) the information and skills needed to achieve the desired learning outcomes.
   d. Evaluate the progress of the client and or significant support person(s) toward achievement of the identified learning outcomes.
   e. Modify the teaching plan based on evaluation of progress toward meeting the learning outcomes.
   f. Provide assistive personnel with relevant instruction to support achievement of client outcomes.

PREPARATION:

CRITERIA:
Part 1 Assessment and Planning
   a. Identify the etiology and defining characteristics of the Knowledge deficiency in assigned client, based on client assessment.
   b. Develop three learning outcomes for the client to achieve. (Cognitive, Psychomotor and Affective)
   c. Develop four therapeutic nursing interventions aimed at outcome achievement.
Part 2 Implementation
   a. Provide the client and/or significant support person(s) with the information, using at least two different teaching strategies.
   b. Teach the client and/or significant support person(s) the information and skills needed to achieve the desired learning outcomes.
Part 3 Evaluation
   a. Evaluate the progress of the client and/or significant support person(s) toward achievement of the identified learning outcomes.
   b. Modify the teaching plan based on evaluation of progress toward meeting the learning outcomes. Teaching plan must be modified in at least one area.
Option
   a. If the client and/or significant support person(s) is unavailable for teaching, provide assistive personnel with relevant instruction to support achievement of client outcomes.

ASSIGNMENT AND DUE DATE:
The student will submit a written report to the pediatric faculty member one week after the pediatric clinical experience, or as determined by that faculty member.
### NUR 214 DEVELOPMENT OF AN INDIVIDUALIZED TEACHING PLAN

<table>
<thead>
<tr>
<th>Defining Characteristics /Substantiating Data</th>
<th>Outcomes</th>
<th>Therapeutic Nursing Interventions (Include at least two teaching strategies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td></td>
<td>1.</td>
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<tr>
<td>Psychomotor</td>
<td></td>
<td>2.</td>
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<tr>
<td>Affective</td>
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<td>3.</td>
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</table>

**Knowledge Deficient (specify) ___________________________ r/t**
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Actual Data</th>
<th>Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive Outcome</strong></td>
<td></td>
<td><strong>Modify</strong> the teaching plan based on evaluation of progress toward meeting the learning outcomes. List modifications suggested:</td>
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<tr>
<td></td>
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<td>Modify Nursing Diagnosis?</td>
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<tr>
<td></td>
<td></td>
<td>Modify Outcomes?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modify Teaching Strategies?</td>
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<td></td>
<td><strong>Teaching Plan must be modified in at least one area.</strong></td>
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<tr>
<td><strong>Psychomotor Outcome</strong></td>
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<td></td>
<td>Modify Therapeutic Nursing Interventions?</td>
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<tr>
<td><strong>Affective Outcome</strong></td>
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</tbody>
</table>

- met ____
- partially met ____
- not met ____
- met ____
- partially met ____
- not met ____