

Trident Technical College

Nursing Division



2011-2012 STUDENT COURSE MATERIALS

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Policy for Formal Writing Assignment

1. For each course, the following must be submitted with the formal writing assignment:
 - a. Grading rubric if used or scoring sheet
 - b. Full text articles (according to course assignment)
 - c. Originality report from Turnitin
 - d. Check for additional requirements per course formal writing assignments
2. Five (5) points will be deducted from the writing assignment grade for each missing component listed above.
3. All formal writing assignments are submitted on the date and time specified in the syllabus. Five (5) points will be deducted for each day or portion of the day including weekends and holidays that the writing assignment is late. If the course requires the writing assignment to be submitted by a specific time, five (5) points will be deducted from writing assignment grade submitted after the specified time on the due date.
4. APA format is required for all formal writing assignments and is worth five (5) points of the grade. Deductions in APA format will be made at the rate of one (1) point per error up to the total of five (5) points. Repeated errors will only be deducted once.
5. Students are to use only professional databases and references published within the timeframe outlined in the course's writing assignment unless prior approval is obtained from the lead instructor to use a classic reference. Five (5) points will be deducted from the final grade for references other than professional references or articles older than outlined in the course's writing assignment or articles that do not otherwise conform to the assignment instructions.
6. Plagiarism is a form of academic misconduct and falls under the Procedure for Disciplinary Action for Academic Misconduct as outlined in the *Trident Technical College Student Handbook & Planner*. Trident Technical College offers students the ability to check for acts of plagiarism in papers through a web-based program called Turnitin. Turnitin generates an originality report, which cites areas of plagiarism within the paper. This originality report is a requirement for all formal writing assignments. Each course has an account on www.turnitin.com. A Class ID log-in and enrollment password will be provided at the beginning of the course. Five (5) penalty points will be deducted for each day or portion of the day (including weekends and holidays) that the originality report is late. The assignment is incomplete without a Turnitin originality report submission. If a report is not received, the assignment will be graded a zero (0).
7. The nursing division will impose a Level 2 penalty for the first plagiarism offense. This means that the student who plagiarizes will receive a grade of "0" for the writing assignment with no opportunity to resubmit the writing assignment for a grade. If the student has had any other instance of academic misconduct, a higher level penalty will be imposed.
8. A student with questions about a grade on a formal writing assignment should make an appointment with the instructor who graded the formal writing assignment and clarify questions about the grade. The student must follow the line of communication outlined in the *Student Nurses Handbook* if questions remain unanswered.
9. Re-admitted students must submit a new writing assignment on a different topic when the course is repeated a second or third time.

GRADING GUIDELINES FOR TESTS TAKEN IN TESTING CENTER

Dosage Proficiency Testing:

1. A two-minute grace period will be given beyond the ending time stamped on the test to allow time for the student to complete the requested information on the test booklet.
2. If the two-minute grace period is exceeded, the test will be graded with a zero.

Theory Testing:

1. Students will complete the information on the Scantron sheet prior to being given the test booklet and entering the room for testing. A two minute grace period will be given beyond the designated testing time to allow time for the student to complete the requested information on the test booklet.
2. Points on tests for students exceeding the 2 minute grace period will be deducted based on the time allotted for each item on the test.
 - Example 1: For a 60 minute, 50 item test the value of each item is two (2) points and the students has 1.2 minutes per item. If a student takes six (6) minutes beyond the grace period the points deducted for exceeding the grace period will be ten (10). This is calculated by dividing the total number of minutes exceeded (6 minutes) by the minutes allotted per item (1.2 minutes) = 5 items x the value of each item (2 points) = 10 points.
 - Example 2: For a 90 minute (time and a half), 50 item test the value of each item is two (2) points and the student has 1.8 minutes per item. If a student takes six (6) minutes beyond the grace period the points deducted for exceeding the grace period will be 6.6. This is calculated by dividing the total number of minutes exceeded (6 minutes) by the minutes allotted per item (1.8 minutes) = 3.3 items x the value of each item (2 points) = 6.6 points.

Reviewed: Spring 2004
Spring 2005
Spring 2006
Spring 2008

LABORATORY STUDIES

BASIC METABOLIC PANEL (BMP)

Na Sodium
K Potassium
Cl Chloride
CO₂ Carbon Dioxide
Ca Calcium
BUN Blood Urea Nitrogen
Creatinine
Glucose

COMPREHENSIVE METABOLIC PANEL (CMP)

Na Sodium Albumin
K Potassium Total bilirubin
Cl Chloride ALP
CO₂ Carbon Dioxide Total protein
Ca Calcium AST
BUN Blood Urea Nitrogen Globulin
Creatinine
Glucose

HEME PANEL

WBC White blood cell
RBC Red blood cell
Hgb Hemoglobin
Hct Hematocrit
MCV Mean corpuscular volume
MCH Mean corpuscular hemoglobin
MCHC Mean corpuscular hemoglobin concentration
PLT Platelet

COMPLETE BLOOD COUNT AND DIFFERENTIAL COUNT

(CBC and diff)

WBC Neutrophil
RBC Lymphocyte
Hgb Mononuclear
Hct Eosinophil
MCV Basophil
MCH
MCHC
PLT

HEPATIC FUNCTION

LIVER FUNCTION TEST (LFT)

Albumin
Total bilirubin
Direct bilirubin (conjugated)
Indirect bilirubin (unconjugated)
Alkaline Phosphatase (ALP)

SGPT Serumgluta pyruvic transaminase (ALT)
SGOT Serumglutamic-oxalacetic transaminase (AST)

LIPID PANEL

Total Cholesterol
HDL High density lipoprotein
Triglycerides
LDL Low density lipoprotein
Risk factor (ratio of HDL and LDL)

ARTERIAL BLOOD GAS (ABG)

pH
PaCO₂ partial pressure CO₂
PaO₂ partial pressure O₂
HCO₃ bicarbonate
O₂ Sat O₂ saturation

BE Base Excess

ARTHRITIS PANEL

ESR Erythrocyte Sedimentation Rate
Uric Acid
RA Rheumatoid Arthritis
ANA Antinuclear antibody

CARDIAC INJURY PROFILE (CIP)

CPK Creatine phosphokinase
CK-MB
Troponin I
Myoglobin

NOTE: These panels may vary depending on the individual medical facility. The student should become familiar with lab tests included in panels for clinical site.

Revised: Spring 2006
Spring 2009

REFERENCE:

Normal ranges for laboratory tests are found in Davis Drugs & Diagnostic Tests located on Nursing Central, the Unbound Mobile Platform © 2000-2011.

ABBREVIATIONS

abd	abdomen	Δ = change
ABG	arterial blood gas	\uparrow = increase, up
ac	before meals	\downarrow = decrease, down
ad lib	as desired	
ADL	activities of daily living	
AFB	acid fast bacilli	
AIDS	acquired immunodeficiency syndrome	
AKA	above knee amputation	
AKI	acute kidney injury (ARF)	
AMA	against medical advice	
AMI	acute myocardial infarction	
AMS	altered mental status	
AP	anterior & posterior	
ARDS	acute respiratory distress syndrome	
AROM	active range of motion or artificial rupture of membranes	
ASA	aspirin	
ASD	atrial septal defect	
ASHD	arteriosclerotic heart disease, atherosclerotic	
AX	axillary	
BE	barium enema	
bid	twice a day	
BKA	below knee amputation	
BM	bowel movement	
BMI	body mass index	
BMR	basal metabolic rate	
BNP	brain natriuretic peptide	
BP	blood pressure	
BPH	benign prostatic hyperplasia or hypertrophy	
BRP	bathroom privileges	
BS	blood sugar	
BSC	bedside commode	
BUN	blood urea nitrogen	
C	Centigrade	
\bar{c}	with	
C ₁ , C ₂ (etc.)	first cervical vertebra, second cervical vertebra, etc.	
CA	carcinoma	
Cap	capsule, capillary	
CAD	coronary artery disease	
cath	catheter	
CC	chief complaint	
CHO	carbohydrate	
cm	centimeter	
CNS	central nervous system	
c/o	complains of	
CO	cardiac output	
COPD	chronic obstructive pulmonary disease	
CPAP	continuous positive airway pressure	
CPR	cardiopulmonary resuscitation	
CPT	chest physiotherapy	
CR	controlled release	
C&S	culture and sensitivity	
CSF	cerebrospinal fluid	
CT	computed tomography, chest tube	
CV	cardiovascular	
CVA	cerebrovascular accident	
CVP	central venous pressure	
CXR	chest x-ray	

ABBREVIATIONS (Cont)

D ₅ /0.9% NaCl	5% dextrose and 0.9% normal saline
D ₅ W	5% dextrose in water
D&C	dilatation and curettage
DNR	do not resuscitate
DRG	diagnostic related group
DOA	dead on arrival
DOE	dyspnea on exertion
Dsg	dressing
DTR's	deep tendon reflexes
DVT	deep vein thrombosis
Dx, dx	diagnosis
ECHO	echocardiography
EEG	electroencephalogram
EENT	eye, ear, nose, throat
EGD	esophagogastroduodenoscopy
EKG, ECG	electrocardiogram
ER	extended release
ER, ED	emergency room
ERCP	endoscopic retrograde cholangio pancreatography
ESRD	end stage renal disease
F	Fahrenheit
FBS	fasting blood sugar
Fe	iron
FROM	full range of motion
FSBS	finger stick blood sugar
FUO	fever of unknown origin
Fx, fx	fracture
GB	gall bladder
GERD	gastroesophageal reflux disease
GFR	glomerulo filtration rate
GI	gastrointestinal
Gm or g	gram
GPA	gravida, para, abortus
gr	grain
gtt	drop
GU	genitourinary
GYN	gynecologic
H & H	hemoglobin and hematocrit
H & P	history and physical exam
HCO ₃	bicarbonate
HF	heart failure
Hg	mercury
HIV	human immunodeficiency virus
HOB	head of bed
H ₂ O	water
H ₂ O ₂	hydrogen-peroxide
hr	hour
hs	hour of sleep
ht	height
HTN	hypertension
Hx	history

ABBREVIATIONS (Cont)

ICD	implanted cardiac defibrillator
ICP	intracranial pressure
ICU	intensive care unit
I & D	incision & drainage
IM	intramuscular
Imp.	impression or working diagnosis
INR	international normalization ratio
I & O	intake and output
IPPB	intermittent positive pressure breathing
IS	incentive spirometry
IV	intravenously
IVP	intravenous pyelogram
IVPB	intravenous piggyback
KCl	potassium chloride
kg	kilogram
KUB	kidney, ureter, bladder
KVO	keep vein open
L	liter
lab	laboratory
LFT	liver function test
LLL	left lower lobe (lung)
LLQ	left lower quadrant (abdomen)
LMP	last menstrual period
LOC	level of consciousness
LP	lumbar puncture
LR	Lactated Ringers Solution
LUL	left upper lobe (lung)
LUQ	left upper quadrant (abdomen)
LVH	left ventricular hypertrophy
MDI	metered dose inhaler
mEq	milliequivalent
MI	myocardial infarction
mL	milliliter
mm	millimeter
MRI	magnetic resonance imaging
N	nitrogen
NaCl	sodium chloride
NC	nasal cannula
neg	negative
NG	nasogastric
NKA	no known allergies
NPO	nothing by mouth
NRB	non-rebreather
NS	normal saline
NSAIDS	non-steroidal anti-inflammatory drugs
n/v	nausea & vomiting

ABBREVIATIONS (Cont)

o	orally
O ₂	oxygen
OA	osteoarthritis
OB	obstetrics, occult blood
OOB	out of bed
OR	operating room
ORIF	open reduction internal fixation
OT	occupational therapy
oz	ounce
\bar{p}	after
pc	after meals
PE	physical exam or pulmonary embolus
Peds	pediatrics
PEG	pneumoencephalogram or percutaneous endoscopic gastrostomy
PERRLA	pupils equal, round, reactive to light and accommodation
PET	positron emission tomography
pH	hydrogen ion concentration
PICC	peripherally inserted control catheter
PID	pelvic inflammatory disease
PMH	past medical history
po, PO	by mouth, orally
PPD	purified protein derivative
prn	whenever necessary
PT	physical therapy, prothrombin time
PTA	prior to admission
PTT	partial thromboplastin time
PUD	peptic ulcer disease
PVC	premature ventricular contraction
PVD	peripheral vascular disease
q	every
qid, QID	four times a day
RA	rheumatoid arthritis
Resp	respiratory
Rh ⁺	positive Rh factor
RLL	right lower lobe (lungs)
RLQ	right lower quadrant (abdomen)
R/O	rule out
ROM	range of motion or rupture of membranes
ROS	review of systems
RUL	right upper lobe (lungs)
RUQ	right upper quadrant (abdomen)
Rx	treatment, prescription

ABBREVIATIONS (Cont)

̄	without
S & A	sugar and acetone (urine)
SBE	subacute bacterial endocarditis
SBO	small bowel obstruction
SCD	sequential compression devices
SOB	shortness of breath
sp gr	specific gravity
SSE	soap suds enema
STAT	at once
Sx	symptoms
T & A	tonsillectomy and adenoidectomy
tab	tablet
TB	tuberculosis
TCDB	turn, cough, deep breathe
TF	tube feeding
tid	three times a day
TPN	total parenteral nutrition
TPR	temperature, pulse, respiration
TURP	transurethral resection of prostate
UGI	upper gastrointestinal series (x-ray)
URI	upper respiratory infection
UTI	urinary tract infection
UA	urine analysis
VDRL	venereal disease research laboratory (flocculation test for venereal disease)
VO	verbal order
VS	vital signs
VSD	ventricular septal defect
w/c	wheelchair
wk	week
WM	with meals
WNL	within normal limits
wt	weight
yr	year

NOTE: Most of these abbreviations and symbols are universally accepted. However, approved abbreviations and symbols for individual hospitals may vary. The student should become familiar with the institution's list of abbreviations and symbols and use **ONLY** those in that institution.

Reviewed: May 2004
 May 2006
 May 2010

Rounding Guidelines for Answers

Below is a summary of all of the rounding guidelines that you must memorize.

Guideline 1: Round answers for tablets and suppositories scored in half to the nearest half. Round to the nearest fourth if the tablet or suppository is scored in fourths.

Guideline 2: Rounds answers for capsules and enteric coated tablets to the nearest whole.

Guideline 3: Round answers for oral liquid medications and injections of greater than 1 mL to the nearest tenth.

***Important Point:* To round to the nearest 10th, carry the answer out two decimal places.**

When the number representing hundredths is five or larger, the number representing tenths is increased by one.

Ex: 1.57 is rounded to 1.6
 3.85 is rounded to 3.9
 5.96 is rounded to 6

When the number representing the hundredths is less than five, the number representing the hundredths is dropped.

Ex: 1.84 is rounded to 1.8
 9.92 is rounded to 9.9
 3.61 is rounded to 3.6

Guideline 4: Round answers for oral liquid medications and injections of less than 1 mL to the nearest hundredth.

***Important Point:* To round to the nearest 100th, carry the answer out three decimal places.**

When the number representing thousandths is five or larger, the number representing hundredths is increased by one.

Ex: 0.399 is rounded to 0.4
 0.567 is rounded to 0.57
 0.995 is rounded to 1

When the number representing the thousandths is less than five, the number representing the thousandths is dropped.

Ex: 0.654 is rounded to 0.65
 0.893 is rounded to 0.89
 0.992 is rounded to 0.99

Guideline 5: When converting from kilograms to pounds or pounds to kilograms round to the nearest tenth. This is the rule you are to follow.

Guideline 6: Round answers for drops per minute (gtt/min) IV infusion rates to the nearest whole number because a portion of a drop cannot be counted.

Guideline 7: Round answers for milliliter per hour (mL/hr) IV rates on IV infusion pumps to the nearest tenth.

***Important points:* 1) Rounding guidelines do not apply to conversions. 2) Wait until the end to round when you are solving a problem, except when the problem requires converting to pounds/kilograms. Convert weight at the time you need it to solve the problem.**

DRUG CALCULATION FOR IV PUSH MEDICATIONS

When giving IV Push medications, you must consider the following factors.

1. How much medication will you withdraw from the vial/ampule?
2. How much diluent will you add to the medication if it must be diluted?
3. How many mL per minute will you give?
4. How many minutes will it take to give the medication?

EXAMPLE #1: Drug Order: Digoxin 0.125 mg. IV Push
 Supply on Hand: Digoxin 0.5 mg./1 mL
 Dilute for a total of 10 mL with NS and give no faster than 0.25 mg./min.

1. How much drug will you withdraw from the ampule?

$$\begin{array}{rcl}
 0.125 \text{ mg.} : x \text{ mL} & = & 0.5 \text{ mg.} : 1 \text{ mL} \\
 0.125 & = & 0.5x \\
 0.25 & = & x
 \end{array}$$

x = 0.25 mL

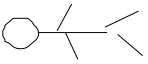

2. How much saline will you add to the medication?

$$10 \text{ mL} - 0.25 \text{ mL} = 9.8 \text{ mL of NS}$$

3. How many mL per minute will you give?

$$\begin{array}{rcl}
 0.125 \text{ mg.} : 10 \text{ mL} & = & 0.25 \text{ mg.} : x \text{ mL} \\
 2.5 & = & 0.125 x \\
 20 & = & x \\
 [20 \text{ mL per minute}] & &
 \end{array}$$

10 mL per 30 seconds

 .125 m g.	 10 ml
Policy .25 m g.	? m ls

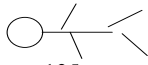
OR

$$\begin{array}{rcl}
 \text{Order} : \text{Total Volume} & = & \text{Policy} : x \text{ mls} \\
 .125 \text{ mg.} : 10 \text{ mL} & = & .25 \text{ m g.}
 \end{array}$$

4. How many minutes will it take to give the medicine?

$$\begin{array}{rcl}
 0.25 \text{ mg.} : 1 \text{ min} & = & 0.125 \text{ mg.} : x \text{ min} \\
 0.25 & = & 0.125
 \end{array}$$

x = 1/2 minute

Policy .25 m g.	Time 1 m in
 .125 m g.	x m in

OR

$$\begin{array}{rcl}
 \text{Policy} & & \text{Order} \\
 .25 \text{ m g.} : 1 \text{ m in} & = & .125 \text{ m g.} : x \text{ m in}
 \end{array}$$

DRUG CALCULATION FOR IV PUSH MEDICATIONS HANDOUT (Cont)

EXAMPLE #2: Drug Order: Administer digoxin 0.25 mg. IV
 Supply on Hand: 0.5 mg./2 mL
 Dilute in normal saline for a total volume of 5 mL and administer at a rate not to exceed 0.125 mg./minute

- How much medication will you withdraw from the ampule?

$$\begin{array}{rcl} 0.5 \text{ mg.} : 2 \text{ mL} & = & 0.25 \text{ mg.} : x \text{ mL} \\ 0.5x & = & 0.5 \end{array}$$

$x = 1 \text{ mL}$

- How much saline will you add to the medication?

$$5 \text{ mL} - 1 \text{ mL} =$$

4 mL of NS

- How many mL per minute will you give?

$$\begin{array}{rcl} 0.25 \text{ mg.} : 5 \text{ mL} & = & 0.125 \text{ mg.} : x \text{ mL} \\ 0.25x & = & 0.625 \end{array}$$

$x = 2.5 \text{ mL/min}$

- How many minutes will it take to give the medication?

$$\begin{array}{rcl} 0.125 \text{ mg.} : 1 \text{ minute} & = & 0.25 \text{ mg.} : x \text{ minutes} \\ 0.125x & = & 0.25 \end{array}$$

$x = 2 \text{ minutes}$

EXAMPLE #3: Drug Order: Give Versed® 6 mg. IV Push
 Supply on Hand: Versed® 10 mg./2 mL
 Dilute for a total of 10 mL and administer no faster than 2 mg./minute

- How much medication will you withdraw from the vial?
- How much saline will you add to the medication?
- How many mL per minute will you give?
- How many minutes will it take to give the medicine?

EXAMPLE #4: Drug Order: Dilantin® 200 mg. IV Push
 Supply on Hand: Dilantin® 100 mg./5 mL
 Directions: May give undiluted at a rate not to exceed 25 mg. per minute

- How much medication will you withdraw from the vial?
- How much saline will you add to the medication?
- How many mL per minute will you give?
- How many minutes will it take to give the medicine?

PSYCHOSOCIAL DEVELOPMENT HANDOUT

ERIKSON'S EIGHT STAGES OF MAN

Stage 1: Infancy – Birth to 1 Year

Conflict: Trust vs Mistrust (Hope vs. Dependency or Paranoia)	Needs maximum comfort with minimal uncertainty to trust himself/herself, others and the environment
Major Developmental Task	To develop a basic trust in the mothering figure and be able to generalize it to others.
Positive Outcome (Trust)	Infant's need for care, familiarity, comfort and nourishment are met. Consistency and responsiveness of parents essential for sense of trust to develop. When the parents present consistent, adequate, and nurturing care, the child develops basic trust and realizes that people are dependable and the world can be a safe place. The child develops a sense of hope and confidence; this is a belief that things will work out well in the end.
Negative Outcome (Mistrust)	Babies who are not securely attached to their mothers are less cooperative and more aggressive in their interactions with their mothers. As they grow older, they become less competent and sympathetic with peers. They also explore their environment with less enthusiasm and persistence. When the parents fail to provide consistent, adequate, and nurturing care, the child develops basic mistrust , resulting in depression, withdrawal, and maybe even paranoia.
Significant Event	Feeding, Bonding/Attachment

Stage 2: Toddler – 1 to 3 years

Conflict: Autonomy vs. Shame and Doubt (Will vs. Obsession/Impulse or Avoidance)	Works to master physical environment while maintaining self-esteem.
Major Developmental Task	To gain some self-control and independence within the environment.
Positive Outcome (Autonomy)	Child must take more responsibility for own feeding, toileting, and dressing. Parents must be reassuring yet avoid overprotection. If parents guide children gradually and firmly, praise and accept the child's attempts towards independence, autonomy develops. The result will be a sense of will which helps us accomplish and build self-esteem as children and adults.
Negative Outcome (Shame and Doubt)	If parents do not reassure, and promote confident skills, children may begin to feel shame; they may learn to doubt their abilities to manage the world on their own terms. Children who experience too much doubt at this stage will lack confidence in their own powers throughout life. If parents are too permissive, harsh, or demanding, the child can feel defeated, and experience extreme shame and doubt , and grow up to engage in neurotic attempts to regain feelings of control, power, and competency. This may take the form of obsessive behavior (if you follow all rules exactly then you will never be ashamed again). If the child is given no limits or guidance, the child can fail to gain any shame or doubt and be impulsive. Some impulsivity is good, as it causes us to question the outcomes of our actions, and consider others' well-being. This may also result in avoidance (if you never allow yourself to be close to others, they can never make you feel ashamed).
Significant Event	Toilet Training, Walking, Grasping, Learning Control

ERIKSON’S EIGHT STAGES OF MAN: (cont.)**Stage 3: Early Childhood – 3 to 6 years**

Conflict: Initiative vs. Guilt
(Purpose vs. Constricted or
Antisocial/Narcissistic)

Begins to initiate, not imitate, activities; develops conscience and sexual identity.

Major Developmental Task

To develop a sense of purpose and the ability to initiate and direct own activities.

The child becomes curious about people and role models adults. Erikson believed the child does attempt to possess the opposite sex parent and experiences rivalry toward the same sex parent; however, a true Oedipal Complex only develops in very severe cases.

Positive Outcome (Initiative)

The child must learn to accept without guilt, that there are certain things not allowed. Children must be guilt free when using imagination. They must be reassured that it is okay to play certain adult roles. If parents are understanding and supportive of a child’s efforts to show **initiative**, the child develops **purpose**, sets goals and acts in ways to reach these goals.

Negative Outcome (Guilt)

If children are not allowed to do things on their own, a sense of guilt may develop and they may come to believe that what they want to do is always wrong. If children are punished for attempts to show initiative, they are likely to develop a sense of **guilt**, which in excess can lead to **inhibition**. Too much purpose and no guilt can lead to **ruthlessness**. The person may achieve their goals without caring who they step on in the process.

Significant Event

Independence, Assertiveness, Initiative

Stage 4: School-Age Child – 6 to 12 years

Conflict: Industry vs. Inferiority
(Competency vs. Helplessness or
Shallowness)

Tries to develop a sense of self-worth by refining skills. The child must deal with demands to learn new skills or risk a sense of inferiority, failure and incompetence.

Major Developmental Task

To achieve a sense of self-confidence by learning, competing, performing successfully, and receiving recognition from significant others, peers, and acquaintances.

Occurs during Latency, but Erikson did not think this was a rest period.

Positive Outcome (Industry)

It is essential for the child at this stage to discover pleasure in being productive and the need to succeed. The child’s relationship with peers in school and the neighborhood become increasingly important. The child begins school and must tame imagination and impulses, and please others. If adults support the child’s efforts, a sense of **competence** develops.

Negative Outcome (Inferiority)

Difficulty with the child’s ability to move between the world at home and the world of peers can lead to feelings of inferiority. If caretakers do not support the child, feelings of inferiority are likely to develop. Too much **inferiority**, and **inertia** or helplessness occurs (underachievers). Too much competency and the child becomes an adult too fast, and develops either into a **Histrionic** or **Shallow** person.

Significant Event

School/Learning New Skills

ERIKSON’S EIGHT STAGES OF MAN: (cont.)**Stage 5: Adolescence – 12 to 20 years**

Conflict: Identity vs. Role Confusion (Fidelity vs. Identity Diffusion or Fanaticism)	Young adults attempt to develop identity and ideas about strengths, weaknesses, goals, occupations, sexual identity, and gender roles. Teens “try on” different identities, going through an identity crisis , and use their friends to reflect back to them who they are.
Major Developmental Task	To integrate the tasks mastered in the previous stages into a secure sense of self.
Positive Outcome (Identity)	Adolescents must make a conscious search for identity. This is built on the outcome and resolution to conflict in earlier stages. If they resolve this crisis, they develop fidelity ; “the ability to sustain loyalties freely pledged in spite of the inevitable contradictions of value systems” (can be friends with very different people).
Negative Outcome (Role Confusion)	If adolescent cannot make deliberate decisions and choices, especially about vocation, social relationships, and life in general, role confusion becomes a threat. If they fail to resolve the crisis, they develop identity diffusion ; their sense of self is unstable and threatened. They have too little identity and they may join cults or hate groups. If they have too much identity, they may show fanaticism .
Significant Event	Peer Relationships/Identify Role

Stage 6: Young Adulthood – 20-30 years

Conflict: Intimacy vs. Isolation (Love vs. Promiscuity or Exclusion)	Learns to make personal commitment to another as spouse, parent or partner.
Major Developmental Task	To form an intense, lasting relationship or a commitment to another person, or cause, institution, or creative effort.
Positive Outcome (Intimacy)	Young adult must develop intimate relationships with others. Not resolving this conflict leaves the young adult feeling isolated. The young adult must be willing to be open and committed to another individual. Intimacy is the ability to be close, loving, and vulnerable with romances and friends. It is based in part upon identity development, in that you have to know yourself to share yourself with others. The virtue gained here is love .
Negative Outcome (Isolation)	An individual may retreat into isolation if a sense of identity is not developed and will fear a committed relationship. Failure to develop intimacy can lead to promiscuity (getting too close too quick and not sustaining it), or exclusion (rejecting relationships and those who have them).
Significant Event	Love Relationships

ERIKSON’S EIGHT STAGES OF MAN: (cont.)**Stage 7: Middle Adulthood – 30 to 65 years**

Conflict: Generativity vs. Stagnation
(Care vs. Stagnation or Overextension)

Seeks satisfaction through productivity in career, family, and civic interests. Each adult must find some way to satisfy and support the next generation.

Major Developmental Task

To achieve the life goals established for oneself, while also considering the welfare of future generations.

Positive Outcome (Generativity)

To have and nurture children and/or become involved with future generations. If you have a strong sense of creativity, success, and of having “made a mark” you develop **generativity**, and are concerned with the next generation. This virtue is called **care**, and represents connection to generations to come, and a love given without expectations of a specific return.

Negative Outcome (Stagnation)

Individual must deal with issues they are concerned with or it can lead to stagnation in later life. Adults that do not feel they have “made a mark” develop a sense of **stagnation**, are self-absorbed, feel little connection to others, and generally offer little to society. Too much stagnation can lead to **rejection** and a failure to feel any sense of meaning (the unresolved mid-life crisis), and too much generativity leads to **overextension** (someone who has no time for themselves because they are so busy).

Significant Event

Freedom, time and ability to give to others.

Stage 8: Late Adulthood – 65 years to death

Conflict: Integrity vs. Despair
(Wisdom vs. Presumption or Disdain)

Reviews life accomplishments, deals with loss and preparation for death. The culmination is a sense of oneself as one is and of feeling fulfilled.

Major Developmental Task

To review one’s life and derive meaning from both positive and negative events, while achieving a positive sense of self-worth.

Positive Outcome (Integrity)

Adult feels a sense of fulfillment about life and accepts death as an unavoidable reality. This entails facing the ending of life, and accepting successes and failures, aging, and loss. People develop **ego integrity** and accept their lives if they succeed, and develop a sense of **wisdom**, a “detached concern with life itself in the face of death itself.”

Negative Outcome (Despair)

Individuals who are unable to obtain a feeling of fulfillment and completeness will despair and fear death. It’s too late to change their lives. Too much wisdom leads to **presumption**, too much despair leads to a **disdain** for life.

Significant Event

Reflection on and acceptance of one’s life.

REFERENCE:

Townsend, M.C. (5th ed.). (2011). *Essentials of psychiatric mental health nursing*. Philadelphia: F.A. Davis.

THERAPEUTIC COMMUNICATION TECHNIQUES

- **Offering Self:** Make yourself available to the patient. (“I’ll stay with you if you would like to talk.”)
- **Open-ended Questions:** Ask neutral questions, using when, where, how and what, that encourage the patient to discuss concerns. (“What makes the pain worse?”)
- **Broad Openings:** Allow the patient to take the initiative in introducing the topic using a specific open-ended question. (“What would you like to discuss?”)
- **Offering General Leads:** General leads let the patient know you are listening, engaged in the conversation and prompt the patient to continue. (“Go on...”, “I see.”)
- **Verbalizing the Implied:** Put into words what the patient has only implied or indirectly stated. (Pt: “It’s a waste of time to talk to my doctor.” Nurse: “Are you feeling that no one understands?”)
- **Placing an Event in Time or Sequence:** Clarify the relationship of events in time to view them in perspective. (“When did your symptoms become worse in relationship to beginning your exercise program?”)
- **Encouraging Comparison:** Ask the patient to compare similarities and differences in ideas, experiences, or interpersonal relationships. (“Tell me how your blood sugar levels compared to when you were on the diet and when you were not.”)
- **Opening Remarks:** Use general statements based on observations and assessments of the patient to initiate discussion. (“I noticed that you seemed sad after speaking with the doctor.”)
- **Restatement:** Repeat to the patient the various content of his or her conversation typically using the same words. Restatement communicates that the nurse is listening but it also communicates that the nurse is playing an active role. Pick out the primary thought or feeling to restate. Overuse of this technique produces a “mimic effect”. (Pt: “I’m worried about my potential disability.” Nurse: “You’re worried about your ability to function.”)

Therapeutic Communication Techniques (Cont)

- **Reflection:** Identify the various emotional themes in a conversation and direct these back to the patient. (Pt: “My husband may look at me differently after the surgery.” Nurse: “You’re anxious about how this surgery may affect your relationship with your husband.”)

Examples of Reflection - Connect Feelings to Content

Pt: “I hate this diet. You are telling me I can’t eat all the sweets I want.”

(Feeling – Anger) Nurse: “You’re angry that your disease is limiting your choices and behavior.”

Pt: “The doctor said that I won’t be able to have children.”

(Feeling – Disappointment) Nurse: “It sounds like not being able to conceive is a disappointment for you.”

Pt: “I can’t believe that I reacted so strongly when the night nurse woke me up to take my temperature.”

(Feeling – Embarrassment) Nurse: “Sounds like you are embarrassed by your behavior.”

Pt: “I was able to list five other behaviors to use when I think about dealing with my problems with alcohol.”

(Feeling – Pleased) Nurse: “You seem really pleased that you could accomplish that task.”

- **Focusing:** Guide the patient to narrow in on key concerns. Can be termed “Exploring” when delving further into a subject, idea, experience or relationship without probing. (“You’ve told me about your support system; can we talk about who will assist you when you first get home from the hospital?”)
- **Seeking Clarification:** Assist the patient to put into words unclear thoughts or feelings. Seeking clarification decreases the potential for the nurse to guess and/or assume incorrectly. The nurse can clarify the patient’s words or can clarify assumptions about the patient’s non-verbal behaviors. (“Help me to understand your expectations of the treatment.”)

Therapeutic Communication Techniques (Cont)

- **Giving Information:** Share with the patient relevant information about his or her healthcare and well being. Provide patient education. (“I’m going to review the side effects of this new medication.”)
- **Looking at Alternatives:** Help the patient see options and participate in the decision-making process. (“How do you think you can best stay on your diabetic diet?”)
- **Silence:** Allow for a pause in the conversation that permits the nurse and patient time to think about what has taken place. Non-verbal behaviors can communicate caring during silence. Silence can also focus the patient and call attention to what the patient has just verbalized. Time is bought to allow the patient to reevaluate or absorb the impact of a verbalization. Silence is also used when words are not an adequate response. (No verbalization)
- **Summarizing:** Highlight the importance of a conversation by condensing what was said. Can be used to evaluate learning. Summarizing represents a set of feelings that might have been communicated over a period of minutes. It is a paraphrase that pulls together several feelings. (“We have reviewed the side effects of this medication; how to take it, and how to store it.”)

REFERENCE:

Townsend, M.C. (5th ed.). (2011). *Essentials of psychiatric mental health nursing*. Philadelphia: F.A. Davis.

NON-THERAPEUTIC COMMUNICATION BLOCKS

- **False Reassurance:** Give reassurance that is not based on the real situation, minimizing the patient's concerns. ("You've got nothing to worry about.")
- **Giving Advice:** Tell the patient what to do. Focus exclusively on the nurse's experience and opinions. ("Why don't you rely on your family for financial support?")
- **Changing the Subject:** Introduce an unrelated topic, with the nurse taking over the direction of the discussion. (Pt: "How long do people with this disease usually live?" Nurse: "Didn't you say your family was coming to visit?")
- **Being Moralistic (Approving or Disapproving):** See a situation as good or bad, right or wrong. ("It is great that you made that decision.")
- **Requesting an Explanation:** Ask the patient "why" they have certain thoughts, feelings, or behaviors. ("Why did you stop taking your blood pressure medication?")

This sets up an unrealistic expectation of patients (rarely are patients aware of the reasons for their actions) and often puts patients on the defensive.

- **Belittling Expressed Feelings:** Make statements that diminish the patient's feelings, fail to recognize the patient's discomfort and ignore the uniqueness of the patient's situation. ("All post-operative patients experience some degree of pain.")
- **Making Stereotyped or Superficial Comments:** Offer meaningless clichés or trite expressions. ("Time will heal." "It all happened for a reason.")
- **Closed-ended Questions:** Ask questions that can be answered with one word (like "yes" or "no") and limit the patient's responses. ("Are you in pain?")

REFERENCE:

Townsend, M.C. (5th ed.). (2011). *Essentials of psychiatric mental health nursing*. Philadelphia: F.A. Davis.

DEFENSE MECHANISMS

Defense Mechanisms	Definition	Example	Possible Meaning
Rationalization	Offering a socially acceptable and more or less logical explanation for an act or decision actually produced by unconscious factors.	I'm going to die of something anyway, so why quit smoking?	I am addicted to smoking and am unable to quit.
Compensation	Overemphasizing a characteristic to make up for a real or imagined failure or handicap.	I don't have time for dates, I'm too busy with my ceramics.	No one likes me enough to ask me out, but I can still feel important by excelling in art.
Displacement	Shifting the emotional component from one object, idea, or situation to another.	How many times have I told you to keep that bike out of the driveway!	The boss was really upset with me today.
Projection	Attributing one's own thoughts or impulses to another as if they originated in the other person.	It's all your fault that I did not win the contest.	I cannot accept that I am not the best, so my loss must be your fault.
Repression	The involuntary exclusion of emotionally painful material from awareness.	I can't seem to remember my supervisor's name.	I find my supervisor attractive. This feeling is unacceptable to me so my supervisor is blocked from my conscious level of thought.
Conversion Reaction	Going to the opposite extreme to avoid carrying out an unacceptable or inappropriate impulse.	I am blind, I just suddenly went blind. The doctors can't find out why.	No one will know why, either. What I saw is so horrible I cannot even think about it.
Regression	A return to an earlier, more primitive form of behavior.	Since Jenny has been sick, she constantly cries for her mother.	When Jenny was younger, things were more secure. She had her parents to take care of her and help when things went wrong.
Identification	Unconsciously modeling one's self after another person or group.	I have decided which shirt I want you to buy me. It's that one.	That shirt is just like Uncle Joe's. I really admire Uncle Joe and I want to be just like him.

DEFENSE MECHANISMS (Cont)

Defense Mechanisms	Definition	Example	Possible Meaning
Suppression	The intentional exclusion of material from consciousness.	I'm really sorry I forgot. Now that you mention it, I do recall.	I wish she hadn't reminded me. I really didn't want to remember that.
Sublimation	Diverting the force of an instinctual drive into other, usually constructive.	I really love children, but I'm not ready for marriage. I will get a job working with children in a daycare center.	Working with children in a daycare center protects my ego because it is a more acceptable way for me to fulfill my desire of working with children than having my own children without being married.
Denial	An attempt is made by persons to screen or ignore unacceptable realities by refusing to acknowledge them.	A woman, though told her father has metastatic cancer, continues to plan a family reunion 18 months in advance.	Used as a temporary insulation from the full impact of a traumatic situation.
Intellectualization	A mechanism by which an emotional response that normally would accompany an uncomfortable or painful incident is evaded by the use of rational explanations that remove from the incident any personal significance and personal feelings.	The hurt over a parent's sudden death is reduced by saying "They wouldn't have wanted to live disabled".	Protects self-image from hurts and traumatic events.
Reaction Formation	A mechanism that allows persons to act exactly opposite to the way they feel.	An executive resents his bosses for calling in a consulting firm to make recommendations for changes in his department but verbalizes complete support of the idea and its exceedingly polite and cooperative.	Aids in reinforcing repression by allowing feelings to be acted out in a more acceptable way.

DEFENSE MECHANISMS (Cont)

Defense Mechanisms	Definition	Example	Possible Meaning
Introjection	Form of identification that allows for the acceptance of others' norms and values into one's self, even when contrary to one's previous assumptions.	A seven year-old-boy tells his little sister, "Don't talk to strangers." He has introjected this value into his self from the instructions of parents and teachers.	Used to help people avoid social retaliation and punishment. Particularly important for child's development of superego.
Undoing	An action or words designed to annul some disapproved thoughts, impulses, or acts in which the person relieves guilt by making reparation.	A father spanks his child and the next evening brings home a present for him. A teacher spent only a little time writing an exam and then curved it beyond what was usual.	Allows persons to appease guilty feelings and atone for mistakes.
Isolation	Splitting off of emotional components of a thought, which may be temporary or long term.	A second year medical student dissects a cadaver for her anatomy course without being disturbed by thoughts of death.	Allows student to perform task and not be overcome by feelings.

REFERENCE:

Townsend, M.C. (5th ed.). (2011). *Essentials of psychiatric mental health nursing*. Philadelphia: F.A. Davis.

Reviewed: May 2004
 May 2006
 May 2010

SYMPTOM ANALYSIS

When assessing a patient with a symptom or health concern, the nurse uses a symptom analysis to help the patient describe the problem fully. A method for obtaining a systematic and thorough assessment, the symptom analysis is easy to remember with the mnemonic device, PQRST. The following questions are preceded by **O**, onset, and serve as a guide to effective symptom analysis.

P	Q	R	S	T
<p>PROVOCATIVE OR PALLIATIVE What causes the symptom? What makes it better or worse?</p> <p>*First occurrence. What were you doing when you first experienced or noticed the symptom? What seems to trigger it: stress? position? certain activities? arguments? (For a physical symptom such as a discharge: What seems to cause it or make it worse? For a psychological symptom: Does the depression occur when you feel rejected?) What relieves the symptom: changing diet? changing position? taking medication? being active? *Aggravation. What makes the symptoms worse?</p>	<p>QUALITY OR QUANTITY How does the symptom feel, look or sound? How much of it are you experiencing now?</p> <p>*Quality. How would you describe the symptom – how it feels, looks, or sounds? *Quantity. How much are you experiencing now? Is it so much that it prevents you from performing any activities? Is it more or less than you experienced at any other time?</p>	<p>REGION OR RADIATION Where is the symptom located? Does it spread?</p> <p>*Region. Where does the symptom occur? *Radiation. In the case of pain, does it travel down your back or arms, up your neck, or down your legs?</p>	<p>SEVERITY SCALE How does the symptom rate on a severity scale of 1 to 10, with 10 being the most extreme?</p> <p>*Severity. How bad is the symptom at its worst? Does it force you to lie down, sit down, or slow down? *Course. Does the symptom seem to be getting better, getting worse, or staying about the same?</p>	<p>TIMING When did the symptom begin? How often does it occur? Is it sudden or gradual?</p> <p>*Onset. On what date did the symptom first occur? What time did it begin? *Type of onset. How did the symptom start: suddenly? gradually? *Frequency. How often do you experience the symptom: hourly? daily? weekly? monthly? When do you usually experience it: during the day? at night? in the early morning? Does it awaken you? Does it occur before, during, or after meals? Does it occur seasonally. *Duration. How long does an episode of the symptom last?</p>

REFERENCES:

Potter, P. A. & Perry, A.G. (6th ed.) (2007). *Basic nursing: Essentials for practice*. St. Louis: Mosby Elsevier.
 Montgomery, J., & Mitty, E., Resident condition change: Should I call 911? *Geriatric Nursing*, 29(1), 15-26.
 doi: 10.1016/j.gerinurse, 2007.11.009.

Reviewed: May 2004
 May 2006

DOCUMENTING PHYSICAL ASSESSMENT "HEAD TO TOE"

Below are various components one would identify and evaluate during a systematic physical assessment. Within each system various data have been identified using the appropriate terminology for documentation. Variations have been listed in parentheses.

PSYCHOSOCIAL

Patient's mental health, pre-existing mental illness (depression – signs/symptoms), knowledge and understanding of disease, patient's support systems: family and financial, plans for discharge.

NEUROLOGICAL

Awake, alert, oriented to person, place, and time (**sleepy, but easily aroused, oriented to person, not place or time**). Moves all extremities (**moves only right arm and leg, left arm and leg flaccid, MAE but no purposeful movement present**). Follows commands appropriately (**does not follow commands**). Equally strong bilateral hand grasp and foot press (**hand grasp weaker on the right than the left**). Pupils equal, round, react to light briskly and 2 mm (**pupils unequal, react sluggishly or nonreactive**). Speaks clearly and coherently (**speech is slurred, incoherent, confused, cooperative, appropriate**). Differentiates various sensations appropriately (**pinprick, squeezing, pinching, pressure**).

CARDIOVASCULAR

S₁S₂ (**murmur, rub, gallop, or click**). Apical pulse regular (**irregular, irregularly irregular, distant**). Palpable, peripheral pulses x4 (**weak, thready, strong, bounding absent, right pedal strong and palpable, left pedal weak and thready or absent**). Radial pulses equally strong, 2+. Capillary refill brisk or less than 3 seconds (**capillary refill sluggish or greater than 3 seconds, nailbeds pink, dusky, or cyanotic**). Edema present (**both hands, lower legs, ankles, feet etc., pitting or non-pitting generalized**). Skin (**warm, dry, cool, clammy, diaphoretic, pale, pink, flushed**). JVD (**present or absent**).

RESPIRATORY

Respirations even and unlabored (**labored, irregular, use of accessory muscles present, shortness of breath or dyspnea on exertion present**). Equal, bilateral chest expansion with breath sounds present in all lobes bilaterally (**chest expansion unequal, breath sounds diminished in the lower lobes or bases**). Breath sounds clear in all lobes anteriorly and posteriorly (**crackles, wheezes, rhonchi and/or congestion present - where?**). Mucous membranes pink (**dusky, pale**). Coughing non-productively (**dry, hacking cough present, cough productive of thick pale yellow sputum**). Oxygen saturation on Room Air or O₂ (**2 L/NC, 100% NRB mask**).

DOCUMENTING PHYSICAL ASSESSMENT: "HEAD TO TOE" (Cont)

GASTROINTESTINAL

Abdomen soft, non-tender to palpation (**abdomen tender in the RUQ, abdominal distention present, semi-firm or firm**). Bowel sounds present x4 (**BS present only in the RUQ, absent in all other quadrants, BS active, hyper-hypoactive**). Last BM. Tolerating regular diet well (**NGT via right nare with Ensure TF full strength infusing at 50 mL/hr**).

GENITOURINARY

Pertaining to the male or female genitals, menstruation, menopause. Voiding clear, yellow urine (**urine is cloudy, mucus or sediment is present, amber, straw, bloody, or tea colored**). Denies burning, frequency, urgency, hesitancy with urination (**or one or several of these are present**). No bladder distention is palpable (**bladder distention is palpable 3 finger breadths above the symphysis pubis**).

MUSCULOSKELETAL

Moves all extremities with full range-of-motion (**range-of-motion is limited in right arm, contracture of the right leg present, fine motor movement absent, gross motor movement intact**). Strength is adequate in all extremities (**equal, bilaterally strong hand grasp, ambulates with assistance of one/two to the BR and back to bed**).

INTEGUMENTARY

Good skin turgor (**fragile, poor**). No redness, edema, discoloration, irritation, or breakdown present (**4 cm x 2 cm reddened area present on sacrum, blue-black areas of discoloration present on both arms**). Incision lines dry, intact, without redness, edema, or exudate (**incision line red, edematous and draining foul-smelling yellow drainage**).

REFERENCE:

Bickley, L.S. (10th ed.). (2008). *Bates' guide to physical examination and history taking*. Philadelphia: Lippincott Williams & Wilkins.

Reviewed: May 2004
May 2006
May 2010

THE NURSING PROCESS

Definition: The nursing process is a series of planned steps and actions directed toward assisting the patient to meet self-care needs. It is a systematic *problem solving approach* to nursing practice.

STEPS OF THE NURSING PROCESS

Assessment
Diagnosis
Outcome Identification
Planning
Implementation
Evaluation

ASSESSMENT

Assessment involves the collection of valid data about a specific patient. Data is **uninterpreted** materials, facts, and clinical observations collected during an assessment activity.

*****Very important to avoid judgments in this step*****

During the assessment process, the nurse completes the following specific activities:

- A. Collecting Data:** Gathering information **about the patient**
- Data Collection:** Begins when an individual enters the health care system and continues as long as there is a need for health care.

Sources for Data Collection:

- i. **Primary Sources:**
 - a) **Interview:** Collection of information by interviewing patient/family/significant other
 - b) **Primary source = Patient** (if alert) gather information related to patient's past medical history and current complaint.
 - c) **Physical Examination**
- ii. **Secondary Sources:**
 - a. Diagnostic Studies: Lab result – x-rays, urinalysis, blood work etc.
 - b. Nursing Records
 - c. Medical Records
 - d. Verbal and Written Consultations
 - e. Relevant Literature

Assessment data is therefore categorized as:

1. Subjective Data: Patient Statements

Examples:

“My head is throbbing.”

“My stomach is burning.”

“I hurt all over.”

“I feel short of breath.”

“I feel sad.”

“My legs feel weak.”

2. Objective Data:

a) Observation Data:

Nurse can see by observation or inspection cyanosis of skin

Nurse can feel lump in breast

Nurse can hear bowel sounds

b) Measurable Data:

Nurse can count or measure-vital signs

Height/weight

of feet patient ambulated

of cm/s of edema of calf, arm etc.

of cm/s of incision, cut, abrasion etc.

Can estimate # of mL/s of vomitus, sputum, bleeding

etc.

Note: Secondary sources can also be used for Objective Data:

Data Validation:

Does the data that you have collected from a specific patient reflect **NORMAL** or **ABNORMAL** findings or standards? Does the **Objective** data support the **Subjective** data? Was **data** collected **accurately**?

The nurse also compares a patient’s subjective and objective data, verifying that the objective data support the subjective data.

For example: *“I feel nauseated”*

Patient vomits approx. 200 mL/s of yellow/green fluid

“I am in extreme pain”

Patient lying quietly in bed.

DIAGNOSIS

DIAGNOSING: After the data is collected, the nurse and health team members sort through the data and cluster (organize, group) the data to portray a picture of the patient's strengths and problems. A cluster forms a composite (the whole picture) of similar pieces of data and represents a sequence of behavior over time rather than isolated incidents.

We will utilize the following Functional Health Patterns to group data:

1. Psychosocial Patterns
2. Developmental Stage
3. Respiratory Function
4. Cardiovascular, Circulatory, and Hematologic Function
5. Fluid and Electrolyte Balance
6. Immunologic Function
7. Integumentary Function
8. Neurological Function
9. Sensorineural Function
10. Musculoskeletal Function
11. Metabolic and Endocrine Function
12. Digestive Function/Gastrointestinal Function
13. Urinary/Renal Function
14. Reproductive Function
15. Pharmacology

When determining an appropriate nursing diagnosis, first compare data with the norms, then identify the inter-relationship of the data (cues & clusters).

1. Is what the patient accepts as "normal" detrimental to his health?
2. What is "normal" for an individual who is this patient's age and physical stature?
3. What is "normal" for an individual who has this patient's type of beliefs or culture?
4. What is "normal" for a patient with this disease process?
5. What is "normal" for patient's occupation, socioeconomic level, and lifestyle?
6. Are there too many "slightly abnormal" factors when you cluster the data? → may signify an overall picture of an abnormality.

There are several categories of nursing diagnoses. The two categories discussed here are:

1. **Actual Nursing Diagnoses:** Describes human responses to health conditions that actually exist at the present time.

Supported by **DEFINING CHARACTERISTICS**, subjective or objective.

Clinical manifestations, signs, and symptoms

2. **Risk Nursing Diagnoses:** Describes human responses to health conditions that may develop in vulnerable individuals.

Supported by **RISK FACTORS** that contribute to increased vulnerability.

Note: There are other nursing diagnosis categories: Possible & Wellness. Please utilize references noted on p. B-36.

Components of an ACTUAL Nursing Diagnosis:

1. **Problem:** NANDA diagnostic label

Definition of Problem Label:

- provide the meaning of NANDA labels
- **assist** the nurse in selecting the appropriate label
- **NOT** written in the Nursing Diagnosis

Example: Label: Impaired Skin Integrity

Definition: A state in which the individual experiences damage to the skin

2. **Related Factors or Etiology:** Conditions or circumstances that contribute to the development of nursing diagnoses

- **Etiology or cause of the Problem**
- **Causes may differ from one patient to another → all causes are not the same**
- The phrase **Related To – RT** connects the **Problem** with the cause
- Example of same Problem with different related factors (causes)

Label: Impaired Skin Integrity

RT: Immobility

Excessive secretions from tracheostomy

Excoriated skin fold

Notes about ‘related to’ factors:

1. **Please resist your temptation to document a medical or surgical diagnosis for your RT = out of the realm of nursing practice**
2. **Related factors MUST be something that a NURSE can help to improve**
3. **Also be real careful not to implicate the nurse with related factors**
 Ex: Impaired Skin Integrity RT patient not being turned →
 Implicates Nurse → poor nursing care

3. **Defining Characteristics:** Evidence to support the **Problem**

- signs/symptoms or cues/inferences that, when clustered, provide evidence that a problem exists!!!
- signs (objective data) or symptoms (subjective data)
- Every Actual Nursing Diagnosis **MUST** be validated by defining characteristics.
- The phrase **“as evidenced by”** is used to connect **Related Factors** to the defining characteristics.
- The defining characteristics must provide sufficient evidence to support the problem.

Ex. CORRECT:

Problem:	Impaired Skin Integrity
Related Factors:	RT immobility secondary to stroke
Defining Characteristics :	as evidence by 2 cm lesion on sacral area

2. **Components of a Risk Nursing Diagnosis:**

- **Risk Nursing Diagnoses** describe human responses (Problems) that **MAY DEVELOP – because the patient has risk factors that contribute to increased vulnerability**
- High Risk Nursing Diagnoses **DO NOT HAVE** Defining Characteristics
- If defining characteristics were present = Actual Nursing Diagnosis
- EX. High Risk for Impaired Skin Integrity RT immobility

OUTCOME IDENTIFICATION AND PLANNING

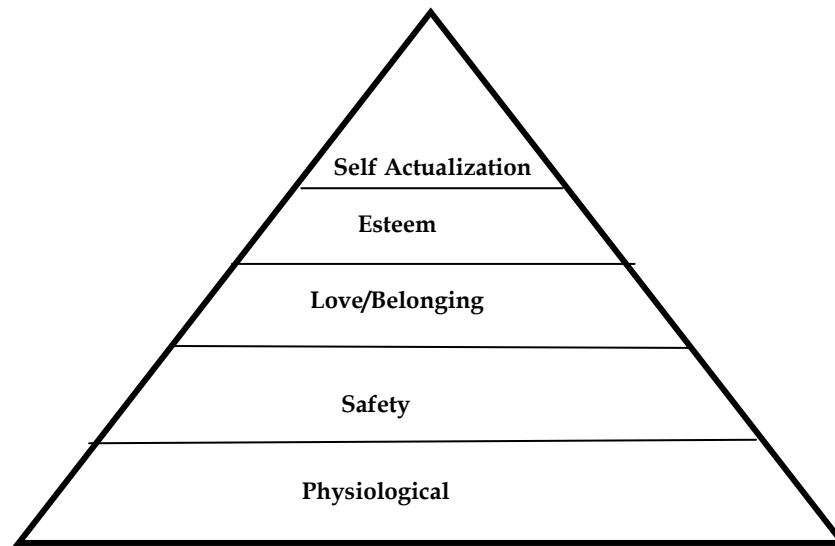
Components of Outcome Identification and Planning:

1. Priority Ranking of Nursing Diagnoses (Can also be a part of analysis)
2. Establishing measurable outcomes
3. Specifying nursing interventions

Priority Ranking of Nursing Diagnoses
 As a nurse, ask the following questions.

- “What is the urgency of treating each patient problem?”
- “Which patient problems should be resolved first?”
- “When are patient problems referred to other health care members?”

Establishing the ranking of nursing diagnoses is simplified by the use of Maslow's Hierarchy of Needs:



Nursing Diagnosis prioritization:

- | | |
|--|---------------------|
| 1. = Life Threatening (Ineffective Airway) | 1. Highway Priority |
| 2. = Health Threatening (Impaired Skin) | 2. Medium Priority |
| 3. = Normal Developmental Needs (Financial need) | 3. Low Priority |

For Example: It is more important to maintain an open airway than change a patient's position to prevent skin breakdown.

Derive MEASURABLE Outcomes: from each nursing diagnosis

OUTCOMES→: Realistic, measurable **goals or objectives** that the patient is expected to achieve in order to resolve each Nursing Diagnosis on the priority problem list.

1. Key Concept: Outcomes for each nursing diagnosis should reflect:
2. For Actual Nursing Diagnoses:
 - Resolution of the Problem
 - Evidence of Progress toward problem resolution
3. For High Risk Nursing Diagnoses:
 - Maintenance of Present Health
4. Outcomes are also referred to as:
 - Goals**
 - Objectives**
 - Expected Outcomes**
 - Desired Patient Outcomes**
 - Outcome Criteria**
5. Note: We use "expected outcome" more often. A "goal" is more broad, and expected outcomes are more specific under the goal.

6. Outcome Statement: Must Include:

- | | |
|---------------------|----------------|
| 1. Date Written | 4. Conditions |
| 2. Subject | 5. Criteria |
| 3. Measurable Verbs | 6. Target Date |

*Subject: A noun:
signals WHO is to achieve the outcome = patient or part of the patient
Usually this is the patient (identified by initials)
If patient can not perform the desired activity → subject can be ie., Family, S.O., etc.

Ex : **A.B. will.....**
 A.B.'s pulse
 A.B.'s urinary output
 A.B.'s pressure ulcer

*Measurable verb: Indicate the patient centered behaviors
 The Action that the subject will take

Write in future tense → A. B. **will ambulate**
use only verbs that you can measure/observe

ambulate	cough	drink	eat	describe
discuss	state	expectorate	perform	identify

Avoid verbs that are not measurable/observable

learn	understand	try	feel	accept
increased	improved	adequate	good	normal

*Condition: Circumstances, if important, under which the patient behavior may be performed. It explains: what, where, when, or how.

All goals will not need a condition → if the condition is important
-Put it in the goal statement - if not, leave it out.

Ex.: with the help of a walker
 independently
 with the help of family

*Criteria of Desired Performance: The level at which the patient will **perform a certain behavior**.

i.e. speed, accuracy, distance, and quality

Ex.:

- 10 feet
- Accurately
- Using proper technique

*Target Date: Specific time period desired to reach outcome/goal

- By end of shift
- By 2:00 pm today

Formula for Writing A Goal:

Subject + Verb + Condition + Criteria + Date

A.B. Will Ambulate Independently 10 feet by tonight

Long-Term Goals vs. Short-Term Goals

Long-Term Goals:

- Long-term goals are goals that cover a longer time span.
- Used a lot in extended care.

Impaired Skin Integrity:

1. A.B. will demonstrate intact skin by discharge.
2. A.B. will demonstrate a decrease in size of pressure ulcer by 0.5 cm by discharge.
3. A.B. pressure ulcer will not increase in size throughout hospitalization.
4. A.B. will maintain intact skin throughout hospitalization.

Short Term Goals:

Measurable expected out comes

Stepping stones used to meet the Long-Term goal

Relate to the cause of the Problem

aim = improve/eliminate etiology/cause

1 S.T.G. will not alone achieve problem resolution***

A.B. will demonstrate an increase in range of motion from 45 degrees to 90 degrees by tonight.

Nursing Interventions:

Should be specific for this patient and should relate to the expected outcome

1. Encourage slow, deep breathing
2. Evaluate pain – Be specific
3. Relieve pain by.....

Now → these nursing interventions should

- eliminate or reduce Related Factors.
- ultimately lead to Problem Resolution or Problem Reduction or Problem Prevention.

Type of Nursing Interventions:

Independent: those activities that nurses are licensed to initiate on the basis of their knowledge and skills.

Interdependent or Collaborative: those activities performed by the nurse under physician's orders

EVALUATION

- Did patient achieve the expected outcome/goal?
- Does the plan need to be modified?
- Does the plan need to be discontinued?
- Were the interventions appropriate?

REFERENCES:

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