Philadelphia University
Faculty of Nursing
2nd Semester 2020/2021

Course Title: Adult Health Nursing 1/ Clinical	**Course code: 0911216**
Course Level: 2nd year	**Course prerequisite(s) and/or co requisite(0911219/Co-request with adult health nur**
Clinical day date: : Sunday 8:00am-4:00pm	**Credit hours: 3 credit hours**

Academic Staff Specifics

Name	**Office number and Location**	**Office Hours**	**E-mail Address**
Ms. Hayat Abu-Shaikha	Office 501	**As scheduled**	habushaikha@philadelphia.edu.jo

Course Description:

This course is designed to provide nursing students with the skills required to care competently and safely for a wide variety of patients in different specialty areas. Care of adult patients with specific and complex problems will be studied in the lab due to the limited access to clinical areas in the hospital during COVID 19 pandemic. Nursing process as a mean of maintaining physiological, psychological and socio-cultural integrity is applied. Critical analysis of virtual patient's data and responses to nursing interventions are emphasized, communication skills, critical thinking, decision making, psychomotor skills, teaching-learning principles, keeping updated with current literature, and moral principles are emphasized.

Course Objectives:

At the end of this module, student will be able to:

- Provide competent and safe nursing care to patients as per the case scenarios or the Vsim program cases in the following areas: Medical ward, Surgical ward, Day case Surgery, Recovery room, Orthopedic and Hemodialysis
- Demonstrate nursing process according to the specific virtual patient.
- Identify complications of disease process or health problem either potential or collaborative.
- Demonstrate teaching abilities.
- Implement basic concepts from allied sciences and nursing in assisting virtual patients to meet their needs.
- Demonstrate ability to function within a team.
- Demonstrate responsibility for their nursing interventions.
- Apply ethical standards of the nursing profession in the care of adult clients.
- Organize time and resources in providing nursing care.

Course Components:

- Construct a continually modified nursing care plan based on the medical patients changing conditions: respiratory, gastro-intestinal tract, hematologic, muscle-skeletal, arterial and venous, renal, endocrine and metabolic disorders.
- Perform physical assessment using inspection, palpation, percussion and auscultation as per case scenario.
- Identify nursing diagnosis according to virtual patients' condition and priority.
- Implement nursing care plan and specified nursing interventions
- Implement nursing evaluation to each nursing care plan.
- Assess and record vital signs.
- Assist the virtual patient undergoing diagnostic procedures: ECG, paracentesis, thoracentesis, blood and urine specimen.
- Provide nursing intervention according to the individualized patient's needs.
- Provide basic comfort measures: positioning and bed making, turning, lifting, ambulation, elimination, hygienic measures, safe environment in the lab
- Perform therapeutic procedures according to patient's needs: pressure ulcer care, nasogastric tube feeding, suctioning, oxygen therapy, tube irrigation, catheter care, rehabilitative measures and precaution: chest physiotherapy, exercises, positioning with rehabilitative devices.
- Administer oral and parenteral medication following the ten rights of medication.
- Provide special care for immobile patients
- Prepare a balanced plan for fluid & nutritional intake.
- Record and or report essential data related to patients and nursing intervention.

Text Book(s) and Supporting Materials: 1

1- Brunner and Suddarth's Textbook of Medical-Surgical Nursing byJanice L Hinkle and Kerry H Cheever. Publisher: Lippincott Williams & Wilkins. 13th edition 2018

2- Title: Nursing procedures
Author(s): Baranoski et al 2006
Publisher: Lippincott Williamas and Willkins, 6thed.
ISBN**: 1-58255-281-9**

3- Clincal Nursing skills and techniques, 5th edition. Perry Potter.

4- Mosby's Pharmacology for Nurses
5- Nursing diagnosis application to clinical practice. 14th edition, by Lynda Juall Carpenito.
Publisher: Lippincott Williamas and Willkins.

- In addition to the above, the students will be provided with handouts by the lecturer.

Teaching Methods:

1. Clinical lab experience
2. Nursing procedures: ECG, blood sample, medication administration
3. Case study and care plans
4. Case presentations and group discussions
5. Practice with medication

Learning Outcomes (ILOS): At the end of this course the student will be able to:

1 Knowledge and understanding

1.1 Obtain a concise virtual patient history

1.2 Obtain and label routine specimen.

1.3 Prepare a balanced plan for fluid & nutritional intake.

2 Cognitive skills (thinking and analysis).

2.1 Interpret results of diagnostic procedures and laboratory findings

2.2 Work according to priorities

2.3 Recognize the need to view client as a holistic being

3 **Professional practical skills**

3.3 Prepare and Provide health teaching

3.4 Provide psychological care as per the case scenarios

4 Transferable Skills

4.1 Provide special care for patients with different medical and surgical problems.

4.2 Value the importance of utilizing communication skills in providing quality nursing care.

4.3 Greater confidence and the attitudes necessary for independent patient- nursing care

4.4 Self, time and care management skills

4.5 team work skills

4.6 Communication and presentation skills

4.7 Critical, applied and reflective thinking

Course Evaluation

Modes of Assessment:

Modes of Assessment:	Score
1.Clinical Performance Evaluation: (Lab) Two Evaluations/ semester	10
2. Procedures exam	20
4. Case Presentation: (See Appendix C)	10
5. Quiz 2	20
6. Focused Nursing care plan 1 /semester (See Appendix D)	10
Total	**70**
Final clinical exam	20
Final clinical written exam	10
Total	**100**

Attendance Policy:

Absence from lectures and/or tutorials shall not exceed 15%. Students who exceed the 15% limit without a medical or emergency excuse acceptable to and approved by the Dean of the relevant college/faculty shall not be allowed to take the final examination and shall receive a mark of zero for the course. If the excuse is approved by the Dean, the student shall be considered to have withdrawn from the course.

Documentation and Academic Honesty

Submit your homework covered with a sheet containing your name, number, course title and number, and type and number of the home work (e.g. tutorial, assignment, and project).

Any completed homework must be handed in to my or Ms. Ruba office (according to your group) by 15:00 on the due date. After the deadline "zero" will be awarded. You must keep a duplicate copy of your work because it may be needed while the original is being marked.

- **Protection by Copyright**

1. Coursework, laboratory exercises, reports, and essays submitted for assessment must be your own work, unless in the case of group projects a joint effort is expected and is indicated as such.
2. Use of quotations or data from the work of others is entirely acceptable, and is often very valuable provided that the source of the quotation or data is given. Failure to provide a source or put quotation marks around material that is taken from elsewhere gives the appearance that the comments are ostensibly your own. When quoting word-for-word from the work of another person quotation marks or indenting (setting the quotation in from the margin) must be used and the source of the quoted material must be acknowledged.

3. Sources of quotations used should be listed in full in a bibliography at the end of your piece of work.

Avoiding Plagiarism.

1. Unacknowledged direct copying from the work of another person, or the close paraphrasing of somebody else's work, is called plagiarism and is a serious offence, equated with cheating in examinations. This applies to copying both from other students' work and from published sources such as books, reports or journal articles.
2. Paraphrasing, when the original statement is still identifiable and has no acknowledgement, is plagiarism. A close paraphrase of another person's work must have an acknowledgement to the source. It is not acceptable for you to put together unacknowledged passages from the same or from different sources linking these together with a few words or sentences of your own and changing a few words from the original text: this is regarded as over-dependence on other sources, which is a form of plagiarism.
3. Direct quotations from an earlier piece of your own work, if not attributed, suggest that your work is original, when in fact it is not. The direct copying of one's own writings qualifies as plagiarism if the fact that the work has been or is to be presented elsewhere is not acknowledged.
4. Plagiarism is a serious offence and will always result in imposition of a penalty. In deciding upon the penalty the Department will take into account factors such as the year of study, the extent and proportion of the work that has been plagiarized, and the apparent intent of the student. The penalties that can be imposed range from a minimum of a zero mark for the work (without allowing resubmission) through caution to disciplinary measures (such as suspension or expulsion).

Course policy

1. Demonstration of safety criteria by the student enables her/ him pass in the course
2. According to the university regulations, absenteeism for 10% will result in an absenteeism warning letter.
3. Absenteeism of 15% of the course in the semester will not qualify the student to attend the final examination on the basis of absenteeism failure notice.
4. Compulsory attendance for all the in-course and final assessment evaluations and examinations. The examinations will not be postponed for the student without any emergency reasons or medical certificates.
5. Students who are not prepared for the clinical experience during any clinical days should meet the clinical instructor personally for the required.
6. Non-adherence to complete student uniform, attendance, punctuality and professional behaviors will affect the clinical evaluation and total grade.
7. Students who remain absent for the clinical days should meet the Course Co-ordinator. Those who are sick will produce a medical certificate certified by the University Health Center or any MOH and submit it to the respective clinical instructors.
8. Complete all the learning experiences depending on the feasibility in the unit.

Clinical Guidelines

1. By the end of the semester each student should have two clinical evaluation

2. At the end of each clinical day, post conference will be conducted in order to discuss clinical focus topics.
3. Each student should be prepared for post conference topics.
4. Students will be assigned to discuss specific topics with his lab instructors and colleagues.
5. Each student should use nursing process as a framework for virtual patient care.
6. Each student should accurately obtain health history and physical exam findings using proper medical terminology for his assigned patient.
7. At the end of semester students should attend a final written and clinical exam which will be used as an evaluation tool for the clinical practicum exam. This exam will be given at the end of the course, utilizing simulated environment for evaluation of knowledge, data gathering skills (history), technical skills (physical exam) and psychomotor skills.
8. Each student should prepare and distribute the medication for his/her assigned virtual patient under supervision of clinical instructor: Student are required to know the medication ordered for his/her virtual patient why they were ordered, dosage, side effect, and are able to correctly calculate the doses: When administering medication remember Ten Rights of Medication Administration

INSTRUCTIONS FOR STUDENTS

1. Student should be present in the lab from 8:00am – 16:00pm and clinical attendance will be maintained by clinical instructors.
2. All pocket articles, stethoscope, and clinical requirement formats should be carried by the students without fail.
3. Identify the nursing procedures, demonstrate the procedures to the clinical instructor
4. Maintain the break timing (30 mins two times a day)
5. Students should complete the total credits and be present for their contact hours for the entire Clinical course including the exam days (16 hours/week for 15 weeks).
6. Attendance starts on the orientation day until the last day of clinical posting and all the days of the examination.
7. Be present for the clinical evaluation and examination
8. Timely submission of weekly assignments and care plans.
9. Write one drug every week and submit at the end of each week to the Clinical Instructor.
10. Students are expected to complete one case presentation, and one Focused Care Plan.
11. Students will be given a Warning Notice after 5% absenteeism.

12. Absenteeism of 15% in the clinical course in a semester will not qualify the student to attend the final examination on the basis of Absenteeism Failure Notice.
13. Be responsible and accountable for your professional action and safety practices.
14. Maintain professional nursing standards while providing care to the patients.
15. Adhere to the Jordanian Nursing and Midwifery Code of ethics and conduct.

UNSAFE PRACTICE CRITERIA

Unsafe practices that compromise patient's life is defined as any action threatening patient's life.

1. Error in patient identification.
2. Omission of any of the 10 rights of medication, lack of knowledge regarding action or effects of medications and medication administration error.
3. Lack of aseptic technique while handling central lines, while taking care of immuno-compromised patients, repeatedly contaminating lines, avoiding hand washing.
4. Leaving patients unattended, e.g. unconscious patients, disabled patients, disoriented, neurological conditions.
5. Causing environmental hazards that jeopardize patient's safety and excessive property damage such as fire, lack of infection control, causing patient's fall.
6. Error in communicating significant information in documentation/ reporting.
7. Unsafe handling of equipments, syringe pump, lifesaving equipments.
8. Unsafe and improper handling of sharps and needles.
9. Omission of major scientific steps in nursing procedures, e.g. not checking nasogastric tube placement before each feeding, not checking pulse, BP, and blood sugar as required.
10. Negligence or threatening patient's life while on oxygen therapy, suctioning, vital signs etc.
11. Any other activity that is not listed above and evaluated or judged as unsafe by the Clinical Instructor's.

ETHICS AND PROFESSIONALISM

During clinical postings while caring for patients the student nurses should maintain professional standards and appropriate behavior. Students are expected to adhere to the Jordanian Nursing and Midwifery Council code of ethics and nursing standards of care. These behaviors are evaluated during the ongoing clinical performance and exit examinations. During the lab days the students are expected to show such behaviors.

Examples of some of the behaviors to be seen in a student are:

1. Shows caring and empathy
2. Shows genuine concern and is helpful
3. Shows confidence and competence
4. Is reliable and dependable
5. Is accountable and responsible
6. Uses critical thinking and problem solving
7. Accepts corrections and improves performance
8. Takes initiative and identifies limitations
9. Adhere to safety principles and hospital policies
10. Follows critical elements during the procedures

11. Builds rapport and healthy communication
12. Improves professional and interpersonal relationship
13. Pleasant general appearance and behavior
14. Maintains attitude and professional etiquettes
15. Professional nursing standards of care
16. Maintains Code of dress
17. Adheres to Code of ethics (JNMC)

Jordanian Code for Nurses

Jordanian Code for Nurses, first published in 1996, describes the primary goals, obligations, duties, and values of nursing profession. It shapes and defines the commitments that nurses make to patients and the public. The following are major principles:

- The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
- The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.
- The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.
- The nurse assumes responsibility and accountability for individual nursing judgments and actions.
- The nurse maintains competence in nursing.
- The nurse exercises informed judgment, uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.
- The nurse participates in activities that contribute to the ongoing professional knowledge development.
- The nurse participates in the profession's efforts to implement and improve standards of nursing.
- The nurse participates in the profession's efforts to establish and maintain conditions of employment conductive to high quality nursing care.
- The nurse participates in the profession's efforts to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.
- The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

Clinical Objectives

On the completion of the course, the nursing students will achieve the following objectives in the laboratory.

1. Use nursing process as a framework in providing nursing care
2. Demonstrate competency in performing focused health as per the case scenarios
3. Identify health care needs (physiological, psychological, social and spiritual responses to acute or chronic health alterations) based on the case scenarios
4. Identify the learning needs of patients based on the case scenarios
5. Integrate knowledge from nursing, medical, and psychosocial sciences to provide scientific-based nursing care to patients experiencing potential and actual health alterations in the selected body systems / organs and their families as per the scenarios.
6. Set appropriate health outcomes to evaluate the effectiveness of nursing care provided
7. Show knowledge of medications used for health alterations in the selected body systems / organs and ensure safe and accurate administration of these medications
8. Show awareness of the clinical labratory policies and regulations
9. Demonstrate competency in performing nursing skills / procedures relevant to care of patients experiencing potential or actual health alterations in the selected body systems / organs
10. Demonstrate effective communication skills when interacting with peers, instructors, and virtual patients in the lab.
11. Show collaboration skills with teamwork
12. Use time effectively and efficiently in completing nursing care required and course-related assignments.
13. Practice within legal and ethical standards established by JNMC
14. Show responsibility for one's own actions and safe practice
15. Show information seeking behavior

Course academic calendar

Week	Topic	Case Study Brunner & Suddarth's textbook of medical-surgical nursing. 2018	Procedure
(1)	• **Orientation** - Fluid and electrolytes: balance and disturbance	• Ch-13 case study on fluid and electrolytes, balance and disturbances	• Hand washing • IV cannulation • IV fluid administration and calculation
(2)	- Parental fluid therapy - Acid – Base Disturbances		• Intravenous sampling
(3)	• Pre and post operative nursing care	• Ch- 17,18,19 case studies on pre, intra, post operative nursing management	• Medication administration
(4)	• **Pain assessment and management** - Types of pain, Pathophysiology , effect - Management strategies	• Ch- 12 case study on pain management	• **Written Quiz** • **Procedure Exam**
(5)	• **Respiratory system** - Chronic Obstructive Pulmonary Disease (Chronic Bronchitis, Emphysema). - Chronic pulmonary diseases: (Bronchiectasis, - Asthma)	• Ch-23 case study Management of Patients With Chest and Lower Respiratory Tract Disorders • Ch-24 case study Management of Patients With Chronic Pulmonary Disease	• Introduction to oxygen therapy and respiratory physical therapy
(6)	• Hypertension & Hypertension Crisis • **First Exam**	• Ch-31 case study on assessment and management of patient with hypertension	• BP measurement

(7)	• Arterial & Venous Disorders	• Ch-30 case study of Assessment and Management of Patients With Vascular Disorders and Problems of Peripheral Circulation	• **Written Quiz** • **Procedure Exam**
(8)	• **Endocrine system** - Diabetes mellitus (DM)	• Ch-51 case study of assessment and management of patients with diabetes	• Blood glucose monitoring
(9)	• **Digestive system** - Gastritis - Peptic Ulcer - Acute Inflammatory - Intestinal Disorders	• Ch- 44 case study of Digestive and Gastrointestinal Treatment Modalities • Ch-46 case study of Management of Patients With Gastric and Duodenal Disorders	• Sampling • Enema • NG tube insertion, care, and removal • Gastric gavage • Gastric lavage **Nursing Care plan Submission**
(10)	• **Digestive system** - Intestinal Obstruction and disease of Anorectum - Abnormalities of fecal elimination	• Ch-47 case study Management of Patients With Intestinal and Rectal Disorders	
(11)	• **Hematologic disorders** - Hypo proliferative & Hemolytic Anemia • **<u>Second Exam</u>**	• Ch-32 case study Assessment of Hematologic Function and Treatment Modalities	**Case Study presentation**
(12)	• **Renal system** - Upper urinary tract infections - Lower urinary tract infections - Urinary incontinence and retention	• Ch- 55 case study Management of Patients With Urinary Disorders •	• Urine analysis • Urine culture • Midstream urine sample • Urine sample from folys catheter • Urinary catheterization
(13)	• **Renal system** - Renal failure and dialysis	•	

(14)	• **Musculoskeletal system** - Fracture, contusion, strains, sprains, dislocation (Cast & Traction) - Injuries and amputation - Low back pain	• Ch-42 case study Management of Patients With Musculoskeletal Trauma	• Patient lifting (range of motion, patient mobility, body mechanism) • Bandaging
(15)	• **Musculoskeletal system** - Arthritis - Orthopedic Surgery (Amputation, internal and external fixation & Total Hip Replacement)	• Ch-41 case study Management of Patients With Musculoskeletal Disorders	• **Final Exam**
(16)	• **Final Exam**	•	

Item	0	1	Comments
(pre procedure) a- Hand washing or gloving (0.5) b- Student appearance (0.5)			
Prepare equipments a- complete (0.2) b- within rational time (0.4) c- appropriate for patient (0.1) d- Insuring infection control precautions. (0.3)			
Explain the procedure a- face to face communication (0.3) b- appropriate tone (0.4) c- appropriate terminology (0.3)			
Fitness for actual skills a- comfortable and stable (0.3) b- within rational time (0.3) c- effectiveness (0.2) d- independency (0.2)			
Safety measures and finishing work Note: If this criterion WAS BREAKED student mark will be Zero of 5			
Total		**/5**	

Procedure – Check List Evaluation paper

Adult Health Nursing

Faculty of Nursing
Adult – clinical

Case Study -Evaluation Sheet

Student name: **Date :**
Instructor name: **Clinical area :**

Item	Actual mark	Achieved mark	Comments
Medical Dx **Present Hx & CC**	**3**		
Pathophysiology	**1**		
Past medical and surgical Hx	**2**		
Medication and IV fluid	**2**		
Nursing Dx **(At least 2)**	**4**		
Planning	**1**		
Interventions	**3**		
Evaluation	**1**		
Physical examination	**2**		
Lab investigation	**1**		
Total marks	**20**		

Instructor signature:

Comprehensive Nursing Care Plan Evaluation Criteria

Each student will complete 4 comprehensive nursing care plan. The comprehensive care plan will be evaluated using the following criteria:

1	**Patient Profile**
2	**Health History** A. Chief Complaints on admission C. Health Habits D. Past Health History F. Family History
3	**Review of Body Systems**
4	**Physical Examination**
5	**Special Diagnostic Procedures**
6	**Medications:** (Classification, Nursing Consideration)
7	**Assessment:** Assessment includes objective data which establishes the nursing diagnosis Assessment includes subjective data which establishes the nursing diagnosis
8	**Diagnosis:** Nursing Diagnosis are derived from the subjective and objective data Nursing Diagnosis are prioritized Nursing Diagnosis are stated in appropriate terminology
9	**Planning:** Goals and objective relate specifically to the identified nursing diagnosis Goals and objective reflect the direction of the nursing diagnosis Goals and objective attainable, measurable, and observable
10	**Implementations:** Nursing interventions are specific and inclusive Nursing interventions are prioritized Nursing interventions are individualized Teaching interventions are based on the identified needs Nursing interventions are based on up-to-date knowledge Rationales are scientifically correct
11	**Evaluation:** Evaluations reflect stated objective and goals

	Evaluations indicate how well objective were achieved/ not achieved Evaluations indicate if any and why objective were not appropriate

Faculty of nursing
Nursing Care Plan

Student Name:

Date: clinical area:

1-Patient Data: /2

Patient Name: Age:

Room/Bed: Gender:

Occupation: Education:

Marital status:

Admission Date:

Surgical Procedure: Date:

Activity Limitations:

Medical Diagnosis:

Intake and output (according to patient condition):

2- History (Chief complaints on admission and significant events): /4

3- Past (medical &surgical) history: /2

4-Family history (draw family genogram for 3 generations) /1

5- Life style: **/1**

Smoking: cigarette / day

Alcohol consumption yes / no

Over the counter drugs (OTC) use (list them)

Environmental hazards

Activity and exercise

6-Health assessment:

A- Physical examination (related to the case) /3

Assessment (Subjective Data)*

***Please tick only the symptoms related to each pattern…**

1. **Health maintenance-perception pattern.**
   A: Smoking : NO:____ Yes:_____ No. of cigarettes per day : ____
   (if) quit date \\ .

   B: Alcohol : NO:____ Yes:_____ Amount:_____.

C: Allergies (drug, food, tape, dyes…etc): NO_____ Yes: _____
specify:_____ .

2. **Activity \ exercise pattern:**
   Self care ability: (use codes: 1-independent 2- needs assistant 3- dependent)

Activity	1	2	3
Feeding ----------( )		( )	( )
Bathing----------( )		( )	( )
Dressing----------( )		( )	( )
Toileting----------( )		( )	( )
Mobility----------( )		( )	( )

- Assistive device: NO:_____ Yes:_____ (specify):_____

3. **Nutrition / Metabolic patterns:**

   A. Diet : typical diet at home :_____
      Prescribed diet :_____ .

   B. appetite Normal:____ Increased ____ Decreased _____
   C. nausea No:____ Yes:____
   D. vomiting: No:____ Yes:____

E. Dysphagia : Yes:____ No:____
F. Weight changes last 6 months No:____ Yes:_____ kg gained or lost:
G. Dentures: Upper:____ Lower:____ Partial:_____ .

4. Elimination patterns:

A. Bowel habits .
No. of bowel motions per day:____, Last bowel motion:_____, Constipation:____, Diarrhea :____, Incontinency :____ ,Bleeding:____, painful defecation:____, Ostomy:____, Assistive device (if yes specify):_____

B .Urinary habits.

Frequency:___ , Color:_____, Dysuria:___ , Urgency:___, Hematurea:___ , Anuria:___, Incontinency:____, Nocturia:____ , Retention:____, Burning:___, Assesstive device (if yes specify):_____.

5. Sleep & Rest Patterns :

A. Sleeping habits: hrs/night :____ AM naps :____ PM naps:_____
B. Problems (if yes specify):_____ .
C. use of drugs: (if yes specify):_____ .

6. Cognitive\ Perceptual Pattern.

A. Hearing :Rt \ Lt , Deaf : Rt \ Lt . Hearing aids :_____, tinnitus:_____ None:____.

B: Vision :Impaired: Rt\ Lt :____ , Blind:____ Rt\ Lt :____None:____ .

C: Vertigo NO:____ Yes:_____.

D: Discomfort / Pain : NO:____ Yes:____(Describe):_____.

7. Coping Stress / Self perception Pattern :

A: Major concerns regarding hospitalization or illness: _____
_____ .

B. Major loss / changes NO:____ Yes:____
(specify):_____
_____ .

C. Coping mechanism :
_____ .

8. Sexuality / Reproductive Pattern :

A: Menstruation : Last menstrual period (date) \ \ .
Menstrual Problems (if yes specify) :_____.
B: Use of contraceptives (if yes specify) :_____.
C: Vaginal bleeding or discharge
(if yes specify) :_____.

9. Role – Relationship Pattern :

A: Occupation:_____.
B: Household members/ Relationships:_____.
C: Family concerns regarding hospitalization :_____ .

10. Value – Belief Pattern :

A: religion :_____ .
B: Spiritual needs :_____ .

PHYSICAL EXAMINATION (OBJECTIVE DATA).

1. **Clinical data:**
General appearance :_____
Height :_____ , weight :_____, temperature :_____

2. **Respiratory / circulation :**

A: Blood pressure :_____
B: Respiration :Rate:_____ , Rhythm :_____
Describe :_____ .
Lung auscultation, abnormal sounds NO:___ Yes :___
(Describe): _____ .
C: Pulse , Apical rate :_____ , Radial rate :_____ , Rhythm:_____
Heart auscultation , Abnormal sounds NO :___, Yes :___,
(Describe):_____ .

3. **Metabolic – integumentary :**

A. Skin: color:_____ ,skin temperature :_____
Turgor :_____, Edema :_____ (If yes where)
:_____ .Lesions:_____(if yes
where):_____ , Pruritus : _____ (if yes
specify
):_____.
Tubes: (if present specify):_____ .

B: mouth : Gums (Describe):_____ .
Teeth (Describe):_____ .
Tongue(Describe) :_____ .
C: Abdomen : Bowel sounds, Present____, Absent:____, Rate:_____ .
Masses , NO :____ Yes :_____(Describe):_____ .
Organomgally NO:____, Yes :____, (Describe):_____ .
Tenderness: No:___, Yes:___ (Describe):_____ .

4. **Neuro / sensory :**
A: Mental status- Orientation :_____ .
Level of consciousness:_____ .
B: Speech, Language:_____ Any Difficulties, No :___, Yes:____
(Describe) :_____ .
C:

Pupil's	Rt	Lt
size(1-9 from the GCS)--------	( )	( )
Reactive to light(Yes/NO)---	( )	( )
Shape(Normal/abnormal)------	( )	( )
Equal(Yes/NO)----------	( )	( )

5. **Muscular / Skeletal :**
A: Range of motion, Full:___ ,Other(specify):_____ .
B: Balance and gait : Steady:_____, Unsteady:_____ .

C:

Hand grasp(Tick only)	Rt	Lt
Strong----------	( )	( )
Weak----------	( )	( )
Paralysis----------	( )	( )
Equal----------	( )	( )

D:

Leg muscle (Tick only)	Rt	Lt
Strong	( )	( )
Weak	( )	( )
Paralysis	( )	( )
Equal	( )	( )

7- Treatments (specify type and frequency): /2

Tx	If yes specify	No	frequency
Positioning			
O2 therapy			
CPT			
Suctioning			
Nebulizer			
Physiotherapy			
Blood transfusion			
Others			

8- Medications: /3.5

	Name of medication	Classification	Dose	Route	frequency	Time	Nsg interventic
1	Scientific: Trade:						
2	Scientific: Trade:						
3	Scientific: Trade:						

4	Scientific: Trade:						
5	Scientific: Trade:						

9- I.V. Therapy: /1.5

Infusion 's type	Concentration	Amount	Frequency	Rate and last 24 hrs intake (iv.f)

10-lab investigations & Diagnostic Procedures :(ordered as main category and its components) /4

Name of Procedure	Results	Normal Value	Explain if result high or low

11- Subjective Data :(prioritized)(what did client say –use direct quotation) /2

12- Objective Data :(prioritized)(what did you see\ hear \ smell and feel) /2

13- Nursing Care Plan: /10

Nsg Dx			
Planning(p.t will) **Goal :** **Objective:(specific, measurable)**	**Implementations : (nurse will)** **1-** **2-** **3-** **4-** **5-**	**Rational (reason for intervention)**	**Evaluation(what happened)**

Nsg Dx			
Planning(p.t will) **Goal :** **Objective:(specific, measurable)**	**Implementations : (nurse will)** **1-** **2-** **3-** **4-** **5-**	**Rational (reason for intervention)**	**Evaluation(what happened)**

Nsg Dx			
Planning(p.t will) **Goal :** **Objective:(specific, measurable)**	**Implementations : (nurse will)** **1-** **2-** **3-** **4-** **5-**	**Rational (reason for intervention)**	**Evaluation(what happened)**

Nsg Dx			
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Philadelphia University
Faculty of Nursing
Adult /clinical
Nursing note

Student name:
Date:

Patient name: _____ Age: _____ sex: _____ date of birth:_____ wt:___

Ward :_____ admission date :_____ medical diagnosis:_____

date	Note	Time &signature

Adult clinical
Case study exam
Final form

Evaluation Criteria

Student name:-…….. Section:…..…….
Hospital:-……Unit:……...
Patients Diagnosis:……..……..date of admission:……

Items of Evaluation	Grade allotted	Grade Acquired	Comments
● Health history Demographic data Medical surgical history	(2)		
● physical examination General and systematic examination ● Lab investigation	(1) (2)		
● Medication	(2)		

●knowledge Definition, causes, S&S Diagnostic procedures Medical managements	(3)		
●assessment and nursing care plan subjective, objective data nursing diagnosis 1- 2- 3- expected patients outcome	(10) (2) (3) (1)		

1- 2- 3- nursing intervention 1- 2- 3- Evaluation 1- 2- 3-	(3) (1)		
Total Score	(20)		

Instructor note:

Date of examination: Start at: End at:

Supervisor signature:

Staff member signature: