PN 110 Introduction to Practical Nursing Concepts 1

Credits: 3 Contact Hours: 5

Pre-Requisites: Formal acceptance into the Practical Nursing Program, NUR 100 (B- or higher), EN 101 and PY 201(with a grade of C or higher), GH 125 (C or higher) or BI 117 (C or higher), or BI 121 and BI 122 (C or higher)

Co-Requisites: NUR 115 PN 115

Course Description:

This course (including the corresponding lab component) introduces Health care recipient concepts, health and illness, and professional nursing and health care concepts. Health care recipient concepts include culture and functional ability. Health and illness concepts include nutrition, fluid and electrolytes, elimination, perfusion, gas exchange, infection, inflammation, immunity, pain, stress & coping and substance misuse/addiction. Professional nursing and health care concepts include professional identity, clinical judgment, health promotion, communication, collaboration, and safety. Upon completion, students will incorporate the concepts introduced in this course (theory and lab) to conduct a thorough health history and health assessment, differentiate between normal and abnormal assessment findings, and demonstrate safe nursing care in a simulated setting.

Course Outcomes:

1. Coordinated Care: The practical nursing student identifies ways that nurses collaborate with health care team members to facilitate effective client care. (1.A)
2. Safety and Infection Control: The practical nursing student contributes to the protection of clients and health care personnel from health and environmental hazards. (1.B)
3. Health Promotion and Maintenance: The practical nursing student identifies nursing care for clients that incorporate the knowledge of expected stages of growth and development, and prevention and/or early detection of health problems. (2)
4. Psychosocial Integrity: The practical nursing student identifies care that assists with promotion and support of the emotional, mental and social well-being of clients. (3)
5. Basic Care and Comfort: The practical nursing student identifies ways to comfort to clients and assist in the performance of activities of daily living. (4.A)
6. Pharmacological and Parenteral Therapies: The practical nursing student identifies appropriate care related to the administration of medications and for clients who are receiving parenteral therapies. (4.B)
7. Reduction of Risk Potential: The practical nursing student identifies interventions to reduce the potential for clients to develop complications or health problems related to treatments, procedures or existing conditions. (4.C)
8. Physiological Adaptation: The practical nursing student participates in identifying care for clients with acute, chronic or life-threatening physical health conditions. (4.D)

(Outcomes 1-8 refer to the NCLEX-PN® Detailed Test Plan Item Writer/Item Reviewer/Nurse Educator Version. Parentheses refer to the NCSBN Framework)

Theory

Outline	Health Care Recipient Concepts	Exemplars

Introduction of Health Care Recipient Concepts A. Definition B. Scope C. Attributes D. Theoretical Links E. Context to Nursing and Health Care F. Interrelated Concepts G. Exemplars		
	Culture	
	Functional Ability	Osteoarthritis
Outline	**Health & Illness Concepts**	**Exemplars**
Introduction of Health and Illness Concepts A. Definition B. Scope C. Individual Risk Factors and Populations at Risk D. Physiologic Process and Consequences E. Assessment 1. History 2. Examination 3. Diagnostic Studies F. Clinical Management 1. Primary Prevention 2. Secondary Prevention 3. Collaborative Interventions G. Interrelated Concepts H. Exemplars		
	Addiction	Tobacco use Disorder
	Elimination	Constipation
		Diarrhea
	Fluid & Electrolytes	
	Gas Exchange	Influenza
	Immunity	Allergies
		Anaphylaxis
	Infection	Healthcare Acquired Infections (HAI)
		MDROs
		Types of Isolation
		UTIs
	Inflammation	
	Pain	

	Perfusion	Anemia
	Stress & Coping	
Outline	**Professional Nursing and Health Care Concepts**	**Exemplars**
Introduction of Professional Nursing and Health Care Concepts A. Definition B. Scope C. Attributes D. Theoretical Links E. Context to Nursing and Health Care F. Interrelated Concepts G. Exemplars		
	Clinical Judgment	Clinical Judgement Model
		Nursing Process
	Collaboration	
	Communication	Interviewing
		SBAR
		Therapeutic communication
	Health Promotion	Height/Weight Assessment
		Primary, Secondary, Tertiary
		Vital Signs Assessment
	Professional Identity	
	Safety	National Patient Safety Goals

Clinical/Lab

Competencies (per NCLEX Test-Plan)	Leveling of Competency Verb	Assessment Methods
Promote client self-advocacy (1A)	Identify	Head to Toe & Health History older adult assignment
Use data from various credible sources in making clinical decisions (1A)	Identify	CCM
Organize and prioritize care based on client needs (1A)	Identify	case study CCM
Apply evidence-based practice when providing care (1A)	Identify the role	case study CCM

Participate in client data collection (1A)		simulation Head to Toe & Health History case study older adult assignment
Acknowledge and document practice error (e.g., incident report) (1B)		lab activity room of blunders and or virtual video of errors case study
Collect data for health history (e.g., client medical history, family medical history) (2)		simulation Head to Toe & Health History case study older adult assignment
Collect baseline physical data (e.g., skin integrity, height, and weight) (2)		Head to Toe & Health History
Identify barriers to communication (2)	Identify	Head to Toe & Health History older adult assignment
Identify barriers to learning (2)		Self Care Assessment and Plan
Identify clients in need of immunizations (2)	Identify	Head to Toe & Health History
Participate in health screening or health promotion programs (2)		Case study Head to Toe & Health History CCM
Collect data regarding client psychosocial functioning (3)	Identify	Head to Toe & Health History Self Care Assessment and Plan
Identify client use of effective and ineffective coping mechanisms (3)		Head to Toe & Health History Self Care Assessment and Plan
Recognize stressors that affect client care (3)	Identify basic stressors	Head to Toe & Health History Self Care Assessment and Plan Case study Simulation
Plan care with consideration of client spiritual, cultural beliefs and/or gender identity (3)	Identify ways in which	Case Study CCM Self Care Assessment and Plan
Use therapeutic communication techniques with client (3)	Identify basic	Head to Toe & Health History Client Interview
Promote a therapeutic environment (3)		Head to Toe & Health History Self Care Assessment and Plan
Assist with activities of daily living(4A)	Identify	simulation Head to Toe & Health History case study older adult assignment
Monitor diagnostic or laboratory test results (4C)	Identify	Simulation Worksheet case study

Perform focused data collection based on client condition (e.g., neurological checks, circulatory checks) (4C)		Head to Toe & Health History
Identify client risk and implement interventions (4C)		lab activity room of blunders and or virtual video of errors case study
Use precautions to prevent injury and/or complications associated with a procedure or diagnosis (4C)	Identify basic measures	Simulation
Provide cooling/warming measures to restore normal body temperature (4D)	Identify measures to promote	Simulation
Recognize and report change in client condition (4D)	Identify basic changes	Case Study