

MODULE MATA KULIAH BAHASA INGGRIS
FOR THE THIRD SEMESTER STUDENT OF NURSING
DEPARTEMENT AT POLITEKNIK MAKASSAR



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Chapter One

HOW TO BUILD UP TO SPEAK ENGLISH

Unit 1.

Personal Details

1. Self Introduction

Introducer : David, this is Catherine

David : Hi, how are you?

Catherine : Fine, thanks

David : Nice to meet you

What's your name? : Nice to meet you too.

Could you tell me your name
please? : My name's

May I know your name?
or I'm (Name)

2. Asking a Job

What's your occupation? I'm a midwife,

What's your job? I'm a mechanic,

What's your profession? I'm in Business.

What do you do for a living? I repair cars,

What do you do? I work in the hospital. I'm a nurse

Where do you work? I work for Siloam Hospital

Who do you work for?

Are you a journalist (lawyer, judge? Yes, I'm. or No, I'm a painter

3. Place of Birth

Where were you born?	I was born in...(place)
Where do you come from?	I come from ...(place)
Where are you from?	I'm from (place).

4. Date of Birth (Age)

When were you born?	I was born (on June 7, 1996)
How old are you?	I'm ... years old.
What's your age?	My old is about 15 years
Are you still very young?	That's right. I'm exactly 27 years old. Yes, I'm two years older than she is.
Are you older than your cousin?	

5. Nationality

What nationality are you?	I'm an Australian,
What's your nationality?	I'm from Sydney,
Where are you from?	Australia
Are you Japanese / Are you from Japan?	Yes, I'm Japanese by birth but I'm American by marriage.

6. Marital Status

What's your marital status?	Married/Single/unmarried/widow(er)
Are you married?	Yes, I'm or no I'm not
Are (still) single?	(Tergantung keadaan sesungguhnya)
Aren't you married?	Yes, I'm or no, I'm not
Are you engaged?	Yes, I'm or no, I'm not

Are you divorced? Yes, I'm or no, I'm not

7. Address

What's your address? Jln Abdullah Dg. Sirua, Blok A.1 No.8

Where do you live? I live in Jl..Number..or at Number ..Jl.

Do you live far or near from here? It's about 5 minute walk.

What's your (tele) phone number?

What's your office address? (0411)871811

What's your office phone number?

It's on Jl A. P.Petrani

(0411)405973

8. Height

What's your height? 1.60 cm

How tall are you? I'm 160 cm tall

9. Weight

What's your weight? 60 kg

How much do you weight?

10. Interest/hobbies

What's your hobby? I collect stamps

What are your hobbies? or I don't really have any hobbies.

Do you have any hobbies? I like playing chess

What do you do in your spare time?

11. Family

How many brothers and sisters do you have? I've one brother and two sisters

How many children do you have?

What child are you in?

I have three children.

I'm the third child.

12. Language Spoken

How many languages do you speak?

I speak three languages.

What language do you speak?

I speak Indonesia and Bugis.

What foreign language(s) do you speak? English and Arabic.

Do you speak any foreign language? Yes, I speak English

13. Education (School and University Attended)

Where and when did you get your-
Midwifery / Nursery education?

What's your last education?

Are you a university graduate?

Do you have a Master/Ph.D Degree? What's
your major?

What's your specialization?

Unit 2. ENGLISH VERB TENSES

General Purpose:

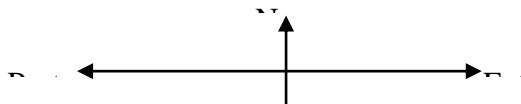
The students understand and apply the English verb tenses in Present, Past and Future.

Specific Purpose:

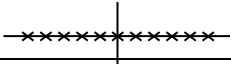

After the learning process, the students are an enable to:

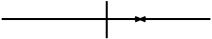
1. Understand and apply: simple present, continuous, perfect and perfect continues tenses
2. Understand and apply: simple past, past continues, past perfect, and past perfect continues
3. Understand and apply: simple future, future continues, future perfect and future perfect continues.

This diagram will be used in describing the three formed of tenses in English:

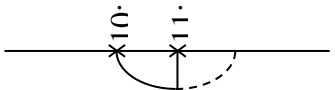
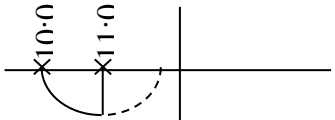
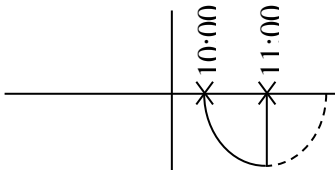


The Simple Tenses

TENSE	EXAMPLE	MEANING
SIMPLE PRESENT 	(a) It Snows in Alaska (b) I watch television every day.	In general, the simple present expresses events or situations that exist always, usually, habitually; they exist now, have existed in the past, and probably will exist in the future.
SIMPLE PAST 	(c) It Snowed yesterday (d) I watched television last night.	At one particular time in the past, this happened. It began and ended in the past.

<p>SIMPLE FUTURE</p> 	<p>(e) It will Snow tomorrow (f) I will watch television tonight.</p>	<p>At one particular time in the future, this will happen.</p>
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1. The Progressive Tenses*

<p>Form : be + -ing (present participle)</p> <p>Meaning: The progressive tenses give the idea that an action is in progress during a particular time. The tenses say that an action begins before, is in progress during, and continues after another time or action</p>		
<p>PRESENT PROGRESSIVE</p> 	<p>(a) He is sleeping right now</p>	<p>He went to sleep at 10:00 tonight. It is now 11:00 and he is still sleep. His sleep began in the past, is in progress at the present time, and probably will continue.</p>
<p>PAST PROGRESSIVE</p> 	<p>(b) He was sleeping when I arrived.</p>	<p>He went to sleep at 10:00 last night. I arrived at 11:00 . He was still sleep. His sleep began before and was in progress at particular time in the past. It probably continued.</p>
<p>FUTURE PROGRESSIVE</p> 	<p>(c) He will be sleeping when we arrive.</p>	<p>He will go to sleep at 10:00 tomorrow night. We will arrive at 11:00. The action of sleeping will begin before we arrive and it will be in progressive at a particular time in the future in the past.. It probably continued</p>

Exercise 1. Use either the *simple present* or the *present progressive* of the verbs in parentheses.

- Kathy (*sit, usually**) in the front row during class, but today she (*sit*) in the last row.
- Diana can't come to the phone because she (*wash*) her hair.
- Diana (*wash*) her hair every other day or so.
- Please be quite, I (*try*) to concentrate.
- (*Lock, you, always*) the door to your apartment when you leave?
- Look!. It (*snow*)
- Mika (*go, not*) to school right now because it is summer. He (*attend*) college from September to May every year, but in the summers he (*have, usually*) a job at the post office. In fact, he (*work*) there this summer. Right

now I (*look*) around the classroom. Ahmad (*write*) In his book. Carlos (*bite*)

Exercise 2. Use the *simple past* or the *past progressive* in the following

1. I (*read*) only two chapters last week.
2. I (*read*) A book last night when you called.
3. I (*call*) John at nine last night, he (*be, not*) at home. He (*study*) at the library.
4. I (*hear, not*)..... the thunder during the storm last night because I (*sleep*)
5. My brother and sister (*argue*)..... about something when I (*walk*)into the room.
6. When I (*open*) The package, I (*find*) a surprise.
7. He (*climb*) the stairs when he (trip) And (*fall*) Luckily, he (*hurt, not*) himself.
8. While I (*read*) The little boy a story, he (*fall*) asleep, so I (*close*) the book and quickly (*tiptoe*) out of the room.

2. The Perfect Tenses

Form : have + -ed (past participle)		
Meaning : The perfect tenses all give the idea that one thing <i>happens before</i> another time or event.		
<p>PRESENT PERFECT</p>	(a) I have already eaten	I finished eating sometime before now. The exact time is not important
<p>PAST PERFECT</p>	(b) I had already eaten when they arrived	First I finished eating. Later they arrived. My eating was completely finished before another time in the past
<p>FUTURE PERFECT</p>	(c) I will already have eaten when they arrive	First I will finish eating. Later they will arrive. My eating will be completely finished before another time in the future

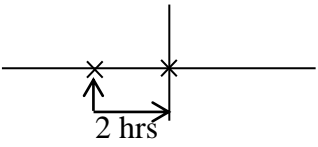
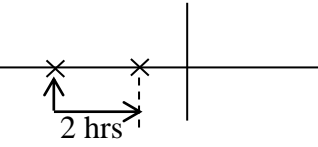
Exercise 3. Oral (books closed) Begin your response with “I have never”

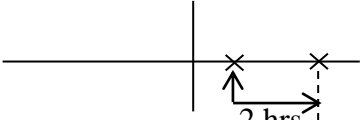
Example: see that movie

Response: I've never seen that movie

- | | |
|-------------------------------|---|
| 1. Drive truck | 14. have a car accident |
| 2. Buy an airplane | 15. speak to (a local personage) |
| 3. Read that book | 16. steal anything |
| 4. Break the window | 17. fall off a mountain |
| 5. Draw a picture of yourself | 18. bring a friend to class |
| 6. Ride a horse | 19. hold a snake |
| 7. Eat paper | 20. feed a lion |
| 8. Teach English | 21. build a house |
| 9. Catch a butterfly | 22. forget your name |
| 10. Win a million dollars | 23. wear a kimono |
| 11. Fly an airplane | 24. drink Turkish coffee |
| 12. Sleep past ten o'clock | 25. understand theory of relativity |
| 13. Lose your wallet | 26. leave your umbrella at a restaurant |

3. The Perfect Progressive Tenses

<p>Form : have + been + (V1+ing)</p> <p>Meaning: The perfect progressive tenses give the idea that one event is in progress immediately before, up to, until another time or event. The tenses are used to express the duration of the first event</p>		
<p>PRESENT PERFECT PROGRESSIVE</p> 	<p>(a) I have been studying for two hours</p>	<p>Event in progress: Studying. When? Before now, up to now. How long? For two hours</p>
<p>PAST PERFECT PROGRESSIVE</p> 	<p>(b) I had been studying for two hours before my friend came</p>	<p>Event in progress: Studying. When? Before another event in the past. How long? For two hours</p>

<p>FUTURE PERFECT PROGRESSIVE</p> 	<p>(c) I will have been studying for two hours by the time you arrive</p>	<p>Event in progress: Studying. When? Before another event in the future.</p>
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Exercise 4. Use the present perfect or the present perfect progressive. In some sentences, either tense may be used with little or no change in the meaning.

1. It (*snow*) all day. I wonder when it will stop.
2. We (*have*) three major snowstorms so far this winter. I wonder how many more we will have.
3. It's ten P.M. I (*study*) for two hours and probably won't finish until midnight.
4. I (*write*) them three times, but I still haven't received a reply.
5. I (*live*) here since last March
6. The telephone (*ring*) four times in the last hours, and each time it has been for my roommate.
7. The telephone (*ring*) ... for almost a minute. Why doesn't someone answer?
8. The little boy is dirty head to foot because he (*play*) ... in the mud.

Exercise 5. Written: Complete the following with your ideas (Perfect progressive):

1. since 8 o'clock this morning.
2. since I came to
3.since 19.. (Year).
4.since (month).
5.since(day).

Exercise 6. Use the simple past or the past perfect. Are there some blanks where either tense is possible?

1. He (*be*)a newspaper reporter before he (*become*) a businessman.
2. I was late, the teacher (*give, already*) A quiz when I (*get*) to class.
3. The anthropologist (*leave*) the village when she (*collect*) enough data.
4. It was raining hard, but by the time class (*be*) Over, the rain (*stop*)

Exercise 7. Use the present perfect progressive or the past perfect progressive:

1. It is midnight. I (*study*) for five straight hours. No wonder I'm getting tired.
2. It was midnight. I (study) For five straight hours. No wonder I was getting tired.
3. Jack suddenly realized that the teacher was asking him a question. He couldn't answer because he (*daydream*) for the last ten minutes
4. Wake up!. You (*sleep*)long enough. It's time to get up.
5. At least two hundred people were waiting in line to buy tickets to the game. Some of them (*stand*)in line for more than four hours. We decided not try to get tickets for ourselves.

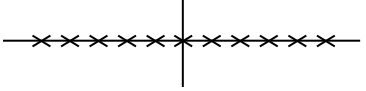
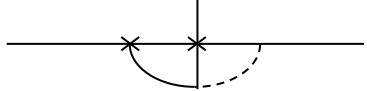
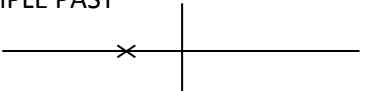

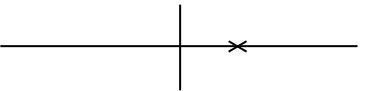
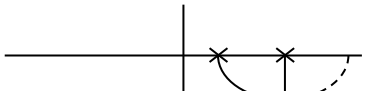
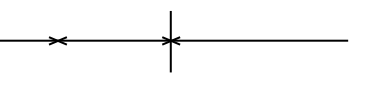
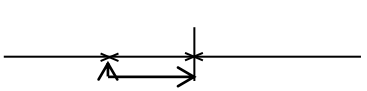



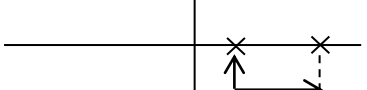
Exercise 8. Use the simple future/be going to* or the simple present.

1. I'm going to leave in half an hour. I (*finish*) will finish/am going to finish all of my work before I (*leave*) leave.
2. I'm going to eat lunch at 12.30. After I (*eat*) Lunch, I (*take*) a nap.
3. I'll get home around six. When I (*get*)home, I (*Call*)Sharon.
4. I'm going to watch a TV program at nine. Before I (*watch*)that program at nine, I (*write*)to my parents.

Exercise 9. Use the future progressive or simple present.

1. Right now I am attending class. Yesterday at this time, I was attending class. Tomorrow at this time, I (*attend*)class.
2. Tomorrow I'm going leave for home. When I (*arrive*)at airport, my whole family (*wait*)for me. Fast
3. When I (*get*) Up tomorrow morning, the sun (*shine*), the birds (*sing*), at my roommate (lie, still).....in bed fast asleep.

Summary Chart of Verb Tenses

<p>SIMPLE PRESENT</p>  <p>The World is arround.</p>	<p>PRESENT PROGRESSIVE</p>  <p>I am studyng right now.</p>
<p>SIMPLE PAST</p>  <p>I studied last night</p>	<p>PAST PROGRESSIVE</p>  <p>I was studying when they came.</p>
<p>SIMPLE FUTURE</p>  <p>I will studv tomorrow</p>	<p>FUTURE PROGRESSIVE</p>  <p>I will be studying when you come</p>
<p>PRESENT PERFECT</p>  <p>I have alredy studied chanter one</p>	<p>PRESENT PERFECT PROGRESSIVE</p>  <p>I have been studying for two hours</p>
<p>PAST PERFECT</p>  <p>I had already studied Chapter One</p>	<p>PAST PERFECT PROGRESSIVE</p>  <p>I had bee studying for two hours before my</p>
<p>FUTURE PERFECT</p>  <p>I will already have studied Chapter four</p>	<p>FUTURE PERFECT PROGRESSIVE</p>  <p>I will have been studying for two hours by</p>

Unit 3.
PASSIVE VOICE

Formula:

<p style="text-align: center;">Simple : S + be + (VIII+ed) or (Past Participle) +O</p> <p style="text-align: center;">Continuous: S + be + being + Past Participle + O</p>
--

S : I, you, we, they

S (The thirds person singular): He, she, it, Any, Badu, a Cat

Present (I)	Past Tense (II)	Past Participle (VIII + ed) (III)
Be :		
Am	Was	Have been (I, you, we, they)
Is	Was	Has been (He, she, it, ani,
are	were	badu, a cat
Go	went	Gone (irregular verb)
Eat	ate	Eaten (irregular verb)
Speak	spoke	Spoken (irregular verb)
Drink	drank	Drunk (irregular verb)
Clame	clamed	Clamed (regular verb)
Play	plaied	plaied
Make	made	made
Start	started	Started (voiced) disuarakan
End	ended	Ended disuarakan
Call	called	Called (voiceless) tdk disuaraakan
Increase	increased	Icreased (tdk disuaraakan)
Manage	managed	managed
Know	knew	known

Subjective	Adjective Possessive	Adjective Pronoun
I	My	Mine
You	Your	Yours
He	His	His
She	Her	Hers
It	Its	Its
We	Our	Ours
They	Their	Theirs

Examples:

1. Any is injected by the nurse. (be +VIII = di) dalam bt present
2. Armin is being injected by the nurse. (sedang disuntik) progressive
3. Diabetic patients were injected by the nurse yesterday (telah disuntik)
- 4. Mr. Baddu is not injected by the doctor. (tidak disuntik)
5. Are the patients injected by the nurse? (apakah pxs disuntik)
6. By who is a patient injected? (Oleh siapa pts disunik?)
7. Eka is called by head of nursig department
8. Eka is beeing called by head of nursing department

Exercises1: Correct the underline word in these passive voice sentences.

1. All bottles was frozen before transportation.
2. Everything are forbidden.
3. Everything is going be forgotten.
4. Everything that had is overheard remained a secret.
5. I have not be given the money.
6. It had not been knew for years.
7. It are said that learning English is easy.
8. John and Ann was not misled.

9. Our horses is well fed
10. Peter and Tom was hurt in an accident yesterday.
11. South Florida and Hawaii has been hit by a hurricane.
12. The battles for liberation had been frighten before the liberation of the Iron Curtain.

Unit 4. CONDITIONAL SENTENCES

Conditional Sentences have two parts: the **if clause and the main clause**. In the sentence, **If it rains I shall stay at home**. 'If it rains' is the if clause, and 'I shall stay at home' is the main clause

There are three kinds of Conditional Sentences. Each kind contains a different pair of tenses. With each type certain variations are possible but students who are studying the conditional for the first time should ignore these and concentrate on the basic forms.

Conditional Sentences Type I: Probable

True in the present or future

- a. The verb in the if-clause is in the present tense; the verb in the main clause is in the future simple. It doesn't matter which comes first.

If he runs he'll get there in time.

The cat will scratch you if you pull her tail.

This type of sentence implies that the action in the **if**-clause is quite probable.

The meaning here is present or future, but the verb in the **if**-clause is a present, not future tense. If +will/would is only possible with certain special meaning

- b. Possible variation of the basic form

1) Variation of the main clause

Instead of **if** + present + future, we may have:

- a) If + present + may/might (possibility)

if the fog gets thicker the plane may/might be diverted. (Perhaps the plane will be diverted.

- b) if + present + may (permission or ability)

If your documents are in order you may/can leave at once.

If it stops snowing we can go out (permission or ability)

- c) if + present + must, should or many expressions of command, request or advice

If you want to lose weight you must /should eat less bread

If you want to lose weight you had better eat less bread.

If you want to lose weight eat less bread

If you want to lose weight

- d) if + present + another present tense

if + two present tenses is used to express automatic or habitual results

If you heat ice it turns to water (will turn is also possible)

e) When it is used to mean as/since

Ann hates in london, --If she hates it why does she live in there?

2) Variation of the **if**- clause.

Instead of **if** + present tense, we can have

a) If + present continuous, to indicate a present action or future arrangement

If you are waiting for a bus (present action) you'd better join int queue.

If you staying for another night I will ask the manager to give a better room.

b) If + present perfect

If you have finished dinner I ask the waiter for the bill.

If they haven't seen the museum we'd better go there today.

Conditional Sentences Type II

Untrue or contrary to fact in the present or future

a). The verb in the **if**-clause is in the past tense; the verb in the main clause is in the conditional sentence:

If I had a map I would lend it to you (But I haven't a map. The meaning here is present)

If someone tried to blackmail me I would tell the police. (But I don't expect that anyone will try to blackmail me. The meaning here is he future)

c) When the supposition is contrary to known facts:

If I were you I'd plant some trees round the house. (I am not you)

If I lived near my office I'd be in tme for work. (But I don't live ner my office)

Conditional Type III

Untrue or contrary to fact in the past

Example:

a) **He would have come** if you **had invited** him last week.

b) **If you had invited him, he would have come last week**

c) **He would hae come if you had invited him last week.**

SUMMARY:

Meaning of the “If Clause”	Verb form in the “If Clause”	Verb form in the “Result Clause”
True in the present/future	Simple present	Simple present Simple future
Untrue in the present/future	Simple past	Would + simple form
Untrue in the past	Past perfect	Would have + past participle

Examples:

1. The lecturer teach us if he can come tomorrow (I)
2. The students would go to supermarket if it didn't rain now. (II)
3. The students would have visited me if they had known my address last week. (III)
4. What would you do if you were a governor now? (II)
5. If I were a buird I would fly in the sky (II)

UNIT 5.

DEGREES OF COMPARISON

The Degrees of Comparison in English Grammar are made with the adjective and adverb to show the qualities, numbers and positions of the nouns (person, things and places) in comparison to the others mentioned in the other part of the sentence or expression.

An adjective is a word which qualifies a noun or a pronoun in a sentence. An adjective can be attributive which comes before a noun or predicative which comes in the predicate part.

Examples:

He is a tall man. (Attributive)

This man is tall. (Predicative)

An adverb is a word which adds to the meaning of a main verb (how it is done, when it is done, etc) of a sentence. It normally ends with '-ly', but there are some adverbs without '-ly'.

Examples:

She ate her lunch quickly.

They run fast.

Positive Degree

The Positive Degree is used to denote the mere existence of quality.

Example:

Tom is a tall boy.

In this sentence the word 'tall' is an adjective telling how 'Tom' is. There is no other person or thing in this sentence to compare Tom with, but it is the general way of saying about persons, animals and things that they have some quality above the average in general sense. The adjective word 'tall' is said to be in positive form. There are two more comparisons with the positive forms of the adjective words. They are Degree of Equality and Degree of Inequality.

Degree of Equality

This comparison is used to compare two persons, things or animals which are having the same quality.

Example:

The brown cat is as beautiful as the grey cat.

The word 'beautiful' is an adjective in the positive form and with conjunctions '...as...as...' it expresses the degree of quality.

Degree of Inequality

This comparison is used to compare two persons, animals or things which are not having the same quality.

Example:

The brown cat is not so beautiful as the grey cat.

The word 'beautiful' is an adjective in the past form and with conjunctions '...so...as...' and the negative 'not', it expresses the degree of inequality.

COMPARATIVE DEGREE

The Comparative Degree is used to compare the qualities of two persons or things.

Example:

Tom is taller than his sister.

In this word 'taller' is an adjective used to compare the tallness of these two persons – Tom and his sister. It shows that Tom has more quality of tallness. Therefore an adjective word 'taller' which shows the difference of quality between two persons, animals or things is said to be in the comparative form. The Comparative Degree is two forms – Parallel Degree and Progressive Degree.

Parallel Degree

The quality or quantity of the adjective or adverb continues to increase or decrease as the time passes. The adjective or adverb in its comparative form is repeated using the conjunction 'and'.

Examples:

The days are getting hotter and hotter.

It is getting hotter and hotter day by day.

Progressive Degree

Two adjectives or adverbs are being compared to show that one continues to increase or decrease when the other increases or decreases. The adjective or adverb is in its comparative form with the definite article 'the' before it.

Example:

The steeper the hill, the more difficult it is to push the rock up.

Superlative Degree

The Superlative Degree denotes the existence of the highest degree of the quality. It is used when more than two things are compared.

Example:

The Blue Whale is the largest of all animals.

In this sentence the word 'the largest' is an adjective used to compare the largeness of the blue whale and shows that the blue whale has the most quality of largeness. This comparison is used to compare one person, thing or animal and shows that the particular one has the highest degree of that particular quality. The adjective 'large' is said to be in the superlative form.

Forms of Adjectives and Adverbs in the Degrees of Comparison

Most of the adjectives and adverbs in Positive Degree take '-er' to change to Comparative Degree and '-est' to change to Superlative Degree. However, the meaning of an adjective or adverb in Comparative and Superlative form does not change. It is only the form that is changed but not the meaning.

Rules

1. The word which ends in 'e' takes only 'r' in Comparative form and 'st' in the Superlative form.

Examples:

Brave – braver – bravest

Large – larger – largest

2. The words which end in any letter other than 'e'/'y' take 'er' in Comparative form and 'est' in Superlative form.

Examples:

Sweet – sweeter – sweetest

Tall – taller – tallest

Young – younger – youngest

Old – older – oldest

3. Words which end in 'y' preceded by a consonant lose that last letter 'y' and take 'ier' in Comparative and 'iest' in Superlative.

Examples:

Easy – easier – easiest

Heavy – heavier – heaviest

4. Words which end in 'y' preceded by a vowel take 'r/er' in Comparative and 'st/est' in Superlative form.

Examples:

Gay – gayer – gayest

5. The word which ends in a consonant having a vowel before that consonant doubles the consonant letter and take 'er' in Comparative and 'est' in Superlative form.

Examples:

Red – redder – reddest

Hot – hotter – hottest

Thin – thinner – thinnest

6. The words which have more than two or more sounds take 'more' in Comparative and 'most' in Superlative.

Examples:

Beautiful – more beautiful – most beautiful

7. The words which do not take any suffix or any other word before them change their spelling and pronunciation entirely.

Examples:

Good/well – better – best

Bad/evil – worse – worst

Many/much – more – most

8. There are some words which take more than one form in Comparative and Superlative form. Each of the two words gives a different meaning.

Examples:

He is later than I expected.

Raj and Ram are my friends, the latter is a teacher.

The last chapter is interesting.

This is not the latest fashion.

Language of comparison

Comparatives and superlatives are used to express degrees of comparison

Comparatives are used to show the difference between two things:

Auckland is better than Wellington

Superlatives are used to show the greatest degree of a quality or quantity among three or more things.

It is the most exciting city in NZ.

Comparatives are formed by adding the suffix “er” or the preceding word “more.” Superlatives are formed by adding the suffix “est” or the preceding word “most.” The correct comparative and superlative forms of an adjective depend on the number of syllables in the adjective

	comparative	superlative
Adjectives of one syllable: cheap, fast, large, weak	... er than cheaper, faster, larger, weaker	(the) ...est cheapest, fastest, largest, weakest
Adjectives of three or more syllables: convenient, efficient, suitable	more ... than less ... than more suitable than,	(the) most (the) least the least suitable
Adjectives that have two syllables follow one or other of the above rules: <ul style="list-style-type: none"> • Those ending with “ful” or “re” • Those ending with “y”, “er”, “le” or “ow”: heavy, clever, simple narrow, gentle, 	more doubtful more obscure heavier, cleverer, simpler, narrower, gentler	most doubtful most obscure heaviest, cleverest, simplest, narrowest, gentlest
Irregular forms: good bad far far little	better worse farther further less	(the) best (the) worst (the) farthest (the) furthest (the) least

Unit 6.
QUESTION WORDS

QUESTION WORDS	FUNCTION	EXAMPLES
1. When	Ask question about time	When did you arrive? When does he go?
2. Where	Ask question about place	Where is Bawakaraeng Montain? Where is your father?
3. Why	Ask Question About Reason	Why does she choose midwifery department? Why do you want to be a nurse?
4. How	Ask question about manner.	How do you come? How does he drive?
	Ask question about countable and uncountable noun.	How much money does it cost? How many people came to ...?
	Used with adjective and adverbs.	How cold is it? Or How old is she? How soon can you get there? How fast are you driving?
	Ask the length of ime. Ask About Frequency Ask About Distance	How long have you been living in ..? How often do you go ...? How far is it to Palopo from here?
5 Who	Used As The Subject of a Question	Who can Answer that question? Who came to visit you?
	Usually Followed By a singular verb, even if the speaker Is asking more then one person	Who is coming to the dinner tonight Who wants to come with me?
6. Whom	Used as object of a verb or preposition whom is used only informal question	Who (m) did you see? Who (m) are visiting? Who (m) should I take to? To whom should I take?
7. Whose	Ask question about possession	Whose book did you borrow? Whose key is this?
8. What	Used as the subject of a question	What made you angry? What went wrong?
	also as used as an object	What do you need? What did she write about?
	Accompanied by a noun	What class are they taking? What country did you visit?
9. What		What time did she finally arrive? What program do you like on TV?

10. Which	Used instead of what when a question concern choosing.	Which pen do you want? Which one do you want? Which books should I buy?
	In some cases , there is a Little in different meaning between which and what	Which country did he visit on his trip? What country did he visit on his trip? Which class are you in? What class are you in?
11. That		That 's to be expected That's all right That ll do That very good That remands me

The Using Of Question Words + Be + Subject In Composing Questions

QUESTION WORDS	BE	SUBJECT
Who	Is	That Man
Who	Are	They
Where	Was	Mary
Where	Were	The Girls
What Colors	Is	Her Dress
What Colors	Are	His Eyes

Exercises

Chapter Two
SKILLS IN NURSING ASSESSMENT

Unit 7.
DIALOGUE BETWEEN A NURSE AND A CLIENT

Dialogue 1

Nurse: What the matter with you mister (Mr.) E?

Client: I'm not feeling very well,

Nurse: What exactly is the trouble?

Client: I feel uncomfortable after meals.

Nurse: You have been working very hard, lately haven't you?

Client: Yes, I have.

Nurse: And I expect you have been worrying too.

Client: The work has been rather troublesome.

Nurse: You smoke rather heavily, I notice.

Client: I'm afraid, I do

Nurse: Well, I think I can soon put you right.

Client: I suppose you'll say, workless, smokeless and eatless?

Exercise:

- 1) Students in pairs
- 2) Material the part of body

Dialogue 2

Client: Good morning, Nurse

Nurse: Good morning too. What can I do for you, Sir?

Client: Yes, I would like to meet Dr. Mirna.

Nurse: Of course, but if you don't mind telling me, what for do you want to meet her?

Client: I have an appointment with her at 10.30 a.m.

Nurse: I see, and what's your name, sir?

Client: My name is Latinro Handoko.

Nurse: Sorry, how do you spell your last name?

Client: It's H-A-N-D-O-K-O and my first name is L-A-T-I-N-R-O.

Nurse: And what is your occupation, Sir?

Client: I'm an orthopedic surgeon from Pare-Pare Hospital.

Nurse: Well, Mr. Latinro, would you wait here for a moment, I am going to inform her first.

Client: Thanks a lot

Nurse: With my pleasure

Unit 8. Nursing Terminology

A sign of disease is something that a nurse can see or feel for her self.

She can observe it (data that can be observed by a nurse without examining the client).

A symptom of disease is something that only the patient knows about. The patient tells the nurse about it (a nurse knows the data after the client telling it).

Some terminologies are usually used bellows:

- *Bruising* (bruise), an injury which makes a mark on the skin but does not break the skin.
- *Rash*, red spots on the skin. A sign of certain illnesses such as measles.
- *Swelling*, a part of the body which has become enlarges by disease or injury. Examples: sprained ankle, Swollen glands are a sign of mumps.
- *Nausea*, feeling sick or wanting to vomit. The adjective is nauseated.
- *Insomnia*, inability to sleep
- *Ache*, an ache is a kind of pain. The term ache cannot be used for a pain in every part of the body, but only: backache, earache, stomachache, toothache, and headache.
- *Irregular pulse or respiration*, the pulse or respiration rate varies, from fast to slow.
- *Dizziness*, vertigo; feeling that everything is turning around you, and that you will lose your balance.
- *Haematemesis*, blood in the vomit.
- *Pallor*, lack of the adjective is pale or pallid.
- *Diarrhea*, frequent loose of stools, passed through the bowels.
- *Jaundice*, the skin and eyes of client look yellow.
- *Constipation (constipated)*, when the client cannot open his bowels or only with difficulty, he has constipation or he is constipated.
- *Cyanosis*, blue skin caused by insufficient oxygen in the blood. The adjective is cyanosed.
- *Anorexia*, lack of appetite.
- *Laceration*, a cut with broken edges. The adjective is lacerated.
- *Abrasion*, rubbed or torn skin
- *Inflammation*, a red, hot, swollen, painful place on the skin. The adjective is inflamed.
- *Shallow pulse or respiration*, a light, faint pulse
- *Respiration*, breathing *rapid*, quick.

- *Edema (edema)*, swelling caused by excessive fluid in the tissues.

Task :

1) Classify the data above into the subjective and objective data and explain its reason

.a. Subjective data

b. Objective data

2) Make dialogue by using the terminology

Unit 9. NURSING HISTORY

The nursing health history interview is the first part of the assessment of the client's health status and is usually carried out before the physical assessment. This is a structured interview designed to collect specific health data and to obtain a detailed health record of the client. Its purposes are:

- To elicit information about all the variables that may affect the client's health status.
- To obtain data that help the nurse understand and appreciate the client's life experience.
- To initiate a nonjudgmental, trusting interpersonal relationship with client.

Data obtained are then used in collaboration with the client to develop nursing diagnosis and subsequent plans for individualized care.

Components of the nursing history include (a) biographic data ,(b) chief complaint or reason for visit , (c) history of present illness (current health status), (d) past history, (e) family history of illness , (f) review of system , (g) life style, (h) social data, (h) psychological data and (j) patterns of health care.

a. Biographic Data

Biographic data obtained include the client's name , address, age, sex, race marital status , occupation, religious orientation, health care, financing and usual source of medical care.

b. Chief Complaint Or Reason For Visit

The chief complaint (CC) is the answer given to the question "what is troubling you?" or "what brought you to the hospital or clinic?" and should be recorded in the client own words. If the client states , " I have heart trouble " or " have cancer" the nurse should encourage the client to collaborate by discussing specific symptoms and their duration further investigation may produce a chief complaint, example ; " **I've had chest pain for the past two hours**" or " I've lost 4 pounds in the past month.

c. History of Present Illness

The history of present illness (HPI) is a sequentially : (a) Usual health status , (b) Chronologic story, (c) Relevant family history , and (d) Disability assessment . To obtain a description of the client's usual health status, ask the client "How would you describe you health until this time?" Answer such as terrible as "good "need to be clarified further. For example ask the client, "What do you mean by terrible or good)?".

The chronologic story is a narrative section where the client's chief complaint is documented in the proper of events. The chronologic story includes these:

- When the symptoms started
- Whether the onset of symptoms was sudden or gradual.
- Available, specific dates when the problem was experienced
- How often the problem occurs
- Exact location of the distress
- Character of the complaint (e.g., intensity of pain or quality of sputum , emesis or discharge).
- Amount of discharge, mucus, blood, stool, or urine or the size of a lesion.
- Activity which the client was involved when the problem occurred.
- Phenomena or symptoms associated with the chief complaint.
- Factor that aggravate or alleviate the problem.

d. Past History

Included in the past history are all previous immunizations and experiences with illness, Including the following:

- Childhood illness such as chickenpox, mumps measles , rubella (German measles) , rubella (red measles), streptococcus infections, scarlet fever, rheumatic fever and other significance illnesses.
- Childhood immunizations and the date of the last tetanus
- Allergic to drugs, animals, insects or other environmental agents ant the type of reaction that occurs.
- Accidents and injuries: how, when and where the incidents occurred, type injury, treatment received and any complication.
- Hospitalization for serious illnesses, reason for hospitalization, date, location of hospital, name of physician, surgery performed , course of recovery and any complications
- Medications: all currently used prescriptions and over the counter medications such as aspirin nasal spry, vitamin or laxatives

e. Family History of Illness

The family history reveals risk factors for certain diseases. This information should include the age of siblings, parents and grandparents, their current state of health or (if they are deceased), the cause of the death. Particular attention should be given to disorders such as heart diseases, cancer, diabetes, hypertension, obesity, allergies, arthritis, tuberculosis, jaundice bleeding, migraine and alcoholism. **Review of System**

The ROS is a review of all health problems by body system. Its purpose is to prevent the omission of the data related to the present illness and to discover any other problems that may have been missed. It is a review of the past and the present status of each system. Generally a head to toe approach is used, and agency checklists are often available. A head to toe approach is also used in the physical examination, but the data obtained in this part of the history focus on subjective data by given the clients.

f. Life Style

Investigation of the client life style provides data about factors that can be used for planning health promotion, maintenance and, restoration. The nurses obtain the data about personal habits, diet, sleep/rest pattern, ADL, and recreation/hobbies.

- Personal habits

The nurse documents the frequency of all substances abuse, including the use of tobacco, alcohol, coffee, tea, drugs, etc.

- Diet. Dietary data may include the description of a typical diet on a normal day or of any prescribed special diet, number of meals and snacks per day, who cooks and shops for food, ethnically distinct food patterns, method used for food preparation, likes dislikes, and allergies. A detailed nutritional history form is provided

- Sleep/rest patterns. Sleep and rest clearly affect the total well-being of the client. The nurse notes the usual daily sleep/wake times, difficulties sleeping.

- Activities of daily living (ADLs).The nurse collects data about the client's perception of any difficulties experienced in the basic activities of eating, elimination and locomotion.

g. Social data.

Social assessment includes family relationships, ethnic affiliation, educational history, economic status, and home and neighborhood condition.

- Family relationships/friendships such as single parents, unmarried couples, homosexual couple.
- Ethnic affiliation, Data ethnic affiliation help the nurse understand the client's customs and beliefs
- Educational history. Data about the client's highest level of education attained and any past difficulties with learning can help the nurse make appropriate adjustments in plans for client teaching.
- Occupational history. The occupational history should focus on all jobs the client has held, the client's current employment status, the number of days missed from work because of illness, any history of accidents.
- Economic status. Financial status is another sensitive area of inquiry that is best handled initially by an open ended question.

h. Psychological Data

- Major stressor. Determine major stressor the client has experienced in the past year and the client's perception of them.
- Usual coping patterns. Ask what the client normally does to cope with a serious problems or high level of stress.
- Communication stress. Observe the client's nonverbal communication and ability to verbalize appropriate emotion. Nonverbal communication such as: eye movement, gestures, use of touch and posture, the client's. Self concept
- Mood. The nurse may need to ask about mood if the client appears under active (flat or unresponsive) Pattern of health care.

Unit 10. PHYSICAL EXAMINATION

Eyes and Vision

- ❖ Inspect the external eyes structures:
 - a. Eyelashes for evenness of distribution and direction of curl
 - b. Eyelids for surface characteristics, position, and movement
 - c. Palpebral and bulbar conjunctiva for color, texture, and lesions
 - d. Lachrymal apparatus for edema or tenderness
 - e. Cornea for clarity and texture
 - f. Pupils for color, size and equality
- ❖ Test visual acuity.
- ❖ Test peripheral visual fields.
- ❖ Test extra ocular movements.

Ears and Hearing

- Inspect the auricles for color, texture, symmetry of size, position
- Using an otoscope, inspect the external ear canals for cerumen, inflammation, scaling, foreign bodies, or other lesions.
- Using an otoscope, inspect each internal ear: . tympanic membrane for color and gloss
- Test hearing acuity:
 - a. Loss hearing acuity by response to voice tones
 - b. Tuning fork tests (Weber, Rinne, Schwabach tests)

Nose and Sinuses

- Inspect the mucosa for redness, swelling, growths, discharge, and nasal polyps.
- Inspect the nasal septum for deviation.
- Palpate the external nose for tenderness.
- Palpate the maxillary and frontal sinuses for tenderness.
- Neck
- Inspect the neck muscles for swellings or masses.
- Assess neck movement and strength of muscles.

- Palpate for enlarged lymph nodes.
- Palpate trachea for position.
- Inspect and palpate thyroid gland for symmetry and masses.

Mouth and Oropharynx

- Inspect the lips for symmetry of contour, color, and texture.
- Using gloves to inspect the inner mucosa and the buccal mucosa for color, moisture, texture, and lesions: palpate the mucosa.
- Inspect the teeth for color, presence of fillings, dental caries, partial or complete dentures, and tartar.
- Inspect the gums for bleeding, color, retraction, edema, and lesions; palpate the gums to determine firmness and texture.
- Inspect the tongue for color, size, texture, position, mobility, and coating/membrane.
- Palpate the tongue and floor of the mouth for tenderness, nodules, lumps, or excoriated areas.
- Examine the hard and soft palates for color, shape, texture, and the presence of bony prominences.
- Observe the uvula for position and mobility.
- Inspect the salivary gland openings for swelling or redness.

Oropharynx

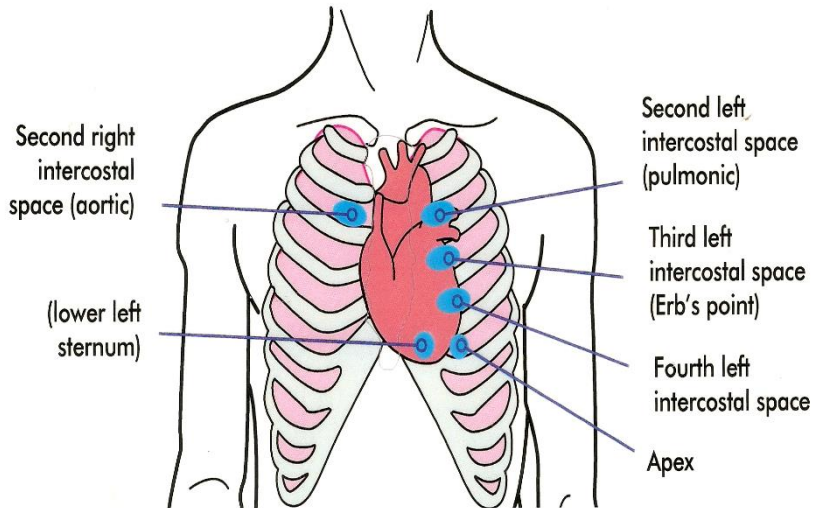
- Inspect the palatine arches for redness, lesions, and plaques.
- Inspect the tonsils for color, discharge, and size.
- Inspect the oropharynx for edema, inflammation, lesions, or exudates.
- Assess the gag reflex.

Neck

- Inspect the neck muscles for swellings or masses.
- Assess neck movement and strength of muscles.
- Palpate for enlarged lymph nodes.
- Palpate trachea for position.
- Inspect and palpate thyroid gland for symmetry and masses.

Unit 11.
PHYSICAN ASSESSMEN ON THE THORAX

Anterior Heart Sites



Base on the picture above, explain:

- | | |
|------------------------|-----------------------|
| 1) Air way process, | 4) The lung sound |
| 2) Parts of the Lungs, | 5) Parts of the heart |
| 3) The Lungs function, | 6) The heart function |

A. The Lungs

You have to breathe because all of the cells in your body require oxygen. Without oxygen, your body wouldn't move. It would be like a parked car without no battery. The car might have gas, but without a battery, forget it! So you might have blood in your body, but without oxygen, forget it!

You receive oxygen from breathing in air and then the oxygen goes into your blood which is then circulated throughout your entire body. You breathe with the help of your diaphragm (which is a dome-shaped muscle under your rib cage) and other muscles in your chest and abdomen. These muscles will literally change the space and pressure inside your body

cavity to accommodate your breathing. When your diaphragm pulls down, it is making room for the lungs to expand. The lungs get bigger with air and pushes the diaphragm down. The diaphragm also lowers the internal air pressure

Outside of your body, the air pressure is greater and you suck in air when you inhale. The air then expands your lungs like two balloons being blown up. When your diaphragm relaxes, it moves up and the cavity inside your body gets smaller. Your muscles will then squeeze your rib cage and your lungs begin to collapse as the air is pushed up and out your body when you exhale. Cool huh?

About 18 - 20 times a minute, you breathe in. When a doctor puts his or her hand on your shoulder or back and looks at the clock, they are keeping track of how many times you breathe within one minute. This is how one of your vital signs is measured, called "respiration."

When you breathe, you inhale air and pass it through your nasal passages where the air is filtered, heated, moistened and enters the back of the throat. The esophagus (food tube) is located at the back of the throat and the trachea (windpipe) for air is located at the front of the throat. When you eat, a tiny flap called the "epiglottis" closes down to cover the windpipe so food won't go down the wrong pipe.

Air flows down through the windpipe, past the vocal cords (voice box), to where the lowest ribs meet the center of your chest. This is where your windpipe divides into two tubes which lead to each of the two lungs that fill most of your ribcage. Each lung feels just like a sponge. Inside each of your sponge-like lungs, there are tubes called bronchi which branch into even smaller tubes just like the branches of a tree. At the end of these tubes are millions of itty bitty bubbles or sacs called alveoli. If you were to spread out flat all of the air sacs in the lungs of an adult, the tissue would cover an area about the third of the size of a tennis court

The alveoli sacs bring new oxygen from air you just breathed to your bloodstream. It is here that a phenomenal exchange takes place. The oxygen is exchanged for waste products, like carbon dioxide, which the cells in your body have made and can't use.

This phenomenal exchange works with the assistance of the red blood cells in your bloodstream. Your red blood cells are like box cars on a railroad track. They will show up at the sacs at just the right time, ready to trade in old carbon dioxide that your body's cells have made for some new oxygen you just breathed in. During this process, the red blood cells turn from purple to a sparkling red color as they start carrying the oxygen to ALL the cells in your body.

The carbon dioxide (waste) that your body made and now can't use will go through the lungs, back up your windpipe and out with every single exhale. This is a chemical exchange of breathing in and out (inhalation/exhalation). This is an automatic process that you don't even have to think about. Unless of course you smoke, then you'd be depriving ALL of your cells of oxygen.

Task 1: Answer The Following questions correctly

1. What is the purpose of breathing?
2. What is the process of breathing?
3. What are the those tiny air sacs for?
4. What do the sacs do?
5. How does the oxygen/waste exchange work?
6. What happens to the carbon dioxide?
7. Find the terms of lung usually use in nursing area.

B. The Heart

1). Location of the Heart

The center of the circulatory system is the **heart**, which is the main pumping mechanism. The heart is made of muscle. The heart is shaped something like a cone, with a pointed bottom and a round top. It is hollow so that it can fill up with blood. An adult's heart is about the size of a large orange and weighs a little less than a pound.

The heart is in the middle of the chest. It fits snugly between the two lungs. It is held in place by the blood vessels that carry the blood to and from its chambers. The heart is tipped somewhat so that there is a little more of it on the left side than on the right. The pointed tip at the bottom of the heart touches the front wall of the chest. Every time the heart beats it goes "thump" against the chest wall. You can feel the thumps if you press there with your hand. You can also listen to them with your ear.

2) Structure of the Heart

If you looked inside your heart, you would see that a wall of muscle divides it down the middle, into a left half and a right half. The muscular wall is called a septum. The septum is solid so that blood cannot flow back and forth between the left and right halves of the heart. Another wall separates the rounded top part of the heart from the cone-shaped bottom part. So there are actually four chambers (spaces) inside the heart. Each top chamber is called an atrium (plural: atria). The bottom chambers are called ventricles. The atria are often referred to as holding chambers, while the ventricles are called pumping chambers. Thus, each side of the heart forms its own separate system, a right heart and a left heart. Each half consists of an

atrium and a ventricle, and blood can flow from the top chamber to the bottom chamber, or ventricle, but not between the two sides.

3) The Valves

Blood can flow from the atria down into the ventricles because there are openings in the walls that separate them. These openings are called valves because they open in one direction like trapdoors to let the blood pass through. Then they close, so the blood cannot flow backwards into the atria. With this system, blood always flows in only one direction inside the heart. There are also valves at the bottom of the large arteries that carry blood away from the heart: the aorta and the pulmonary artery. These valves keep the blood from flowing backward into the heart once it has been pumped out.

4) Branching Blood Vessels

The heart is a pump whose walls are made of thick muscle. They can squeeze (contract) to send blood rushing out. The blood does not spill all over the place when it leaves the heart. Instead, it flows smoothly in tubes called blood vessels. First, the blood flows into tubes called arteries. The arteries leaving the heart are thick tubes. But the arteries soon branch again and again to form smaller and smaller tubes. The smallest blood vessels, called capillaries, form a fine network of tiny vessels throughout the body. The capillaries have extremely thin walls so that the blood that they carry can come into close contact with the body tissues. The tiny red blood cells can then pass easily through the walls of the capillaries to deliver the oxygen they carry to nearby cells. As the blood flows through the capillaries, it also collects carbon dioxide waste from the body cells. The capillaries containing carbon dioxide return this used blood to the heart through a different series of branching tubes: The capillaries join together to form small veins. The veins, in turn, unite with each other to form larger veins until the blood from the body is finally collected into the large veins that empty into the heart. So the blood vessels of the body carry blood in a circle: moving away from the heart in arteries, traveling to various parts of the body in capillaries, and going back to the heart in veins. The heart is the pump that makes this happen

Task 2: Answer the following questions correctly

1. What is the functions of the heart?
2. Mention part of the heart!
3. How does the heart work?
4. Mention the valve of the heart!
5. Explain the pulmonary circulation?
6. What is systole and diastole?
7. Find the terms of the heart usually
Used in nursing area!

Unit 12.
PHYSICAN ASSESSMEN ON THE ABDOMEN

A. Abdominal organs

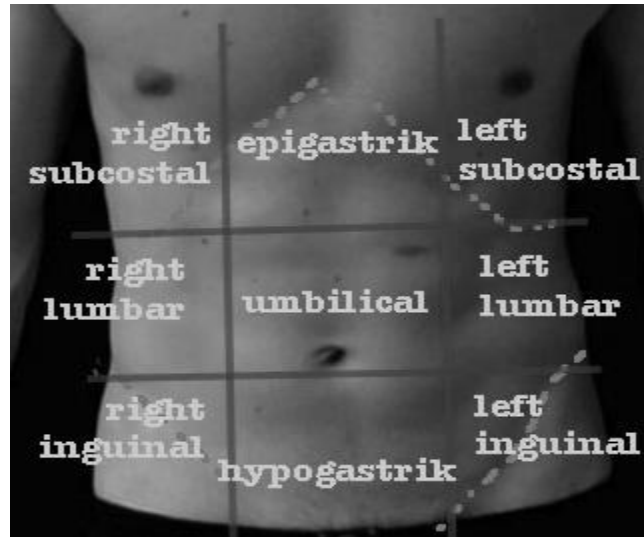
- Digestive tract: [Stomach](#), [small intestine](#), [large intestine](#) with [cecum](#) and [appendix](#)
- Accessory organs of the digestive tract: [Liver](#), [gallbladder](#) and [pancreas](#)
- Urinary system: [Kidneys](#) and [ureters](#) - but technically located in [retroperitoneum](#) - outside peritoneal membrane
- Other organs: [Spleen](#)
- These three horizontal and two vertical lines divide the abdomen into nine "regions." (Note that "hypo" means "below" and "epi" means "above", while "chond" means "cartilage" (in this case, the cartilage of the rib) and "gast" means stomach. The reversal of "left" and "right" is intentional, because the anatomical designations reflect the position on the patient)

Task 1: Answer the following questions correctly

1. Explain part of the abdomen!
2. Which part of the abdomen including the digestive system?
3. Which of the abdominal organs including accessories?
4. Based on the abdominal region, specify the meaning of these words:
 - Hypo
 - Epi
 - Chond
 - Gast

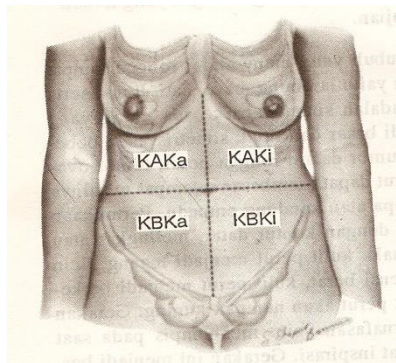
B. Region of Abdomen

9-Region scheme



Surface lines of the front of the thorax and abdomen

4-region scheme



Regio with four quadrants

Task 2: Students demonstrate in front of the class and show the region of the abdomen to the other students

C. Physical Assessment of The Abdomen

Inspection consists of visual examination of the abdomen with note made of the shape of the abdomen, skin abnormalities, abdominal masses, and the movement of the abdominal

wall with respiration. Abnormalities detected on inspection provide clues to intra-abdominal pathology; these are further investigated with auscultation and palpation.

Auscultation of the abdomen is performed for detection of altered bowel sounds, rubs, or vascular bruits. Normal peristalsis creates bowel sounds that may be altered or absent by disease. Irritation of serosal surfaces may produce a sound (rub) as an organ moves against the serosal surface. Atherosclerosis may alter arterial blood flow so that a bruit is produced.

Palpation is the examination of the abdomen for crepitus of the abdominal wall, for any abdominal tenderness, or for abdominal masses. The liver and kidneys may be palpable in normal individuals, but any other masses are abnormal.

D. Technique Of Physical Assessment

1) Inspection

The abdomen is inspected by positioning the patient supine on an examining table or bed. The head and knees should be supported with small pillows or folded sheets for comfort and to relax the abdominal wall musculature. The entire abdominal wall must be examined and drapes should be positioned accordingly. The patient's arms should be at the sides and not folded behind the head, as this tenses the abdominal wall. Good lighting is essential, and it is helpful to have tangential lighting available, for this can create subtle shadows of abdominal wall masses.

First, the general contour of the entire abdominal wall is observed. The contour should be checked carefully for distention and note made as to whether any distention is generalized or localized to a portion of the abdomen. Similarly, the flanks should be checked for any bulging.

The abdominal wall skin should be inspected carefully for abnormalities. Any areas of discoloration should be noted, such as the bluish discoloration of the umbilicus (Cullen's sign) or flanks (Grey Turner's sign). The skin should be inspected for striae, or "stretch marks," and surgical scars. Careful note of surgical scars should be made and correlated with the patient's recollection of previous operations. The skin of the abdomen should also be checked carefully for engorged veins in the abdominal wall and the direction of blood flow in these veins. This is performed by placing the tips of the index fingers together, compressing a visible vein. The fingertips are then slid apart, maintaining compression, producing an empty venous segment between the fingers. A finger is removed from one end and the vein is watched for filling. The procedure is then repeated, but the opposite finger is removed

and the vein again checked for filling. Above the umbilicus, blood flow is normally upward; below the umbilicus, it is normally downward. Obstruction of the inferior vena cava will cause reversal of flow in the lower abdomen. In addition to these large dilated veins, note should be made of any spider angiomas of the abdominal wall skin.

Next, the abdomen should be inspected for masses. This should be performed from several angles. It is important to differentiate abdominal wall from intra-abdominal masses. A mass of the abdominal wall will become more prominent with tensing of the abdominal wall musculature, whereas an intra-abdominal mass will become less prominent or disappear. Useful maneuvers are to have the patient hold his head unsupported off the examining table, to hold his nose and blow, or to raise his feet off the table. Abdominal wall masses are most commonly hernias (either umbilical, epigastric, incisional, or spigelian), neoplasms (benign and malignant), infections, and hematomas.

Once a mass is determined to be intra-abdominal, its location should be described in relation to the abdominal quadrants. The relationship of intra-abdominal organs to these quadrants should be considered in attempting to determine the cause of the mass. The mass should be examined for movement with respiration or for pulsation with each heartbeat. Also, the mass should be observed for peristalsis, as it may well represent dilated bowel.

Lastly, the abdominal wall should be observed for motion with respiration. Normally, the abdominal wall moves posteriorly in a symmetrical fashion with inspiration. With peritonitis, there may be localized or generalized rigidity of the abdominal wall so that this motion is absent.

2) Auscultation

The patient is positioned comfortably in the supine position as described in Inspection. The stethoscope is used to listen over several areas of the abdomen for several minutes for the presence of bowel sounds. The diaphragm of the stethoscope should be applied to the abdominal wall with firm but gentle pressure. It is often helpful to warm the diaphragm in the examiner's hands before application, particularly in ticklish patients. When bowel sounds are not present, one should listen for a full 3 minutes before determining that bowel sounds are, in fact, absent.

Auscultation for abdominal bruits is the next phase of abdominal examination. Bruits are "swishing" sounds heard over major arteries during systole or, less commonly,

systole and diastole. The area over the aorta, both renal arteries. and the iliac arteries should be examined carefully for bruits.

Rubs are infrequently found on abdominal examination but can occur over the liver, spleen, or an abdominal mass.

3) Palpation and Percussion

The patient is positioned supine with head and knees supported, as for Inspection and Auscultation. Take the history and perform inspection and auscultation before palpation, as this tends to put the patient at ease and increases cooperation. In addition, palpation may stimulate bowel activity and thus falsely increase bowel sounds if performed before auscultation. Ask patients with abdominal pain to point to the area of greatest pain. Then reassure them that you will try to minimize their discomfort and examine that point last.

In palpating the abdomen, one should first gently examine the abdominal wall with the fingertips. This will demonstrate the crunching feeling of crepitus of the abdominal wall, a sign of gas or fluid within the subcutaneous tissues. In addition, it will demonstrate any irregularities of the abdominal wall (such as lipomas or hernias) and give some idea as to areas of tenderness.

Deep palpation of the abdomen is performed by placing the flat of the hand on the abdominal wall and applying firm, steady pressure. It may be helpful to use two-handed palpation, particularly in evaluating a mass. Here the upper hand is used to exert pressure, while the lower hand is used to feel. One should start deep palpation in the quadrant directly opposite any area of pain and carefully examine each quadrant. At each costal margin it is helpful to have the patient inspire deeply to aid in palpation of the liver, gallbladder, and spleen.

In the flanks it is often helpful to elevate the flank to be examined slightly and place one hand on the lower ribs of that flank to “push” the retroperitoneal contents up to the examining hand. In this way, small renal masses that would otherwise be missed may be appreciated.

Abdominal tenderness is the objective expression of pain from palpation. When elicited, it should be described as to its location (quadrant), depth of palpation required to elicit it (superficial or deep), and the patient’s response (mild or severe). Spasm or rigidity is

the involuntary tightening of the abdominal musculature that occurs in response to underlying inflammation. Guarding, in contrast, is a voluntary contraction of the abdominal wall musculature to avoid pain. Thus, guarding tends to be generalized over the entire abdomen, whereas rigidity involves only the inflamed area. Guarding can often be overcome by having the patient purposely relax the muscles; rigidity cannot be. Rigidity is thus a clear-cut sign of peritoneal inflammation.

Rebound tenderness is the elicitation of tenderness by rapidly removing the examining hand. Again, this is a difficult sign for the beginning examiner to master. The most common error is to remove the hand very quickly with an exaggerated motion and thus startle the patient. All that needs to be done is smoothly but quickly to lift the palpating hand off the abdomen and observe for pain, facial grimace, or spasm of the abdominal wall. Both tenderness and rebound tenderness may be elicited by palpation in a different quadrant. Thus, palpation of the left lower quadrant may produce tenderness and rebound tenderness in the right lower quadrant in appendicitis (Rovsing's sign). This is called referred tenderness and referred rebound.

When abdominal masses are palpated, the first consideration is whether the mass is intra-abdominal or within the abdominal wall. This can be determined by having the patient raise his or her head or feet from the examining table. This will tense the abdominal muscles, thus shielding an intra-abdominal mass while making an abdominal wall mass more prominent. If the mass is intra-abdominal, important points are its size, location, tenderness, and mobility.

Palpation and percussion are used to evaluate ascites. A rounded, symmetrical contour of the abdomen with bulging flanks is often the first clue. Palpation of the abdomen in the patient with ascites will often demonstrate a doughy, almost fluctuant sensation. In advanced cases the abdominal wall will be tense due to distention from the contained fluid. Gas-filled intestines will float to the top of the fluid-filled abdomen. Thus, in the supine patient with ascites there should be periumbilical tympany with dullness in the flanks. One should mark the level of dullness on the skin and then turn the patient on one side for a full minute. A change in the level of dullness is termed shifting dullness and usually indicates more than 500 ml of ascitic fluid. Another physical sign of ascites is demonstration of a transmitted fluid wave. The patient or an assistant presses a hand firmly against the abdominal wall in the umbilical region. The examiner places the flat of the left hand on the right flank and then taps the left flank with his right hand. In the presence of ascites, a sharp

tap will generate a pressure wave that will be transmitted to the left hand. Unfortunately, fat will also transmit a fluid wave, and there are frequent false-positives with this test.

In addition to detection of ascites, percussion can be used to help define the nature of an abdominal mass. Tympany of an abdominal mass implies that it is gas filled (i.e., intestine). Percussion is also used to define liver size.

Normal peristalsis of the intestine produces bowel sounds as gas and fluid are passed through the intestinal lumen. Normally, the bowel sounds are intermittent, low-pitched, chuckling sounds. Bowel sounds may be decreased or increased in disease states.

Ileus is a failure of peristalsis and is the normal physiologic response of the intestine to laparotomy or peritoneal inflammation. In addition, ileus is seen in a number of disease states that do not affect the peritoneum directly, including pneumonia, congestive heart failure, and uremia. Bowel sounds will be markedly diminished or absent in ileus as the intestine distends with gas in its paralyzed state.

Early mechanical bowel obstruction produces hyperactive peristaltic waves proximal to the mechanical obstruction. These waves are increased in frequency and force and produce a concomitant increase in bowel sounds with characteristic "rushes." As the bowel gradually dilates with gas and fluid, the bowel sounds become high pitched and tinkling, and there may be periods of hypoactive bowel sounds that alternate with hyperperistaltic rushes. These rushes correlate with the increased peristaltic activity. Finally, in late intestinal obstruction there may be loss of all bowel sounds due to loss of peristaltic activity from vascular compromise.

Vascular bruits are the audible manifestation of turbulent blood flow. They are found normally in thin patients, but in heavier individuals will be muffled because of the surrounding fat. Loud systolic bruits are due to atherosclerotic plaques within arteries, producing turbulent flow. These plaques are common in the aorta and iliac arteries and less common in the renal arteries. In addition, turbulent flow within an abdominal aortic aneurysm may create a bruit. Bruits that are present in both systole and diastole are strongly suggestive of an arteriovenous communication.

Rubs are uncommon on abdominal auscultation but, when found, are the result of inflamed peritoneal surfaces grating on each other during respiration. This can be the result of a neoplastic or infectious process that destroys the normally smooth peritoneal surfaces.

Crepitus is produced by gas (air) and/or fluid within tissues. In the abdominal wall, it either is due to traumatic introduction of air or is secondary to infection (gas gangrene). Subcutaneous emphysema can occur from rupture of a pulmonary bleb or penetrating chest injury with dissection of air into the subcutaneous spaces. In addition, penetrating abdominal trauma may introduce enough air into the abdominal wall to produce crepitus. Gas gangrene can occur as a complication of intra-abdominal surgery and produce crepitus of the abdominal wall. The gas is produced by anaerobic bacteria (usually clostridia species) and is a very specific clinical sign when found in the patient with wound infection.

Abdominal tenderness occurs as a result of irritation of the parietal peritoneum. While inflammation or irritation of the visceral peritoneum will cause abdominal discomfort, anorexia, and poorly localized pain, it will not cause tenderness and rigidity of the abdominal wall. Irritation or inflammation of the parietal peritoneum will stimulate the pain fibers of the parietal peritoneum and abdominal wall, creating the symptoms of localized pain and the signs of tenderness, rigidity, and rebound tenderness. Thus, if there is diffuse irritation of the peritoneum, as in diffuse peritonitis, there will be diffuse tenderness and rigidity.

Abdominal masses arise from the surrounding structures, thus the importance of topographic relationships. The presence or absence of tenderness of a mass gives important information as to its etiology. An appendiceal abscess will be tender as it inflames the parietal peritoneum, whereas carcinoma of the cecum will be nontender because there is no inflammation involved. Tympany over a mass implies it is gas filled. In the abdomen, this usually signifies the mass is dilated bowel, as only rarely will there be enough gas in any other mass to produce tympany.

Ascites is the presence of intra-abdominal fluid and occurs because of overproduction of intra-abdominal fluid or lack of absorption. It is most commonly seen in cirrhosis in which there is an increase in portal pressure and hypoalbuminemia. The increased portal pressure hydrostatically increases transudation of fluid through capillaries, whereas the hypoalbuminemia hydrostatically favors ascites formation. Thus, there is accumulation of fluid in the peritoneal space, which signifies severe liver disease. Other common causes of ascites include carcinomatosis in which there is both an increase in fluid formation and difficulties in clearing intraperitoneal fluid, and congestive heart failure in which there is a hydrostatic increase in venous pressure.

Task 3: Answer the following question correctly

1. What is the meaning of the inspection, percussion, palpation and auscultation?
2. what the purpose of the abdominal examination?

Task 4: Apply the the technique of abdomen phisiycal assment in your profession as a nurse

Task 5: Complete the following sentence in accordance with the above passage

1. The abdomen is inspected by the patient supine on an examining table or bed
2. Auscultation of the abdomen is performed for.....
3. Deep palpation of the abdomen is performed by

E. Abdominal Pain

When the nurse describes to a doctor the pain a patient is suffering from, she can describe what kind of pain it is and exactly where it is. Pains are described as severe if they are bad and slight if they are not very bad. A throbbing pain beats like a pulse, a constant pain is always present, while an intermittent pain comes and goes.

The exact location of the pain must be described. The diagram shows the different areas of the abdomen. The epigastrium is the area at the top of the diagram, just below the costal margin. At the bottom of the diagram is the supra pubic area. Above this area is the left lower quadrant and right lower quadrant. The right upper quadrant and left upper quadrant are between the lower quadrants and the epigastrium.

Task 6: Write a brief note on each of the following situation:

1. A patient has a bad pain just below the ribs...
2. He always fells pain in the upper part of his stomach on the right...
3. He fells a little pain just above the pubic area ...
4. He has a beating pain low in his abdomen on the left side...

Unit 13. NURSING PROCESS

A. Assessment

Five components of nursing process :



The assessment component involves:

1. The systematic of data collection about the patient's health status,
2. Analysis of the data to determine his actual and potential health needs,
3. and use of the data to formulate nursing diagnoses.

The nursing diagnoses then become the basis for the Nursing Care plan

The skills involved in interviewing a patient include the following:

1. Listening and questioning,
2. Observing and interpreting,
3. Synthesizing,
4. Incorporating what is learned into a plan of care.

To learn about a patient, one must talk little and listen a lot.

Nursing Diagnostic

Importance of Diagnosing:

1. Facilitating the individual care,
2. Promoting the professional accountability and autonomy the Independence area of nursing practice,
3. Providing an effective vehicle for communication among nurse and other health care professional,
4. Helping to determine the assessment parameters and,
5. Facilitating the continuity of care.

Examples:

1. Deficit fluid volume related to nausea and vomiting associated with pain and stress.
2. Chest pain related to reduced oxygenation of myocardium.
3. Activity intolerance related to decreased cardiac output.
4. Anxiety related to anticipation of financial difficulties because of being away from his business.
5. Ineffective breathing patterns related to depressant effects of medications.
6. Constipation related to decreased mobility, necrotic and fear

Planning

The planning component of the nursing process is developed. This phase involves the following:

- The assignment of priorities to the nursing diagnoses
- The specification of immediate, intermediate, and long-term goals of nursing action
- The identification of specific nursing interventions appropriate for attaining the goals
- The identification of interdependent interventions
- The specification of expected outcomes
- The documentation of the nursing diagnoses, goals, nursing interventions, and expected outcomes on the nursing care plan

Formulating the Nursing Care Plan:

The nursing care plan serves to communicate the following information to all members of the nursing team:

- The nursing diagnoses and their priorities,
- The goals of the nursing interventions,
- The nursing interventions, which are expressed in the form of nursing orders,
- The expected outcomes, which identify the expected behavioral responses for the patient,
- The critical time period within which each outcome must be met.

Implementation:

The activities of all persons involved in implementation are coordinated by the nurse.

- The nursing care plan serves as the basis for implementation
- The immediate, intermediate, and long-term goals are used as a focus for the implementation of the-signed nursing interventions
- While implementing nursing care, the nurse continually assesses the patient and his response to the nursing care.
- Alterations are made in the care plan as the patient's condition. Problems and responses change and as reassignment of priorities is required.

Evaluation

In this part, the nurse should evaluate what he has done. Whether the care plan is suitable or could overcome the clients' problem. or may cause the new problems.

Unit 14.
NURSING REPORT

All members of health care team must have the same information about clients to ensure an organized and comprehensive plan of care. Records and reports serve to communicate specific information about a client's health care so all interventions are directed toward the same goals.

Documentation and reporting are two of the most important functions a nurse performs. Unless information about a client's care is communicated with careful thought, serious errors can occur. Good documentation and reporting must reflect accurately the status of the client.

Six important guidelines must be followed for quality documentation and reporting:

1. Accuracy

Information about clients and their care must be correct. It is important for the nurse to report objective data resulting from specific observations and measurements.

Example:

Objective data : respirations 14 per minute, regular, with 2 cm chest excursion

Subjective data : 'client states pain 'feel likes a burning sensation'

2. Conciseness

Concise data are easy to understand. Lengthy notes are difficult to read. Sketchy notes may leave in impression that nursing care was hurried or incomplete.

Example:

Concise entry	Lengthy entry
L toes are warm, color pink, nail beds show good capillary return, dorsalis pedis pulse strong 4+, no inflammation or pain present	The client's left toes appear to be warm with color pink. There is no inflammation. There is good capillary return present. Dorsalis pedis pulse in left foot is strong. The client denies pain.

3. Thoroughness

A good report or record is thorough, with complete information about a client. Criteria to provide for thorough communication exist for certain health problems or nursing activities.

Examples of criteria for reporting and recording :

Topic	What to report or record
Symptom (pain, nausea, headache, dizziness) Sign (rash, tenderness on palpitation of body part, diminished breath sounds)	Description of episode, location of symptom, severity, onset, precipitating factors, frequency, duration, aggravating factors, relieving factors, associated symptoms. Location of sign, description or quality of finding, aggravating or relieving factors
Nursing care measures (enema, bath, dressing change)	Time administered, equipment used if appropriate, client's response to nursing action
Medication administration (analgesic)	Time administered, any required preliminary observations (pulse, blood pressure), client response (positive) or nursing measures taken if negative response occurs.
Patient teaching	Information or topic presented, method of instruction (discussion, role playing, demonstration), resources used (videotape, booklet) and evidence that client understand instruction

4. Currentness

Delays in recording or reporting can result in serious omissions and untimely delays for needed care. Decisions about a client's care based on currently reported information.

Activities must be communicated at the time they occur include administration of

medications or other treatments; preparations of clients for diagnostic tests or surgery; change in a client's status; admission, transfer, or discharge of a client; and treatment initiated for sudden changes in a client's condition. Routine activities such as bedmaking or giving a bath do not need to be charted immediately.

5. Organization

The nurse communicates information in a logical format or order. Health team members will better understand information given in the order in which it occurred. The following example compares a well organized note with a disorganized note.

Organized note	Disorganized note
<p>Client reports sharp pain in left lower quadrant of abdomen, worsened by turning. Positioning on left side offers minimal relief. Abdomen is tender to touch, rigid, dull to percussion. Bowel sounds are absent. Dr. Philid notified; ordered Demerol 75 mg IM for pain and a CT scan of abdomen</p>	<p>Client experiencing sharp pain in lower quadrant of abdomen. MD notified. Abdomen tender to touch, rigid with bowel sounds absent. Percussion note is dull. Demerol 75 mg IM ordered for pain. Positioning on left side offers minimal relief of pain. CT scan ordered of the abdomen.</p>

6. Confidentiality

All health member must keep confidential any information noted in the record. The nurse is legally and ethically obligated to keep information about a client's illness and treatment confidential. A legal suit can be brought against any nurses who disclose information about client without their consent. Only staff members directly involved in the client's care have legitimate access to the client's record.

Nurses and other health care professionals may have reason to use records for data gathering, research, or reason to continuing education. These are not breaches of confidentiality as long as the records are used as specified.

Written documentation of a client's health care is accessible to many personnel. Nurses are responsible for protecting records from unauthorized readers such as visitors. The nurse must know the location of the client's record at all times. If it is misplaced, every effort should be made to find it. The record is stored by the health care agency once treatment ends.

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