LOS ANGELES COUNTY COLLEGE OF NURSING AND ALLIED HEALTH
School of Nursing

Nursing 113 L:

INTRODUCTION TO MEDICAL/SURGICAL NURSING CLINICAL

Spring 2018

COURSE TITLE:	**N113L - INTRODUCTION TO MEDICAL/SURGICAL NURSING CLINICAL**
PRE-REQUISITES	Admission to the Nursing Program
UNITS:	4 Units
HOURS:	12 Hours per week
LENGTH:	18 Weeks
PLACEMENT:	Semester I
CONCURRENCY:	All semester theory courses are taken concurrently with the clinical courses.
COURSE DESCRIPTION:	This clinical course provides the student with opportunities to apply semester I theoretical content. The focus of the nursing process is on assessment of the adult client and applications of nursing interventions for acute care clients. The physiological, psychological, sociocultural, developmental and spiritual variables as identified in the Neuman System Model are utilized in assessing basic human responses. Selected methods of health promotion and health maintenance are practiced in a skills laboratory and applied in acute care setting. The student has an opportunity to practice basic psychomotor and communication skills and utilize an established plan of care.
COURSE OBJECTIVES:	Upon satisfactory completion of the course, the student will:

1. Apply the steps of the nursing process for safe patient-centered care of individuals with common health problems while assessing, promoting, and maintaining health utilizing evidence based practice.

2. Utilize the principles of therapeutic communication and nursing informatics in the care of individuals with common health problems while assessing, promoting and maintaining health.

3. Identify issues in teamwork and collaboration to function effectively with inter-professional healthcare teams in the care of common health problems for promoting health maintenance.

4. Identify legal and ethical behaviors that reflect the value of professional accountability, and to provide and improve quality of care for individuals with common health problems.

5. Identify nursing responsibilities in decision-making as a member of the inter-professional healthcare team in

assessing, maintaining and promoting health to achieve safe, quality patient-centered care.

6. Use selective teaching strategies utilizing evidence based practice in health promotion and maintenance based on individuals' values.

7. Correlate and value cultural variations in patient-centered care for individuals with common health problems.

STUDENT LEARNING OUTCOME: Students competently provide basic care through the beginning application of the nursing process and basic psychomotor communication skills to clients with common health problems in acute care settings.

TEACHING METHODS: Faculty utilize lectures/discussions, demonstrations and return demonstrations, video presentation, and skills lab simulation.

METHOD OF EVALUATION:

- Satisfactory completion of Intake and Output Exercises
- 70% or greater on Abbreviation Exercise
- 85% or greater on Drug Dosage Calculation Competency
- Satisfactory completion of weekly Clinical Worksheets
- Satisfactory grade on:
  - 2 Nursing Care Plans
  - Skills Competency Exam
  - Skills lab demonstrations and practice
- Active participation in clinical conferences
- Absences not exceeding 3 clinical days
- Tardies not exceeding 3 times
- Satisfactory grade at end of semester clinical evaluation

GRADING SCALE: Satisfactory/Unsatisfactory grading scale is used as the method of scoring and determining final grade in course. (See your Student Handbook on grading policy).

REQUIRED READING:

Berman, A., Snyder, S. & Frandsen, G. (2016). *Kozier & Erb's Fundamentals of nursing: Concepts, process and practice* (10th ed.) (Kozier, Erb). New Jersey: Prentice-Hall, Inc.

Kee, J.L., Hayes, E., & McCuistion, L.E. (2015). *Pharmacology: A patient-centered nursing process approach* (8th ed.). St. Louis: Elsevier.

Lewis, S.M., et.al. (2017). *Medical surgical nursing: Assessment and management of clinical problems* (10th ed.) St. Louis, MO: Mosby.

RECOMMENDED READING:

Ackley, B. & Ladwig, G. (2013). *Nursing diagnosis handbook: An evidenced-based guide to planning care* (10th ed.). St. Louis,

MO: Mosby.

Alfaro-LeFevre, R. (2013). *Applying nursing process: The foundation for clinical reasoning* (8th ed.). Philadelphia, PA: Lippincott

BRN Nursing Practice Act. http://www.rn.ca.gov/regulations/npa.shtml

Carpenito-Moyet, L.J. (2012). *Nursing diagnosis: Application to clinical practice* (14th ed.). Philadelphia, PA: Lippincott

Corbett, J.V. (2012). *Laboratory tests and diagnostic procedures with nursing diagnoses* (8th ed.). Prentice Hall.

Harvey, W. (2008). *Spanish for health care professionals* (3rd ed.). Hauppauge, NY: Barron's Educational Series, Inc.

Kee, J. LeFever, (2013). *Laboratory and diagnostic tests with nursing implications* (9th ed.). Prentice Hall.

Intranet Clinical Resource Materials:

- Policies and Procedures: LAC+USC Medical Center
- Micromedex Drug Information
- Intranet → Departments → Clinical Services → Nursing Services → Patient Education

Internet Clinical Resource Materials:

- Nursing Reference (download software application)
- Taylor's Video Guide to Clinical Nursing Skills: https://www.youtube.com/playlist?list=PLSIOO0iz0IyXQfF2bwfWensbHw6j8MEw4

PROFESSIONAL STANDARDS / CLINICAL EXPECTATIONS

PROFESSIONAL STANDARDS**:** Professional standards of the student are valuable qualities and necessary for your development in becoming a professional nurse. The qualities listed below are the **EXPECTED** standards at this level.

The student will demonstrate responsible, accountable and consistent behaviors in the following areas:

1. Provide safe and professional care.
2. Follow all hospital policies/procedures and accepted standards of care.
3. Be accountable for previously learned knowledge/skills.
4. Keep instructor and professional staff informed of the client's status in a timely manner.
5. Keep instructor and staff informed of whereabouts at all times.
6. Function effectively within nursing and foster open communication, mutual respect, and shared decision-making in a professional manner.
7. Prepare each day to care for their clients. Preparation includes knowledge of clients:
   - History/diagnosis
   - Expected findings
   - Current medication and effect on client
   - Diagnostic exam and rationale for exam
   - Anticipated complications
   - Rationale for plan of care
   - Cultural practices and values
   - Erickson's Developmental Stages
     - Client's expected behavior for developmental stage across the life span
     - Interventions/collaborations to promote client's growth and development
     - Priority teaching needs of client and family
8. Performs safe and consistent total client care. Total client care includes, but is not limited to:
   - ADL
   - Medication administration
   - Daily assessment
   - Education of client/family
   - Treatment
   - Documentation
9. Observe dress code standards according to the Student Handbook.

CLINICAL EXPECTATIONS**:**

1. Clinical evaluation is based on satisfactory completion of **ALL** objectives. Failure of one clinical objective will constitute an unsatisfactory grade for the course.

2. All written assignments are due at specified times. No late assignments will be accepted.

3. Students are expected to prepare the day before their clinical experience and clinical preparation sheets must be completed prior to 0700 on the day of the clinical. If students are not prepared they are deemed unsafe and will be dismissed from the clinical area. Dismissal will be counted as ABSENT and the student will be placed on academic warning. A second incident will constitute failure of a course objective.

4. Students are expected to actively participate in clinical conference.

5. The clinical competency must be completed with a passing grade. A second competency will be scheduled after notification of failure.

6. Clinical attendance is mandatory. Student is responsible for the information in Policy #210 – School of Nursing Attendance for Clinical Courses.

NOTE: Failure to adhere to professional standards / clinical expectations will result in a written academic warning.

CLINICAL PERFORMANCE EVALUATION SUMMARY

Student: _____ Class: _____

Faculty: _____ Date: _____ Rotation: _____ Grade: ☐ Satisfactory ☐ Unsatisfactory

Date: _____ Rotation: _____ Grade: ☐ Satisfactory ☐ Unsatisfactory

Date: _____ Rotation: _____ Grade: ☐ Satisfactory ☐ Unsatisfactory

Date: _____ Rotation: _____ Grade: ☐ Satisfactory ☐ Unsatisfactory

From: _____ To: _____ Midterm Grade: _____ Final Grade: _____

Clinical Outcomes		**S**	**U**
Clinical Outcome I: Nursing Process / Patient-Centered Care, Safety Apply the steps of the nursing process for safe patient-centered care of individuals with common health problems while assessing, promoting, and maintaining health utilizing evidence based practice.			
Objectives	**Learning Activity**	**Evaluation Criteria**	**MT/Final**	
A. Utilizes the steps of the nursing process in the assessment of the following: • health assessment status • culturologic • integument • HEENT • thorax, lung, and breast • cardiovascular/peripheral vascular • gastrointestinal • genitourinary • musculoskeletal • neurological	1. Completes a focus assessment on assigned client. 2. Submits two nursing care plans (NCP) with completed assessment tool. 3. Completes Elderly Health Focused Discussion Questions and discusses in clinical conference • Community settings	Discusses assessment data which reflect written guidelines. Written documentation: 1. Completes assessment tool as directed. 2. Writes care plan reflecting the effective use of nursing process in identifying priority needs. 3. Identifies and discusses priority health needs of the elderly client.		

Instructor Comments:

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Each instructor signs and dates comments

Student Comments:

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Each student signs and dates comments

Clinical Outcomes			S	U
Clinical Outcome I: Nursing Process / Patient-Centered Care, Safety (Cont'd) Apply the steps of the nursing process for safe patient-centered care of individuals with common health problems while assessing, promoting, and maintaining health utilizing evidence based practice.				
Objectives	**Learning Activity**	**Evaluation Criteria**	**MT/Final**	
B. Applies the nursing process in the care of individuals with the following problems: • peri-operative • pain • anemia • mobility • hypertension • oxygenation • inflammation • infection and wound healing • aberrant cell growth	1. Completes weekly clinical worksheet. 2. Completes pain, physical and other health assessments on assigned client.	1. Completes and submits clinical worksheet as a preparation for delivery of safe client care. 2. Discusses and writes accurate assessment data in a timely manner. Plans intervention appropriately.		

Instructor Comments:

Each instructor signs and dates comments

Student Comments:

Each student signs and dates comments

Clinical Outcomes			S	U
Clinical Outcome II: Communication / Nursing Informatics Utilize the principles of therapeutic communication and nursing informatics in the care of individuals with common health problems while assessing, promoting and maintaining health.				
Objectives	**Learning Activity**	**Evaluation Criteria**	**MT/Final**	
A. Develops therapeutic nurse-client relationships through effective use of common principles of verbal and non-verbal communication.	1. Demonstrates verbal and non-verbal communication with client and other members of the health care team. 2. Documents assessment and care.	1. Interacts with clients on a one-to-one basis focusing on client needs. 2. Responds appropriately to clients' questions and needs. 3. Communicates and documents data accurately.		

Instructor Comments:

Each instructor signs and dates comments

Student Comments:

Each student signs and dates comments

Clinical Outcomes	S	U
Clinical Outcome III: Collaboration / Teamwork Identify issues in teamwork and collaboration to function effectively with inter-professional healthcare teams in the care of common health problems for promoting health maintenance.		

Objectives	Learning Activity	Evaluation Criteria	MT/Final	
A. Identifies problems requiring collaboration for the provision of health promotion activities. B. Identifies issues for collaboration with other healthcare professionals in the management of clients with health problems	1. Lists issues or client problems that require collaboration for the management of care. 2. Consults with other healthcare team members regarding issues pertinent to client care.	1. Collaborates effectively with members of the health care team. 2. Discusses in clinical conference(s) the collaborative role on the ward.		

Instructor Comments:

Each instructor signs and dates comments

Student Comments:

Each student signs and dates comments

Clinical Outcomes			S	U
Clinical Outcome IV: Accountability / Quality Improvement Identify legal and ethical behaviors that reflect the value of professional accountability, and to provide and improve quality of care for individuals with common health problems.				
Objectives	**Learning Activity**	**Evaluation Criteria**	**MT/Final**	
A. Demonstrates personal accountability for own: • professional behavior • attendance & punctuality • professional appearance	1. Adheres to professional standards.	1. Attends clinical days in skills lab and clinical sites. 2. Tardies not exceeding 3 times and absences not exceeding 3 clinical/skills lab days. 3. Consistently maintains professional appearance and demeanor.		
B. Follows legal-ethical guidelines in the administration of medications.	1. Administers medications to assigned clients according to hospital policy and procedure. 2. Documents behaviors/activities related to medication administration.	1. Follows correct hospital policy/procedures in the administration of medications. 2. Verbalizes knowledge of medications (action, classification, therapeutic dose, side effects, contraindications, and nursing considerations). 3. Maintains medical asepsis during preparation and administration of medications. 4. Applies the eight rights during the preparation and administration of medications. 5. Documents medications, treatments, and care appropriately and in a timely manner.		

Instructor Comments:

Each instructor signs and dates comments

Student Comments:

Each student signs and dates comments

Clinical Outcomes	S	U
Clinical Outcome IV: Accountability / Quality Improvement (Cont'd) Identify legal and ethical behaviors that reflect the value of professional accountability, and to provide and improve quality of care for individuals with common health problems.		

Objectives	Learning Activity	Evaluation Criteria	MT/Final	
C. Demonstrates legal behaviors which reflect accountability for individual: • pre-operative • operative • post-operative • pain experience	1. Completes or reviews a pre-operative checklist. 2. Performs post-operative assessment. 3. Provides client care to a minimum of one client.	▪ Completes or reviews pre-operative checklist following hospital guidelines. ▪ Documents assessment data accurately. ▪ Safely provides client care within the scope of semester 1 clinical skills.		

Instructor Comments:

Each instructor signs and dates comments

Student Comments:

Each student signs and dates comments

Clinical Outcomes			S	U
Clinical Outcome V: Decision Making / Teamwork & Collaboration Identify nursing responsibilities in decision-making as a member of the inter-professional healthcare team in assessing, maintaining and promoting health to achieve safe, quality patient-centered care.				
Objectives	**Learning Activity**	**Evaluation Criteria**	**MT/Final**	
A. Utilizes decision-making process in developing a plan of care.	1. Lists the priority needs of assigned client.	Clinical Conference: 1. Discusses client's condition and assessment findings. 2. Prioritizes client's needs and care. Priorities are organized according to Maslow's Hierarchy of Needs. 3. States rationale for clinical decisions made.		

Instructor Comments:

Each instructor signs and dates comments

Student Comments:

Each student signs and dates comments

Clinical Outcomes	S	U
Clinical Outcome VI: Education / EBP Use selective teaching strategies utilizing evidence based practice in health promotion and maintenance based on individuals' values.		

Objectives	Learning Activity	Evaluation Criteria	MT/Final	
A. Identifies the teaching strategies for individuals with problems such as: • inflammation/infection • wound healing • peri-operative • pain management • nutrition/fluid intake • medications • disease process • safety measures • health maintenance and promotion.	1. Identifies teaching needs for assigned client with a health problem. 2. Implements and documents teaching plan to meet client needs.	Clinical Conference: 1. Discusses teaching/learning needs identified by students. 2. Discusses teaching strategies 3. Identifies the level of clients' understanding. 4. Identifies resources for clients' education. 5. Discusses the effectiveness or appropriateness of teaching plan in meeting the needs of the clients.		

Instructor Comments:

Each instructor signs and dates comments

Student Comments:

Each student signs and dates comments

Clinical Outcomes			S	U
Clinical Outcome VII: Cultural Sensitivity / Patient-Centered Care Correlate and value cultural variations in patient-centered care for individuals with common health problems.				
Objectives	**Learning Activity**	**Evaluation Criteria**	**MT/Final**	
A. Demonstrates cultural sensitivity including socioeconomic influences in assessing and promoting health of individuals with various beliefs and values.	1. Assesses cultural variations incorporating socioeconomic influences.	Clinical Conference: 1. Discusses cultural findings related to the client's condition. 2. Discusses health promotion measures that would demonstrate cultural sensitivity.		

Instructor Comments:

Each instructor signs and dates comments

Student Comments:

Each student signs and dates comments

	S	U
CLINICAL COMPETENCY EXAMINATION RESULTS		
Drug Dosage Calculation Competency		
Skills Competency		

Instructor Comments:

Student Comments:

NURSING SKILLS COMPETENCY READING LIST AND VISUAL AIDS		
Topic	**Readings** Fundamentals of Nursing	**Visual Aids** **Computer Lab***
DOCUMENTATION		
• Documentation Principles	Chapter 15, pp. 221-236	
VITAL SIGNS		
• Body temperature • Pulse • Respiration • Blood pressure • Height and weight • Documentation	Chapter 29, pp. 477-512 Chapter 30, p.522	01 Taylor's Vital Signs
• Oxygenation	Chapter 50, pp. 1241-1263, Oxygenation saturation, pp. 507-509, Inhaled medications, pp. 820-822	14 Taylor's Oxygenation
• Intake and Output	Chapter 52, pp. 1312-1313, 1334-1335	
ASEPSIS/UNIVERSAL/STANDARD PRECAUTIONS		
• Handwashing • Gloving • Donning and Removing Sterile Gloves	Chapter 31, pp.612-616	02 Taylor's Asepsis
• Isolation Technique - Caring for clients on isolation precautions	Chapter 31, pp. 602-612, 616-626	
HYGIENE		

NURSING SKILLS COMPETENCY READING LIST AND VISUAL AIDS		
Topic	**Readings** Fundamentals of Nursing	**Visual Aids** **Computer Lab***
• Personal Hygiene - Oral Care, Foot Care, Peri-Care - Giving a bed bath - Making an occupied bed	Chapter 33, pp. 669-717	07 Taylor's Hygiene
SURGICAL ASEPSIS		
• Donning and Removing Sterile Gloves • Care of Wounds - Preparing a sterile field - Cleaning a wound and applying clean dressing - Clean vs. sterile	Chapter 31, pp. 632-633 Chapter 31, pp. 626-631; Chapter 36, pp.846-856	08 Taylor's Skin Integrity and Wound Care
MATH		
• Basic Arithmetic • Conversion by: - Metric System - Apothecaries' System - Household system • Dosage calculation based on weight	See Dosage Calculation Module	
ACTIVITY		
• Turning/transferring of clients - Turning a client in bed - Moving a client in bed • Assisting a client to transfer from bed to chair • Range of motion exercises - Passive - Active • Restraints	Chapter 44, pp. 1010-1065 Chapter 32, pp. 659-666	09 Taylor's Activity
MEDICATIONS		

NURSING SKILLS COMPETENCY READING LIST AND VISUAL AIDS		
Topic	**Readings** Fundamentals of Nursing	**Visual Aids** **Computer Lab***
• Medications	Chapter 35, pp. 750-779	
• Aspirating medications - From a vial - From ampule	Chapter 35, pp. 784-789	
• Administering - Oral medications - Topicals - Eye installations - Ear installations - Nasal installations - Rectal installations - Vaginal installations - Subcutaneous injection - Intramuscular injection - Intradermal injection - Intravenous fluid therapy	Chapter 35	03 Taylor's Oral and Topical Medications 04 Taylor's Injectables
• Laboratory Values - Potassium - Sodium - Glucose - Blood Urea Nitrogen (BUN) - Creatinine - Red Blood Cell Count - Hemoglobin - Hematocrit - White Blood Cell Count - Platelet	*Corbett* • Correlating pages distributed throughout book • Specific pages available in class	
PHYSICAL ASSESSMENT		
• Overview of Physical Exam • Skin	Chapter 30, pp. 513-599	

NURSING SKILLS COMPETENCY READING LIST AND VISUAL AIDS		
Topic	**Readings** Fundamentals of Nursing	**Visual Aids** **Computer Lab***
• Head • Neck • Throat • Lungs • Breast • Cardiovascular • Abdomen • Rectum • Genitalia • Neurological • Musculoskeletal		

* All videos not shown in skills lab are recommended for viewing.

N113L Clinical Simulation

Student Learning Objectives:

1. Identify risk factors and disease process in a preoperative client
2. Evaluate the client's and/or family member's understanding to preoperative teaching
3. Develop an individualized plan of care for the nursing management of a preoperative client
4. Prioritize the implementation and approach to the nursing care of a preoperative client
5. Evaluate the client's response to interventions and modify the nursing care as appropriate
6. Identify legal ramifications of obtaining operative consent forms

Student Preparation for Clinical Simulation

1. Clinical simulation will account for 6 clinical hours. Preparation is required.
2. Students must arrive on time, in uniform, with all necessary equipment (stethoscope, black pen, pencil, pen light, calculator, etc.) to **Administration Building, Main Lobby.** Assigned date and time will be provided later in the course.
3. Medication administration according to 8 Rights/3 Checks.
    A. Review drug dosage calculations formulas (including IV therapy).
    B. Review injection sites and correct technique of medication administration.
    C. Review steps to programming Alaris pump/regulating IV drip rate to gravity.
4. Know normal ranges for lab values (CBC/Chem-7/LFTs)
5. Come prepared with resources.
6. Anticipate one of three conditions:
    A. Abdominal stab wound,
    B. Cholecystitis, or
    C. Appendicitis.
7. Review the following pages in preparation for the clinical simulation:
    A. Peri-operative Teaching: Berman Chapter 37, pages 868-878.
    B. Peri-operative Care: Lewis Chapter 17, pages 301-314.
    C. Preoperative checklist: Lewis Chapter 17, page 312

NURSING 113L CLINICAL COMPETENCY

Clinical Skills Examination: Tuesday and Wednesday, 05/08/2018 & 05/09/2018
All students will meet in Carlson Classroom at 0700 to sign in the attendance for both days.
The two competency days are full clinical days. Students are expected to be at the designated sites from 0700 – 1330.

Skills Practice Workshops: Both days from 0700 – 0730, check in with your instructor for clarification on any skills and distribution of examination appointment times. You may independently practice skills in Carlson Classroom (bring your skills bag). You may also use this time to study in the Library or use the Computer Lab. Each instructor will dismiss his/her group at the end of each clinical competency day.

GUIDELINES

In order to assist you with the preparation for your clinical competency examinations, review the following information on your N113L syllabus:

- Skills Competency Procedures on Medication Administrations, Intravenous Fluid Therapy, Wet-to-Moist Dressing, and Basic Physical Assessment
- Skills Competency Rubrics

SKILLS EXAMINATION

- The skills competency will consist of student's actual demonstration of randomly selected skills.
  - On Day One, two skills on medication administration: 1) medication via oral, eye, ear, subcut, or IM route with a time limit of 15 minutes each skill, 2) IVF therapy via gravity or pump with a time limit of 20 minutes will be demonstrated.
  - On Day Two, wet-to-moist dressing change with a time limit of 25 minutes will be demonstrated.
  - The basic physical assessment (random selection of one system assessment only) with a time limit of 15 minutes will be done at the clinical setting. Clinical instructor will announce the specific schedule for this competency with his/her respective clinical group.
- Students are expected to report promptly to their scheduled testing time.
- Students will be notified at the completion of their skills demonstration whether or not they passed that portion of the competency examination.
- All students will remain at one of the designated areas, i.e. meeting room, Library and Computer Lab on both days. These areas will be designated as quiet areas. Students are advised to bring school-appropriate materials to work on.
- **If the student is absent on the clinical competency examination day(s) or on the designated clinical demonstration time, it will be considered a failure. There will be no make- up for absences. A second competency will be scheduled.**
- Please remember that the students need to successfully complete the clinical competency examination to be able to progress to Semester 2.
- For any further question, your clinical instructor will answer or facilitate your understanding of the Skills Competency guidelines.

SKILLS LAB OBJECTIVES

Documentation

1. State the definition of documentation as related to nursing and health care records.
2. Identify several purposes of documentation in clients' records.
3. Describe the different methods that are used in health care documentations.
4. Explain the use of computers in the documentation of nursing and health care.
5. Discuss the advantages and disadvantages of standardized documentation forms.
6. Identify essential data that is required when using selected nursing/health care records.
7. List general guidelines for documentation in clients' electronic health records (EHR).
8. Protect confidentiality of clients' EHR.
9. Discuss healthcare facilities' documentation policies.

SKILLS LAB OBJECTIVES

Medical Asepsis

1. Define infection and healthcare associated infection.
2. Identify the sequence of events in the “Chain of Infection”.
3. Differentiate between Medical and Surgical Asepsis.
4. Define (Standard) Universal Precautions and list the principles used when delivering client care.
5. Discuss Standard (Universal) Precautions and how they protect health workers and clients from infection.
6. Discuss principles of isolation and the category-specific isolation recommended by the Centers of Disease Control and Prevention.
7. Discuss the psychosocial needs of a client in isolation.
8. Demonstrate medical aseptic techniques in the skills lab and clinical environment, i.e., hand washing, isolation technique.
9. Value own role in preventing infection.

SKILLS LAB OBJECTIVES

Oxygenation

1. Discuss the nursing actions required for safe and effective administration of oxygen, pulse oximetry, hand-held nebulizer (HHN), and metered dose inhaler.
2. Demonstrate the steps necessary to administer oxygen therapy.
3. Demonstrate proper application of oxygen delivery devices discussed.
4. Demonstrate the correct application of pulse oximeter.
5. Demonstrate the correct use of the peak flow meter, metered dose inhaler with or without spacer.
6. Demonstrate the correct assemblage of a hand-held nebulizer.
7. Recognize client's needs, expectations, and treatment health outcomes.
8. Demonstrate documentation of oxygen therapy in EHR.

SKILLS LAB OBJECTIVES

Activity/Exercise and Use of Restraints

Activity/Exercise:

1. Identify basic abbreviations related to activity and exercise.
2. Define basic terminology related to activity and exercise.
3. Identify the basic guidelines for safe and effective body movement.
4. Discuss the basic assessment components related to activity/exercise.
5. Identify the guidelines for proper technique for joint range of motion (ROM) exercises.
6. Demonstrate proper technique for joint range of motion (ROM) exercises.
7. Discuss the consequences of immobility (physiological/psychological).
8. Demonstrate proper body mechanics when positioning, moving, lifting, and ambulating clients.
9. Approach client in a supportive manner throughout the procedure.
10. Collaborate with physical therapist to reinforce client teachings.
11. Demonstrate documentation of activity/exercise in EHR.

Use of Restraints:

1. Identify situations warranting the use of client restraints.
2. State the types of restraints utilized.
3. Demonstrate proper application of restraints.
4. Discuss the healthcare facilities' Restraint Protocol.
5. Acknowledge the need for consistent monitoring of client while in restraints to ensure safety.
6. Demonstrate documentation of use of restraints in EHR.

SKILLS LAB OBJECTIVES

Vital Signs/Measurements

1. Define relevant terms related to vital signs, i.e., blood pressure, temperature, pulse, and respiration, height and weight, pain, input and output.

2. Describe factors, which affect these vital signs.

3. Identify the normal ranges for each vital sign.

4. Discuss guidelines necessary when obtaining vital signs.

5. Describe various ways vital signs can be obtained and compare the advantages and disadvantages between each method.

6. Identify situations when vital signs are to be reported to assigned registered nurse caring for the client.

7. Demonstrate correct technique when obtaining vital signs.

8. Recognize variations in vital signs that affect client care.

9. Demonstrate documentation of vital signs in EHR.

SKILLS LAB OBJECTIVES

Personal Hygiene/Bed Making

PERSONAL HYGIENE

1. Identify facts influencing personal hygiene practices within the hospital setting.

2. List the nursing activities performed when providing nursing care to clients.

3. State the purposes of a bath and types of baths given in a health care setting.

4. Describe guidelines for planning and implementing the following nursing interventions:
   a. skin care
   b. nail care
   c. care of the nose, mouth and ears.

5. Demonstrate hygiene procedures performed in the skills lab environment and in the clinical area.

6. Respect client by ensuring privacy during procedure.

7. Discuss healthcare facilities' protocol on personal hygiene.

8. Demonstrate documentation of personal hygiene procedures in EHR.

BED MAKING

1. Discuss the clinical guidelines for safe bed making.

2. Demonstrate the following bed making skills:
   a. occupied and unoccupied bed making
   b. postoperative open and closed bed.

3. Approach the client in a supportive manner during the procedure, specifically occupied bed making.

4. Discuss healthcare facilities' protocol on changing linens and bed making.

5. Demonstrate documentation of bed making procedure in EHR.

SKILLS LAB OBJECTIVES

Intake and Output (I&O) Monitoring

1. Discuss I&O monitoring and its significance to client care
   - Routine I&O
   - Strict I&O
2. Identify minimum and normal urinary output for an adult.
3. List clients who need to be placed on I&O monitoring.
4. Explain the use of calibrated receptacles in the conversion for accurate recording of I&O.
5. Memorize the list of liquid measurement equivalents for intake and output listed in syllabus.
6. Differentiate clear liquids from full liquids by naming 5 of each.
7. Explain the procedure for measurement of I&O for clients with various situations:
   - Fever/diaphoresis
   - Diarrhea
   - Foley catheter
   - Hourly urinary measurements using an urometer
   - Jackson Pratt/NG Tube/Hemovac or other drains
   - Clients who wear diapers.
8. Plan a schedule for a client on a fluid restriction per shift.
9. Discuss I&O monitoring for clients with various medical/surgical conditions.
10. Acknowledge the significance of standardization of I&O monitoring and documentation in providing care and monitoring health outcomes.
11. Document intake and output in EHR.

INTAKE AND OUTPUT
LIQUID MEASUREMENT EQUIVALENTS

Water (1 large cup) = 480 mL - 500 mL

Ice cube = 5 mL

Broth dish = 180 mL

Ice cream = 120 mL

Juice cup = 120 mL

Milk carton = 120 mL (small) 240 mL (large)

Jell-O = 120 mL

1 oz. = 30 mL

Styrofoam cup
a. Coffee = 150 mL
b. Tea = 150 mL

Please note the following:

1. Memorize these equivalents for the Intake and Output Quiz.

2. Measure all items that are naturally fluid at room temperature.

3. Do not measure foods such as the following: oatmeal, pureed foods. Remember these are solid foods prepared in a different form.

4. Complete the Intake and Output practice on the following page and bring to I&O class/Exercise Practicum.

INTAKE AND OUTPUT PRACTICE

Time	
0700	1 large cup of water served at bedside.
0710	voided 450 ml
0800	coffee 2 cups juice 1 cup milk (large carton) 2 oz.
1000	voided 250 ml
1200	soup 1/2 bowl broth 1/2 bowl milk 1 large carton Jell-O 1/3 serving
1300	voided 200 ml
1400	fresh water consumed by client. 6 oz. cold H_2O (water) remained in large cup.

Determine the total fluid intake and output from 0700 to 1400.

ANSWER SHEET TO INTAKE AND OUTPUT PRACTICE

Time	**mL in Container**	**Type**	**Amt. taken**	**Time**	**Urine**				
0700	480	H_2O	300	0700	450				
0800	150	Coffee x2	300	1000	250				
	120	Juice	120	1300	200				
	240	Milk	60						
1200	180	Broth	90						
	240	Milk	240						
	120	Jell-O	40						
1400			1150		900				

SKILLS LAB OBJECTIVES

Non-Parenteral Medication Administration

1. Discuss the nursing responsibilities related to medication administration.
2. Identify the "8 Rights" of medication administration.
3. Identify the types and essential parts of medication orders.
4. Describe the correct steps to verify a medication order prior to medication administration.
5. Discuss situations when medications are withheld.
6. Describe the essential steps for safely/correctly administering non-parenteral medications.
7. Demonstrate correct administration technique for oral medication, application of ointments and instillation of eye and ear drops.
8. Discuss the steps to follow when a medication error occurs.
9. Recognize own role in preventing a medication error.
10. Demonstrate accurate documentation related to medication administration in EHR.

Student Name: _____

SKILLS COMPETENCY RUBRIC

Medication Administration

All criteria must be satisfactory to pass the Skills Competency.

Criteria	Description	Satisfactory	Unsatisfactory/Needs Improvement
Skill Performance	Demonstrated the ability to perform all psychomotor steps and skills in an organized and competent manner.		
Asepsis	Observed aseptic technique during the skill demonstration.		
Safety	Followed hospital policies on client safety (e.g. client identifiers, allergies, "8 Rs" in medication administration, "3 checks", etc.)		
Communication	Verbally communicated to the client/mannequin the steps that need to be performed as necessary.		
Documentation	Accurately and completely documented in health record.		
Timeliness	Completed the skill demonstration in a given time frame.		

Instructor's Comments:

Instructor's Signature: _____ Date:_____

Evaluator _____ Student Name_____

SKILLS COMPETENCY PROCEDURES

Medication Administration (Non-Parenteral)

	S	U	Comments
ASSESSMENT/PREPARATION			
1. Verify medication orders in the computer - MD's orders and MAR. Check for medication allergies.			
2. Identify and assess client's condition and readiness for procedure. Determine assessment parameters, if indicated before administering medications.			
3. Wash hands.			
4. Select the correct medication from the storage device adhering to the eight rights. Check expiration date and integrity of each medication.			
5. Prepare each medication following the three-check method for medication administration adhering to the eight rights: <u>Unit Dose</u> • When taking medication from storage device • Before opening unit dose package to pour pill into medication cup at the bedside • After opening package at the bedside <u>Stock Medication</u> • When taking medication from storage device • Before placing medicine into medicine cup • Before returning container to storage place Place medication in separate cup for drugs that require assessment before administration (e.g., digoxin).			
6. Correctly calculate dosage, if necessary, and check dosage to be administered.			
7. Pour liquid by setting medicine cup on firm surface. At eye level read fluid level at the lowest point of the meniscus.			
IMPLEMENTATION			
8. Proceed to client's bedside with medications.			
9. Perform hand hygiene within 30 seconds of entering client's room.			
10. Login to EHR and open Medication Administration Wizard (MAW).			

	S	U	Comments
11. Check client's identification band, and ask client to state his/her name. Use two identifiers to identify client. Scan client's identification band barcode.			
12. Ask client for allergies.			
13. Scan the medication. Perform medication check before and after opening medication package adhering to the eight rights of medication administration.			
ORAL MEDICATIONS			
14. Assist client to a sitting or side-lying position.			
15. Determine assessment parameters, if indicated, before administering medications.			
16. Give a brief explanation to the client what medications are being given and the action the medication will produce.			
17. Give medication cup to client, or assist client in placing medication in mouth. Offer water. Assure that medications have been swallowed.			
18. Ensure client safety.			
19. Remove gloves and wash hands.			
20. Document in any required fields in HER.			
21. Sign EHR.			
EYE DROPS			
22. Wash hands. Don clean gloves.			
23. Assist client to a comfortable position, either sitting or lying.			
24. Give a brief explanation to the client what medications are being given and the action the medication will produce.			
25. Cleanse eyelid margins with damp washcloth or damp cotton ball, if necessary from inner canthus to outer canthus.			
26. With clean tissue resting below lower lid, gently press downward to expose conjunctival sac. Ask client to look at ceiling.			
27. Instill prescribed number of drops into conjunctival sac.			
28. After instilling drops, ask client to close eye gently.			

	S	U	Comments
29. Apply gentle pressure to nasolacrimal duct for 10 seconds.			
30. Ensure client safety.			
31. Remove gloves and wash hands.			
32. Document in any required fields in EHR.			
33. Sign EHR.			
EAR DROPS			
34. Wash hands. Don clean gloves.			
35. Assist client to a comfortable position, side-lying with the ear being treated uppermost.			
36. Give a brief explanation to the client what medications are being given and the action the medication will produce.			
37. Clean the pinna of the ear and the meatus of the ear canal using cotton-tipped applicators and solution to wipe the pinna and auditory meatus.			
38. Warm the medication container in your hand. Straighten the auditory canal by pulling the pinna upward and backward for clients over 3 years.			
39. Instill prescribed number of drops along the side of the ear canal.			
40. Apply gentle but firm pressure on the tragus of the ear for 10 seconds.			
41. Ask client to remain in the side-lying position for about 5 minutes to prevent the drops from escaping and allowing the medication to reach all sides of the ear cavity.			
42. Ensure client safety.			
43. Remove gloves and wash hands.			
44. Document in any required fields in EHR.			
45. Sign EHR.			
EVALUATION			
46. Assess client for drug action and side effects.			

SKILLS LAB OBJECTIVES

Health Insurance Portability and Accountability Act (HIPAA) Compliance

1. Identify the three components of HIPAA:
   - Privacy rule
   - Security rule
   - Transaction and Code Set Standards.

2. State five examples of Protected Health Information (PHI).

3. Discuss guidelines with regard to client confidentiality in handling client information in the following situations:
   - FAX'd information
   - Over the phone client information.

4. Discuss the healthcare facilities' confidentiality policies.

5. Discuss nursing responsibilities related to:
   - De-identification of health information
   - Notice of privacy practices
   - Use and disclosure.

6. Discuss client's right to PHI.

7. Discuss provider's responsibilities related to HIPAA: training; violations; fundraising; marketing; HIPAA security; civil and criminal penalties.

8. Value teamwork and collaborative intervention to protect clients' health information.

SKILLS LAB OBJECTIVES

Laboratory Values

1. Identify normal laboratory values and ranges.
2. Define the basic function of laboratory test components.
3. Describe the etiology of abnormal values.
4. Recognize the signs and symptoms of abnormal laboratory values affecting client care.
5. Identify pertinent Nursing Diagnoses in relation to abnormal laboratory values.
6. Discuss how to incorporate significance of findings into the clinical worksheet, in developing nursing care plans, and in the provision of individualized quality client care.
7. Interpret and apply basic laboratory results related to electrolytes, complete blood count and clotting studies.

SKILLS LAB OBJECTIVES

Parenteral Medication Administration

1. Use the steps of the nursing process in the administration of medications.
2. Utilize abbreviations and symbols common to the use of parenteral medications.
3. Discuss the eight rights that must be utilized to ensure accuracy in medication administration.
4. Discuss the selection of needle and syringe for injection of various medications.
5. Describe the procedure for reconstitution of a medication from a multidose vial/bottle.
6. List the steps for withdrawal of a medication from an ampule.
7. Discuss appropriate selection of injection sites and equipment with consideration to developmental factors.
8. Discuss the procedure for administration of parenteral injections: intramuscular (including Z-track technique), subcutaneous, and intradermal.
9. List three types of clients for whom the usual medication administration procedure must be modified.
10. Acknowledge the standardization and reliability of safety measures in medication administration.
11. Demonstrate documentation related to medication administration in EHR.

INJECTIONS FOR ADULTS

	Intradermal	**Subcutaneous**	**Intramuscular**
Location	Just below epidermis	Between epidermis and muscle	Into deep muscle tissue
Gauge	25 or 27 gauge	25 to 30 gauge	Deltoid: 23-25 gauge Ventrogluteal: 21-22 gauge
Needle Length	1/4 to 5/8 inch as small as possible	1/2 to 1 inch	1 to 1 1/2 inches
Syringe Size	Tuberculin 1 ml	1-3 ml syringe	3-6 ml syringe
Air Lock	No	See recommendations	See recommendations
Hold Skin	Taut	Grasp and bunch	Taut
Insertion Angle	5-15°	45° to 90°	90°
Max. Amt. Med.	usually < 0.5 ml	Never more than 1 ml	1-3 ml
Aspirate	No	See recommendations	Yes
Massage	No	No massage with anticoagulants/insulin	Not necessary
Special Considerations	Hold skin tautly Bevel upward Needle @ 15° angle Drug will produce a small bleb under the skin Do not rub	Do NOT aspirate Heparin Aspiration is not recommended with Insulin Do NOT massage anticoagulants/Insulin	Only use 1 ml at deltoid site Larger gauge may be used if medication is vicious
Common Sites	Inner aspect of forearm Scapula Upper aspects of anterior chest	Lower abdomen wall Dorsal upper arm Anterior thigh Upper back	Dorsogluteal Ventrogluteal Vastus Lateralis Rectus Femoris Deltoid

Berman, A., Snyder, S., Frandsen, G. (2016). *Fundamentals of nursing: Concepts, process and practice* (10th ed). p. 797.

Evaluator _____ Student Name_____

SKILLS COMPETENCY PROCEDURE

Medication Administration (Injections)

	S	U	Comments
ASSESSMENT/PREPARATION			
1. Verify medication orders in the computer - MD's orders and MAR. Check for medication allergies.			
2. Perform hand hygiene within 30 seconds of entering client's room. Identify and assess client's condition and readiness for procedure. Determine assessment parameters, if indicated, before administering medications. Perform hand hygiene upon exit of client's room.			
3. Wash hands.			
4. Select the correct medication from the medication storage device adhering to the eight rights. Check expiration date and integrity of each medication.			
5. Select correct size syringe and needle for injection.			
6. Correctly calculate dosage, if necessary, and check dosage to be administered.			
7. Draw up each medication following the three-check method for medication administration: • When taking medication from storage device • Before drawing up the medicine into the syringe • Before returning container to storage place in medication room or before administering medication to client in client's room			
8. Change needle, if necessary. Ensure needle remains sterile.			
IMPLEMENTATION			
9. Proceed to client's bedside with medications.			
10. Perform hand hygiene within 30 seconds of entering client's room.			
11. Login to EHR and open Medication Administration Wizard (MAW).			

	S	U	Comments
12. Check client's identification band, and ask client to state his/her name. Use two identifiers to identify client. Scan client's identification band barcode.			
13. Ask client for allergies.			
14. Scan the medication. Perform medication check adhering to the eight rights of medication administration.			
15. Choose an appropriate injection site. Assist client to an appropriate position for the injection. State and demonstrate the correct landmarks for IM injection.-			
16. Don clean gloves.			
17. Determine assessment parameters, if indicated, before administering mediations.			
18. Give a brief explanation to the client what medications are being given and the action the medication will produce.			
SUBCUTANEOUS INJECTIONS			
19. Ensure injection site is swabbed.			
20. Grasp subcutaneous tissue between thumb and forefinger, using non-dominant hand.			
21. Hold syringe like a dart or between thumb and forefinger, using dominant hand.			
22. Inject medication by inserting needle at a 45° or 90° angle, depending on the length of the needle.			
23. Withdraw the needle quickly. Immediately activate safety device on needle. Wipe the injection site with alcohol swab or dry sterile gauze. Note: Injections of anticoagulants and insulin are <u>not</u> massaged.			
24. Discard needle and syringe in sharps container.			
25. Ensure client safety.			
26. Document in any required field in EHR (medication given, site used).			
27. Sign EHR.			
EVALUATION			
28. Assess client for drug action and side effects.			

	S	U	Comments
IMPLEMENTATION			
INTRAMUSCULAR INJECTIONS			
29. Ensure injection site is swabbed.			
30. Spread skin taut between thumb and forefinger of non-dominant hand.			
31. Hold syringe like a dart or between thumb and forefinger, using dominant hand.			
32. Quickly insert needle at a 90° angle.			
33. Hold syringe barrel with non-dominant hand and aspirate by pulling back on the plunger. If blood does not appear, continue with the injection. If blood appears, withdraw the needle/syringe, discard, and prepare a new injection.			
34. Inject medication slowly.			
35. Withdraw needle quickly. Immediately activate safety device on needle. Massage area with alcohol wipe swab or dry sterile gauze (optional). Apply bandage.			
36. Discard supplies in appropriate areas.			
37. Ensure client safety.			
38. Remove gloves and wash hands.			
39. Document in any required field in EHR (medication give, site used).			
40. Sign EHR.			
EVALUATION			
41. Assess client for drug action and side effects.			

SKILLS LAB OBJECTIVES

Surgical Asepsis

1. Define terms commonly used with surgical asepsis.
2. Differentiate between concepts of cleaning, disinfecting and sterilization.
3. Discuss four (4) common methods of sterilization.
4. Discuss the basic principles of surgical asepsis.
5. List three (3) situations where surgical asepsis is used.
6. Recognize client's needs and readiness prior to procedure.
7. Demonstrate use of surgical asepsis principles when completing the following procedures in the skills laboratory or in the clinical environment:
    a. opening sterile field
    b. adding supplies to a sterile field
    c. donning sterile gloves
    d. completing the following types of dressing changes:
        1) dry dressing.
        2) wet to moist dressing change.
        3) irrigation of a wound and applying dressings.
8. Demonstrate correct removal of a dressing.
9. Demonstrate documentation of procedure in EHR.

Student Name: _____

SKILLS COMPETENCY RUBRIC

Wet-to-Moist Dressing

All criteria must be satisfactory to pass the Skills Competency.

Criteria	Description	Satisfactory	Unsatisfactory/Needs Improvement
Skill Performance	Demonstrated the ability to perform all psychomotor steps and skills in an organized and competent manner.		
Comfort	Assessed for pain and provided comfort including premedication for pain prior to procedure		
Asepsis	Observed aseptic technique during the skill demonstration		
Safety	Observed patient safety precautions during skill performance including proper handling and disposal of sharps after the procedure		
Communication	Verbally communicated to the client the steps that need to be performed as necessary		
Documentation	Accurately and completely documented in health record		
Timeliness	Completed the skill demonstration in a given time frame		

Instructor's Comments:

Instructor's Signature: _____ Date: _____

Evaluator _____ Student Name_____

SKILLS COMPETENCY PROCEDURE

Wet-to--Moist Dressing Change

	S	U	Comments
Assessment and Preparation			
1. Verify dressing change order in MD's orders.			
2. Perform hand hygiene within 30 seconds of entering room. Identify and assess client's condition and readiness for procedure.			
3. Assess appearance of old dressing. Assess client for pain and time of last pain medication. Administer pain medication if necessary. Perform hand hygiene upon exit of room.			
4. Gather sterile dressing equipment and materials (gauze dressing, sponges, abdominal pad, cotton-tipped applicators, solution, tape, sterile barrier, sterile gloves, clean gloves, disposal bag, and suture removal kit). Ensure proper integrity of materials and equipment, e.g., expiration date, discoloration.			
Implementation			
5. Perform hand hygiene within 30 seconds of entering client's room.			
6. Assist client to an appropriate position for the dressing change.			
7. Wash hands thoroughly.			
8. Don clean gloves. Assess the wound and any drainage while removing old dressings. Measure the wound.			
9. Remove and discard clean gloves.			
10. Prepare equipment/supplies. Set up sterile field, open and drop the sterile supplies onto sterile field. Pour ordered solution into solution container.			
11. Don sterile gloves. Clean wound with saline as needed.			
12. Saturate dressing with solution. Wring out gauze, if needed.			

	S	U	Comments
13. Pack wound loosely with wet dressing to edges of the wound to avoid skin maceration.			
14. Apply secondary dressing over wet dressings to absorb exudates. Cover dressing appropriately to protect wound from external contaminants.			
15. Remove gloves and discard them.			
16. Apply tape or secure dressing.			
17. Assist client to comfortable position.			
18. Don clean gloves to dispose old dressing materials appropriately.			
19. Clean area and store any reusable supplies in client's bedside drawer.			
20. Ensure client safety.			
21. Remove gloves and wash hands.			
Evaluation			
22. Assess how the client tolerated the procedure.			
23. Document procedure in EHR and collaborate effectively if changes in wound management are needed.			

SKILLS LAB OBJECTIVES

Physical Assessment

1. Identify the purposes of the physical assessment.
2. Explain the four techniques used in physical assessment: inspection, auscultation palpation, and percussion.
3. Demonstrate physical assessment in a systematic and organized manner.
4. Respect client by ensuring comfort and privacy throughout the procedure.
5. Identify expected normal findings and variations during physical assessment.
6. Demonstrate accurate and appropriate documentation and reporting of assessment findings.

Student Name: _____

SKILLS COMPETENCY RUBRIC

Physical Assessment

All criteria must be satisfactory to pass the Skills Competency.

Criteria	Description	Satisfactory	Unsatisfactory/Needs Improvement
Assessment	Performed complete system assessment (randomly chosen) utilizing all the assessment variables required in a specific system		
Skill Performance	Demonstrated physical assessment in an organized and competent manner Utilized assessment strategies (e.g. hearing acuity test by doing watch tick test, etc.) during the skill performance		
Asepsis	Observed the standard precaution/medical asepsis throughout the physical assessment.		
Safety	Followed fall precaution and safety procedures as necessary		
Communication	Verbally communicated to the client the assessment that needs to be performed		
Timeliness	Completed the skill demonstration in a given time frame		

Instructor's Comments:

Instructor's Signature: _____ Date: _____

Evaluator _____ Student Name_____

SKILLS COMPETENCY ASSESSMENT CRITERIA

One randomly selected system will be demonstrated for competency. All criteria must be demonstrated and/or verbalized during assessment to successfully pass the Skills Competency.

Basic Physical Assessment

	S	U	Comments
NEUROLOGICAL: • alert and oriented to person, place, time, and environment (X 4) • behavior appropriate to the situation. Explain if client's behavior is inappropriate • ability to follow commands • verbalization clear and understandable • intact reflexes • pupils equal, round and reactive to light and accommodation (PERRLA) SENSORY – PERCEPTUAL • vision • hearing • pain, dizziness			
RESPIRATORY: • rhythm and rate • symmetrical chest expansion • use of accessory muscle, dyspnea if present • cough - frequency, productive or nonproductive • sputum, amount, color, consistency, odor • breath sounds, anterior and posterior, bilateral • oxygen flow, rate and method of administration, O_2 saturation • chest tubes if in place, drainage--amount and color			
CARDIOVASCULAR: • strength and rhythm of pulses including apical • peripheral pulses (0 to +4) /bilateral equal • edema - location and extent (+1 to +4) • calf – redness, tenderness, pain, swelling • presence of IV or Saline lock • capillary refill less than 3 seconds			

	S	U	Comments
GENITOURINARY • mode of elimination--voiding with/without dysuria, foley catheter, condom catheter • frequency and amount of voiding • comparison of daily weights, if available • bladder distention • urine color, odor, sediment • penile/vaginal drainage, if any • presence of other drains, tubes, and their output • continent of urine			
GASTROINTESTINAL: • diet tolerance (type) • nausea and/or vomiting • inspection - distention, present or not, soft, contour • bowel sounds • last BM, color of stool, rectal bleeding, hemorrhoids • no pain with palpation: tenderness present or not, rigid or soft, pain • presence of drains or tubes and output • condition of mouth, oral mucosa, teeth • continent of stool			
INTEGUMENTARY: • general condition • skin color - warm, dry, intact • mucous membranes moist • turgor • reddened, blanched, rash, petechia, hives • decubitus ulcers with description (size, location, stage, odor)			
MUSCULOSKELETAL: • activity tolerance, general mobility, gait • normal ROM of all joints • absence of joint swelling and tenderness • traction, cast, sensation and pulses distal to involved extremity • contractures, foot drop • restraints • motor and sensory - strength and sensation with comparison of right to left side			

SKILLS LAB OBJECTIVES

Intravenous Therapy

1. State the purpose of intravenous therapy including types of solutions/medications.

2. Discuss intravenous therapy treatment protocol and guidelines to include the following:
   a. An intravenous order
   b. Protocol for maintaining the system to include:
      1) solution/bag.
      2) tubing.
      3) assessment of intravenous cannula site.
      4) site dressing changes.
      5) maintenance of the saline lock system.
      6) criteria for discontinuance of an intravenous therapy.

3. Demonstrate the proper psychomotor techniques of:
   a. Changing intravenous solution and tubing.
   b. Priming intravenous tubing.
   c. Flushing a saline access device.

4. List the common complications seen when administering intravenous therapy and discuss the nursing responsibilities to prevent or reduce their occurrence.

5. Demonstrate the proper psychomotor skills when initiating the following types of intravenous delivery systems:
   a. Gravity method:
      1) demonstrate the proper procedure for infusion of intravenous solution.
      2) ability to calculate the rate of infusion.
   b. Pump method:
      1) demonstrate the proper method of infusion of intravenous solution.
      2) ability to calculate the proper rate of infusion.

6. Value the significance of monitoring client's health outcomes during intravenous therapy.

7. Value technologies (IV pumps and EHR) that support error prevention and care coordination.

8. Demonstrate correct documentation related to intravenous therapy.

Student Name: _____

SKILLS COMPETENCY RUBRIC

Intravenous Fluid Therapy (IVF) Administration via Peripheral Venous Access Device

All criteria must be satisfactory to pass the Skills Competency.

Criteria	Description	Satisfactory	Unsatisfactory/Needs Improvement
Assessment	Performed assessment of IV access/line prior to administration		
Skill Performance	Demonstrated all psychomotor steps necessary for IVF skill performance in a systematic and organized manner		
Asepsis	Consistently observed aseptic technique during the procedure		
Safety	Followed safe medication administration per hospital policies and procedures		
Communication	Verbally communicated to the client the procedure that needs to be performed		
Documentation	Accurately and completely documented in health record		
Timeliness	Completed the skill demonstration in a given time frame		

Instructor's Comments:

Instructor's Signature: _____ Date: _____

Evaluator: _____ Student Name: _____

SKILLS COMPETENCY PROCEDURE

Intravenous Fluid Therapy (IVF) Administration via Peripheral Venous Access Device

Criteria for IV Therapy Administration	S	U	Comment
Assessment/Preparation			
1. Verify IVF therapy order in MD's order and MAR.			
2. Perform hand hygiene within 30 seconds of entering client's room.			
3. Check client's identification band, and ask client to state his/her name. Use two identifiers to identify client.			
4. Assess IV access (saline lock or peripheral IV). Perform hand hygiene upon exit of client's room.			
5. Gather all materials and equipment • Correct IV fluid solution • Correct type of tubing • IV Pole/IV Infusion pump • Saline flush (as needed) • Alcohol wipes or chlorohexadine (Chloroprep) and tape • Labels for IVF bag and tubing			
Implementation and Evaluation			
6. Perform hand hygiene within 30 seconds of entering client's room.			
7. Don clean gloves.			
8. Perform all procedures observing asepsis Demonstrate correct saline lock flush technique (as needed) Hang new IV tubing when necessary • Remove appropriate tubing from package • Clamp tubing • Spike container without damage to container or injury to self • Prime tubing, removing all large bubbles • Connect primary tubing to client's peripheral IV access			

9. Administer IVF using either: A. Gravity drip method to deliver IVF therapy at the correct rate • Calculate by gravity method with gtt factor specific for the tubing B. Infusion pump to deliver IVF therapy at the correct rate			
10. Label IVF bag and tubing.			
11. Ensure client safety.			
12. Remove gloves and wash hands.			
13. Document in EHR: • Type of IVF solution, additives if indicated-and rate • Condition of IV line, insertion site, and dressing • Client teaching and response			
Evaluation			
14. Evaluate IV site during infusion and how client is tolerating the therapy.			

SEMESTER I

REFERENCES and WORKSHEETS

SEMESTER 1
APPROVED ABBREVIATIONS – GENERAL LIST

a.c.	antecibum (before meals)
abd	abdominal; abdomen
ad lib	ad libitum (as desired)
ADL	activities of daily living
AKA	above knee amputation
AMA	against medical advice
amb	ambulatory
a.m., A.M.	ante meridiem (morning)
AMS	altered mental status
AU	aures unitas or auris uterque (both ears)
ax	axillary
BIB	brought in by
b.i.d.	bis in die (twice a day)
BKA	below knee amputation
BM	bowel movement
BP	blood pressure
BRP	bathroom privileges
BS	bowel sounds
bx	biopsy
CA	carcinoma, cancer
CAP	community acquired pneumonia
CAUTI	catheter associated urinary tract infection
CBD	common bile duct
CLABSI	central line associated bloodstream infection
C/O	complains of
COPD	chronic obstructive pulmonary disease
C&S	culture and sensitivity
CT Scan	computerized tomography scan
CX	culture
CXR	chest x-ray
d/c	discharge, discontinue
DIC	disseminated intravascular coagulation
DKA	diabetic ketoacidosis
DM	diabetes mellitus
d/o	disorder
DOB	date of birth
DTR	deep tendon reflex
DVT	deep vein thrombosis
dx	diagnosis
ECG, EKG	electrocardiogram
elix	elixir
ERCP	endoscopic retrograde cholangiopancreatography
ETOH	ethyl alcohol

FROM	full range of motion
FUO	fever of undetermined/unknown origin
FWB	full weight bearing
fx	fracture
GB	gallbladder
GSW	gunshot wound
GTT	glucose tolerance test
gtt	drops
HAP	hospital acquired pneumonia
HF	heart failure
HCT	hematocrit
hgb	hemoglobin
H&P	history and physical
HOB	head of bed
HTN	hypertension
hx	history
I&D	incision and drainage
I&O	intake and output, in and out
JP	Jackson-Pratt drain
JVD	jugular venous distention
KUB	kidney, ureter, bladder
L	liter
L/min	liters per minute
LE	lower extremity
LLQ	left lower quadrant
LOC	level of consciousness
LUQ	left upper quadrant
MDR	multidrug resistant
Mets	metastases
MI	myocardial infarction
MN	midnight
min	minute
MOM	milk of magnesia
MRI	magnetic resonance imaging
MRSA	methicillin-resistant staphylococcus aureus
MVA	motor vehicle accident
N/C	no complaints
NG	nasogastric
NKA	no known allergies
NPO, npo	nothing by mouth
NSR	normal sinus rhythm
N&V, N/V	nausea and vomiting
NVD	nausea, vomiting and diarrhea
NWB	nonweight bearing
OD	oculus dexter (right eye)
OU	oculus uterque, each eye (both eyes)
O/D	overdose
OSH	outside hospital
OOB	out of bed
O&P	ova and parasites
ORIF	open reduction internal fixation

OS	oculus sinister (left eye)
OT	occupational therapist
PCN	penicillin
PERRLA	pupils equal, round, reactive to light and accommodation
p.m., P.M.	post meridiem (evening)
PMH	past medical history
PNA	pneumonia
PO	per, os, by mouth
prn	pro re nata (as needed)
PSH	past surgical history
pt	patient
PT	physical therapy
PWB	partial weight bearing
q	every
qh	every hour
qhs	every hour of sleep (at bedtime)
q.i.d.	quater (in) die (four times a day)
RLQ	right lower quadrant
RUQ	right upper quadrant
R/O	rule out
RT	respiratory therapy
RTC	return to clinic
Rx	prescription
SCD	sequential compression device
SH	social history
SOB	shortness of breath
S/P	status post
subcut	subcutaneous
S/S	signs and symptoms
STAT	statim (immediately)
SW	stab wound or social work
SZ	seizure
t.i.d.	three times a day (ter in die)
tx	treatment/therapy
UO/UOP	urinary output
US, UTS	ultrasound
UTI	urinary tract infection
VRE	vancomycin resistant enterococci
VO	verbal order
VS	vital signs
VSS	vital signs stable
WBAT	weight bearing as tolerated
W/C	wheelchair
W/D	wet to dry dressing change
WNL	within normal limits
YO	year old

SYMBOLS

$\overline{a}$	before
$\overline{p}$	after
L	left
R	right
♀	female
♂	male
$\overline{c}$	with
$\overline{s}$	without
$\overline{x}$	except
1^o	primary
2^o	secondary
Δ	changed to
~	approximate
+	positive, present
—	absent, negative

60-Second Situational Assessment"

Purpose: This exercise is designed to assist you in the development of "situational awareness", or the art of client observation. This includes routine use of a general survey (observation) of the client, family, and environment during initial assessment and periodically throughout the day. Situational awareness promotes a safe client care environment and helps the nurse prioritize clinical problems and safety concerns.

Directions: Enter the client's room and observe the client, family, and environment for up to 60 seconds, while reviewing the following questions in your mind and noting any concerns. Discuss notes/concerns with instructor.

General Observation:	Question to Ask:	Situational Notes/Concerns:
ABCs without touching the client	• What data leads you to believe there is problem with *the airway, breathing, or circulation?* • Is the problem urgent/ or non-urgent? • What clinical data indicates immediate action is needed? Why? • Who should you contact? Do you have a recommendation/suggestion for treatment?	
Tubes and Lines	• Does the client have any tubes or an IV? • Is the IV solution correct (compared to the MAR)? • Why does the client need these tubes? • Are there any complications with the tubes? • What further assessment needs to be done?	
Respiratory Equipment	• Is the client on oxygen? • If **yes**, what should you be monitoring? • If **no**, does the client need oxygen? • How do you know it is functioning properly?	
Client Safety Survey	• What are your safety concerns with this client? • Should you report this problem? • If yes, who will you report to?	
Environmental Survey	• Are there any environmental hazards? • If yes, how will you manage these concerns? • Are necessary items within client's reach?	
Sensory	• What are your senses telling you? • Do you hear, smell, see, or feel something that needs to be explored? • Does this situation seem "right" overall?	

ASSESSMENT CHECKLIST

SUICIDE RISK

- ❑ On admission and if issue arises during hospitalization
- ❑ If yes having to suicidal ideation, do full assessment and repeat Q 8 hours

NEUROLOGICAL

- ❑ WNL: Awake and alert, oriented to person, place, time and purpose. Eyes open spontaneously, speech clear, face symmetrical, sensation intact all extremities
- ❑ PERRLA
- ❑ Head tenderness? Check for lesions, nodules, depressions, symmetry
- ❑ Lymph nodes: palpable or non-palpable (watch face for any grimacing)
- ❑ Conjunctiva sac: color, lacrimal sac area: swelling? excessive tearing?- palpate gently- regurgitation?
- ❑ Sclera: color
- ❑ Note any eye pain, orbital swelling, redness
- ❑ Ptosis: (present or not)
- ❑ Palpate auricles- tenderness?
- ❑ Cerumen
- ❑ Identify odors? (coffee, alcohol?)
- ❑ Ask if any difficulty smelling
- ❑ Tremor?
- ❑ Numbness?
- ❑ Dizziness?
- ❑ Vision: glasses? contact lenses? Can count fingers at 3 ft, 4ft, and 5ft?
- ❑ Hearing: able to hear normal tone voices? Whispers? Use of hearing aids

RESPIRATORY

- ❑ WNL: Breathing even and unlabored on room air
- ❑ Rate, rhythm (regular vs. irregular)
- ❑ Symmetrical chest expansion
- ❑ Breath sounds: check bilaterally/ AP
- ❑ O_2 Therapy
- ❑ Oxygen saturation
- ❑ Coughing? Productive? Sputum- consistency, color, amount, frequency?
- ❑ Breast Symmetry? Swelling? Dimpling? Discharge?
- ❑ Ask if pt doing self-breast exams
- ❑ Sinus- tenderness?
- ❑ Nares- patent bilaterally?

CARDIOVASCULAR

- ❑ WNL: Skin warm and dry to touch, pulses palpable in all extremities, brisk capillary refill, no edema
- ❑ IV site, saline lock / peripheral IV? IV fluid?
- ❑ Edema- location, pitting (trace to 4+)
- ❑ Apical pulse (regular, irregular), rate, S1/S2 heard
- ❑ Peripheral pulses (0-4+) equal bilaterally?

GASTROINTESTINAL

- ❑ WNL: abdomen soft, non-tender, absence of N/V/D, constipation.
- ❑ NPO?
- ❑ % of meal consumed
- ❑ Assistance needed?
- ❑ Chewing, swallowing problems?
- ❑ Diet tolerated? Type?
- ❑ Abdominal scars? drains?
- ❑ Bowel sounds- Auscultate FIRST then palpate
- ❑ Pain on palpation?
- ❑ Any nodules, masses felt on palpation?
- ❑ Abdomen (soft, hard, rigid, or tender)
- ❑ Last BM? (amount, color, consistency)
- ❑ Continent of stool
- ❑ Oral status: lips (dry/moist), Teeth (color, missing teeth, dentures)
- ❑ Any feeding tubes?

GENITOURINARY

- ❑ WNL: Urinates spontaneously w/out difficulty, clear, yellow urine.
- ❑ Note presence of catheter (indwelling or condom?)
- ❑ Any difficulty? Pain?
- ❑ Odor?
- ❑ Clarity: clear or cloudy?
- ❑ Color
- ❑ Bladder distention?
- ❑ Continent?
- ❑ Penile/vaginal discharge noted or stated

MUSCULOSKELETAL

- ❑ WNL, moves all extremities, no physical limitations, performs ADL's independently
- ❑ ROM
- ❑ Joint swelling?
- ❑ Gait
- ❑ Alignment/curvatures
- ❑ Hand-grasp bilaterally
- ❑ Leg strength-against gravity and my strength
- ❑ Orthopedic/Assistive devices
- ❑ Casts/injuries: note neurovasc checks
- ❑ Note restraints if present
- ❑ Movement: smooth and coordinated?

INTEGUMENTARY

- ❑ WNL: intact, warm/dry, absence of rash, blisters, bruising, lesions, puritus, hives, wounds.
  *Note: some areas may not be visible due to dressings.
- ❑ Mucous membranes and oral mucosa moist and intact. Note color of skin
- ❑ Skin turgor: tenting? reforms immediately?
- ❑ If there are lesions: note type, size, shape, etc. Maybe more than one type.
- ❑ Hair/scalp (texture, distribution, lesions, alopecia, shaven scalp?)
- ❑ Nails (shape, texture)
- ❑ Pressure areas: decubitus (stage, size, location, odor)
- ❑ Dressings (intact, drainage?)
- ❑

BEHAVIOR

- ❑ WNL: interactive, calm, cooperative
- ❑ Communication: main language spoken
- ❑ What most troubled by?
- ❑ Any recent stressful events prior to/during hospitalization?

LEARNING/TEACHING

- ❑ Learning needs:
  - ➢ Medication
  - ➢ Nutrition
  - ➢ Equipment
  - ➢ Disease Process
  - ➢ Safety
  - ➢ Pre/Post-Operative
  - ➢ Discharge instructions
  - ➢ Others
- ❑ Barriers to learning
- ❑ Readiness to learn

COMFORT

- ❑ WNL: denies pain/reports acceptable level of comfort
- ❑ Spiritual needs expressed or identified?
- ❑ Pain scale, location and characteristics?

OTHER PERTINENT DATA/ NOTES

- ❑ All prior health problems include surgeries w/approx. dates.
- ❑ All medications prior to hospitalization; pts. Reason for taking meds incl. all prescriptions and OTC meds
- ❑ List all significant family health hx.
- ❑ Allergies?
- ❑ Substance abuse
  - ➢ Alcohol? type? amount consumed? Last use?
  - ➢ Drugs? type? amount consumed? Last use?
  - ➢ Smoking?/per day
  - ➢ Caffeine?/cups per day
- ❑ Admitting dx. Discuss briefly
- ❑ Current dx.
- ❑ Summarize what has happened to the patient since being admitted to the hospital incl. all diagnostic studies
- ❑ List all medical orders (incl. all rationales for med. and tx.)
- ❑ Urinalysis
- ❑ Diagnostic test – why/what for? results?
- ❑ Predominant stressors?
  - ➢ Intra – w/health
  - ➢ Inter – w/family, other people
  - ➢ Extra – financial, job, others?

WARD ORIENTATION GUIDE

WARD_____

PHONE # _____

TOTAL # BEDS_____

1. **Indicate name and function of the following hospital personnel**.

NAME FUNCTION

Chief Nursing Officer (CNO)_____

Area Nursing Director_____

Nurse Manager_____

Charge Nurse (if applicable)_____

RNs_____

Nursing Attendants_____

Ward Secretary_____

Social Worker_____

Dietitian_____

2. **Which rooms are considered "clean"? Which sinks are "clean?" "Dirty?"**

3. **Indicate location of:**

Wash basins
Emesis basins
Urinals
Bed pans
Oral hygiene supplies
Soap, shampoo, lotion, etc.
Disinfecting solution
Supplies for dressing, IV, etc.
Linen hampers
Biohazard containers
Fire extinguishers (hose, water, chemical CO_2)
Fire exits - fire alarms (what is the procedure for reporting a fire), emergency cart
Procedure manual

4. **Identify items in client's unit and handle controls of:**

a. Bed control
c. Call light system and how it works
d. Bed curtains
e. Overbed table
f. Bedside table
g. Bedrails
h. Chair
i. Trash and biohazard containers
j. Linen
k. Wash basin
l. Emesis basin
m. Bed pan

5. **What type of information is found in the**:

a. Staff's Assignment sheet

6. **Find and read the consent for care. Is it signed?**

7. **What items are found in the nurses' station?**

8. Make a list of all safety measures you observed being practiced or should be practiced on your ward and bring to conference for discussion.

Student's Name: _____ **Date Submitted:** _____

CLINICAL WORKSHEET RUBRIC

Section	Description	Satisfactory	Unsatisfactory/Needs Improvement
Records from Charts	Information collected pre- clinical (client dx, hx) is complete. Chief complaint that brought client to hospital, use "OLD CART" format.		
Pathophysiology	Comprehensive discussion of current primary diagnosis. Secondary diagnosis (es), brief discussion only.		
Medical Information and Vital Signs	Complete list of medical information including vital signs.		
Pertinent Data	Identify significance of lab value to your client's disease process and nursing interventions specific to your client. Trend if applicable.		
Organizational Plan	Identify planned activities throughout the shift.		
Summary of Medications	Follow the guidelines for medication preparation.		
Nursing Diagnoses	Appropriate utilization of NANDA diagnoses: arranged in priority, stated in the format of PES/PE.		
Goals	Goals must be observable, attainable/achievable, measurable, and stated realistically with time frame.		
Interventions	Appropriate, independent nursing intervention plan for Nursing Diagnoses. Utilize assess, do, teach, & document.		
Rationale	Each intervention should have a scientific rationale.		
Implementation	Independent nursing intervention plan has been implemented. Client's response or result is listed per intervention		
Evaluation	Goal is met/partially met/unmet. If goal is not met or partially met, follow-up revision plan is clearly written.		

Instructor's Comments:

Instructor's Signature: _____ Date: _____

Student's Name: _____ Date: _____

CLINICAL WORKSHEET

CLINICAL PREPARATION PRIOR TO CLINICAL DAY:

Client's Initials: _____ Code Status: _____ Admission Date: _____

Room # _____ Age: _____ Gender: _____

Client's Chief Complaint(s):

PMH:

PSH:

SH:

Admitting Diagnosis (es):

Current Diagnosis(es):

Pathophysiology of Diagnosis (es): Include typical signs and symptoms seen in the disease process, abnormal labs and possible complications. Indicate common treatment modalities (Site references utilized)

Medical Information:
1. Allergies: _____
2. Diet: _____
3. Activity Level: _____
4. Nursing Treatments:

Client's parameters
Notify MD on the following:

Vital Signs:
Date: _____ Time: _____
T_____ BP _____ HR ____ RR _____ Pain _____ O_2 Sat_____

Lab Values: Date: Date:

Lab Test	Normal Values	Admission Labs	Lab Results	Significance of Findings
Na^+				
K^+				
Glu				
HCT				
Hgb				
RBC				
WBC				
Platelets				
BUN				
CR				
Other significant lab results				

*After midterm, include three (3) additional labs

Organizational Plan for Tuesday. Note any change for Wednesday's Plan

0700:
0800:
0900:
1000:
1100:
1200:
1300:

SUMMARY OF MEDICATIONS

Time (Frequency)	Classification	Medications (generic & trade names)	Action of Drug	Dosage (normal dosage range)	Route	Indication(s) for your client	Side Effects	Nursing Responsibilities/ Client teaching

*Cite references

Nursing Diagnosis	Goal	Independent Nursing Interventions
1.		
2.		

Select one of the nursing diagnoses applicable to your client this week and complete a nursing care plan using the format on the next page. Cite reference(s).

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
		Goal: ***Independent Nursing Interventions:***		***Goal:***

LAC School of Nursing
N113L – Introduction to Medical Surgical Nursing Clinical –Fall 2017

Student Name:_____ Client Initials:_____ Room #:_____ Age:_____ Gender:_____

Allergies:_____ Reactions:_____ Admission Date:_____ Ethnicity:_____ Language:_____

Diet: _____ Activity:_____ Code Status:_____ Latest VS _____

Past Med Hx:

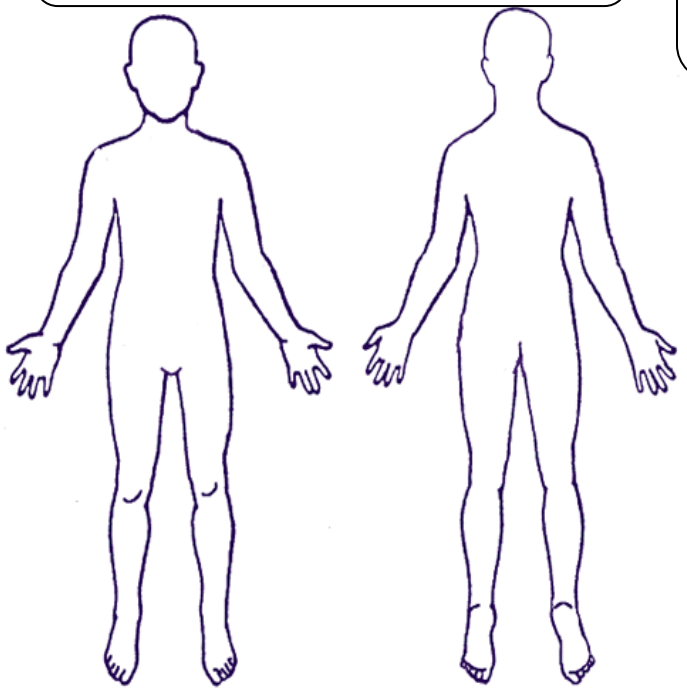
Past Surgical Hx:

Social Hx:

Chief Complaint:

Current Medical Dxs:

S/S (Textbook):



Client Assessment Findings:

Pathophysiology
Current Dxs:

Secondary Dxs (list):

Time	Medications (dose, route, frequency)	Indication(s)

IVF:
Tx:

Abnormal Labs	Significance

Diagnostics & Results:

Priority NDx #1:	Priority NDx #2:	Potential Complications (list):
Goal:	Goal:	
Interventions:	Interventions:	

Submit one completed ADPIE

SBAR COMMUNICATION REPORT

Name of Student: _____ Date: _____
Client's Name and/or Initial _____ Room # _____

S	**Situation:** Gender: _____ Age: ____ Ethnicity/Language _____ Date of Admission: _____ Chief Complaints: _____ Admitting diagnosis: _____ VS: BP ____/____ Pulse ___ Resp ___ Temp ___ Pain level ____ location _____
B	**Background:** Pertinent Medical History (including allergies): Pertinent Surgical History: Code status:
A	**Assessment:** Activities: ☐ Ambulates ☐ Chair ☐ Bedrest ☐ Fall Risk Other: _____ Diet:_____ ☐ Fluid Restriction: _____ Neuro: ☐ Oriented x _____ ☐ Confused Cardiovascular: Chest Pain: Y / N Dizziness: Y / N Resp: Breath sounds _____ O2 Sat: _____ O2 L/min _____ GI: Last BM: _____ ☐ Incontinent ☐ NGT ☐ GT ☐ Tube feeding ☐ Colostomy/Ileostomy Skin: ☐ Pressure sore(s) Stage: _____ Location: _____ Wound: Site: _____ Wound Care: _____ Urological: ☐ Voiding Last void: _____ ☐ Foley ☐ Suprapubic ☐ Incontinent ☐ Diapers Abnormal Lab Values: _____ Rehab: ☐ PT ☐ OT ☐ Speech Therapy Pertinent Medications: _____ Pain mgmt: Med given: _____ Time: _____ Response: _____ IV: Site: _____ ☐ SL ☐ Continuous IV Solution: _____ Treatments: _____ Isolation type: _____ Psychological/Special needs: _____
R	**Recommendations:** Priority Nsg Dx: Focus of care: Follow-up needed on these tests: ☐ CXR ☐ CBC ☐ CHEM ☐ C/S ☐ EKG ☐ ABG Other: Discharge plans/needs and/or Social Services Needs: Other Needs: Narrative:

COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICES

LOS ANGELES COUNTY + USC MEDICAL CENTER

Check appropriate box for Yes, No, or NA / Record comments as necessary.	Ward RN
1. General Consent	
a. General Consent complete: signature, date witness (& relationship of signee to patient if indicated).	☐ Yes ☐ No
b. Advance Directive response is noted on General Consent.	☐ Yes ☐ No ☐ NA
c. If Advance Directive response is yes, it is present on chart.	☐ Yes ☐ No ☐ NA
2. Surgical Consent completed:	
a. All fields are responded to (all blanks filled)	☐ Yes ☐ No
b. Surgery identified on consent matches physician documentation	☐ Yes ☐ No
c. Informed consent validated by patient/family	☐ Yes ☐ No
d. Patient or authorized designee signature	☐ Yes ☐ No
e. Physician signature	☐ Yes ☐ No
f. Date (day/month/year) and time documented with each signature	☐ Yes ☐ No
g. Witness signature and title are present and legible	☐ Yes ☐ No
h. Two witness signature & title, if patient signature illegible or patient is unable to sign name	☐ Yes ☐ No ☐ NA
i. Translators & title recorded, if applicable, Language: _____	☐ Yes ☐ No ☐ NA
j. Sterilization consent signed within 180 days, if applicable	☐ Yes ☐ No ☐ NA
3. Blood consent completed: signatures, dates, times	☐ Yes ☐ No ☐ NA
4. Site of surgery completed	
a. Verified with physician note & consent	☐ Yes ☐ No
b. Surgeon marked site & pt initialed site in ward, clinic or holding area (not in OR)	☐ Yes ☐ No ☐ NA
5. Preop Work-up (chart)	
a. H & P on chart	☐ Yes ☐ No
b. Hgb/Hct (all females, males over 40) Hgb: _____ Hct: _____	☐ Yes ☐ No ☐ NA
c. Chest X-ray (all adults)	☐ Yes ☐ No ☐ NA
d. ECG, if over 45 years old	☐ Yes ☐ No ☐ NA
e. Preop orders completed. Time pre-op meds given: _____	☐ Yes ☐ No
g. Pregnancy test	☐ Yes ☐ No ☐ NA
6. Identification	
a. ID card, band, & chart (face sheet) all match, & verified with patient/family. All ID includes first & last name, & MRUN #, & is correct & legible	☐ Yes ☐ No
b. Complete chart & ID sent to OR & ID band on patient	☐ Yes ☐ No
7. Physical/Psychological	
a. Family/other aware of surgery	☐ Yes ☐ No ☐ NA
b. Allergies or no allergies recorded. Allergic to: _____	☐ Yes ☐ No
c. NPO status or last PO intake recorded. Time of last intake: _____	☐ Yes ☐ No
d. BP & TPR within 4 hrs recorded. BP: _____ Temp: _____ R: _____ P: _____ Time: _____	☐ Yes ☐ No
e. Height & weight (actual or estimated) recorded: Height: _____ Weight: _____	☐ Yes ☐ No
f. Isolation type noted, if applicable. Type: _____	☐ Yes ☐ No ☐ NA
g. Indwelling catheter or time of last urination recorded (except infant/toddler). Time of last urination: _____	☐ Yes ☐ No ☐ NA
h. Property, clothing and valuables secured in unit or sent home with family and not send to OR	☐ Yes ☐ No ☐ NA
i. Patient does not have nail polish or make-up	☐ Yes ☐ No
j. If Patient diabetic, Last blood sugar _____ Date/Time: _____ Last insulin given, Type/Dose/Time: _____	☐ Yes ☐ No
k. Was the patient taking Aspirin or other NSAIDs, type: _____ Date and Time: _____	☐ Yes ☐ No
l. Cast bivalve; traction released, if appropriate	☐ Yes ☐ No ☐ NA
m. IV lines present & patent – Type of IV fluids: _____ Rate: _____	☐ Yes ☐ No ☐ NA
n. Check if TPN/Medication is Infusing _____ Discontinue _____ Type: _____ Rate: _____	☐ Yes ☐ No ☐ NA

Signature of Ward RN who Completed Checklist	Date	Time
Signature of Ward RN releasing pt to OR	Date	Time
Signature of Admitting Preop/OR RN who reviewed the ward checklist	Date	Time
Signature of Anesthesiologist/Designee	Date	Time

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)

T-H49

FILE IN MEDICAL RECORD

PAGE 1 OF 1

PRE-OPERATIVE CHECKLIST

H49 (4-14)

STUDENT'S NAME _____ DATE_____

CLINICAL REFLECTION QUESTIONS

Purpose:

The purpose of this activity is to provide the student an opportunity to debrief, to reflect on what was learned, and to explore methods to improve clinical learning.

Directions:

Please take a few minutes and collect your thoughts about your clinical day. Write down your responses to the questions that follow. These responses will prepare you for the discussion in the post clinical conference. Your instructor will direct the conference by focusing on the questions and your responses. There is no right or wrong response. This activity can only be successful if you actively participate with your colleagues.

1. What was a valuable learning experience or insight gained during your clinical experience this week?

2. What issues or concerns remain unclear or need clarification regarding the clinical experience? How would you go about addressing these issues or concerns?

3. If you could redo the clinical experience, what would you change and why?
   What, if anything, would be a better approach while rendering client care?

4. What did you like the most about your care? What would you keep in your clinical practice? Please elaborate.

   In your opinion, what was your most effective intervention/interaction when rendering client care?

5. Do you have any other thoughts or concerns that were not covered? Please elaborate.

Student's Name: _____ **Date Submitted: _____**

Nursing Care Plan Rubric

Section	Description	Satisfactory	Unsatisfactory/ Needs Improvement	Revision(s) as Needed
Medical Information	Collected information (i.e. chief complaint, medical history, medical diagnoses, summary of hospitalization, and list of medical orders including drug information) was written accurately.			
Pathophysiology	Discussion of current primary diagnosis was comprehensive. Secondary diagnosis (es) was integrated and briefly discussed. Reference source(s) in APA complete format.			
Diagnostic tests	Lab values/diagnostic test results were identified and correlated to clinical condition and nursing interventions. Trend identified if applicable.			
Physical Assessment	Physical assessment was detailed following the N113L Assessment Documentation Guide.			
Other Variables	Brief discussion of stressors and other variables utilized Neuman Model.			
Prioritization	List of priority nursing diagnoses (actual and/or risk) was complete and in order of priority.			
Nursing Care Plan	One physiologic and one psychosocial nursing care plan			
a. Assessment	Accurate assessment data was categorized as subjective and objective.			
b. Diagnosis	NANDA diagnoses were utilized appropriately. Written in PES/PE and other prescribed format.			

Section	Description	Satisfactory	Unsatisfactory/ Needs Improvement	Revision(s) as Needed
c. Planning	Goals were written following ROAM and with timeline. Independent nursing intervention plan utilized Assess, Do, Teach, and Document format. Scientific rationale per intervention was clearly written.			
d. Implementation	Independent nursing intervention plans were implemented. Client's response or result was written per intervention.			
e. Evaluation	Goals were met/partially met/unmet. If goal was not met or partially met, follow up revision plan was briefly discussed.			
Spelling, Grammar and Format	Paper was neatly written with correct grammar and spelling. Prescribed format was followed.			

Comments:

Instructor's Signature: _____ **Date: _____**

HEALTH ASSESSMENT SUMMARY

Student's Name _____ Date of Assessment_____ Location of Client_____
Client's Initials _____Code Status: _____ Date of Admission _____ Primary Language_____

Summarize or briefly state what caused the client to come to the hospital (chief complaint) (include age, sex, race):

List all prior health problems including surgeries with approximate dates:

List medications client was taking prior to this hospitalization and client's reason for taking medication (including prescriptions, herbs, over-the-counter):

List significant family health history:

Allergies: No ☐ Yes ☐_____ Ht. _____ Wt._____
Substance Use/Abuse:

Alcohol	No ☐Yes ☐	Type _____	Amount consumed/day _____	Last use: _____
Drugs	No ☐Yes ☐	Type _____	Amount consumed/day _____	Last use: _____
Smoking	No ☐Yes ☐	Packs per day _____		
Caffeine	No ☐Yes ☐	Cups per day _____		

Admitting Diagnosis (discuss briefly):

Current Diagnosis (including pathophysiology):

Summarize, in narrative form, what has happened to this client since being admitted to the hospital (include all diagnostic tests):

List **all orders** (include rationales per order) written on the last seven (7) days including admission, transfer, post-op, discontinued, and completed orders:

Client's Initials: _____

All Lab values within the 7 day period of hospitalization

NORMAL		ADMISSION LABS	DAY #1	MOST CURRENT	SIGNIFICANCE OF FINDINGS
Na					
K					
Calcium					
Magnesium					
Phosphate					
Glucose					
BUN					
CR					
WBC					
HCT					
HGB					
RBC					
Platelets:					

URINALYSIS:	**SIGNIFICANCE OF FINDINGS:**
pH _____	_____
SG _____	_____
Blood _____	_____
Protein _____	_____
Bacteria _____	_____

ALL DIAGNOSTIC TESTS:	**RESULTS:**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

N113L - PHYSICAL ASSESSMENT

CLIENT'S INITIALS: _____
Date and Time of Assessment: _____
Vital Signs: BP _____ T _____ P _____ R _____ Pain _____ O_2 Sat_____

Neurological: _____
_____
_____

Cardiovascular: _____
_____
_____

Respiratory: _____
_____
_____

Gastrointestinal: _____
_____
_____

Genitourinary: _____
_____
_____

Integumentary: _____
_____
_____

Musculoskeletal: _____
_____
_____

Behavior: _____
_____

Other pertinent client information:

a. Predominant stressor:

- Intrapersonal
- Interpersonal
- Extrapersonal

b. Variables:

- Physiological
- Psychological
- Spiritual
- Sociocultural
- Developmental (incorporate Erikson's developmental tasks)

LIST PRIORITY NURSING DIAGNOSES (actual and/or risk):

1. _____
2. _____
3. _____
4. _____
5. _____

NURSING CARE PLAN #1

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
		Goal: ***Independent Nursing Interventions:***		***Goal:***

NURSING CARE PLAN #2

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
		Goal: ***Independent Nursing Interventions:***		***Goal:***

CHANGES THAT FREQUENTLY OCCUR IN THE ELDERLY

Organ or System	Basic "Normal" Aging Change	Disease(s) or Problems
Arteries	Increased peripheral resistance; diminished aortic elasticity	Abdominal pulsation, bruits, and aneurysm
	Increased systolic and diastolic blood pressure	Positive correlation between blood pressure and morbidity; unclear if this is cause and effect or simply a correlation related to a third factor; possible protective effect on brain of moderately elevated blood pressure
	Arteriosclerotic and atherosclerotic changes in blood vessels	Occlusion of arteries leading to ischemia
Gastrointestinal tract	Diminished hydrochloric acid secretion (probable)	Association with increased iron deficiency anemia as well as possible association with gastric carcinoma and/or other absorption difficulties
	Diminished large bowel motility	Diminished frequency of bowel movements
	Diminished hepatic synthesis	Diminished serum albumin
	Decreased sensitivity to thirst.	Constipation; dehydration
	Decreased absorption of calcium	Malabsorption; osteoporosis
Renal	Decrease in size of urinary bladder	Incontinence and frequency
	Decrease in size of kidneys and number of glomeruli; diminished renal blood flow, glomerular filtration rate and tubular function	Drug toxicities when kidney is a major route of excretion; greater tendency toward at least transient, if not permanent, renal insufficiency in the presence of dehydration, diuretics, hypotension, or fever
Genital tract	Enlarged prostate gland	Prostatic obstruction
	Weakening of the pelvic floor	Stress incontinence as well as cystocele and urethrocele
	Diminished vaginal and cervical secretions	Pruritus; dyspareunia
	Some, though not total, decrease in sexual function	Fear of impotence; embarrassment at sexual desires
Musculoskeletal system	Decreased synthesis and increased degradation of bone	Osteoporosis and/or fracture
	Diminished muscle size and strength	Fatigue
Eye	Decreased accommodation to light; decreased ability to distinguish between various intensities of light	Accidents
	Increased density of lens	Cataracts
	Loss of elasticity of lens	Presbyopia
	Change in aqueous kinetics	Glaucoma
Mouth and teeth	Resorption of gum and bony tissue surrounding teeth and bone of mandible	Loss of teeth and periodontal disease
	Decreased saliva flow	Malnutrition; disturbing symptom of "burning tongue" (glossopyrosis)

Organ or System	Basic "Normal" Aging Change	Disease(s) or Problems
	Decreased number of taste buds	Weight loss
Ears	Anatomical change in inner ear and cochlea	Diminished cardiac output (50% decrease by age 65); increased congestive heart failure
	Increased calcification of valves	Murmurs from aortic and mitral area and/or endocarditis; valve stenosis and/or insufficiency
	Calcification of the skeleton of other parts	Conduction defects; irritability of the cardiac muscle may result in alterations in rhythm
	Sclerosis of the conduction system	Most cases of complete heart block are of unknown origin
Lungs	Decreased elasticity and increased size of alveoli	Changes in lung mechanics such as decreased vital capacity, maximal voluntary ventilation (MVV), and increase closing volume
	Decreased diffusion and surface area across the alveolar-capillary membrane	Diminished Po_2
	Diminished activity of cilia and decreased cough	Impaired bronchoelimination and increased incidence of pneumonia
Immunologic status	Decreased T-cell function Maintenance of secondary immune response (B-cell antibody)	Increased negativity in skin tests such as purified protein derivative; possible relationship to increased prevalence for malignancies
Psychological status	Role changes	Retirement
	Losses Physical	Correlation with increased death rate within year of loss of spouse
	Psychological	Depression
	Social	Loss of significant others, family, and friends.
Hormones	Decreased metabolic clearance rate and plasma concentration of aldosterone	Decreased sodium reabsorption
	Decreased estrogen; diminished ovarian function	Postmenopausal decrease of secondary sex characteristics
	Decreased insulin response and peripheral effectiveness	Hyperglycemia
	Increased antidiuretic hormone (ADH) response to hyperosmolarity	Inappropriate ADH with hyponatricemia
	Insensitivity of pituitary gland to thryotopin-releasing hormone in older healthy men	Men less likely to develop hyperthyroidism
Brain	Probable decrease in brain weight and/or number of cells in specific areas	Memory loss and/or senile dementia
	Alteration in sleep patterns; older people tend to dream less and have increased period of wakefulness	Increased complaints of insomnia

Organ or System	Basic "Normal" Aging Change	Disease(s) or Problems
	Increased atherosclerosis of cerebral vessels	Multi-infarct dementia
	Increased activity of monoamine oxidase enzyme	Mental depression
	Decreased reaction time	Decrease in intelligence quotient (IQ) scores when speed of response is a factor; some aspects of IA (verbal and vocabulary skills) increase in late life
Skin	Decreased response to pain sensation and temperature changes	Accidents
	Decreased response to temperature and vibration; increased pain threshold	Burns
	Decreased subcutaneous fat; loss of fat padding over bony prominences	Decubitus ulcers
	Atrophy of sweat glands	Difficulty in body temperature regulation
	Decreased ability of body to rid itself of heat by evaporation	

Modified from Libow, L., Sherman, F. *The core of geriatric medicine* St. Louis, 1981, Mosby. Prepared with the assistance of Rein Tidenksaar, P.A.C., Jewish Institute for Geriatric Care, New Hyde Park, NY, and assistant professor of Allied Health, Health Sciences Center, State University of New York at Stony Brook, Stony Brook, NY; Resnik NM: *Geriatric medicine in current medical diagnosis and treatment*. In Tierney LM, et al, editors *The core of geriatric medicine.*

ELDERLY HEALTH FOCUSED DISCUSSION

1. Compare and contrast the characteristics of older adults in the community with older patients in the hospital setting. Include physical, psychosocial assessment, health beliefs, practices, etc. in your discussion.

2. Identify comments and actions you observed of family, friends, media, and clinical personnel indicating their beliefs about older adults. Did you encounter myths or realities of aging? Give examples.

NURSING SKILLS CHECKLIST

Semester One				
	Skills Lab	**Date**	**Clinical Area**	**Date**
Skills Lab/Ward				
Vital Signs • Body Temperature - Assessing body temperature by oral, rectal and axillary				
• Pulse - Assessing the radial and apical pulse - Peripheral				
• Respiration - Assessing the Respiratory Rate				
• Blood Pressure - Assessing Blood Pressure				
• Documentation - Re: Vital Signs				
Asepsis/Universal Precautions • Handwashing				
• Gloving - Donning and removing sterile gloves				
• Isolation Technique				
• Caring for clients on isolation precautions - Respiratory - Contact - Strict				
• Care of Wounds - Preparing a sterile field - Cleaning a wound and applying clean dressing - Clean vs. sterile				
• Documentation				

Semester One				
	Skills Lab	**Date**	**Clinical Area**	**Date**
Skills Lab/Ward				
Hygiene • Personal Hygiene - Bed bath « Partial « Complete - Bed-making « Occupied « Unoccupied				
Oxygenation • Administering oxygen by: - Nasal cannula - Mask - simple face mask				
• Oximetry				
• HHN (hand-held nebulizer)				
• Peak flow meter				
• Meter-dose inhaler with or without spacer				
Activity • Turning/Transferring of clients - Turning a client in bed - Moving a client in bed (one nurse) - Assisting a client to transfer from bed to chair				
Restraints				
Range of motion exercises • Passive • Active				
Intake and Output Measurement				
Documentation • ADL				

NURSING SKILLS CHECKLIST

Semester One				
	Skills Lab	**Date**	**Clinical Area**	**Date**
Skills Lab/Ward				
Medications • Administering oral medications - Controlled vs. non-controlled				
• Administering of rectal medication (suppository)				
• Aspiration of medications from: - Ampule - Vial				
• Administering a subcutaneous injection				
• Administering an intramuscular injection - "Z" track				
• Topicals - ointments, creams, powders				
• Instillation: - Eye drops - Ear drops				

NURSING SKILLS CHECKLIST

Semester One				
	Skills Lab	**Date**	**Clinical Area**	**Date**
Skills Lab/Ward				
Physical Assessment • Overview of Physical Exam • Skin				
• Head • Neck • Throat				
• Lungs • Breast				
• Cardiovascular • Abdomen				
• Rectum • Genitalia				
• Neurological • Musculoskeletal				

NURSING SKILLS CHECKLIST

Semester One				
	Skills Lab	**Date**	**Clinical Area**	**Date**
Skills Lab/Ward				
Intravenous Therapy (Primary Solution) • Changing primary intravenous solution and tubing				
• Priming intravenous tubing				
• Flushing a saline access device				
• Calculate the rate of infusion				
• Proper method of infusion - Gravity method - Pump method				
• Maintenance of intravenous therapy - Solution/ bag - Tubing - Assessment of intravenous cannula site				
• Maintenance of saline lock				
• Discontinuance of intravenous therapy				
• Documentation				