LOS ANGELES COUNTY COLLEGE OF NURSING AND ALLIED HEALTH

School of Nursing

Nursing 124 L:

MATERNAL CHILD NURSING CLINICAL

Spring 2018

COURSE TITLE:	**N124L MATERNAL-CHILD NURSING CLINICAL**
PRE-REQUISITES:	Completion of Semester I Requirements
UNITS:	2.5 Units
HOURS:	15 hours per week
LENGTH:	9 weeks
PLACEMENT:	Semester 2
CONCURRENCY:	All semester theory courses are taken concurrently with the clinical courses.
COURSE DESCRIPTION:	This clinical course provides the student with opportunities to build on semester 1 and apply semester 2 theoretical content. The application of the nursing process is applied in caring for patients from conception through adulthood. The physiological, psychological, sociocultural, developmental and spiritual variables as identified in the Neuman Systems Model are utilized in formulation, implementation and evaluation of a client-focused plan of care. Methods of health promotion and health maintenance are applied in obstetrical, pediatric, and community settings. The student participates as a member of the health care team and safely applies principles of interaction, teaching-learning and patient advocacy.

COURSE OBJECTIVES:

Upon satisfactory completion of the course, the student will:

1. Apply the nursing process for safe patient-centered care of individuals with emphasis on physiological problems utilizing evidence based practice.

2. Utilize communication skills and nursing informatics in promoting and maintaining the health of individuals with common health problems.

3. Establish methods of teamwork and collaboration with other members of inter-professional healthcare teams for providing and improving patient-centered care.

4. Apply legal-ethical behaviors that reflect the value of professional accountability to provide and improve quality of care for adults 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. Apply teaching strategies utilizing evidence based practice to provide information to individual(s) and/or groups.

7. Integrate socio-cultural values in the provision of patient-centered care for individuals with common health problems.

STUDENT LEARNING OUTCOMES: Students apply and safely integrate the nursing process, legal-ethical behaviors, patient advocacy, sociocultural variables, and effective communication in the collaborative care of childbearing women, neonates, children and their families in acute care settings.

TEACHING METHOD: Skills presentations, Simulation lab participation, video presentation, pre- and post-conference discussions, bedside instruction.

METHOD OF ASSESSMENT: Students achievement of all clinical Performance Evaluation criteria listed below indicates attainment of the student learning outcome:

- Passing score of ≥ 85% on Dosage & Calculation competency
- Absences not exceeding two days (1 in pediatrics and 1 in OB rotation)
- Tardies not exceeding two per clinical course
- Satisfactory completion of the following psychomotor competencies
  - IV pediatric medication administration
  - Newborn assessment
- Passing score of ≥70% on 2 written competency exams on:
  - Fetal monitoring
  - IV pediatric medication administration
- Satisfactory Completion of written assignments:
  - Drug Cards
  - Maternal Nutritional assessment
  - 2 Nursing care plan (ADPIE)
  - Weekly clinical worksheets
  - Observation Summary
- Satisfactory on all course objectives

GRADING SCALE: Satisfactory/Unsatisfactory grading scale is used as the method for scoring and determining final grade in course. (See your student handbook on grading policy.

All academic policies are strictly enforced.

REQUIRED READING: Berman, A., Snyder, S. and Frandsen, G. (2016). *Fundamentals of*

nursing: Concepts, Process, and Practice (10th ed.). New Jersey: Pearson.

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

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

Lewis, S., Bucher, L., Heitkemper, M., Harding, T. (2017). *Medical Surgical Nursing. 10th ed.).* St. Louis: Elsevier.

McKinney, E. James, S., Murray, S., Nelson, K., Ashwill, J. (2018). *Maternal-child nursing* (5th ed.). St. Louis: Elsevier.

REQUIRED VIDEOS:

Newborn Assessment #288-8

Postpartum Care #288-3

RECOMMENDED READING:

Alfaro-LeFevre, R. (2014). *Applying nursing process – a tool for critical thinking (8th ed.).* Philadelphia: J.B. Lippincott.

PROFESSIONAL STANDARDS / CLINICAL EXPECTATIONS:

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.
10. Clinical evaluation is based on satisfactory completion of **ALL** objectives. Failure of one clinical objective will constitute an unsatisfactory grade for the course.
11. All written assignments are due at specified times. No late assignments will be accepted.
12. 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 and will be counted as ABSENT and student placed on academic warning. A second incident will constitute failure of a course objective.
13. Students participate actively in clinical conference.
14. The clinical competency must be completed with a passing grade. A second competency will be scheduled after notification of failure.
15. Clinical attendance is mandatory. You are 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

From: _____ To: _____ Midterm Grade: _____ Final Grade upon completion of N124: _____

Clinical Outcomes

Clinical Outcome I: Nursing Process
Apply the nursing process for safe patient-centered care of individuals with emphasis on physiological problems utilizing evidence based practice.

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
A. Utilizes the steps of the nursing process in the assessment of a patient.	1. Performs one assessment using various variables in the assessment of: • Childbearing patient • Newborn patient • Pediatric patient	1. Written documentation: Satisfactory grade consists of: a. Accurate and complete assessment according to guidelines. b. Assessment should focus on normal and abnormal data. 2. Satisfactory grade consists of assignment completion according to guidelines		

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

Clinical Outcome I: Nursing Process (Cont'd)

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
	2. Completes two patient-centered nursing care plan (ADPIE) (one in Peds and one in OB) utilizing the nursing process format and satisfactorily completes the following: a. Nursing assessment b. One nursing diagnosis – (ADPIE) (physiological or collaborative or educational) c. Patient outcomes for each diagnosis d. Interventions with rationales e. Implementation with patient responses f. Evaluation of goals	2. Written documentation: a. Contains one priority nursing diagnosis. b. Assessment focuses on objective and subjective relevant data. c. Appropriate patient outcome is written for each stated nursing diagnosis. d. Appropriate interventions are written in relation to each outcome. e. Evaluates effectiveness of each goal and attainment of patient outcomes.		

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

Clinical Outcome II: Communication
Utilize communication skills and nursing informatics in promoting and maintaining the health of individuals with common health problems..

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
A. Utilizes communication and assessment skills to develop therapeutic relationship with patients. B. Utilizes communication skills in health promotion	1. Performs a patient-centered nutritional assessment: • Adult childbearing patient	1. Satisfactory grade consists of an accurate and complete assessment according to interview guidelines. 2. Instructor's Observations a. Interacts with patient on a one-to-one basis focusing on needs. b. Responds appropriately to patient's questions and needs.		

Instructor Comments:

Each instructor signs and dates comments.

Student Comments:

Each student signs and dates comments

Clinical Outcomes

Clinical Outcome III: Collaboration
Establish methods of teamwork and collaboration with other members of inter-professional healthcare teams for providing and improving patient-centered care.

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
A. Identifies methods of developing relationships with other health care professionals.	1. Identifies situations that require collaboration in the planning of safe care: a. Students will identify methods of collaboration used to promote women and children's health in clinics, ICU, ER, OR, NICU.	1. Written documentation a. Utilizing the Nursing Care Plan format, the student will satisfactorily identify situations that require collaboration with at least two disciplines. 2. Clinical conference Students will discuss: a. Collaborative methods utilized while interacting with other disciplines (i.e., one-on-one; group) b. Problem resolutions c. Outcomes d. Follow-Up 3. Clinical observation a. Complete N124L Observation Experience Summary b. Summarize experience during clinical conference.		

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

Clinical Outcome IV: Accountability
Apply legal-ethical behaviors that reflect the value of professional accountability to provide and improve quality of care for adults with common health problems.

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
A. Identifies area of nursing accountability specific to the care of patients including children.	1. Lists specific standards in the clinical area for which the nurse is accountable.	1. Discussion: a. Pertinent data that is documented in the Electronic Health Record (EHR)		
B. Demonstrates legal/ethical behaviors which reflect the nursing responsibility in the care of all patients including children. C. Follows legal-ethical guidelines in the administration of medications and treatments	1. Observes nursing behavior related to the care of all patients. 2. Observes nursing activities as they relate to the nurse's role as a patient advocate. 3. Administers medications and treatments accurately and safely under the supervision of the Clinical Instructor.	2. Observation a. Observes caregiver interacting as a patient advocate. b. Discusses activity/ outcome with instructor. c. Assesses, intervenes and performs all procedures and treatments in a safe and therapeutic manner.		

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

Clinical Outcome IV: Accountability (Cont'd)

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
D. Demonstrates accountability for own professional behavior.	1. Observes professional decorum at all times. Punctual for clinical experience.	1. Does not exceed one absence during OB rotation. 2. Does not exceed one absence during Peds rotation. 3. Notifies instructor of absence before 0700 of the clinical day.		

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

Clinical Outcome V: Decision-Making
Identify nursing responsibilities in decision-making as a member of the inter-professional healthcare team in assessing, maintain and promoting health to achieve safe, quality patient-centered care.

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
A. Utilizes decision-making process in developing a patient-focused plan of care in assessing/ promoting/maintaining the health of: • Childbearing patient • Pediatric patient	1. Lists the priority needs for assigned patient. 2. Completes Pediatric Clinical Preparation Worksheet prior to patient care	1. Clinical Conference: a. Discuss patient findings. b. State rationale for decisions made. c. Patient priorities are based on assessment data. d. Priorities are organized according to Maslow's Hierarchy of Needs and Erickson's Developmental Tasks. 2. Written Documentation • Utilizes Clinical Preparation Worksheet to demonstrate decision-making process.		

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

Clinical Outcome VI: Education
Apply teaching strategies utilizing evidence based practice to provide information to individual(s) and/or groups.

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
A. Provides health education information in health promotion. B. Provides information to meet the educational needs of all patients and families.	1. Identifies information to be utilized in promoting health according to age-appropriate guidelines for at least two patients and their families.	1. Discussion The student will: a. Discuss clinical findings. b. Discuss identified teaching needs. c. Identify learning needs of assigned patient. d. Discuss methods on how teaching should be done. e. Identify the level of patient's understanding. f. Identify resources for patient education. g. Discuss the effectiveness of teaching plan in meeting the needs of the patient. 2. Student will implement a patient teaching.		

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

Clinical Outcome VII: Sociocultural Sensitivity
Integrate socio-cultural values in the provision of patient-centered care for individuals with common health problems.

Objectives	Learning Activity	Evaluation Criteria	Mid (S/U)	Final (S/U)
A. Assess sociocultural considerations/variation with individuals. B. Assess sociocultural factors that impact the nursing role.	1. Performs a patient-focused sociocultural assessment related to: • Childbearing patient • Pediatric patient	1. Clinical Conference: Be able to discuss sociocultural issues related to their patient. 2. Discussion with RN / Instructor Student will discuss with RN / Instructor the sociocultural factors that impact the nurse's role.		

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 COMPETENCY EXAMINATION RESULTS

Drug Dosage Calculation Competency	Written Competency	Psychomotor Competency
Score: _____% Sat / Unsat **☐ See Session I evaluation for DDCC score**	**OB Fetal Monitoring Score: _____ Sat / Unsat** **Peds Medication Admin Score: _____ Sat / Unsat**	**OB Newborn Assessement Sat / Unsat** **Peds Medication Admin Sat / Unsat**

CLINICAL SUMMARY

ROTATION SUMMARY: _____		**ROTATION SUMMARY: _____**	
Instructor Comment:	**Student Comment:**	**Instructor Comment:**	**Student Comment:**
Instructor Signature:_____	**Student Signature:_____**	**Instructor Signature:_____**	**Student Signature:_____**
Date: _____	**Date: _____**	**Date: _____**	**Date: _____**

N124L: MATERNAL CHILD NURSING CLINICAL

Semester 2
Tuesdays/Wednesdays

WEEKLY CLINICAL EXPECTATIONS – FALL 2017

WK	DATE		WEEKLY CLINICAL FOCUS	CLINICAL WORKSHEET	CLINICAL CONFERENCE
	Session 1	Session 2			
1	1-16-18	3-27-18	Course Orientation-Skills Lab See Skills Lab Schedule		
	1-17-18	3-28-18	OB/Peds Clinical Orientation		DDCC 1-17-18
2	1-23-18	4-03-18	Accountability	Head-to-toe Assessments	DDCC Retake 1-23-18
	1-24-18	4-04-18	Communication & Education	Maternal nutritional assessment	
3	1-30-18	4-10-18	Nursing Process		Collaboration Strategies
	1-31-18	4-11-18	Collaboration & Decision Making	OB Teaching Plan	
4	2-06-18	4-17-18	Sociocultural	OB & Pediatric ADPIE	Priority Decision Making
	2-07-18	4-18-18			
5	2-13-18	4-24-18	Final Clinical Day		
	2-14-18	4-25-18	Orientation		
6	2-20-18	5-01-18	See week #2		
	2-21-18	5-02-18			
7	2-27-18	5-08-18	See week #3		
	2-28-18	5-09-18			
8	3-06-18	5-15-18	See Week #4		
	3-07-18	5-16-18			
9	3-13-18	5-22-18	See Week #5		
	3-14-18	5-23-18	Final Clinical Day – Evaluations		

* Skills Competency – to be scheduled by Clinical Instructor

DRUG DOSAGE CALCULATION COMPETENCY
READING ASSIGNMENT

(All Readings are from Kee – Nursing Pharmacology)

SEMESTER 2 – Fall 2017

CHAPTER	TOPIC	PAGES / PROBLEMS

REQUIRED

Chapter 14	Pediatric Drug Calculations	Pp. 202 – 209 No BSA Pp. 205-206, #1-8; Pp. 207-208, #1-6 ***Study Guide – Practice Problems:*** Pp. 70 – 74, #1 – 8 Pp. 76 – 78, #10 – 15
Chapter 14	Calculations of Intravenous Fluids	Pp. 190 – 197 Pp. 197 – 198, #1, 2, 3, 4(a,b), 6 ***Study Guide – Practice Problems:*** Pp. 63, #14 – 15, 17 Pp. 64-66, #19(b), 20(a,b), 23(a,b,d) Pp. 67, #24(a), 25(a) Pp. 68 – 70, #26 – 28, 29(a), 30(a)

RECOMMENDED

Review all Semester 1 material – Chapter 14 – Medications and Calculations

Section 14A	Systems of Measurement with Conversion	Pp. 148 – 151
Section 14B	Methods for Calculations	Pp. 152 – 155 Practice Problems: Pp. 159 – 161
Section 14C	Calculations of Oral Dosages	Pp. 165 – 167 Practice Problems Pp. 168 – 171
Section 14D	Calculations of Injectable Dosages	Pp. 174 – 175, 178 Practice Problems Pp. 178 – 179, 184 – 187
Study Guide	Practice Problems	Pp. 45 – 52, Problems 1,4,5,8,11,12,13,21,22 Pp. 55 – 62 Problems 14,15,18,20,22,23,24,27,28,30,31,32

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

STUDY GUIDE: **Kee, J.L., Hayes, E. & McCuistion, L.E. (2015). Study Guide for Pharmacology: A patient-centered nursing process approach (8th Ed). St. Louis: Elsevier.**

NURSING 124L CLINICAL COMPETENCY

Clinical Competency: To be scheduled by clinical instructor and completed by the last day of the clinical session.

GUIDELINES

In order to assist you with the preparation for your clinical competency, please review the following information:

- The Policy for the "Clinical Competency for the Clinical Course".
- The content in your textbooks under the major categories in the "Nursing Skills Competency Checklist".

SKILLS COMPETENCY

The written portion of the competency will cover all of the major concepts listed below. The skill portion of the competency will consist of actual demonstration of all of the skills from the following major concepts:

- Pediatric Medications
  - Safety (calculation)
  - Administration
  - Documentation
- Fetal Monitoring
  - Assessment
  - Documentation
- Newborn Assessment

You will be required to perform all of the skills listed above.

You must be able to competently complete the skills according to the procedure taught in the skills labs and outlined in your textbooks, *Maternal-Child Nursing* by McKinney, and *Fundamentals of Nursing* by Berman, to the satisfaction of the instructor observing you.

If you are unable to competently complete the skills, you will be given the opportunity to repeat the competency. You must correctly complete the skills you failed in order to satisfactorily pass the course or you will be 'Incomplete'.

NURSING SKILLS COMPETENCY READING LIST

TOPIC	FUNDAMENTALS Berman	MATERNAL CHILD McKinney	PHARM Kee
Newborn Assessment	pp. 328 - 335	pp. 425 – 460	pp. 837 - 842
Fetal Monitoring		pp. 332 – 352	
Drug Dosage Calculation			See required reading in syllabus under Drug Dosage Calculation Readings.
Pediatric Medication		pp. 854 – 862	pp. 202 - 209

SKILLS COMPETENCY OBJECTIVES
OBSTETRICS

Fetal Monitoring

1. Discuss the various types of fetal monitoring.

2. Differentiate between external and internal fetal monitoring with rationale.

3. Demonstrate knowledge of normal fetal heart rate and patterns.

4. Explain the various fetal heart rate patterns including assessment, possible causes and/or problems.

5. Discuss appropriate nursing interventions for problems indicated by fetal monitoring.

6. Demonstrate knowledge of appropriate documentation of fetal monitoring and be able to identify the following:
   - Baseline fetal heart rate
   - Periodic pattern
   - Variability
   - Frequency of uterine contractions
   - Duration of uterine contractions
   - Intensity of uterine contractions

Newborn Assessment

1. Perform a complete head-to-toe assessment of the newborn and identify the following:
   - Vital Signs
   - Fontanels & Sutures
   - Intactness of Clavicle
   - Extremities / Skin folds
   - Back / Spine
   - Apical, Brachial, Femoral pulses
   - Facial features / Patency of nares / ears / Palate
   - Chest, Abdomen (cord), Genital assessment
   - Ortolani / Barlow maneuvers
   - Skin, Birth marks
   - Reflexes – Babinski, Moro, Palmar / Plantar Grasp, Rooting, Sucking

2. Explain what is meant by a safe environment during the assessment.

3. Discuss methods to maintain the newborn’s temperature during the assessment.

4. Demonstrate knowledge of appropriate documentation of assessment

Student Name:_____

RUBRIC: NEWBORN ASSESSMENT

All of the Criteria **must** be satisfactorily met to establish competence.

Criteria	Unsatisfactory	Satisfactory	Student performance
Preparation	□ Fails to introduce self to mother of newborn □ Incorrectly identifies patient □ Fails to explain performance of exam to mother of newborn □ Incomplete gathering of equipment □ Incorrect use of equipment □ Violates principles of asepsis / universal precautions	□ Introduces self to mother of newborn □ Correctly identifies patient □ Explains performance of exam to mother of newborn □ Gathers all necessary equipment □ Correct use of equipment □ Maintains principles of asepsis / universal precautions	
Assessment	□ Incorrectly takes vital signs □ Fails to recognize correct parameters □ Incorrectly examines head and face for appropriate features □ Incorrectly examines chest and abdomen for appropriate features □ Incorrectly examines hips, genitalia and legs for appropriate features □ Incorrectly examines back for appropriate features. □ Incorrectly examines skin for appropriate features □ Incorrectly elicits reflex responses appropriately	□ Correctly takes vital signs □ Recognizes correct parameters □ Correctly examines head and face for appropriate features □ Correctly examines chest and abdomen for appropriate features □ Correctly examines hips, genitalia and legs for appropriate features □ Correctly examines back for appropriate features. □ Correctly examines skin for appropriate features □ Correctly elicits reflex responses appropriately	
Evaluation	□ Fails to discuss post procedure assessment and documentation	□ Discusses post procedure assessment and appropriate documentation	
General Competency Evaluation	□ Fails to demonstrate appropriate nursing knowledge required to safely perform psychomotor skill. □ Fails to identify errors or neglects key elements, compromising patient safety.	□ Demonstrates appropriate nursing knowledge required to safely perform psychomotor skill. □ Performs key elements, maintaining basic patient safety.	

□ Unsatisfactory □ Satisfactory

Comments:

Instructor: _____ Date: _____

SKILLS COMPETENCY OBJECTIVES
PEDIATRICS

Medication Administration in Children

1. Identify the significance of age appropriate care when preparing the child and family for general medication administration.
2. Explain how client teaching differs among age groups and how families play a role in these efforts.
3. Discuss the value and significance of the Treatment room.
4. Identify methods in which a client's rights and privacy can be respected during medication administration.
5. Demonstrate accurate calculation of prescribed medications using pediatric dosages including:
    a. Safe dosages (e.g. mg/kg/dose or day)
    b. Maximum IVPB medication concentrations (mg/ml)
    c. IVPB flow rate (ml/hr)
    d. Daily and hourly fluid requirement
6. Describe safe PO, IM, IV, optic and otic medication administration techniques based on age appropriate care and evidence based practice.

Student Name: _____

RUBRIC: PEDIATRICS INTRAVENOUS THERAPY (I.V.) COMPETENCY
Administration of Pediatric IV Medications via Peripheral Venous Access Device

All of the following criteria **must** be satisfactorily met to establish competence.

Criteria	Unsatisfactory	Satisfactory	Student performance
Assessment	□ Fails to verify MDs orders □ Fails to identify patient correctly □ Fails to assess allergies □ Fails to assess / discuss: □ IV site □ IV pump resistance □ Dressing and need for change □ Complications	□ Verifies MDs orders □ Identifies patient correctly □ Assesses allergies □ Accurately assesses / discusses: □ IV site □ IV pump resistance □ Dressing and need for change □ Complications	
Patient Preparation	□ Fails to acknowledge patient /parent as a core member of healthcare team. □ Fails to provide teaching □ Fails to encourage input/questions	□ Acknowledges patient/parent as core member of healthcare team. □ Teaching provided □ Encouraged input/questions	
Equipment	□ Incomplete gathering of equipment □ Incorrect use of equipment	□ Gathers all necessary equipment □ Correct use of equipment	
Asepsis	□ Violates principles of asepsis	□ Maintains principles of asepsis	
Skill Performance ***(any or all may be evaluated)***	□ Fails to follow the *three checks* and *eight rights* of med administration □ Tubing is not loaded or primed correctly. □ Fails to use alcohol caps or wipe the appropriate port with alcohol or disinfectant swab □ Fails to close the tubing clamp when appropriate. □ Fails to utilize ORCHID medication administration correctly. □ Fails to accurately program infusion pump using scanning method when possible □ Fails to administer a calculated safe dose, safe dilution at a safe rate of infusion. □ Fails to complete all labeling of the medication and tubing per protocol. □ Fails to demonstrate correct disposal of equipment and supplies □ Fails to document accurately all components required in EHR	□ Follows the *three checks* and *eight rights* of med administration □ Ensures all tubing is accurately loaded and primed. □ Utilizes alcohol caps or wipes the appropriate port with alcohol or disinfectant swab □ Closes tubing clamp when appropriate. □ Utilizes ORCHID medication administration correctly. □ Accurately programs infusion pump using scanning method when possible. □ Administers a calculated safe dose, safe dilution at a correct rate of infusion. □ Completes all labeling of the medication and tubing per protocol. □ Demonstrates correct disposal of equipment and supplies. □ Documents accurately all components required in EHR	
Evaluation	□ Fails to discuss post procedure assessment and documentation.	□ Discusses post procedure assessment and documentation.	
General Competency Evaluation	□ Fails to demonstrate adequate nursing knowledge required to safely perform psychomotor skill. □ Fails to identify errors or neglects key elements, compromising patient safety.	□ Demonstrates adequate nursing knowledge to safely perform psychomotor skill. □ Performs key elements, maintaining basic patient safety.	

Comments: □ Unsatisfactory □ Satisfactory

Instructor: _____ Date: _____

Student Name: _____

N124L – OB DRUG CARD

GENERIC NAME:

TRADE NAME:

CLASSIFICATION:

DOSAGE & ROUTE:

OBSTETRICAL INDICATION:

FDA PREGNANCY DRUG CATEGORY:

ACTIONS & THERAPEUTIC EFFECTS:

PHARMACOKINETICS:

ABSORPTION, EXCRETION:

PHARMACODYNAMICS:

ONSET, PEAK, DURATION:

NURSING CONSIDERATIONS:

CONTRAINDICATIONS/ADVERSE REACTIONS:

PATIENT EDUCATION:

MATERNAL NUTRITIONAL ASSESSMENT

Student Name _____ Date _____

Patient Initials _____ Age _____ Sociocultural Background _____

G____ P____: (T___ P____ A____ L____) H & H _____ BMI _____

EDD / Delivery Date _____Gestational Age / Delivery Type _____

Gender / gestational age / weight of newborn_____

Ages and birth weight of other children _____

Height _____Current weight _____ Non-pregnant weight _____ Ideal weight _

Problems with this pregnancy: N/V _____Constipation _____Diarrhea ____

Management of these problems _____

Any underlying medical conditions _____

Prenatal vitamins (PNV)/iron supplements _____

Other medications _____

Eating habits: Appetite _____Meals/day _____Snacks/day_____

Non-nutritive foods eaten _____

Food allergies/dislikes _____

***Typical* 24-hour intake for *one* meal**

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How would you breakdown her diet with regard to the following elements (Do Not Count Supplements):

Carbs _____% +Proteins_____% +Fats_____% = 100%

Calcium _____%RDA Vitamin C _____%RDA Iron _____%RDA

Patient perception of normal nutritional needs: _____

_____

_____

Patient perception of present nutritional needs _____

_____

_____

Possible problems related to adequate nutrition:

Financial _____

Transportation _____

Food refrigeration _____

Adequate cooking utensils _____

Physical disability _____

Experience and management of nutritional problems (past or present) _____

_____

_____

Patient teaching regarding nutrition _____

_____

_____

_____

Nursing Diagnosis _____

_____

_____

_____

Evaluation/Summary _____

_____

_____

_____

***Bolded items signify information acquired during patient interview.**

CLINICAL OBSERVATION GUIDELINES

PURPOSE

Observation in clinics and specialty areas will provide the student the opportunity to observe health concepts and nursing principles in the care of patients in an ambulatory or specialty setting.

The student will be assigned to at least one area during the clinical rotation. When possible, the student may select the area of observation. Completion of the Clinical Observation Summary sheet is required during the pediatric rotation and due before the end of the pediatric clinical rotation.

The clinics and specialty areas include:

1. Pediatric Intensive Care Unit
2. Pediatric Emergency Room
3. Pediatric Clinics
4. Neonatal Intensive Care Unit
5. Perinatal Triage
6. Antepartum Testing

During observation, the student may perform functions under the guidance of an RN such as:

1. Limited intake interview.
2. Vital signs and fetal heart tones.
3. Height and weight measurements
4. Infant care, bottle feedings, diaper changes
5. Prepare patient for physical/vaginal/breast examination
6. Observe/assist provider with physical exam
7. Provide teaching on nutrition, hygiene, ADLs, and community resources.

*** Medications may NOT be administered without the <u>supervision</u> of the Clinical Instructor.**

Name: _____ Date: _____

Area of Observation: _____

CLINICAL OBSERVATION EXPERIENCE SUMMARY

1. Describe the atmosphere in the unit.

2. How are assignments made, patient to RN ratio?

3. Describe diagnosis and/or chief complaint of one patient you observed (specify the age and sex).

4. Describe the care of one particular patient you observed while in the unit. Did the RN experience any complications while caring for the patient?

5. List the equipment or instrumentation used for the patient's care.

6. What forms of developmental stimulation did the patient receive (if any)?

7. Describe the necessary characteristics you believe a nurse might need to work in the unit.

8. Describe the interdisciplinary collaboration you observed in the unit.

Be prepared to summarize observational experience during clinical conference.

Date(s): _____ Student's Name: _____

CLINICAL PREPARATION WORKSHEET (PEDIATRICS)

All clinical preparation worksheets must be completed prior to administering care to your pediatric patient.
ALL WORKSHEETS WILL BE COLLECTED.

Patient Initials: _____ Age: _____mo/yrs. **Gender**: (circle one) M F

Language spoken in the home: _____ Rm#: _____ RN: _____

Weight: _____kg. %-ile: _____ **Height:** _____cm. %-ile: _____

Head circumference: _____cm. %-ile: _____

Daily Fluid Requirement: _____mL/day _____mL/hr.

Erickson's stage of development: _____vs. _____
Explain: (relate to hospitalization)

Admission Date: _____

Diagnosis: _____

Chief Complaint(s): _____

Secondary Diagnosis (pre-existing health problems):_____

PATHOPHYSIOLOGY (cite source):

TYPICAL SIGNS & SYMPTOMS seen in the disease process. Highlight those that your patient is experiencing/experienced.

TYPICAL ABNORMAL LAB RESULTS seen with the disease process.

Medical Information:

1. Allergies:_____
2. Diet: _____
3. Activity Level: _____
4. Treatments: _____
5. IV Therapy: _____

Checklist for patient chart assessment:

1. Check physician/MDs orders: _____
2. Review brief patient history: _____
3. Daily Lab results: _____
4. MAR and MAR Summary/verify: _____

Patient parameters: Notify MD if ……

Blood pressure: SBP < _____ or > _____, DBP <_____or >_____
Heart rate: < _____or > _____
Respiratory rate: < _____or > _____ O_2 Saturation <_____%
Temperature: < _____or > _____

Circle vital sign(s) if out of parameter and state intervention taken

Date: _____ Time: _____
Vital Signs: T _____ BP _____ HR _____ RR _____ Pain _____ O_2 Sat _____
Intervention:_____

Date: _____ Time: _____
Vital Signs: T _____ BP _____ HR _____ RR _____ Pain _____ O_2 Sat _____
Intervention:_____

Lab Values Date:_____Date:_____

Test	Normal Values	Admission Labs	Lab Results	Significance of Findings
Na^+				
K+				
Glu				
Hct				
Hgb				
WBC				
Platelet count				
BUN				
CR				
Others:				

Summary of Current Medical Plan (See Physician's Progress Notes):

ORGANIZATIONAL PLAN:

0700:
0800:
0900:
1000:
1100:
1200:
1300:
1400:

Priority assessment for the patient:

Priority nursing diagnosis: (NANDA)

Goal:

Nursing interventions and rationale for the priority nursing diagnosis mentioned above:

1)

2)

3)

4)

Potential complications for primary diagnosis:

PC:

PC:

Teaching (for patient and/or family):

CONCEPT MAP

Student Name _____ Pt initials _____ Room # _____ Age _____Gender _____ Ethnicity _____
Clinical Date_____ RN _____ Height _____(_____)% Weight _____(_____)%
Admission Date _____ Daily Fluid Requirement _____ ml/ day _____ ml/hour

Past Medical Hx:

Chief complaint:

Current Medical Dx:

ALLERGIES:

Textbook S/S
Highlight/circle S/S found after assessment

Pt Assessments
Complete after assessment
Circle on pt & describe findings of priority system

Abnormal labs & Significance:

Medications & Schedule: **(and attach med sheet)**

IV Fluids:

TX ordered:

Diet:
Activity:
Notify MD for: *HR* >___or <___
BP: SBP>___ *or* <___ *DBP*>___ *o*<___
RR>___ *or* <___ *Temp* >___ *or* <___

Pathophysiology:

Diagnostics & Results:

PROBLEM #1:	PROBLEM #2:	PC:
Goal:	Goal:	Goal:
Interventions:	Interventions:	Interventions:

HEAD TO TOE ASSESSMENT CHECKLIST

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

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?
- ❑ Homan's sign present?
- ❑ Edema- location, pitting (trace to 4+)
- ❑ Apical pulse (regular, irregular), rate, S1/S2 heard
- ❑ Peripheral pulses (0-4+) equal bilaterally?

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?
- ❑ Ask if pt doing self breast exams
- ❑ Sinus- tenderness?
- ❑ Nares- patent bilaterally?

REPRODUCTIVE

- ❑ Breast symmetry, tenderness, cracking, inverted nipple, bleeding
- ❑ Uterine fundus
- ❑ Lochia
- ❑ LMP
- ❑ Perineum

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- Ascultate 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

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?)

MOBILITY/ACTIVITY

- ❑ 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?

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?

NURSING CARE PLAN (ADPIE)

Student Name _____ Pt. age/gender _____ Medical Diagnosis _____

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
Subjective: **Objective:**	*Goal:*	*Intervention with rationale*	*Include patient response to intervention*	*Goal:*

NURSING CARE PLAN (ADPIE)

Student Name _____ Pt. initials _____ G _____ P – T_____ P_____ A_____ L_____

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
Subjective: Objective:	Knowledge nursing diagnosis NANDA *Goal:*	*planned teaching intervention with rationale*	*actual teaching implementation with patient response*	*Evaluation of Goal:*

RUBRIC: NURSING CARE (ADPIE) PLAN

Section	Description	S	U	Comments
Nursing Care (ADPIE) Plan	One physiologic or one potential complication (PC) nursing diagnosis.			
a. Assessment	Accurate assessment data was categorized as subjective and objective.			
b. Diagnosis	NANDA diagnoses were utilized appropriately. Written in PRS/PES, PR/PE and other prescribed format.			
c. Planning	Goals were written following ROAM (Realistic, Observable, Achievable, Measurable) and with timeline. Scientific rationale per intervention was clearly written.			
d. Implementation	Intervention plans were implemented. Patient's response 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 & Format	Paper was neatly written with correct grammar and spelling. Prescribed format was followed.			
Accountability	**Nursing Care Plan is due at date specified by Clinical Instructor.**			

Comments:

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