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

Nursing 233 L:

Intermediate Medical/Surgical & Psychiatric Nursing

CLINICAL PACKET

Spring 2020

Student Name _____ Admit Date_____ POD#_____
Pt initials _____ Room # _____ Age _____Gender _____ Ethnicity _____ Psych Hold _____

Current Medical Diagnosis:

Resolved Medical Problems:

Chief complaint:

All Secondary Diagnosis:

Current Nursing Assessment

Allergies:_____

Code Status:_____

IV Site:_____

IV Fluids: _____

Ordered Tx _____

Diet: _____

Activity:_____

Fall Risk/Safety:_____

Skin issues:_____

Attach a Comprehensive Medication Worksheet to this Concept Map

Abnormal Labs & Significance

Pathophysiology:

Diagnostics & Results/ Significance

Priority Nsg Dx #1 (PRS format)	**Priority Nsg Dx #2**(PRS format)	**Potential Complications:**
Goal:	Goal:	
Priority Interventions:	Priority Interventions:	

CLINICAL WORKSHEET

CLINICAL PREPARATION PRIOR TO CLINICAL DAY:

Student Name: _____ Date: _____

Client Initials: _____Admit date: _____Rm#_____Age:_____

Legal Status ☐ 5150 ☐ 5250 ☐ Conservatorship ☐ Other_____

Primary Language: _____ Culture:_____ Code Status: _____

Discuss brief past medical history (Why is the client here?):

Pathophysiology
Diagnosis/Surgical Procedure/Secondary Diagnosis:

Typical signs and symptoms seen in the disease process: (underline manifestations assessed in your client)

Typical abnormal lab results seen with this disease process:

Potential complications (PCs) associated with this disease process (rank order priority):

Medical Information (from electronic medical records):

Allergies:

Diet:

Activity Level:

Treatments (e.g., dressing change, oxygen therapy):

Admission

Most Current

Vital Signs: T _____BP _____HR _____RR _____02 sat _____ Pain level_____

Height: _____ Weight: _____ Strict I&O ☐ BRP ☐

Labs are not limited to those listed below.
All pertinent labs must be included.

Lab Values:

Date: Date:

Lab Test	Normal Values	Admission Labs	Current Results	Significance of Findings Specific to Patient
Anion Gap				
Na^+				
K^+				
Cl				
CO2				
Glucose				
Calcium				
Mg^{++}				
Phosphorus				
BUN				
Creatinine				
Alk Phos				
Total Protein				
Albumin				
AST				
ALT				

WBC				
RBC				
HGB				
HCT				
MCV				
MCH				
MCHC				
RDW				
Platelet				
Neutrophil				
Lymphocyte				
Monocyte				
Esionophil				
Basophil				
Pro-Time				
INR				
APTT				
Troponin				
Pre Albumin				
UA:				
Color				
Clarity				
SG				
pH				
Protein				
Ketones				
Uroblinogen				
ABG:				

pO2				
O2 Sat (pulse ox)				
pH				
pCO2				
HCO3				

List other diagnostic tests and result:

List all medications on the Medication Preparation Worksheet.

MEDICATION PREPARATION WORKSHEET*

Client's Name: _____ **ALLERGIES**: ☐ NKDA

** Copying from the textbook or electronic source does not constitute satisfactory preparation*

MEDICATION	ACTION	NURSING CONSIDERATIONS
Medication: _____ Generic Name: _____ Dose/Route/Frequency: Time: Recommended/Usual Dose:	Classification: _____ Indication: _____ How does it work? Onset/Peak/Duration: Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ Resp Other: _____ Labs: _____ Teaching: Infusion rate: ml/hr _____ gtt/min _____
Medication: _____ Generic Name: _____ Dose/Route/Frequency: Time: Recommended/Usual Dose:	Classification: _____ Indication: _____ How does it work? Onset/Peak/Duration: Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ Resp Other: _____ Labs: _____ Teaching: Infusion rate: ml/hr _____ gtt/min _____
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DAILY ORGANIZATION PLAN*

Clinical Date: **Ward**

Daily Organizational Plan MUST be ready at 0700 each clinical day.

Time	STUDENT ACTIVITY	Time	STUDENT ACTIVITY

Client Initials: **Medical Dx:** **Room/bed #**

PRIORITY NURSING DIAGNOSIS (in PRS Format)	GOALS	INTERVENTIONS
1.		
2.		
3.		

Due the 7th week of each MedSurg Rotation (see schedule for dates)

Clinical Reflection Paper Guidelines

The purpose of this written assignment is to reflect what the student nurse have learned and experienced throughout the clinical rotation. The main focus is to examine the student nurse's thoughts and feelings regarding new experiences that were learned in clinical, those skills that were built upon or enhanced, relationships that may or may not have developed with the nursing staff and perception of the experiences with the patients.

Minimum of 1 page and not to exceed 3 pages

The paper should reflect some of the following concepts:

1. What do you do well?

2. In what areas do you feel you need the most improvement?

3. Were there any defining moments when the "light bulb went on" or had a strong moment of insight?

4. Were there stories involving your patients' that you would want to share or had a profound impact on your learning?

5. What (if any) did you learn from your classmates, other nurses or patients?

9. The paper may include questions that you may not have previously asked, seek clarification of things you did not understand or discuss matters of concern to you.

There is no judgment attached to the paper.

Complete this sheet if assigned MedSurg patient was/is discharged

Patient Custom List

Student Name: _____

POCT: _____ **ISOLATION:** _____ **Wt:** _____

Name/DOB/Age: _____ **Admitted on:** _____ **Room/Bed#** _____

Allergies: _____ **Code status:** _____ **Activity level** _____

Admitting Diagnosis (es): _____

All Secondary Dx: _____

Organ/Systems:

Neuro _____

CV _____ **Pacemaker** _____

Respiratory _____ **Chest Tube** _____

GI _____ **Diet** _____

GU _____ **Foley** _____

MS _____ **Fall Risk** _____

Skin _____ **Braden** _____

Peripheral IV/Shunt/Fistula/Central line _____

Abnormal labs _____

Problems:

Active/inactive: _____

Historical: _____

Care focus: _____

_____

Current procedures: _____

Procedure history: _____

Current Meds with pertinent labs _____

Patient Custom List

Nursing Dx (based on current assessment): **Student Name: _____**

PRIORITY PROBLEMS (in PRS Format)	GOALS	INTERVENTIONS
1.		
2.		
3.		

Additional Notes

Due on the 6th week of each MedSurg rotation

HEALTH ASSESSMENT SUMMARY / NURSING CARE PLAN

Student's Name _____ Date of Assessment_____ Location of Client_____
Client's Initials _____ 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 clients 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 in $_____	Last use: _____
Smoking	No ☐ Yes ☐	Packs per day _____		
Caffeine	No ☐ Yes ☐	Cups per day _____		

HEALTH ASSESSMENT SUMMARY / NURSING CARE PLAN

Admitting Diagnosis (discuss briefly):

Current Diagnosis (including pathophysiology):

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

Other pertinent client information:

a. Predominant stressor: (intra-, inter-, extrapersonal)

b. Variables: (physiological, psychological, spiritual, sociocultural, developmental

MEDICATIONS

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Cl				
CO2				
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Mg^{++}				
Phosphorus				
BUN				
Creatinine				
Alk Phos				
Total Protein				
Albumin				
AST				
ALT				
WBC				
RBC				
HGB				
HCT				
MCV				
MCH				
MCHC				
RDW				
Platelet				
Neutrophil				
Lymphocyte				

Monocyte				
Esionophil				
Basophil				
Pro-Time				
INR				
APTT				
Troponin				
Pre Albumin				
UA:				
Color				
Clarity				
SG				
pH				
Protein				
Ketones				
Uroblinogen				
ABG:				
pO2				
O2 Sat (pulse ox)				
pH				
pCO2				
HCO3				

N233L - ASSESSMENT

Date of Assessment:_____

Vital Signs: BP _____ T _____ P _____ R _____O2Sat _____ Pain Level_____

Neurological: _____

Cardiovascular: _____

Respiratory: _____

Gastrointestinal: _____

Genitourinary: _____

Integumentary: _____

Psychosocial: _____

Musculoskeletal: _____

Other: _____

LIST ALL MEDICAL ORDER: _____

NURSING 233L

List 3-5 nursing diagnoses for your client (PRS format), and collaborative problems.

Rank order the priority of problems identified.

Priority Nursing Diagnoses:

Potential Complications:

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
SUBJECTIVE: **OBJECTIVE:**	**P:** **R:** **S:** **GOAL:**	**INTERVENTIONS:**		***Goal:***

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
SUBJECTIVE: **OBJECTIVE:**	**P:** **R:** **S:** **GOAL:**	**INTERVENTIONS:**		***Goal:***

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
SUBJECTIVE: **OBJECTIVE:**	**P:** **R:** **S:** **GOAL:**	**INTERVENTIONS:**		***Goal:***

PSYCHIATRIC CLINICAL ORIENTATION

- Olive View students will get instructions on parking and meeting place/time by their instructor.

- Augustus Hawkins Mental Health Center
  1720 East 120th Street
  Los Angeles, CA 90059 [is in Willowbrook]
  (Wilmington and 120th Street) PARK in the older looking parking structure across from Fire Department (not in the new structure). Instructor will give you a parking pass prior to the first day.

  - Instructor will give you a Parking Permit prior to the 1st day of Psych.
  - Meet at 0645 in front of the Parking Lot, we will all walk in together. After this day, you will meet instructor at 0645 inside the lobby of Augustus Hawkins hospital. If you meet instructor any time after 0645, you will be marked late. At 0645, instructor takes attendance and gives each student the keys [key MUST be given back at end of day].

- You MUST have a badge on your shoulder – do not leave in your car or you will be marked late if you must retrieve it.

- The following are the items you are NOT to wear [if worn student will be sent home and marked absent]:
  - No tights or leggings, no heavy makeup, no loose long hair, no tight clothing, no long skirts, no short skirts, best to wear dress slacks, no low cut blouses, no jewelry that can be grabbed (necklace, long earrings, bracelets), nothing that will call attention to yourself (super bright colors, t-shirts with any sayings or band names on them), no shoe laces, no long boots, no high heels, no open toed shoes and no fancy bling hairbands or hair ties. No stethoscope needed.

- The following are items that you CAN wear:
  - Dress very conservative. A light sweater or sweater vest is acceptable as there is no room for us to put heavy jackets in. If you have long hair, keep in a bun. No ponytails as they can be grabbed. You may wear a watch/iwatch. Ok to wear a COLORED lab coat with no markings or stripes (no white lab coats allowed).
  - Ok to take your phone but be sure it is on vibrate and kept in your pocket. Do not reveal your phones while with patients, they may ask you to use it – don't allow this to happen.

- If you bring your lunch box, leave it hidden in your car (use ice packs to keep it cool, use a thermos for hot foods). Olive View instructor will discuss where you can keep it.

- Do not bring books. Items to bring into hospital: 1 small pocket notebook, 1 pen or pencil, a protein bar, or small bag of trail mix or nuts in your pocket as a light snack later. Keep money with you. There is no place to put a backpack. We can drink their water (water bottles have been stolen). You may bring the folders instructor will be giving you.

- The main skill is Therapeutic Communication. No meds given, no hands-on assessments, no ADLs performed, no hands-on skills. Students NOT allowed inside patient's bedrooms; you will be in the dayroom. NEVER be in dayroom alone without another student buddy.

- This first day we will be in orientation all day. Do not be absent as there is no makeup.

- Instructor will walk each group of students to their floors only on the first day, after that, you will walk to your units together without instructor.

SAFETY PRECAUTIONS:

Authorization of an instructor is required for visits to the clinical area during unscheduled clinical hours. For professional and safety reasons, students are not to give out phone numbers or addresses to clients or visitors.

Grounds for failure include but are not limited to:

- Hitting or abusing a client (s)
- Falsifying any client's record
- Sexually provocative behavior (verbal and/or non-verbal) or accepting sexual advances
- Giving out personal phone numbers or addresses
- Visiting the client (s) after hour

CLIENT INTERACTIONS:

- When a client is imminently assaultive or actively assaultive, stay out of the way. Do not choose that patient to care for.

- Call for assistance if you observe an agitated client - don't attempt to manage him/her alone.

- When there is an altercation between a client and a staff member - don't become involved - call for assistance.

- If an assaultive client approaches you - move out of the way.

- Interact with clients in the presence of others - don't take a client into a room alone and close the door.

- Be alert when you walk down hallways.

- Avoid touching clients if possible.

- Do not discuss topics on politics, sex, or religion with clients.

PSYCHIATRIC NURSING DOCUMENTATION STANDARDS

The recorded nursing observations should reflect a clear picture of the client's condition on admission and throughout his/her hospital stay as well as nursing interventions. The nursing observations should demonstrate what nursing staff did for the client, how it was done, the frequency with which nursing staff interacted with the client, how the client was behaving, observations of his/her physical condition and how the client responded to nursing staff's interactions. Charting should also include what the client said about him/herself, both verbal and non-verbal and how he/she was able to cooperate with the medical regimen and activities. These observations should be reflected in the care plan established for the individual.

GUIDELINES

Follow the institutional policy established for documentation.

1. Assessment and Progress Notes must be charted about each assigned client each day. Significant behavior, however, should be charted at the time that it occurs.

2. Use the client's own words whenever possible.

3. Use descriptive words and phrases about the client's behavior. Avoid diagnostic terms.

4. Chart objectively what you see and hear, not what you believe, conclude or assume. What or how the client states he/she feels, not what or how you think he/she feels.

5. Never chart another client's name in your client's chart. Refer to the other client as "other male peer" or "other female peer."

CLIENTS WHO ARE AT RISK AND REQUIRE SPECIAL PRECAUTION

THE CLIENT IN RESTRAINTS

It is the responsibility of the Primary Nurse to determine the need for restraints and/or seclusion. It is therefore his/her responsibility to make an entry on the Progress Note regarding the type of "assistive control" necessary. Students should not choose patients in in restraints or seclusion.

THE CLIENT WHO IS SUICIDAL

Chart client behavior and physical whereabouts throughout the charting period. Does the client try to be alone? At what times? Question the client every shift regarding ongoing suicidal ideations and content of hallucination and chart anything the client says. Try to quote these statements exactly if possible. Report these statements to the Charge Nurse and chart that it was reported and to whom. Chart any radical changes in mood or behavior (i.e., if a depressed client suddenly becomes cheerful or more depressed, or if a withdrawn client becomes more active and involved with others). This could be a danger signal and the client needs to be closely observed.

THE CLIENT WHO IS AN ELOPEMENT RISK

Know the client's whereabouts at all times. Chart anything the client says that indicates he wants to leave the hospital. Check with the client throughout the shift regarding continued feelings about leaving.

PSYCHIATRIC CASE PRESENTATION EVALUATION CRITERIA

Purpose: This assignment is designed to help you apply the nursing process to clients with selected psychiatric disorders. This assignment will follow the theory lecture on the assigned disorder.

Preparation: Students will decide, as a group, on one client from the ward who best fits the description of the psychiatric disorder assigned. Each student should spend some time interacting with the client. The presentation should be divided up to assure equal division of labor. There are three (3) areas of investigation necessary to present a thorough case:

The following cognitive skills will be evaluated:

Theory and History:

- Discuss he client's problem. _____
- Describe the client's current behavior. _____
- Describe the reason for hospitalization. _____
- Discuss the past history of psychiatric problems including family history of mental disorder _____

Treatment Team:

- Identify client's goal during hospitalization _____
- Discuss family involvement in the treatment plan _____
- **Medical Doctor** - List medications that the client is on, side effects that the client has experienced? _____
- What is the cognitive level of the client? _____
- What is the leisure activity of the client, prior to hospitalization? _____
- What are the discharge plans for the client? Identify referral sources in the community that maybe of help after D/C, e.g., Medical Case Worker, Social Worker, etc. _____

Nursing Care:

- Formulate a list of all client problems. _____
- Identify the 3-priority nursing diagnosis. _____
- Identify one short-term goal for each nursing diagnosis.
- List two therapeutic interventions appropriate for <u>each</u> of the three-nursing diagnosis. _____

Creativity:

- The group is to prepare a creative way to present the disease process (board game, song, poem, bingo, a skit, poster, etc…) _____

MENTAL HEALTH FIELD ACTIVITY RESOURCES

I. LOS ANGELES SUPERIOR COURT
1945 South Hill Street
Los Angeles, California 90007

Department 95 is where Mental Health matters occur. Department 95 A is on the 4th floor for Conservatorships and Writs.

- The courthouse is open from 8:00 a.m. to 4:30 p.m.
- Parking is about $10-$15 so carpool if you can.
- The Los Angeles Superior Court prohibits certain items inside. See their website below for a list of prohibited items (you will be checked by security) .
- No uniforms required but be sure to wear your badge so that the security process will go faster for you.

II. MENTAL HEALTH COURTROOMS
Hollywood Courthouse
5925 Hollywood Blvd
Los Angeles, California 90028

Criminal cased, competency hearings and Riese cases.

- The courthouse opens at 0830.
- Attend rooms 103, 203 & 213 for hearings which are downstairs.
- See same website below for a list of prohibited items (you will be checked by security).

II. WEBSITES:

http://www.lacourt.org/courthouse/pdf/GeneralOrderreCourtSecurity.pdf

http://www.lacourt.org/courthouse/mode/division/mentalhealth

http://www.lacourt.org/division/mentalhealth/MH0014.aspx

Student Name: _____

PSYCHOTIC DISORDER CLINICAL ASSIGNMENT

Watch the assigned film and answer the questions listed below. Submit the assignment to the psych clinical instructor the day the movie is discussed for post-conference in the Psych Rotation.

1. List three (3) psychotic features in the movie. Provide a description of each psychotic feature.

    a.

    b.

    c.

2. How does the character in the movie relate to the psychiatric concepts from lecture?

3. What is the overall impression of the film?

SUPPORT GROUP / *NAMI
OBSERVATION REPORT

Student name: _____ Date: _____

Name of group: _____ Location: _____

Contact person/facilitator: _____Phone #: _____

Purpose of group: _____

Your perception about group prior to attending the group:

_____

_____

_____

Your perception of the group after attending the group:

_____

_____

_____

How does the group help group members? _____

_____

_____

_____

The experience helped me understand/appreciate the value of support groups.

Strongly agree *Agree* *Disagree* *Strongly disagree*

Because of my experience, I am more likely to refer clients to a support group.

Strongly agree *Agree* *Disagree* *Strongly disagree*

* http://www.nami.org Find your local NAMI chapter. No more than 2 students are allowed to attend most meetings.

INTERDISCIPLINARY COLLABORATION

1. Identify discipline.

2. Discuss the function of this discipline.

3. List the types of collaborative activities.

4. Write a short synopsis of your experience collaborating with this discipline.

5. Identify the resources this discipline can apply to meet client and/or family outcome goals.

6. State the nursing responsibilities in interdisciplinary collaboration.

STUDENT SIGNATURE: _____

CENTRAL VENOUS CATHETER CARE/MAINTENANCE

At the completion of this skills lab, the student will:

1. Demonstrate a central venous catheter dressing change.
2. Identify the complications of central venous catheters.
3. Discuss the clinical indications for a central venous catheter.
4. Discuss the management of a central venous catheter.

TEACHING METHOD:	Skills Lab
EVALUATION METHOD:	Demonstration Video
REQUIRED READING:	Taylor, pp 1582-1584 (watch & learn), 1592 Central Venous Access Devices

CENTRAL VENOUS CATHETER VIDEOS on INTRANET

DEPARTMENTS TAB
↓
CLINICAL SERVICES
↓
UNDER CLINICAL SERVICES CLICK NURSING SERVICES
↓
EDCOS (to the far left column)
↓
CENTRAL VENOUS CATHETER CARE
↓
VIEW EACH OF THE VIDEOS

Video	**Duration**
• Introduction	09:28
• CVC Protocol	16:57
• Accessing Central Line Ports	05:43
• Application of Biopatch (Play All) -Introduction -What is BIOPATCH? -Scope & Magnitude of CRBSI -CRBSI: Pathogenesis & Prevention -How is BIOPATCH Received -Application of BIOPATCH	12:14
• Central Venous Catheter Dressing Change	15:33
• Valve Change	06:58
• Troubleshooting	04:56

1) NURSING CLINICAL STANDARDS **(Central Venous Catheter & IV Therapy)**

a. **Nursing Clinical Protocols (NCP)**: Clinical Standards

   i. 068 - Central Venous Catheter – Section 1
   ii. 069 - Central Venous Catheter – Section 2 (Care and Maintenance Guidelines)
   iii. 134 - Electrolyte Replacement: Intravenous
   iv. 278 – Intravenous Therapy

b. **Nursing Clinical Protocols:** Procedures

   i. Proc 1408 – Central Venous Catheters: Care, Maintenance, Troubleshooting, **(DO NOT REMOVE ANY CVC)**

2) NURSING CLINICAL STANDARDS **(Intravenous)**

a. **Nursing Policy Manual :**

i. Nur911 – Intravenous Therapy

ii. Nur911-A – Attachment: Approved Intravenous Push Medication List-Adult

AIRWAY SUCTIONING

At the completion of this skills lab, the student will:

1. Demonstrate safe and effective airway suctioning.

    a. Select appropriate equipment for suctioning a client
    b. Describe the correct position and method for suctioning a client safely

2. Discuss the nursing responsibilities before, during, and after suctioning.

TEACHING METHOD:	Skills Lab
EVALUATION METHOD:	Demonstration
REQUIRED READING:	Taylor, pp 1517-1518 Tracheostomy, Providing Trach Care, Tracheal Suctioning. Also, pp 1542-1547 Skill 39-6 Suctioning a Tracheostomy: Open System

TRACHEOSTOMY CARE

At the completion of this skills lab the student will be able to

1. Demonstrate suctioning via an artificial airway.

2. Demonstrate tracheostomy care.

* **Note:**
1. Goggles or face shield should be used in standard precautions.
2. Check ward/area protocols before pre-oxygenating clients.

TEACHING METHOD:	Skills Lab
EVALUATION METHOD:	Demonstration
REQUIRED READING:	Taylor, pp 1538-1542 Skill 39-5 Providing Care of a Tracheostomy Tube

CHEST TUBE DRAINAGE SYSTEMS

At the completion of this skills lab, the student will:

1. Describe the purpose, methods, and nursing responsibilities related to chest tubes.

2. Discuss the pathophysiological conditions in which a chest tube is required:

    a. Pleural effusion
    b. Hemothorax
    c. Pneumothorax
    d. Empyema

3. Discuss the common placement/location of chest tubes.

4. Identifies the components of a chest tube drainage system.

    a. Name the three chambers of a chest tube drainage system

5. List the requirements in the management and care of a chest tube.

6. List the steps in troubleshooting problems with chest tubes.

TEACHING METHOD: Skills Lab

EVALUATION METHOD: Demonstration

REQUIRED READING: Taylor, pp 1512-1514

BLOOD AND BLOOD PRODUCTS

At the completion of this skills lab the student will:

1. Discuss the nursing responsibilities in the administration of blood and blood products
   - Prior to transfusion
   - During transfusion
   - After transfusion

2. Select the appropriate equipment required in a blood transfusion.

3. Discuss the signs and symptoms of a blood transfusion reaction
   - Febrile non-hemolytic
   - Allergic
   - Hemolytic transfusion reactions

4. Discuss nursing responsibilities when a blood transfusion reaction occurs (or suspected).

TEACHING METHOD:	Skills Lab
EVALUATION METHOD:	Demonstration
REQUIRED READING:	Blood and Blood Products Protocol Taylor, pp 1513-1515 (Components, cross-matching, typing & administration)

BASIC ECG INTERPRETATION

At the completion of this skills lab, the student will:

1. Identify normal electrocardiogram pattern.

2. Identify two (2) methods to calculate the heart rate.

3. Measure:

   - P-R interval
   - QRS complex
   - QT interval

4. Identify common dysrhythmias:

   - Sinus bradycardia
   - Sinus tachycardia
   - Atrial flutter
   - Atrial fibrillation
   - Premature ventricular contractions (PVC)
   - Ventricular tachycardia (V-tach)
   - Ventricular fibrillation (V-fib)
   - Asystole
   - First degree AV block
   - Second degree AV block
   - Third degree AV block
   - Paroxysmal Supraventricular Tachycardia (PSVT)

5. Demonstrate correct ECG lead placement.

6. Identify ST segment elevation.

TEACHING METHOD:	Skills Lab
EVALUATION METHOD:	Demonstration
REQUIRED READING:	Hinkle, et. al., Medical-Surgical Nursing pp 696-698 and Chapter 26
RECOMMENDED READING:	Basic Arrhythmia Module (in the Library)

Cardiac Cycle: refer to picture/diagram

P wave -	is the depolarization of the atria.
PR Interval -	measures the depolarization time from the sinus more through the bundle of His and into the bundle branches.
QRS Complex -	represents depolarization of the ventricles. Three waves are usually seen: • Q wave is the first negative wave • R wave is the first positive wave • S wave is the first negative wave which follows first positive wave
ST Segment -	may either be isoelectric or slightly elevated.
T Wave -	indicates repolarization or electrical recovery of the ventricles.
U Wave -	occasionally this wave is seen. The exact mechanism of its formation is unknown, but it is sometimes diagnostic. With the appearance of the P wave, the cycle begins again.

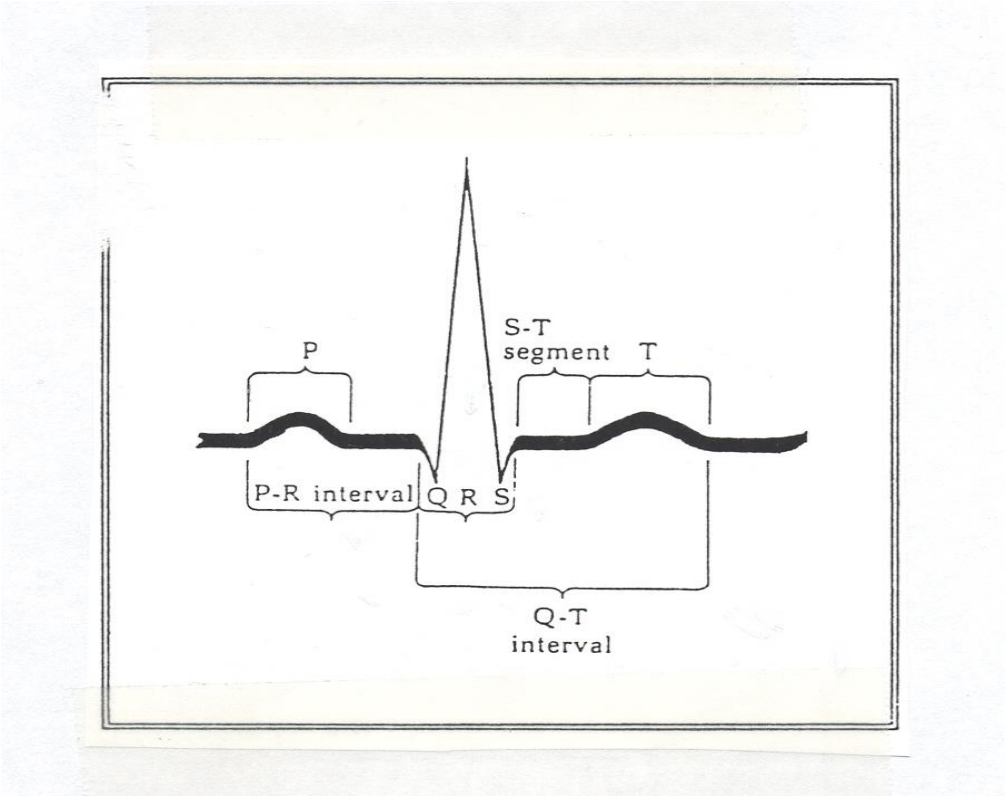
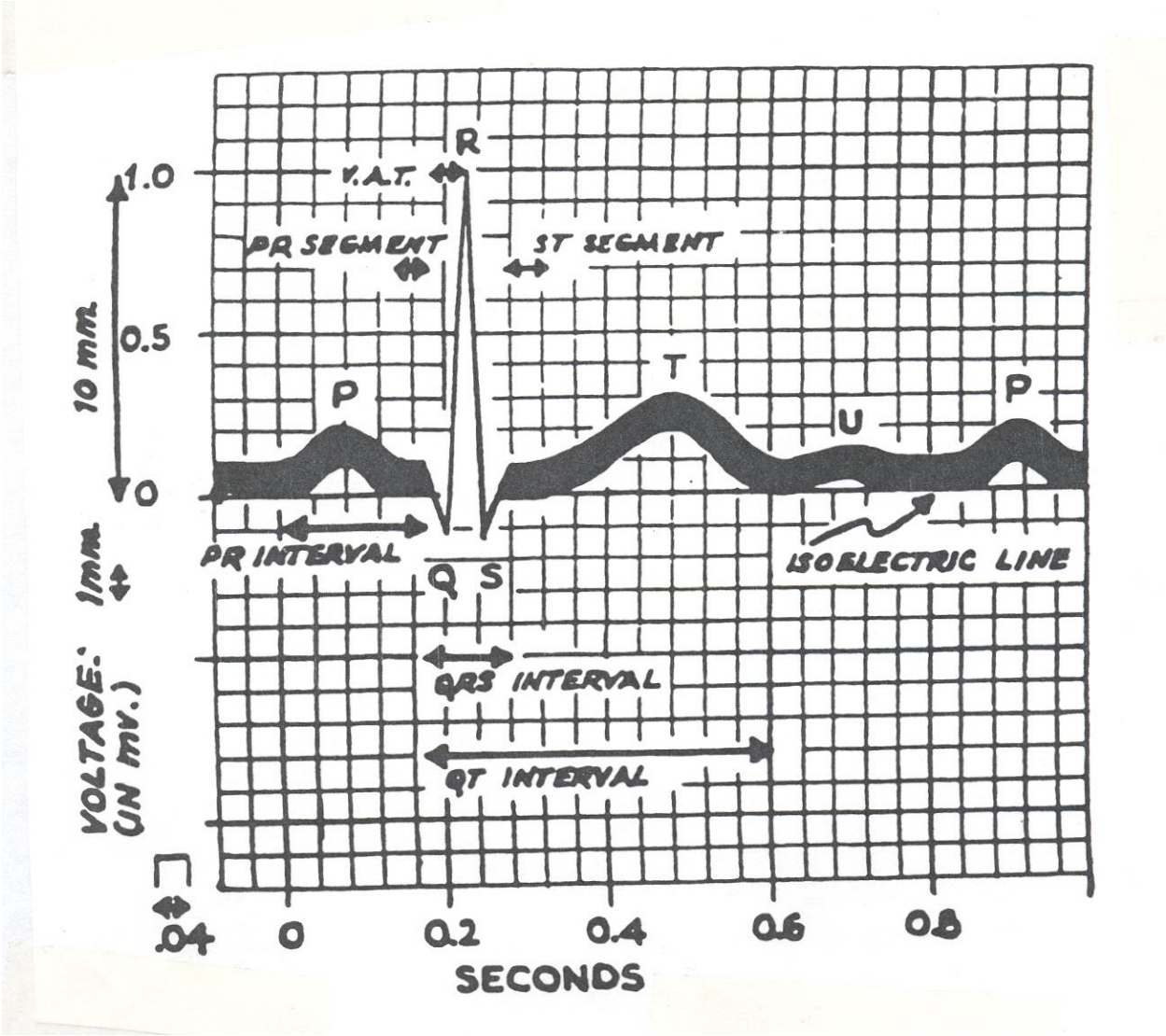


DIAGRAM OF ELECTROCARDIOGRAPHIC COMPLEXES, INTERVALS, AND SEGMENTS



Method to Calculate Heart Rate:

1. Count the number of cycles in a 6-second strip and multiply by 10. This method can be used when the rhythm is either regular or irregular.

   R wave/6-sec strip x 10 = rate/min

2. Counting boxes between R-waves discussed in clinical conference is accurate only if the rhythm is regular.
   - Count the small boxes between R and R and divide into 1500.

Systematic Assessment of Rhythm Strip

1. **What is the rate?**

   a. To determine the ventricular rate, measure the distance between two consecutive R waves (R-R interval).
   b. To determine the atrial rate, measure the distance between two consecutive P wave (P-P interval).

2. **Is the rhythm regular or irregular**?

   a. To determine if the ventricular rhythm is regular or irregular, measure the distance between two consecutive R-R intervals and compare that distance with the other R-R intervals. If the ventricular rhythm is regular, the R-R intervals will measure the same.
   b. To determine if the atrial rhythm is regular or irregular, measure the distance between two consecutive P-P intervals and compare that distance with the other P-P intervals. If the atrial rhythm is regular, the P-P intervals will measure the same.
   c. Generally, a variation of up to 0.12 seconds (3 small boxes) is acceptable. The slower the heart rate, the more acceptable the variation.

3. **Is there one P wave before each QRS?**

   a. Are P waves present and uniform in appearance?
   b. Is there a P wave before each QRS or are there P waves that are not followed by QRS complexes?
   c. Is the atrial activity occurring so rapidly that there are more atrial beats than QRS complexes?

4. **Is the PR interval within normal limits?**

   a. If the PR interval is less than 0.12 or more than 0.20 second, conduction followed an abnormal pathway, or the impulse was delayed in the area of the AV node.
   b. Is the PR interval of conducted beats constant or does it vary?

5. **Is the QRS narrow or wide?**

   a. What is the duration of the QRS complex?

      1) If it is 0.10 second or less (narrow), it is presumed to be supraventricular in origin.

      2) If it is greater than 0.12 second (wide), it is probably ventricular in origin.

   b. Do the QRS's occur uniformly throughout the strip?

6. **Is theQT interval too long?**

   Normal QT interval is 0.34-0.43 (sec)

7. **Interpret the rhythm** specifying the site where the dysrhythmias originated (sinus), the mechanism (bradycardia), and the ventricular rate. For example, "sinus bradycardia with a ventricular response (rate) of 38 minutes."

8. **How is the rhythm clinically significant**?

ARTERIAL BLOOD GAS INTERPRETATION CASE STUDY

When the client develops an acid-base imbalance, the body attempts to compensate. The body will try to overcome either respiratory or metabolic dysfunction in an attempt to return the pH into the normal range.

A client can be uncompensated, partially compensated, fully compensated, or mixed/combined. When an acid base disorder is either uncompensated or partially compensated, the pH remains outside the normal range. **In fully compensated states, the pH has returned to within the normal range, although the other values may still be abnormal. Combined or mixed means that both the CO2 and the HCO3 cause the imbalance.**

Fully Compensated States

	pH	**$PaCO_2$**	**HCO_3^-**
Respiratory Acidosis	normal, but < 7.40	↑	↑
Respiratory Alkalosis	normal, but > 7.40	↓	↓
Metabolic Acidosis	normal, but < 7.40	↓	↓
Metabolic Alkalosis	normal, but > 7.40	↑	↑

Partially Compensated States

	pH	**$PaCO_2$**	**HCO_3^-**
Respiratory Acidosis	↓	↑	↑
Respiratory Alkalosis	↑	↓	↓
Metabolic Acidosis	↓	↓	↓
Metabolic Alkalosis	↑	↑	↑

Notice that the only difference between partially and fully compensated states is whether or not the pH has returned to within the normal range. In compensated acid-base disorders, the pH will frequently fall either on the low or high side of neutral (7.40). Making note of where the pH falls within the normal range is helpful in determining if the original acid-base disorder was acidosis or alkalosis.

List the normal ranges for the listed components of an Arterial Blood Gas:

pH _____ PaO_2 _____ SaO_2 _____ $PaCO_2$_____ HCO_3^- _____

Case # 1

A client is admitted to the hospital and is scheduled to undergo brain surgery. The client becomes extremely anxious and afraid of the upcoming surgery. The client begins to hyperventilate and becomes dizzy. The client loses consciousness and STAT ABGs reveal: pH 7.61, PaCO2 22, HCO3 25. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case # 2

A client, who underwent abdominal surgery, has a nasogastric tube (NGT) placed. The nurse notes that the NGT has drained 900mL in 2 hours of coffee ground secretions. The client is disoriented to person, place, and time. The physician is contacted and STAT ABGs are drawn. The results are as follows: pH 7.57, PaCO2 37, HCO3 30. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #3

A client is brought to the emergency department after falling and injuring both lower extremities. The client is tachycardic and tachypneic. Following the administration of painkillers the client reports still being in pain and was now experiencing muscle cramps, tingling, and paraesthesia. ABG results are as follow: pH 7.6, PaO_2 120, $PaCO_2$ 31, HCO_3- 25. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #4

Interpret the following ABG's

pH= 7.30
PaO_2 = 92
$PaCO_2$ = 46
HCO_3- = 16

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

pH= 7.47
PaCO2= 48
HCO3=30

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

pH= 7.31
PaO2= 90
PaCO2= 40
HCO3=22

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

pH= 7.46
PaCO2=32
HCO3=23

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #5

A 70-year-old-client is admitted to the hospital for two days of intractable vomiting. The client is lethargic, weak, myalgia dry mucous membranes and the capillary refill is > 4 seconds. The client is diagnosed with gastroenteritis and dehydration. ABG reading is as follows: pH 7.50, PaO_2 85, $PaCO_2$ 40, HCO_3^- 34. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #6

A 54-year-old client with a h/o chronic obstructive pulmonary disease (COPD) is rushed to the emergency department with increasing SOB, pyrexia, and a productive cough with yellow-green sputum. He is unable to complete a sentence, crackles and wheezes can be heard in the lower lobe; he has tachycardia and a bounding pulse. His ABGs are as follows: pH 7.3, PaO_2 60, $PaCO_2$ 68, HCO_3^- 28. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #7

A 9-year-old- client is rushed to the hospital due to vomiting and a decreased level of consciousness. The client displays Kussmaul breathing, is lethargic and irritable in response to stimulation. He appears dehydrated—eyes are sunken and mucous membranes are dry and he has a two week history of polydipsia, polyuria, and weight loss. Initial arterial blood gas result is as follows: pH 7.0, PaO_2 90, $PaCO_2$ 23, HCO_3^- 12. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

AMBULATORY CARE ROTATION

Directions for the Ambulatory Care Rotation in the Outpatient Building/Clinic Tower and Comprehensive Health Centers.

A. Clinical Rotation

- 8 days of ambulatory care

Please note the time you are scheduled for the clinics: 0700-1530. There will be some variation on the starting times (and possibly ending times) for certain clinics which will be discussed with you at the beginning of the rotation.

B. Forms That Must Be Completed

1. Twenty (20) informal teachings in the ambulatory care setting by the end of week 4.

2. Weekly activities due at the end of each week (4 in total).

3. One Cultural Assessment Interview (some groups will do it in MedSurg).

4. One Formal Teaching project to be scheduled by instructor by week 4.

5. Evaluation of outpatient clinic experience due at the end of the experience.
   - Evaluations for each clinic to be completed.

C. Under the direction and guidance of an instructor from the College of Nursing and the Outpatient Nurse Manager(s) or designee, the nursing student will:

1. Implement infection control and safety measures per ambulatory health care provider policy and procedure.

2. Participate in screening procedures of the assigned clinic.

3. Utilize all components of the nursing process to implement standards of care that promote health or prevent health care problems.

5. Promote a positive work environment for all ambulatory health care staff members.

6. Prioritize client, client family and/or community education based on the needs identified by the client(s).

7. Devise and implement client and/or client family education which demonstrate sensitivity to ethnic and cultural diversity.

8. Provide care and education (answer questions/concerns)

AMBULATORY CARE / MEDSURG ROTATION
CULTURAL ASSESSMENT INTERVIEW
GUIDELINES

For Ambulatory Care or MedSurg, the following assignment will be required as one of the requisites to satisfactorily pass the rotation:

1. This assignment will only be done one time this semester while in either Ambulatory Care or MedSurg. It cannot be completed while in the Psych rotation.

2. Permission is required from client. Client needs to be from a culture different from your own.

3. Begin the discussion with a brief analysis of the client's country of origin (where is it, how big is it, what is population, what other languages spoken, what is it mostly known for etc…).

4. You will need to ask the client about his/her culture in relation to the following: cultural religion, communication, diet/nutrition, overall description of client's family (authority figure, social role, gender hierarchy), client's health risk, and other information that you find pertinent.

5. Based on the findings from the Cultural Assessment interview, the student will write a formal paper in the role course (see Semester Schedule for due date).

AMBULATORY CARE ROTATION

FORMAL TEACHING PROJECT

Student(s): _____ Clinic: _____

Student(s): _____ Clinic: _____

A. Learning Objectives (State what Clinic the teaching is for and state the Learning Objectives prior to presenting the project)

1.

2.

3.

B. Teaching Strategies and Visual Aids Used (Submit original to instructor and have copies for your audience…if applicable)

C. State how you would know if your teaching is effective.

D. If teaching were ineffective, what could you do differently to make it effective?

AMBULATORY CARE ROTATION - INFORMAL TEACHING

Student:_____ Date: _____

	Client Initials	Clinic Name	Reason for Client's Visit	Teaching Performed	Was Teaching Effective? (yes or no)	Discuss Client's Response to Teaching
1.						
2.						
3.						
4.						
5.						

AMBULATORY CARE ROTATION - INFORMAL TEACHING

Student:_____ Date: _____

	Client Initials	Clinic Name	Reason for Client's Visit	Teaching Performed	Was Teaching Effective? (yes or no)	Discuss Client's Response to Teaching
6.						
7.						
8.						
9.						
10.						

AMBULATORY CARE ROTATION - INFORMAL TEACHING

Student:_____ Date: _____

	Client Initials	Clinic Name	Reason for Client's Visit	Teaching Performed	Was Teaching Effective? (yes or no)	Discuss Client's Response to Teaching
11.						
12.						
13.						
14.						
15.						

AMBULATORY CARE ROTATION - INFORMAL TEACHING

Student:_____ Date: _____

	Client Initials	Clinic Name	Reason for Client's Visit	Teaching Performed	Was Teaching Effective? (yes or no)	Discuss Client's Response to Teaching
16.						
17.						
18.						
19.						
20.						

AMBULATORY CARE ROTATION

WEEKLY ACTIVITIES

Student Name: _____ Date(s): _____

(Week #1)

Time Reported In: (**Day #1)** _____Clinic Assigned: _____

I participated in the following activities on Day #1:

DAY #1: Time Reported Off: _____

Signature of Responsible Person: _____

Time Reported In: **(Day #2)** _____Clinic Assigned: _____

I participated in the following activities on Day #2:

DAY #2: Time Reported Off: _____

Signature of Responsible Person: _____

AMBULATORY CARE ROTATION

WEEKLY ACTIVITIES

Student Name: _____ Date(s): _____

(Week #2)

Time Reported In: (**Day #1)** _____Clinic Assigned: _____

I participated in the following activities on Day #1:

DAY #1: Time Reported Off: _____

Signature of Responsible Person: _____

Time Reported In: **(Day #2)** _____Clinic Assigned: _____

I participated in the following activities on Day #2:

DAY #2: Time Reported Off: _____

Signature of Responsible Person: _____

AMBULATORY CARE ROTATION

WEEKLY ACTIVITIES

Student Name: _____ Date(s): _____

(Week #3)

Time Reported In: (**Day #1)** _____Clinic Assigned: _____

I participated in the following activities on Day #1:

DAY #1: Time Reported Off: _____

Signature of Responsible Person: _____

Time Reported In: **(Day #2)** _____Clinic Assigned: _____

I participated in the following activities on Day #2:

DAY #2: Time Reported Off: _____

Signature of Responsible Person: _____

AMBULATORY CARE ROTATION

WEEKLY ACTIVITIES

Student Name: _____ Date(s): _____

(Week #4)

Time Reported In: (**Day #1)** _____Clinic Assigned: _____

I participated in the following activities on Day #1:

DAY #1: Time Reported Off: _____

Signature of Responsible Person: _____

Time Reported In: **(Day #2)** _____Clinic Assigned: _____

I participated in the following activities on Day #2:

DAY #2: Time Reported Off: _____

Signature of Responsible Person: _____