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

Nursing 243L:

ADVANCED MEDICAL/SURGICAL & GERONTOLOGICAL NURSING CLINICAL CLINICAL PACKET

Spring 2021

CLINICAL ROTATION DOCUMENTS

&

LAB ASSIGNMENTS

TABLE OF CONTENTS

CLINICAL & CLINCAL LAB ASSIGNMENTS

MED/SURG

TEAM LEADING

ACUTE CARE (ICU) (Pending Covid-19 Outcomes)

CLINICAL COMPETENCY EXAMINATION

OPERATING ROOM ROTATION

Attendance for this lab is mandatory

OBJECTIVES

1. Student will attend two (2) scheduled Operating Room (OR) days.
2. Student will participate and/or observe procedures as allowed by the OR staff/coordinator.
3. A satisfactory evaluation from the OR staff or coordinator will be conveyed to Semester Coordinator or Clinical Instructor.
4. Student will complete the Operating Room Rotation Summary and submit it to his/her clinical instructor by the given date.

EXPECTATIONS

1. Student will arrive at 0645 and wait in the Diagnostic Tower, 5th floor hallway for the OR coordinator.
2. Student may leave the OR no earlier than 1430.
3. Student must wear their SON identification badge at all times.
4. Student must follow the directives of the OR coordinator and/or the nurse in charge in the OR suite.
5. Student will arrive in school uniform and change into OR scrubs as directed by the OR coordinator. Student may want to wear layered clothing as the OR temperatures may range from cold to hot. Student will wear closed toed shoes. No canvas shoes.
6. It is advised not to bring valuables, credit cards or large amounts of money. Do bring money for lunch.
7. Cell phones…preferably do not bring. The scrubs may not have pockets. But silencing is the key.

Student Name: _____ Date: _____

OPERATING ROOM ROTATION SUMMARY

1. Please list the operating rooms observed and the types of surgeries you participated in.

2. What was the role of the RN?

3. What was the role of the Surgical/Scrub Tech?

4. What were you allowed to assist with?

5. How did you feel about this rotation?

Submit to Clinical Instructor the next school day.

VENTILATORS

Attendance for this lab is mandatory

At the completion of this skills lab the student will:

1. Identify the different types of ventilators used for assisted breathing.
2. Identify the nurse's responsibilities related to the safety of the client receiving positive pressure mechanical ventilation.
3. Identify common reactions to stressors of positive pressure ventilation and primary and secondary prevention strategies used to manage them.

NURSING RESPONSIBILITIES FOR CLIENTS RECEIVING MECHANICAL VENTILATION

1. Electrical safety: emergency outlets and water hazards.
2. Oxygen tanks: secure, no petroleum, "No Smoking" sign is present, gas pressure >500, correct color (within green area).
3. Settings match physician's orders: Fraction of Inspired Oxygen (F_iO_2), Tidal Volume (V_t or TV), Rate, and Mode.
4. Client safety: restraints; bite blocks; sedation (if indicated); balloon is inflated when PO meds, foods, or liquids are being administered or when tube feedings are given.
5. Alarms functioning: High inspiratory pressure, Low pressure, Low expiratory volume, Low oxygen pressure, Temperature, Inspiratory/Expiratory ratio.
6. Ask questions of Respiratory Care Practitioner and Physician when needed.
7. Assess client status. Remove from ventilator. Ventilate with manual resuscitation bag. Call RT whenever necessary.

NOTE: **Students may NOT make any adjustments to the ventilator without the permission and direct supervision of the clinical instructor.**

TEACHING METHOD: Skills Lab

EVALUATION METHOD: Demonstration

BASIC TROUBLE SHOOTING OF VENTILATOR ALARMS

ALARMS	NURSING ACTIONS
Minimum Pressure and Spirometer	• Begin by checking all circuits for disconnection. • Start with the client and end with the ventilator. • Look, listen, and feel for air leaks. • Reconnect as needed. • Check the meter stick for obstruction and rectify.
Maximum Pressure	• Check breath sounds. • Suction as needed. • Check tubing for kinks. • Check that the client's tubing is not caught in the bedrails. • Check if the client is lying on the tubing. • Remove any fluid blocking the passage of air in the tubing. • Remember not to drain the fluid back into the humidifier.
Inadequate Gas Supply	• Check the tank: Must have at least 500 PSI (pounds per square inch) to function. • Call for a new tank when needed. • Check gas outlet. • Make sure connecting tubing and valves are properly connected. • The valves must be connected to the correct gas outlet. If the gas is being delivered by piped wall unit and troubleshooting fails, call the chief engineer.
Humidifier	• Check the water level. • Add sterile water as needed.

If troubleshooting measures are ineffective, call the Respiratory Care Practitioner and monitor the client until arrival. If the client is in distress, remove the client from the ventilator and use a manual resuscitation device to ventilate the client until the Respiratory Care Practitioner arrives. If manual ventilation is ineffective, call the physician.

CAN ONLY BE PERFORMED/DONE BY STUDENT IN THE PRESENCE OF THE PRIMARY RN AND/OR CLINICAL INSTRUCTOR

COMMON REACTIONS TO STRESSORS OF MECHANICAL VENTILATION

PRIMARY PREVENTION	SECONDARY PREVENTION
AIRWAY OBSTRUCTION from secretions, balloon herniation, or improper endotracheal tube placement.	
• X-ray • Auscultation for tube placement • Assess, suction prn	• Reposition or replace ET tube • Suction
BAROTRAUMA on tissues due to damage from high air pressure.	
• Avoid high pressure settings (inspiratory pressure and PEEP)	• Treat pneumothorax and subcutaneous emphysema with chest tube
DECREASED CARDIAC OUTPUT with increased intra-thoracic pressure, thoracic vessels are compressed. This results in decreased venous return to the heart.	
• Use least amount of PEEP possible	• Reduce PEEP as much as possible • Restoration and maintenance of the circulatory blood volume
SODIUM & WATER IMBALANCE from decreased cardiac output and kidney perfusion.	
• Assess for signs and symptoms • Monitor labs, I&Os	• IV fluids/electrolytes or diuretics
INFECTION (VENTILATOR ASSOCIATED PNEUMONIA-VAP from lack of upper airway defenses, poor nutrition, immobility, immunosuppression	
• HOB elevation 30-45 degrees • Turn, suction, frequently • Aseptic technique	• Antibiotics • Turn, suction • Aseptic technique
ALVEOLAR HYPO- & HYPERVENTILATION from increased or decreased RR or Vt.	
• Check ventilator settings • Use lowest oxygen possible (Hyperventilation) • Check for air leaks (Hypoventilation)	• Reduce RR, Vt and use lowest oxygen possible (Hyperventilation) • Increase RR, Vt and O_2 (Hypoventilation)
TRACHEAL TRAUMA from endotracheal tube cuff pressure damaging the trachea.	
• Use minimal leak technique	• Surgery
STRESS ULCERS & GIB from the stress of intubation, serious illness, and immobility.	
• Antacids • Early tube feedings	• Antacids • Tube feedings
MACHINE DISCONNECTION & MALFUNCTION from accidental ventilator disconnection.	
• Set the alarms, check the tubes for air leak and disconnection • Reconnect the tubes, assess for air leak	• If malfunction sustains, disconnect the client from the machine and manually ventilate with BVM and 100% O_2

ARTERIAL BLOOD GAS ANALYSIS

Attendance for this lab is mandatory

At the completion of this skills lab the student will:

1. List the components and normal values of ABG.
2. Differentiate the types of acid-base imbalances.
3. Discuss the causes, signs and symptoms, and treatment of acid-base imbalances.
4. Interpret the ABG values.
5. Discuss the changes in the ventilator settings based on the ABG results.

TEACHING METHOD:	Skills Lab
EVALUATION METHOD:	Discussion
REQUIRED READING:	Lewis et al., 286-291

ARTERIAL BLOOD GAS ANALYSIS

A blood sample is taken from an artery to determine acid-base status, oxygenation, and ventilation.

Importance

- Evaluates the effects of mechanical ventilation
- Provides client's oxygenation status
- Shows acid-base status

Normal ABG Values

pH	PCO_2	O_2 sat	PO_2	HCO_3	BE
7.35 - 7.45	35 - 45mmHg	95 - 100%	80 -100 mmHg	22 – 26 mEq/L	0 - $\pm$2

Components of ABGs

pH

The negative logarithm of H^+ ion concentration. It reflects the acidity or alkalinity of a solution.

PCO_2

Measures carbon dioxide in the blood. It represents the functioning of the lungs and the acidic component of the blood.

O_2 saturation

An indicator of the percentage of hemoglobin saturated with oxygen. pO_2**:** Refers to the amount of oxygen in arterial blood. It is utilized at cellular level to keep the tissue alive.

HCO_3

Refers to the amount of base found in the blood. It is alkaline and mainly controlled by the kidneys.

Base Excess (BE)

Measures the degree of deviation from the normal buffer base. A negative value expresses a basic deficit or excess of acid. A positive value expresses a base excess or acid loss.

Regulators of Acid/Base

- Metabolic processes produce acids that must be neutralized and excreted.

Regulatory Mechanisms

- *Buffers* (chemical buffers): Are the <u>first line of defense:</u> Act chemically to neutralize acids or change strong acids into weak acids.
- *Respiratory System*: Are the <u>second line of defense</u>: Eliminates CO_2.
- *Renal System*: Are the <u>third line of defense</u>: Eliminates H^+ and reabsorbs HCO_3^+.

Alterations in Acid-Base Balance:

- Imbalances occur when compensatory mechanisms fail.

Classification of Imbalances:

- Respiratory acidosis/alkalosis
- Metabolic acidosis/alkalosis
- Mixed acid-base disorder

Respiratory Acidosis

Causes	Signs & Symptoms	Treatment
- Alveolar hypoventilation - Excess carbonic acid - Compensation	- Hypoventilation - pCO_2 >45 - ALOC - Acute hypoxia - ↑ HR	- Treat the cause - Mechanical ventilation (↑ or ↓ tidal volume and or RR)

Respiratory Alkalosis

Causes	Signs & Symptoms	Treatment
- Hyperventilation - CNS stimulation - Overstimulation of respiratory centers in brain - Early salicylate intoxication	- Hyperventilation - pCO_2 <35 - Giddiness - Convulsions - Coma - Electrolyte disturbances	- Treat underlying cause - ↑ CO_2 retention - Correct electrolyte imbalances - Breathe into a bag

Metabolic Acidosis

Causes	Signs & Symptoms	Treatment
↑ metabolic acids: - Starvation - DKA - Shock states - Renal failure - Excessive ingestion of metabolic acids **Loss of base:** - Diarrhea - ↑ intake of Diamox	- Hyperventilation - Confusion - Hyperkalemia - Hypercalcemia	- Treat underlying cause - Bicarbonate replacement - Electrolyte replacement

Metabolic Alkalosis

Causes	Signs & Symptoms	Treatment
↑retention of HCO_3^+: - ↑ $NaHCO_3^{++}$ administration - Chloride depletion - Renal retention of HCO_3^+ **Loss of metabolic acids:** - NG drainage - Vomiting - Hypokalemia	- Hypoventilation - Confusion - Headache - Cardiac arrhythmias	- Treat underlying cause - Chloride administration - Electrolyte replacement

Compensation

Compensation occurs when the unaffected system attempts to return the pH toward normal.

- Full compensation: If compensatory mechanisms are functioning, the pH will return toward 7.40. When the pH returns to within the normal range, the client has full compensation.
- Metabolic acidosis may be compensated by respiratory alkalosis
- Respiratory acidosis may be compensated by metabolic alkalosis

Combined/Mixed Disorders

- Occurs when two processes occur simultaneously
- pH is not within the normal range

Steps in the Interpretation of ABGs

1. Evaluate pH
2. Analyze $PaCO_2$
3. Analyze HCO_3^+
4. Determine if CO_2 or HCO_3^+ matches the alteration
5. Analyze the pO_2 & O_2 sat
6. Analyze the Base Excess
7. Decide if the body is attempting to compensate or if it is a combined/mixed disorder

Interpretation of ABGs

Respiratory:

↑ pH ↓ $PaCO_2$ ↓ pH ↑ $PaCO_2$

Metabolic:

↑ pH ↑ HCO_3 ↓ pH ↓ HCO_3^+

Examples

	1	**2**	**3**	**4**	**5**	**6**
pH	7.36	7.49	7.32	7.48	7.38	7.11
pCO_2	26	40	48	32	48	52
PO_2	85	94	60	90	87	109
HCO_3^+	13	30	25	24	28	16
FiO_2	0.21	0.40	0.40	0.50	0.40	0.60
Interpretation	Compensated metabolic acidosis	Metabolic alkalosis	Respiratory acidosis with hypoxemia	Respiratory alkalosis	Compensated respiratory acidosis	Mixed/ Combined acidosis

Practice ABGs

	1	**2**	**3**	**4**	**5**
pH	7.48	7.32	7.30	7.38	7.49
pCO_2	32	48	40	48	40
PO_2	90	60	95	87	94
HCO_3	24	25	18	28	30
O_2 saturation	95	90	100	94	99
Interpretation					

	6	**7**	**8**	**9**	**10**
pH	7.35	7.45	7.31	7.30	7.48
pCO_2	48	47	38	50	40
PO_2	62	93	95	65	110
HCO_3	29	29	15	24	30
O_2 saturation	91	97	99	89	100
Interpretation					

MOCK CODE

Attendance for this lab is mandatory

OBJECTIVES:

1. Students will review emergency equipment, EKG rhythms, nursing roles and responsibilities of registered nurses during a code blue.
2. Students will demonstrate competent registered nursing roles.

I. RESUSCITATION: CODE BLUE

A. "Code Blue" is the term used to designate a cardiac arrest.

B. CPR must be initiated unless there is a valid order not to perform basic life support.

C. Student will perform the American Heart Association's BLS provider role with instructor guidance.

II. RESPONSIBILITIES OF NURSING STAFF DURING A CODE BLUE

A. **Physician**
- Runs the code
- Intubates patient

B. **Team leader**
- Assigns specific tasks to code team members
- Directs overall resuscitative efforts
  - Checks that all tasks are being performed and done correctly
  - Monitors cardiac rhythm
  - Redirects staff as needed
- Evaluates and corrects team performance as code progresses
- Does not perform in the code…stands back and observes

C. **Airway manager**
- Checks bag valve mask before use
- Attaches bag tubing to wall oxygen, sets oxygen level (15L)
- Bags patient in rhythm with chest compressions (per BCLS/ACLS protocols)
- Maintains cohesiveness with chest compressor
- Communicates activities to recorder as needed

D. **Cardiac: Chest compressions/defibrillation**
- Checks for pulse (carotid)
- Places EKG pads on client
- Performs chest CPR appropriately per AHA BCLS/ACLS guidelines
- Counts out loud the number of compressions
- Operates defibrillator

- Checks cardiac monitor for rhythm (done when chest compressions are stopped) and announces rhythm to code team
- Maintains cohesiveness with airway manager
- Communicates need to switch compressors (gets tired)
- Communicates activities to recorder as needed

E. **Medication**

- Gathers and checks code medications
- Checks that supplies are at bedside (syringes, flushes, etc.)
- Repeats med orders loudly so all code team members can hear
  - Repeats order after MD gives it
  - States when med is being administered
  - States when med has been administered
- Communicates activities to recorder and verifies recorder has heard

F. **Procedures**

- IV placement (2 sites)
- Lab draw
- VS check (q 2 min)
- IVF administration (coordinate with med nurse)
- Communicates activities to recorder
- Post intubation/code: NGT and F/C

G. **Recorder**

- Records events in a chronological order (uses same time device for all recordings)
- Includes names of code team members and role/intervention each is performing
- Accurate written record of the timing of all interventions
  - Procedures and effectiveness/problems
  - Name and amount of meds
  - Repeats the name of the med before and after administered
- Records VS q 2 minutes
- Records cardiac rhythm announced
- Records when CPR began, held, and re-continued

H. **Runner**

- Runs labs to laboratory or ABG to lab
- Gets supplies/paperwork as directed.

III. LAB ACTIVITIES

A. Students will:

a. View the Mock Code video prior to clinical day.
b. Identify cardiac EKG rhythms
c. Review the Crash Cart and code equipment
d. Practice using the code equipment in “stations”
e. Complete written assignment on cardiac case studies

GERIATRIC EXPERIENCE - HOME VISITS

OBJECTIVES

At the completion of this unit the student will:

1. Discuss communication techniques when interacting with the elderly person.
2. Describe health promotion strategies based on the results of the assessment for the elderly at home.

GUIDELINES FOR THE HOME VISITS

1. Select one person who is living independently or is relatively healthy, over the age of 65 and not a relative.
2. Obtain a signature on the Interview Permission Form from the elderly person (next page).
3. Make three visits lasting 30-60 minutes, Credit hours for these visits are on the clinical schedule and noted as HV#1, HV#2 and HV#3.
4. Complete the Geriatric Assessment Tool.
5. Complete a Nursing Care Plan on the elderly person with the focus on health promotion strategies and client teaching.
6. Contact your clinical instructor if you have questions or encounter any problems with this assignment.

INTERVIEW PERMISSION FORM

I agree to allow a Los Angeles County College of Nursing Student to interview me three times during the semester for the purpose of his/her learning related to his/her understanding of the developmental process of the geriatric. The information obtained will be confidential and discussed only with the instructor and small groups of peers engaged in similar interviews.

Client Signature Date

Student Signature Date

GERIATRIC ASSESSMENT TOOL

Student Name: _____

Client Name: _____ Age: _____

Gender: ☐ F ☐ M Ht _____ Wt _____ Ethnicity: _____

Lives with: ☐ Self ☐ Spouse ☐ Children ☐ Other _____

Finances: ☐ Self ☐ Medicare ☐ Medi-Cal ☐ Medicaid ☐ Other _____

Medical problems currently treated by MD:

Other problems (client's perception); include allergies to food/medication/other:

Problems with:

	Excellent	Good	Poor	Aids Used
Sight				
Hearing				

Prosthesis: ☐ None ☐ Yes Description: _____

Special health care practices (special diet, finger stick, daily weight, B/P, etc.):

Immunization history: ☐ Flu ☐ PNA ☐ DT ☐ Shingles ☐ Hep B ☐ Other _____

Last TB skin test/chest x-ray: _____

Problems with continued:

	No Help	Some Help	Unable	Comments
Telephone				
Shopping				
Meal Prep				
Housekeeping				
Laundry				
Transportation				
Finances				
Bathing Sponge				
Tub				
Shower				
Oral Care				
Grooming				
Dressing				
Continence				
Toileting				
Feeding				
Walk - 50 yds flat surface				
Stairs				
W/C mobility 50 yds				

Activities

Spectator:

☐ Sports ☐ TV ☐ Reading ☐ Radio ☐ Movies ☐ Plays ☐ Programs

Participation:

☐ Cards ☐ Games ☐ Visits with friends ☐ Letter writing ☐ Walks
☐ Other _____

Hobbies and creative arts: _____

Attach the SLUMS Mental Health Status Examination (follows on next page).

SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS) EXAMINATION

The Saint Louis University Mental Status (SLUMS) Examination is a screening tool used to detect mild cognitive problems in elderly clients. Geriatric experts at St. Louis University School of Medicine developed this tool. It has been widely validated, is sensitive and specific at diagnosing dementia. It was developed to give clinicians a better way to gauge early changes that would alarm them to the onset of dementia and indicate to the clinician when they should seek continued testing to support or to rule out a diagnosis of dementia. Many Veteran Administration Hospitals currently use the SLUMS.

You will implement this exam during a geriatric home visit. The interpretation of the results for this exam is compared to the population with a High School education, or less. See the bottom of the exam for scores that are considered *normal*, *mild cognitive impairment*, or *dementia.*

Rosack, J. (2006). New diagnostic test may improve dementia care. *Psychiatric News, 41*(23, 24-25.

VAMC
SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu.

Name _____ Age _____
Is patient alert? _____ Level of education _____

__/1 (0) (1) 1. What day of the week is it?
__/1 (0) (1) 2. What is the year?
__/1 (0) (1) 3. What state are we in?

4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car

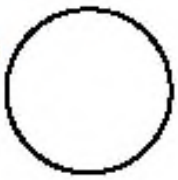
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
(0) (1) How much did you spend?
__/3 (0) (1) (2) How much do you have left?

6. Please name as many animals as you can in one minute.
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 7. What were the five objects I asked you to remember? 1 point for each one correct.

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
__/2 (0) 87 (0) (1) 649 (0) (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(0) (1) (2) Hour markers okay
__/4 (0) (1) (2) Time correct

__/2 (0) (1) 10. Please place an X in the triangle.

(0) (1) Which of the above figures is largest?

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.
Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

(0) (1) (2) What was the female's name?
(0) (1) (2) When did she go back to work?
(0) (1) (2) What work did she do?
(0) (1) (2) What state did she live in?
__/8

_____ TOTAL SCORE

Department of Veterans Affairs

SAINT LOUIS UNIVERSITY

Scoring		
High School Education		Less than High School Education
27-30	Normal	25-30
21-26	MNCD*	20-24
1-20	Dementia	1-19

* Mild Neurocognitive Disorder

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. J am Geriatri Psych (in press).

NUTRITIONAL ASSESSMENT

List everything the client has eaten for one day.

Breakfast:

Lunch:

Dinner:

Snacks:

Summary of Findings:

Teaching Plan:

GERIATRIC NURSING CARE PLAN

Priority Nursing Diagnosis

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
		Client Goal: ***Interventions:***		***Client Goal:***

QUESTIONS TO ASK

1. Have you noticed changes in your health since you started taking these medications?

2. In what areas have you seen improvement?

3. Do you have any new health problems?

4. Do you have problems obtaining your medications? (e.g., transportation, financial, etc.)

5. Do you have problems taking your medications? (e.g., opening containers, reading labels, swallowing)

6. Are there side effects that sometimes make you take the medicine differently than the way it is prescribed?

7. Do you have difficulty staying on your medication schedule?

8. What, if anything, has helped with this problem?

9. What is most likely to cause you to miss a dose?

10. How much does your medication cost each month?

11. Do you have any questions you'd like to ask?

MEDICATION SUMMARY SHEET

Include prescription, OTC, herbal/folk remedies

Medication	Dose, Frequency, Route, Duration	Indication, special considerations or cautions

SUMMARY OF GERIATRIC HOME VISITS

Please summarize your overall experience including benefits, problems, improvements, knowledge gained, etc. What did you learn from this assignment that you did not know before?

COMMUNITY ASSESSMENT ~ GERIATRIC HOME VISIT

Windshield Survey

Name of Community: _____

Survey's Date and Time: _____

PEOPLE

Who did you observe on the streets? (Check all that apply)
☐ Women ☐ Children ☐ Men

What ethnic group represents the predominant group observed?
☐ African American ☐ Asian ☐ Mexican-American ☐ Caucasian
☐ Other (Specify): _____

How would you categorize the residents?
☐ Upper class ☐ Upper-middle class ☐ Middle class ☐ Lower class

Which of the following did you use as a basis for your conclusion?
☐ Dress/appearance of people ☐ Appearance of homes
☐ Maintenance of neighborhood ☐ Availability of community resources

Explain your decision:_____
_____

Did you observe any differences in residential locations of the various racial groups?
☐ Yes ☐ No
If yes, please comment: _____
_____

Based on your observations, was there evidence of any of the following? (Check all that apply)
☐ Communicable disease ☐ Alcoholism ☐ Drug abuse ☐ Mental illness
☐ Other _____

Please indicate how you came to that conclusion (detail your observations)
_____
_____

PLACES

Where is the community located?
City: _____

Major cross streets: _____

Describe its boundaries:

Major cross streets: _____

Natural boundaries_____

Man-made boundaries_____

Were there available health services? ☐ Yes ☐ No
How far will the residents travel to the nearest major health care institutions? _____
Name the nearest major medical center. _____
How far will the residents travel to the nearest ambulatory care facility?_____
Name the nearest ambulatory care facility. _____

Based upon your observations were any environment threats identified? ☐ Yes ☐ No
Which of the following did you observe?
☐ Heavy polluting industries
☐ Lack of transportation
☐ Poorly constructed roads that limit access to available resources
☐ Plants or animals that pose a threat to the health of the community
☐ Other _____
Explain your response: _____
_____
_____
_____
_____

Based upon your observations, how would you evaluate the availability of the housing?
☐ Poor ☐ Average ☐ Above average
How old is the average home? _____ years
Are the homes predominately:
☐ Single dwelling ☐ Multi-dwelling
Are there visible signs of disrepair? ☐ Yes ☐ No
Are there vacant dwellings? ☐ Yes ☐ No
Please explain your conclusions: _____
_____
_____

SOCIAL SYSTEMS:

Were there schools in the area? ☐ Yes ☐ No
Are they in good repair? ☐ Yes ☐ No
Was the quality of educational facilities sufficient for a community of this size?
☐ Yes ☐ No
Were there parks or outdoor recreational opportunities? ☐ Yes ☐ No
Comments: _____
_____
_____

Are any of the following present? (Check all that apply)
☐ Churches ☐ Community centers ☐ Parks
☐ Clinics ☐ Hospitals ☐ Dentists ☐ Social agencies
☐ Other _____

ANALYSIS

Based upon your observations provide a summary of the community you visited.
1. Indicate whether you feel the community resources are adequate.
2. Discuss the needs of the community and whether you feel that the residents have access to resources that are not located within their community.
3. Comment on how you feel these findings will impact on the health status of the community residents, e.g.: What additional resources may be necessary for a community of this size.

4. Provide rationales on why you feel the available healthcare services and/or social systems are adequate or lacking.

DIAGNOSIS

According to your assessment of the neighborhood, identify a priority Community Nursing Diagnosis in PRS format. Provide at least two (2) interventions for this diagnosis.

Diagnosis: _____

Intervention #1: _____

Intervention #2 _____

Student Name: _____ Date: _____

CLINICAL CONFLICT

1. Define conflict:

2. Describe the conflict issue (include date):

3. What was the outcome?

4. If applicable, how would you have handled this situation differently?

HEALTH FAIR / COMMUNITY ACTIVITY

Participation should not be less than 5 hours.

Student Name: _____ Date of activity: _____

Time reported in: _____ Time reported off: _____

Signature of responsible person: _____

Print name: _____

Activity title: _____

Address: _____

I participated in the following activities:

Overall evaluation of the experience:

RESUME

OBJECTIVES

Student will:

1. Discuss the components of a resume and cover letter.
2. Create a resume and cover letter for evaluation.
3. Discuss how to prepare for a professional interview
4. Relate the importance and types of professional behaviors expected in the interview process.
5. Describe what is acceptable dress and appearance for a job interview.

RESUME INSTRUCTIONS

1. Student will follow the guidelines from the N242 Professional Role course lecture on *Resume & Interviews* when completing a resume and cover letter.
    a. Sources for the cover letter and resume format can be found in the lecture handouts and searching for “nursing resumes”, “nurse graduate resume”, and similar word combinations online.
    b. Create a resume that is unique and makes you stand out from the crowd.
2. Use of a Thesaurus to utilize unique words is strongly encouraged.
3. Student will submit a completed resume with cover letter to the Clinical Instructor on the due date given in the Semester 4 Schedule.

Registered Nurse Career Map

Dateline	Plan	Follow up	Notes
1st Year			
2nd Year			
3rd Year			
4th Year			
5th Year			

Registered Nurse Career Map Example

Dateline	Plan	Follow up	Notes
1st Year	• Research employment sites • Take additional trainings (ACLS, PALS, etc.) • Send applications out • Interview • Job placement (e.g.	• LAC+USC, OVMC, Harbor • ACLS completed 2/17/14 • Done • Done	Suzanna Mortimer, Recruiter
2nd Year	• Work on Med/Surg certification • BRN CEU classes (need 30 for license renewal) • Locate university, begin BSN degree		
3rd Year	• Transfer to ER • Begin working on ER certificate • BRN CEUs		
4th Year	• Advance to charge nurse position • BRN CEUs (need 30 for license renewal)		
5th Year	• Begin MSN degree • BRN CEUs		

GERIATRIC POLITICAL-SOCIAL ISSUE PRESENTATION

OBJECTIVES

1. Student will provide a verbal presentation to the clinical group of their Political/Societal Issue Assignment from N242 Professional Role course.
    - If a paper was not submitted, you MUST research a current Political/Societal event or issue from a newspaper or similar publication.

2. Student will adhere to the following evaluative criteria when presenting:
    - Clearly introduce the issue, state your research question or hypothesis, demonstrate critique of readings, discuss all references utilized in the paper, and discuss your views of the issue and how it may be resolved.

ASSIGNMENT MAKING EXERCISE

At the completion of this discussion the student will:

1. Assign personnel according to the individual's scope of practice.
2. Identify if the unit is under- or over- staffed.
3. Make an assignment according to the Nursing Hour Ratio (NHR) and client acuity.

NURSING HOUR RATIO EXERCISE

You are responsible for calculating the Nursing Hour Ratios for your unit. The following is the staff on the unit:

- Day shift (0700-1500): 1 Nurse Manager, 4 RNs, 2 LVNs, 2 NAs, 1 Ward Clerk, and 1 CNA.
- Evening shift (1500-2300): 3 RNs, 2 LVNs (one of the day shift LVNs will be working a double shift), 2 NAs, 1 Ward clerk (who works a split shift of 1000-0500).
- Night shift (2300-0700): 3 RNs, 1 LVN, 1 NA, 1 Ward clerk (who works a split shift of 2100-0500).

The predetermined number for the unit is 10.0

---

1. Calculate the NHR for each shift and for 24 hours. There are 18 clients at the beginning of the day, and 1 admission each on the evening shift and the night shift.

	Shift	
NHR	7-3	_____
NHR	3-11	_____
NHR	11-7	_____
24 Hour Total NHR		_____

2. Are you understaffed or overstaffed? _____

3. List 3 interventions to resolve the above situation.

   a. _____

   b. _____

   a. _____

4. How many staff would you need to meet the predetermined NHR for 24 hours?

   _____

5. What would be the safest and most cost-effective staff mix? Provide rationale.

   _____

   _____

ASSIGNMENT MAKING EXERCISE

Available Staff	Names
1 Nurse Manager	Luisa Huicocheo
2 RNs each with 5+ years' experience	Ethel Eddy / Carlotta Lemone
1 RN with 1 year experience	Barney Klutz
1 RN with < 6 months experience	Carolyn Parker
2 LVNs each with 2+ years' experience	Ruth Omen / Ramsey Rolf
2 NAs each with 10 years' experience	Freddy Figton / Peggy Drew
1 Ward Clerk	Rena Perez
1 Volunteer	Evelyn Applebum

Acuity Census

Acuity 1 = Minimum

6 Maximum Care

Acuity 2 = Moderate

9 Moderate Care

Acuity 3 = Maximum

4 Minimum Care

1 Scheduled admitting transfer from MICU

There are single bed and double bed rooms on this ward.

Room/Bed	Client	Acuity	Room/Bed	Client	Acuity
Rm. 1, bed 1	Joseph Kenly	3	Rm. 9, bed 1	Marsha Diaz	2
Rm. 2, bed 1	June Smith	2	Rm. 10, bed 1	Gene Xavier	2
Rm. 3, bed 1	Pete Anderson	3	Rm. 10, bed 2	Paul Marshall	2
Rm. 4, bed 1	Jill Mosly	1	Rm. 11, bed 1	Ace Ackerman	2
Rm. 5, bed 1	Chalino Sanchez	2	Rm. 12, bed 1	Austin Ridley	1
Rm. 5, bed 2	George Brown	2	Rm. 12, bed 2	(reserved)	
Rm. 6, bed 1	Gloria Croce	1	Rm. 13, bed 1	Lena Rodriguez	2
Rm. 6, bed 2	Lorene Battels	2	Rm. 14, bed 1	Cindy Uno	3
Rm. 7, bed 1	April Hubbard	3	Rm. 15, bed 1	Cheryl Oh	3
Rm. 8, bed 1	Shantie Smith	3	Rm. 15, bed 2	Celia Cruz	1

LAC School of Nursing
N243L - Advanced Medical/Surgical & Gerontological Nursing (Spring 2021)

DAILY NURSING ASSIGNMENT SHEET

Date _____ Ward _____ Shift _____ Nurse Manager _____ Clerk _____

Charge nurse _____

Acuities	1	2	3	4	Census:

15 min breaks		Meals	EMPLOYEES	ASSIGNMENT

Room	Clt Name	Acuity	Room	Clt Name	Acuity	Room	Clt Name	Acuity

CHECKS

Crash carts:	Linen:	Refrigerators:
POCT:	Kitchen:	Clean/Dirty Utility:

NOTICES

Restraints:	Legal hold:
Fall Risk:	Unusual occurrence:
Central lines:	Code Blue:
PCA:	Death:
DXs:	Clt/Family complaints:
Decubitus:	Pyxis/narcotic keys:

EVALISYS® PCS Instruction Guide – Medical/Surgical

Client Classification Care Levels

Medical/Surgical clients are classified according to the care they require:

Level 1 - Minimum Routine Care
Level 2 - Average Care
Level 3 - Above Average Care
Level 4 - Almost Constant Care

A client's classification, or care level, is determined *prospectively* for the next shift by placing a check mark in all the white boxes adjacent to each care indicator that applies to a given client. The check marks in each column are then totaled. The pre-recorded check marks and the 0.5 figure printed on the tool are always included in the total. The column with the highest total indicates the client's care level. The number of clients in each classification then provides a measurement of clinical and nursing services needed by the unit.

It should be emphasized that the care indicators on the tool are **not** intended to represent an exhaustive list of all the individual client care tasks. They are intended to serve as indicators of larger groupings of care requirements that differentiate between the amount and types of care needed by four levels of clients.

The description of each client classification care level is as follows:

CARE LEVEL	TYPE OF CARE	CARE LEVEL DESCRIPTION
Level 1	Minimum Routine Care	The client requires routine nursing assessment and/or intervention. The client is able to manage his/her own hygiene, mobility, and diet needs with little or no supervision, and may be ambulatory. Vital signs are routine and simple dressing changes may be needed. PO medications may be required every 6-8 hours. The client may be immediately preoperative or awaiting discharge. The client and/or family members may require a minimal amount of emotional support and/or teaching. Care management is routine and uncomplicated.
Level 2	Average Care	The client requires an average amount of nursing assessment and/or intervention. The client needs some assistance and/or encouragement to meet personal care needs such as diet, hygiene, and mobility. Symptoms are mild to moderate requiring vital signs and medications every 4-6 hours. The client may have an IV or saline lock, simple dressing changes, and/or uncomplicated treatments and procedures. The client and/or family members may require an average amount of emotional support and/or teaching. Planning and managing care may be moderately complex.

CARE LEVEL	TYPE OF CARE	CARE LEVEL DESCRIPTION
Level 3	Above Average Care	The client requires above average nursing assessment and/or intervention. Partial to complete assistance by nursing staff is required with hygiene, feeding, positioning and/or mobility. The client may have complicated dressing changes, and complex treatments and procedures, or vital signs that require intervention every 2-4 hours. The client may have an IV with additives requiring periodic adjustment. The client and/or family members may require average to above average emotional support and/or teaching. Activities associated with planning and managing care may be moderately to very complex.
Level 4	Almost Constant Care	The client requires the complete assistance of nursing staff to meet hygiene, diet, and/or positioning needs. Vital signs are required more frequently and IVs with multiple additives may be present. Multiple and/or complex treatments, procedures, or initial chemotherapy regimens require almost constant assessment and/or intervention by the nursing staff. The client may have acute or potentially unstable physiological or psychological care needs that require almost constant nursing assessment and/or intervention. The client and/or family members may require above average emotional support and/or teaching. Activities associated with planning and managing care may be moderately to very complex.

The check marks in each column are then added. The check marks already entered in columns 1 and 2 and the 0.5 in column 3 are weighting factors for each classification and should be included in the totals. This weighting is designed to preclude ties in the patient's care level, although a tie may occasionally occur.

The column with the highest total is the correct classification for the patient at the time the licensed staff completes the tool. The corresponding classification is circled at the top of the column under the line titled "CARE LEVEL". In the event of a tie, the higher classification is circled.

Specific guidelines for selecting care indicators are as follows:

CARE INDICATOR	INSTRUCTIONS
ADL: Minimum assist/supervise	The patient can *appropriately* manage his/her own personal care activities such as grooming, hygiene (basin at bedside, tub, or shower), toileting, positioning, and diet with little or no supervision, encouragement, or direction. If this indicator is selected, none of the following Hygiene, Mobility, or Diet indicators can be checked.
Hygiene: Moderate assist/supervise	The patient needs partial assistance, supervision, and/or encouragement to accomplish various hygiene activities. If the patient needs help only to wash his/her back, this indicator should not be checked. This item should not be checked if the patient requires *complete or maximum* assistance and/or supervision with hygiene needs.
Mobility: Moderate assist/supervise OR	The patient can assist in turning or positioning in bed, but cannot move and/or ambulate independently. The patient may need help in maintaining proper body alignment.
Mobility or hygiene: Maximum assist/supervise	The patient requires complete assistance in turning, positioning, range of motion, and/or ambulation. The *patient cannot, will not, or should not* accomplish these activities without the constant presence, supervision, and/or assistance of staff. This indicator should also be checked if the patient requires complete assistance with hygiene (toileting, bathing, grooming). Either "Moderate assist" or "Maximum assist" may be checked, but not both

Note: If the patient is NPO, neither of the "Diet" indicators should be checked.	
Diet: Moderate assist/supervise OR	The patient can feed him/himself after help with opening cartons, cutting meat, etc. The patient may require supervision and/or encouragement to eat.
Diet: Maximum assist/supervise	The patient needs to be fed, or needs constant supervision and/or encouragement to take nourishment. He/she may require tube feedings. TPN is not included and should be accounted for in the appraisal of the amount of assessment and intervention required. Either "Moderate assist" or "Maximum assist" may be checked, but not both.

CARE INDICATOR	INSTRUCTIONS
Note: Do not check for saline lock with routine flushes.	
IV; or Saline lock with additives	The client has an IV and/or saline lock *with* additives.

Note: The following "Assess/intervene" care indicators should reflect the *frequency*, *duration*, *complexity*, and/or *intensity* of assessment and/or intervention required by the client in the following five areas: 1) medications; 2) treatments; 3) procedures; 4) teaching; and/or 5) psychosocial support. This care is over and above the care already indicated, and should include client and family characteristics such as emotional state, age or developmental stage, language ability, and/or cultural issues which may impact the level of assessment/ intervention.	
Assess/intervene: **Average** *OR*	The client requires routine assessment and intervention such as routine vital signs, IV checks, dressing checks, wound checks, shift assessment, and medications. The client's condition is stable. The client and/or family may require a minimal to average amount of emotional support and/or teaching.
Assess/intervene: **Above average** *OR*	The client requires more frequent symptom monitoring and/or intervention such as checks for vital signs, neuro status, output, epidural catheter, dressings, medications, or frequent assistance with elimination, treatments, and/or procedures. Client and/or family teaching and/or emotional needs may be average to above average.
Assess/intervene: **Almost constant**	This client's need for care arises from frequent, multiple, complex, and/or prolonged treatments, procedures, or other associated problems that require almost continual assessment and/or intervention. The care may be further complicated by special equipment, the need for restraints because of agitation, or IV drips necessitating frequent monitoring, etc. The client and/or family members may require an above average amount of psychosocial, emotional support, and/or teaching. Only one of the "Assess/intervene" indicators may be checked. If a client requires almost constant intervention, in most instances the client should be classified as Level 4 regardless of the number of checks in each column.

Note: The next two care indicators relate to the complexity of "Care management" and involve the degree of difficulty associated with the planning, coordination, and management of the client's care. If the client's care management is relatively routine and/or uncomplicated, *neither of these indicators should be selected*.	
Care management: **Moderately complex** *OR*	The client's physiological, psychological, social, and/or spiritual condition and/or circumstances require a considerable amount of planning, coordination, and management by the nurse. These care management activities require an *above average* amount of interaction with others to plan and manage the care.
Care management: **Very complex**	The client's physiological, psychological, social, and/or spiritual condition and/or circumstances are extremely complicated, numerous, and/or difficult to manage requiring an unusual amount of planning, coordination, and management by the nurse. These care management activities require an *extraordinary* amount of interaction with others to plan and manage the care.

CARE INDICATOR	INSTRUCTIONS
Weighting factors	The pre-existing checks in columns 1 and 2 and the 0.5 in column 3 are to be counted in the totals.
Total	The check marks are added in each column, and the total of each column is written in the column "Total" area. The column with the highest total is the client's care level. *CIRCLE* the care level number at the top of the appropriate column. If two columns have the same total, the higher care level is circled.

GENERAL REMINDERS

1. *Check only those care indicators actually applying to the client.* If a care indicator does not describe the client's care needs go on to the next care indicator. These indicators are arranged so that if the client's care needs does not fit a particular care indicator they will be taken into account in a subsequent indicator within the tool.

2. Remember to check all of the white boxes that follow a care indicator if it applies to the client. For example, the "**IV; or saline lock with additives**" indicator has three white boxes following it. If the client has any kind of IV infusion and/or saline lock with additives, check all three white boxes.

3. Total the check marks carefully and circle the appropriate care level (1, 2, 3, or 4) in the top section of the tool.

EVALISYS® 3.0 Client Classification System: Medical/Surgical

	DAY CARE LEVEL				*EVENING* CARE LEVEL				*NIGHT* CARE LEVEL			
CARE INDICATORS	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
ADL: Minimum assist/supervise												
Hygiene: Moderate assist/supervise												
Mobility: Moderate assist/supervise												
Mobility or hygiene: Maximum assist/supervise												
Diet: Moderate assist/supervise												
Diet: Maximum assist/supervise												
IV; or Saline lock with additives												
Assess/intervene: Average												
Assess/intervene: Above average												
Assess/intervene: Almost constant												
Care management: Moderately complex												
Care management: Very complex												
Weighting factors	✓	✓	0.5		✓	✓	0.5		✓	✓	0.5	
Total												
	Signature/Date/Time				Signature/Date/Time				Signature/Date/Time			

	DAY CARE LEVEL				*EVENING* CARE LEVEL				*NIGHT* CARE LEVEL			
CARE INDICATORS												
ADL: Minimum assist/supervise	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Hygiene: Moderate assist/supervise												
Mobility: Moderate assist/supervise												
Mobility or hygiene: Maximum assist/supervise												
Diet: Moderate assist/supervise												
Diet: Maximum assist/supervise												
IV; or Saline lock with additives												
Assess/intervene: Average												
Assess/intervene: Above average												
Assess/intervene: Almost constant												
Care management: Moderately complex												
Care management: Very complex												
Weighting factors	✓	✓	0.5		✓	✓	0.5		✓	✓	0.5	
Total												
	Signature/Date/Time				Signature/Date/Time				Signature/Date/Time			

Organization Addressograph

Medical-Surgical
Clinical Documents

CLINICAL WORKSHEET

PREPARATION PRIOR TO 0700 ON CLINICAL DAY

Student Name: _____ Date: _____ Code Status:_____

Client Initials: _____ Admit Date: _____ Room # _____ Age: _____ Gender: _____

Legal Status/Hold: _____ Primary Language: _____ Ethnicity: _____

Primary Diagnosis: _____

Secondary Diagnoses: _____

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

Pathophysiology for Primary Diagnosis and all Secondary Diagnoses:

Typical signs and symptoms seen in client's diagnoses:

Typical abnormal lab results seen with client's diagnoses:

List potential complications (PCs) associated with client's diagnoses:

Medical Information

Allergies: _____ Diet: _____

Activity: _____ Religion: _____

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

_____

Vital Signs: T _____ BP _____ HR _____ RR _____ Pain Scale: _____

Height: _____cm Admit Weight: _____kg Current Weight: _____kg I&Os _____ O_2 Sat _____

Routine Lab Data

	Normal	Admission	Day #1/Date	Current/Date	Significance of Findings
Na^+					
K^+					
Cl^-					
HCO_3^-					
Ca^{++}					
Phos					
Glucose					
BUN					
Cr					
Uric Acid					
Alk Phos					
Total Protein					
Albumin					
Total Bili					
Direct Bili					
CPK					
LDH					
ALT (SGPT)					
AST (SGOT)					
Pro-time/INR					
APTT/INR					
Platelets					
WBC					
Hgb					
HCT					
RBC					
Mg^{++}					
Amylase					
Lipase					

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

ABGs

Date _____ / _____ / _____ O_2 Sat _____% on _____			Urinalysis:		
pO_2			pH		
O_2 Sat (pulse ox)			S.G.		
pH			Blood		
pCO_2			Protein		
HCO_3			Bacteria		
			Other		

List other labs and results (e.g., medication levels):

List other diagnostic tests and results:

List the most current Medical Plan (found in the MD Progress Notes on Affinity)

MEDICATION PREPARATION WORKSHEET

Client's Name: ____________________________ **ALLERGIES**: ____ ☐ NKDA

Copying from the textbook does not constitute satisfactory preparation

MEDICATION	ACTION	NURSING CONSIDERATIONS
Medication: ____________________ Generic Name: ____________________ Dose/Route/Frequency: Rationale: Time:	Classification: ____________________ Indication: ____________________ How does it work? Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ RR Other: ____________________ Labs: ____________________ Teaching: Infusion rate: ml/hr ________ gtt/min
Medication: ____________________ Generic Name: ____________________ Dose/Route/Frequency: Rationale: Time:	Classification: ____________________ Indication: ____________________ How does it work? Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ RR Other: ____________________ Labs: ____________________ Teaching: Infusion rate: ml/hr ________ gtt/min
Medication: ____________________ Generic Name: ____________________ Dose/Route/Frequency: Rationale: Time:	Classification: ____________________ Indication: ____________________ How does it work? Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ RR Other: ____________________ Labs: ____________________ Teaching: Infusion rate: ml/hr ________ gtt/min

MEDICATION PREPARATION WORKSHEET

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

Copying from the textbook does not constitute satisfactory preparation

MEDICATION	ACTION	NURSING CONSIDERATIONS
Medication: ____________ Generic Name: ____________ Dose/Route/Frequency: Rationale: Time:	Classification: ____________ Indication: ____________ How does it work? Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ RR Other: ____________ Labs: ____________ Teaching: Infusion rate: ml/hr ________ gtt/min
Medication: ____________ Generic Name: ____________ Dose/Route/Frequency: Rationale: Time:	Classification: ____________ Indication: ____________ How does it work? Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ RR Other: ____________ Labs: ____________ Teaching: Infusion rate: ml/hr ________ gtt/min
Medication: ____________ Generic Name: ____________ Dose/Route/Frequency: Rationale: Time:	Classification: ____________ Indication: ____________ How does it work? Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ RR Other: ____________ Labs: ____________ Teaching: Infusion rate: ml/hr ________ gtt/min

DAILY ORGANIZATION PLAN

Clinical Date: ______________________ **Ward: ____________________**

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

Time	STUDENT ACTIVITY		Time	STUDENT ACTIVITY	
	☐ ☐	☐ ☐		☐ ☐	☐ ☐
	☐ ☐	☐ ☐		☐ ☐	☐ ☐
	☐ ☐	☐ ☐		☐ ☐	☐ ☐
	☐ ☐	☐ ☐		☐ ☐	☐ ☐
	☐ ☐	☐ ☐		☐ ☐	☐ ☐
	☐ ☐	☐ ☐		☐ ☐	☐ ☐
	☐ ☐	☐ ☐		☐ ☐	☐ ☐
	☐ ☐	☐ ☐		☐ ☐	☐ ☐
	☐ ☐	☐ ☐		☐ ☐	☐ ☐

PRIORITY NURSING DIAGNOSIS

PRIORITY NURSING DIAGNOSIS IN PRS FORMAT	INTERVENTIONS	RATIONALES
1.		
2.		
3.		

LAC School of Nursing
N243L - Advanced Medical/Surgical & Gerontological Nursing (Spring 2021)

Clinical Concept Map

Student: _____ Date: _____
Pt. _____ Rm # _____ Age _____
Gender ♀ ♂ Ethnic: _____ Acuity: ___
Admit Date _____ Language:_____
POD: _____
Code Status: _____ Allergies _____

Chief Complaint (symptoms - subjective)

Surgical Hx

Social Hx

Signs (sings=objective)

Pathophysiology

PDx

SDx

VS Trends

Laboratory Tests - Trending

Test Result/Significance

Diagnostic Tests

Test Results

Potential Complications

Diet

Activity

IVF pos neg

I/Os pos neg

Teach

Treatments/Procedure/ Interventions

Nsg Dx(s)

Medications

Med	Indication	Monitor

MED-SURG NURSING CARE PLAN

ASSESSMENT AND HISTORY

Student's Name _____ Assessment Date_____ Location of Client_ _____

Client Initials _____ Admission Date _____ Primary Language_____

Age: _____ Gender ☐ M ☐ F Ethnicity: _____

Briefly state what caused the client to come to the hospital (chief complaint)

Health/surgical history:

Social history:

List medications client was taking prior to this hospitalization and client's rationale (include prescriptions, herbs, OTC, and folk remedies).

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 (include 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-, extra- personal)

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

c. List of current medications

Add other labs as needed (include toxic levels & cultures)

Routine Lab Data (date): ____/____/___ Baseline ___/___/____ Other ____/____/___ Most Current

	Normal	*Admission*	*Day #1*	*Current Date*	*Significance of Findings*
Na^+					
K^+					
Cl^-					
HCO_3^-					
Ca^{++}					
P^+					
Glucose					
BUN					
Cr					
Uric Acid					
Alk Phos					
Total Protein					
Albumin					
Total Bili					
Direct Bili					
CPK					
LDH					
ALT (SGPT)					
AST (SGOT)					
Pro-time/INR					
APTT/INR					
Platelets					
WBC					
Hgb					
HCT					
RBC					
Mg^{++}					
Amylase					
Lipase					

ABGs (date): _____/_____/_____ O_2 Sat _____%			**Urinalysis**		
pO_2			pH		
O_2 Sat (pulse ox)			S.G.		
pH			Blood		
pCO_2			Protein		
HCO_3			Bacteria		
Other			Other		

Diagnostic Tests	**Date**	**Results**

N243L - PHYSICAL ASSESSMENT

NAME:_____ Date: _____

Vital Signs: BP _____ T _____ C°/F° P _____ RR _____

HEET: _____

Neuro: _____

CV: _____

Pulmonary: _____

GI: _____

GU: _____

Integumentary: _____

MS: _____

Psycho/social/spiritual: _____

Other (metabolic, lymph): _____

NURSING 243L

List all priority Nursing Diagnoses in PRS format.

List all Potential Complications in order of priority.

MED-SURG NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
		Client Goal: ***Interventions:***		***Client Goal:***

MED-SURG NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
		Client Goal: ***Interventions:***		***Client Goal:***

MED-SURG NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
		Client Goal: ***Interventions:***		***Client Goal:***

Team Leading Rotation Documents

OBJECTIVES FOR THE LEADERSHIP ROTATION (TEAM LEADING)

Expectations

Team leader will:

1. Be accountable to the clinical instructor, nurse manager, charge nurse, and the nurse(s) assigned to clients on the team.

2. Be accountable for all delegated activities assigned to team member(s) in terms of client care and management, procedures, and documentation.

3. Delegate client care assignments to team members.

4. Take report on assigned clients. Obtain report from the team member(s).

5. Each team leading day, complete documentation on each team member: Daily Nursing Assignment Sheet, Client Classification Care Level (client acuity), Team Member Documentation Sheet, and Performance Assessment.

6. At the end of your Team Leader experience, complete and submit the Leadership Rotation Summary.

7. Be a resource person for your team, but do not do their clinical work for them. Provide assistance only if client care may be compromised. Notify the Team Member's clinical instructor.

8. If any problems arise, report them to the Team Member's clinical instructor and your clinical instructor. Problems include, but are not limited to, conduct/communication issues, performance issues; late (or will be) in medication administration, responding to client needs, documentation; etc.

8. Every 2 hours check for MD orders and round on the clients.

9. Obtain progress reports from your team members. Be well informed regarding changes in client status and care.

10. Review and update the client's nursing care plan.

NURSING PATIENT ASSIGNMENT SHEET

Date _____ Ward _____ Shift _____ Nurse Manager _____Clerk _____

Charge nurse _____

Acuities	1	2	3	4	Census:

15 min breaks		Meals	EMPLOYEES	ASSIGNMENT

Room	Clt Name	Acuity	Room	Clt Name	Acuity	Room	Clt Name	Acuity

CHECKS

Crash carts:	Refrigerators:	Linen:
POCT:	Kitchen:	Clean/Dirty Utility:

NOTICES

Restraints:	Legal hold:
Fall Risk:	Unusual occurrence:
Central lines:	Code Blue:
PCA:	Death:
DXs:	Clt/Family complaints:
Decubitus:	Pyxis/narcotic keys:

Team Members

Team Leader: _____ Date: _____

Team Members: _____ Ward: _____

TEAM MEMBER DOCUMENTATION AUDIT

Task	**Rm.**			**Rm.**			**Rm.**			**Rm.**			**Rm.**		
	AM	*PM*	*OTH*	*AM*	*PM*	*OTH*	*AM*	*PM*	*OTH*	*AM*	*PM*	*OTH*	*AM*	*PM*	*OTH*
Time began/ended charting	/			/			/			/			/		
Head-to-Toe Assessment															
Braden Pressure Sore Scale															
Morse Fall Risk Scale															
Nutrition Assessment															
Wound/incision/dsg. changes															
Body tubes (location, size, etc.)															
Procedures, Treatments															
IVF, IVPB, Tubing labeled															
IV site flushed, labeled															
Isolation Precaution															
Delegation: VS, I&O, ADLs															
MARs signed off, on time															
Insulin order sheet															
Vaccines															
Pain Flowsheet															
Labs/Dx results, monitored															
NCP															
Client/Family teaching															
Event comment(s)															
EOSS															

✓ **= Completely in a timely manner** ↓ **= Untimely** ✗ **= Not done** **NA = Not applicable**

Team Members

TEAM MEMBER PERFORMANCE ASSESSMENT

Duties	Notes/Comments
Flow of Oral Report	
Knowledge of Client	
Clinical Performance	
Effective Charting	
Client Advocacy Issues	
Conflict Issues	
Role Clarification	
Other	

Team Members

Team Leader: _____ Date: _____

Team Member: _____ Ward: _____

TEAM MEMBER DOCUMENTATION AUDIT

Task	**Rm.**			**Rm.**			**Rm.**			**Rm.**			**Rm.**		
	AM	*PM*	*OTH*	*AM*	*PM*	*OTH*	*AM*	*PM*	*OTH*	*AM*	*PM*	*OTH*	*AM*	*PM*	*OTH*
Time began/ended charting	/			/			/			/			/		
AM Assessment (focused)															
Head-to-Toe Assessment															
Braden Pressure Sore Scale															
Morse Fall Risk Scale															
Nutrition Assessment															
Wound/incision/dsg. changes															
Body tubes (location, size, etc.)															
Procedures, Treatments															
Sepsis Pathway															
Restraints															
Acuity Check															
IVF, IVPB, Tubing labeled															
IV site flushed, labeled															
Central line(s)															
Isolation Precaution															
Delegation: VS, I&O, ADLs															
MARs signed off, on time															
Insulin order sheet															
Vaccines															
Pain Flowsheet															
Labs/Dx results, monitored															
NCP updated															
Pt/Family teaching															
Off-ward, Return-to-ward															
Event comment(s)															
EOSS/AIE															
MD orders signed															

✓ = Completely in a timely manner **↓ = Untimely** **✗ = Not done** **NA = Not applicable**

Team Members

TEAM MEMBER PERFORMANCE ASSESSMENT

Duties	Notes/Comments
Flow of Oral Report	
Knowledge of Client	
Delegation of Tasks	
Effective Charting	
Client Advocacy Issues	
Conflict Management	
Role Clarification	
Other	

LEADERSHIP ROTATION SUMMARY

Student Name: _____ Date: _____

1. What assignment-making method did you incorporate?

2. What conflicts and/or problems did you encounter?

3. What leadership styles did you use and in what circumstances? Provide rationales.

4. What were your team leading strengths?

5. What were your team leading weaknesses?

6. Describe situations in which you utilized the 4 “Cs” of Communication:

7. Describe how you felt about team leading overall.

Acute Care Rotation Documents

OBJECTIVES FOR THE ACUTE CARE CLINICAL EXPERIENCE

At the completion of the acute care experience, the student will:

1. Care for a client with an acute multisystem problem each day under the supervision of the clinical instructor and primary RN.
    a. Individualize and prioritize nursing diagnoses and potential complications.
    b. Evaluate drug-to-drug and drug-to-food interactions
    c. Demonstrate knowledge of the multisystem effect of medications
2. Calculate IV drug/dosage of all medications.
3. Reconstitute and administer medications under direct supervision of the clinical instructor or primary RN.
4. Record and measure two (2) electrocardiographic tracings each day.
5. Circle the complex bring measured
    a. Include rhythm, rate, PRI, QRS and QTI. (I = interval)
6. Identify invasive monitoring lines, tubes and drains and explain the results.
7. Explain ordered diagnostic tests and client results.
8. Interpret two (2) ABG results each day and follow up labs.
    a. Include pH, acid/base, compensated/uncompensated
9. Complete documentation of shift data (nursing, pain and restraint flow sheets– as applicable; nursing care plan, and other ward required documents).
10. Collaborate with other disciplines on client care management.
11. Client and family education as indicated.
12. Perform procedures under RN or clinical instructor supervision such as:
    a. Inserting NGT, Foley catheter, and IVs
    b. Suctioning, ROM, dressing changes
    c. Blood draws from the peripheral/triple lumen/cordis site

ACUTE CARE CLINICAL WORKSHEET

Student name: _____ Date: _____

Client initials: _____ Room: _____ Age: _____ Gender: _____

Chief complaint:

Diagnosis:

Treatment plan:

Medications: (indication and nursing responsibilities)

List 3 priority Nursing Diagnoses _____ List three (3) priority PCs _____

Discuss the multisystem involvement.

Validation of the findings (lab and diagnostic tests)

ACUTE CARE *DO's & DON'Ts* GUIDELINES

Do with Supervision

- Phlebotomy: from venous or arterial lines
- Hemodynamic monitoring
- ICP monitoring and drainage
- Physical assessments
- ADLs
- Vital signs
- Peripheral IV catheter insertion
- IV therapy: IVF maintenance and IVPB
- Bladder catheterization
- Empty, measure, report Foley bag contents
- Ostomy care
- Central line dressing changes
- Nasogastric tube placement and care
- Enteral feedings
- Chest tube drainage system care
- Basic ECG interpretation
- Basic ABG interpretation
- Oral and ET suctioning
- Oxygenation: change settings or equipment
- Medications: PO, SQ, IM, IVP, IVPB
- Assist in Code Blue as directed by lead nurse
- Blood glucose checks
- Measure and report I&Os
- Wound Care

Do NOT

- Begin care without report from RN
- Begin care before introducing yourself to the primary RN and discussing what you will be doing for the client
- Administer or adjust titrated medications
- Draw ABGs **(NEVER allowed, even if RN or MD states you can)**
- Manipulate ET or change ET tape
- Adjust or change vent settings
- Manipulate balloon pumps
- Remove or change C-collars
- Manipulate or remove arterial lines
- Manipulate EVDs
- Do anything you have not been taught or performed in skills lab
- Do anything without the ICU nurse present

IV PUSH (IVP) ONLY UNDER DIRECT SUPERVISION OF THE PRIMARY RN OR CLINICAL INSTRUCTOR

Call your Clinical Instructor any time you are in doubt.

BRING THIS TO THE WARD AND POST ON BULLETIN BOARD (BRN REQUIREMENT)

CLINICAL COMPETENCY EXAMINATION

N243L CLINICAL COMPETENCY EXAM

DIRECTIONS

1. There are two parts: A & B. Part A is the scenario research and Part B is the comprehensive written exam with the Medical-Surgical and Nursing Role content.
2. The exam is considered a mandatory clinical day where both parts are administered. Part A which is Med/Surg is given first with a break between the two parts. The semester retains the option to switch the order of the comp exam parts.
3. Date and time of the exam is in the semester syllabus.
4. The exam will have a combination of the following types of questions: multiple choice, essay, true/false, and fill-in blanks.
5. Use the required textbooks from semesters 1 thru 4 to research any information in the scenarios that are unfamiliar. Instructors will grade exam based on these textbooks only.

You are encouraged to review all the scenarios prior to the Clinical Competency Review.

STUDY TIPS

Study expectations for the exam are not limited to the tips below but, hopefully, the following information will help you to organize your method of study:

1. Know and understand the pathophysiology of disease processes. Questions usually do not focus on the patho, but you will need to know it to recognize client status.
2. Know all abbreviations provided in the scenarios.
3. Develop nursing care plans related to the primary diagnoses, in PRS format and the:
   - Priority interventions (independent and collaborative)
   - Potential complications
4. Review nursing responsibilities for all procedures and treatments: Know all pre- and post- nursing care, PC (s/s), and required PC interventions/labs/diagnostic tests.
5. Review medications including considerations before administration, recognizing side effects/adverse reactions, and required interventions.
   - Review drug-to-drug and drug-to-food interactions
   - Administration timing, dosage, drug peak/trough levels, and toxicity
6. Know client teaching regarding disease process, meds, treatments, discharge, etc.

7. Comprehend lab values (normal and abnormal) and their implications for clients.
8. Recognize errors and/or inconsistencies in both physician orders and in the scenarios themselves.
9. Know how to make drug dosage computations taught in this program (e.g. NHR, TBSA, pediatrics med calculations, drip rate calculations, etc.)
10. Know the scope of practice for subordinates, priority assignment-making, proper delegation of tasks, leadership concepts, and staffing rationales, etc.
11. Identify leadership styles and rationale for using each type of style.
12. Review clinical conflict issues and how they can be resolved.
13. Know how to complete a staff assignment sheet.
14. Be able to use the Evalysis acuity system and apply to clients in the scenarios.
15. Be able to identify staff delegation of tasks within their scope of practice.
16. Be able to prioritize client tasks, client order of assessment, and provide rationales.

NOTE: This may not be a complete list. You are responsible for all didactic and clinical concepts taught throughout the program. This exam tests on those concepts and practices. However, not all concepts may be on the exam.0