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

Nursing 113 L:

INTRODUCTION TO MEDICAL/SURGICAL NURSING CLINICAL

Fall 2022

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

COURSE OBJECTIVES:

Upon satisfactory completion of the course, the student will:

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

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

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

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

5. Identify nursing responsibilities in decision-making as a member of the inter-professional healthcare team in assessing, maintaining, and promoting health to achieve safe, quality patient-centered care.

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

7. Identify the value of cultural variations in patient-centered care for individuals with common health problems.

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

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

METHOD OF EVALUATION:

- 70% or greater on Abbreviation Exercise
- 85% or greater on Drug Dosage Calculation Competency
- Satisfactory completion of weekly Clinical Worksheets/Concept Maps
- Satisfactory grade on:
  - Nursing Care Plan
  - Skills Competency
  - Written Clinical Competency with a score ≥70%
  - Skills lab demonstrations and practice
- CoursePoint+ vSim for Nursing
  - Complete all components of the simulation
- Complete Documentation Assignment (Word file) and Guided Reflection Questions
- -All assignments are due on specified dates/times. No late assignments will be accepted.
- Active participation in clinical conferences
- Absences not exceeding 3 clinical days
- Tardies not exceeding 3 times
- Satisfactory grade at end of semester clinical evaluation

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

REQUIRED READING: Hinkle, J. L., Cheever, K. H., & Overbaugh, K.J. (2022). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (15th ed.). Wolters Kluwer.

Taylor, C., Lynn, P., Bartlett, J. L. (2019). *Fundamentals of nursing: The art and science of person-centered nursing care* (9th ed.). Wolters Kluwer.

Swearingen, P. L. & Wright, J. D. (2019). *All -in -One Nursing Care Planning Resource: Medical-Surgical, pediatric, Maternity, and Psychiatric-Mental Health* (5th ed.) Elsevier

REQUIRED MATERIALS: One single function calculator
Skills Bag with contents

Lippincott CoursePoint+ for Taylor: Fundamentals of Nursing, Ninth Edition

How to Access Lippincott CoursePoint+:

1. If you don't already have access to Lippincott CoursePoint+ for Taylor: Fundamentals of Nursing, Ninth Edition, redeem your **ACCESS CODE** and complete registration at http://thePoint.lww.com/activate

2. From the **"My Content"** page, click on Lippincott CoursePoint+ for Taylor: Fundamentals of Nursing, Ninth Edition.

3. On the welcome screen or from "**My Classes**", select "**Join a Class**", enter your **CLASS CODE: FA044B60** and click "**Enroll**"

For video reference: thePoint Registration and Product Activation

If you experience any problems, check the code again and re-enter it. If it does not work, contact Lippincott Online Product Support at 1-800-468-1128 or techsupp@lww.com for assistance.

Not sure what an ACCESS CODE is?

Learn more at http://thepoint.lww.com/Help/BookAccess

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

Intranet Clinical Resource Materials:

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

Internet Clinical Resource Materials:

- Lippincott Advisor for Education (included in CoursePoint+)
- CoursePoint+ Watch and Learn Videos

PROFESSIONAL STANDARDS / CLINICAL EXPECTATIONS

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

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

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

CLINICAL EXPECTATIONS**:**

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

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

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

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

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

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

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

All academic policies are strictly enforced.

For any conflict or issue, students must first meet with their respective instructor to discuss a solution. If issue is not resolved, students must adhere to the appropriate chain of command starting with the Semester Coordinator, SON Dean, and Provost

CLINICAL PERFOMANCE EVALUATION

Student: _____ **Class:** _____ **Faculty:** _____

Date: _____ **Midterm Grade:** ☐ Satisfactory ☐ Needs Improvement ☐ Unsatisfactory

Date: _____ **Final Grade:** ☐ **Satisfactory** ☐**Unsatisfactory**

Grading Guidelines:

- Clinical performance utilizing core competencies are evaluated on a Satisfactory (S), Needs Improvement (NI), Unsatisfactory (U) basis using the following criteria:
  - Satisfactory: Student is consistently meeting measurement criteria – core competencies and course objectives at the expected achievement level.
  - Needs Improvement: Performance level is inconsistent. The student must demonstrate consistent objectives at the expected achievement level by the end of the semester to pass clinical.
  - Unsatisfactory: Student is not meeting measurement criteria at expected level of achievement
  - N/A: Not applicable
- **Student must receive Satisfactory on all items during the final clinical evaluation to pass the course.**

CORE COMPETENCY	MIDTERM				FINAL	
1. **Patient-Centered Care:** Recognizes the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values and needs. **(Course Objectives 1, 6 & 7)**	S	NI	U	NA	**S**	**U**
a. Develops an individualized plan of care with focus on assessment and planning utilizing the nursing process and comprehensive assessment skills						
b. Demonstrates caring behaviors						
c. Conducts comprehensive assessment while eliciting patient values, preferences and needs.						
d. Assesses the presence and extent of pain and suffering utilizing the appropriate pain tool						
e. Interprets patient assessment data appropriately						
f. Implement interventions to address physical and emotional comfort, pain, and/or suffering						
g. Educates patients/family members regarding nursing procedures, health promotion, wellness, disease management, and prevention using therapeutic communication						
h. Respects diversity of individuals						
i. Demonstrates sociocultural sensitivity in providing patient care						

2. **Teamwork and Collaboration:** Functions effectively within nursing and inter-professional teams, fostering open communication, mutual respect and shared decision making to achieve quality patient care. **(Course Objective 3)**	S	NI	U	NA	**S**	**U**
a. Utilizes effective communication skills (verbally, non-verbally, and though Electronic Health Record (EHR) documentation with patients, family, and health care team members						
b. Identifies and utilizes relevant data for communication with proper use of Situation, Background, Assessment, Recommendations (SBAR)/Identify, Situation, Background, Assessment, Recommendations, Read Back (ISBARR) format						
c. Identifies roles and scope of practice of health care team members						
d. Seeks assistance for concerns out of students' scope of practice						
e. Identifies need for help when appropriate to situation						
3. **Evidence-Based Practice:** Integrates best current evidence with clinical expertise and patient/ family preferences and values for delivery of optimal health. **(Course Objective 6)**	S	NI	U	NA	**S**	**U**
a. Utilizes evidence-based literatures and practice in written assignments, nursing care plans and clinical activities						
b. Values the concept of evidence-based practice in determining best clinical practice						
4. **Quality Improvement**: Uses data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems. **(Course Objective 4)**	S	NI	U	NA	**S**	**U**
a. Provides care in a timely and effective manner						
b. Recognizes that nursing and other health care professions are parts of systems of care and care processes that affect outcomes for patients and families						
c. Values own contributions to outcomes of care						

5. **Safety:** Minimizes risk of harm to patients and providers through both systems effectiveness and individual performance. **(Course Objectives 1, 4 & 5)**	S	NI	U	NA	**S**	**U**
a. Demonstrates effective use of technology, standardized practices, and policies that support safety and quality						
b. Identifies and discusses national patient safety goals and quality measures						
c. Demonstrates competency in nursing skills appropriate to the course expectations						
d. Implements strategies to reduce risk of harm to self and others						
e. Demonstrates appropriate clinical decision-making						
f. Communicates observations or concerns related to hazards and errors to patient, families, and health care team						
g. Demonstrates safe, timely administration of medications with verbalization of pharmacologic implications and considerations to assigned patient(s)						
h. Organizes multiple responsibilities and provides care to minimum of one patient in a timely manner						
6. **Informatics:** Uses information and technology to communicate, manage knowledge, mitigate error, and support decision-making**.** **(Course Objective 2)**	S	NI	U	NA	**S**	**U**
a. Navigates appropriately the EHR for patient information and data gathering necessary in clinical						
b. Documents clear and concise assessment and responses to care in the EHR						
c. Manages data, information, and knowledge of technology in an ethical manner						
d. Protects confidentiality of EHR						
7. **Professionalism:** Demonstrates professional behavior towards patients, families, inter-professional team members, faculty, and fellow students. **(Course Objectives 2 & 4)**	S	NI	U	NA	**S**	**U**

a. Demonstrates core professional values (caring, altruism, autonomy, integrity, human dignity, and social justice) while recognizing own values						
b. Maintains professional behavior and appearance						
c. Complies with the Nursing Code of Ethics, Standard of Practice, and policies and procedures of Los Angeles County College of Nursing and Allied Health, School of Nursing, and clinical agencies assigned						
d. Assumes responsibility for learning						
e. Engages in self-evaluation						
f. Accepts constructive criticism and develops plan of action for improvement						
g. Maintains a positive attitude and communicates with inter-professional team members, faculty, and fellow students in a positive, professional manner						
h. Provides evidence of preparation (clinical worksheet, concept map, SBAR) for clinical learning experiences						
i. Arrives to clinical site at assigned times prepared to receive report and perform patient care						
j. Completes tasks and nursing activities according to course expectations in a timely manner						
k. Accepts individual responsibility and accountability for assessment, nursing interventions, outcomes, and other actions						

Other Methods of Evaluation	**Satisfactory**	**Unsatisfactory**
Drug Dosage Calculation Competency	☐	☐
Skills Competency	☐	☐
Written Competency	☐	☐
Written Assignments		
NCP	☐	☐
vSim	☐	☐

Attendance Summary	**Midterm**			**Final**		
	Number	**Dates**	**Student Signature**	**Number**	**Dates**	**Student Signature**
Absences						
Tardies						

Midterm Evaluation

Faculty Comments (Address strengths and opportunities for improvement):

Plan for improvement (Required for any "Needs Improvement" and "Unsatisfactory" competencies):

Student Comments:

Student Signature: _____ Date: _____

Faculty Signature: _____ Date: _____

Final Evaluation

Faculty Comments (Address strengths and opportunities for improvement):

Plan for improvement (Required for any "Needs Improvement" and "Unsatisfactory" competencies):

Student Comments:

Student Signature: _____ Date: _____

Faculty Signature: _____ Date: _____

SKILLS LAB OBJECTIVES

Documentation

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

Required Reading:

Taylor, Lynn, & Bartlett: Chapter 19, pp. 453-483

SKILLS LAB OBJECTIVES

Medical Asepsis

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

Required Reading:

Taylor, Lynn, & Bartlett: Chapter 24, pp.594-638

Visual Aids:

Watch and Learn Videos (CoursePoint+):

Asepsis: Performing Hand Hygiene

SKILLS LAB OBJECTIVES

Vital Signs/Measurements

1. Define relevant terms related to vital signs, i.e., blood pressure, temperature, pulse, and respiration, height and weight, pain, input, output, and oxygen saturation.
2. Describe factors, which affect these vital signs.
3. Identify the normal ranges for each vital sign.
4. Discuss guidelines necessary when obtaining vital signs.
5. Describe various ways vital signs can be obtained and compare the advantages and disadvantages between each method.
6. Identify situations when vital signs are to be reported to assigned registered nurse caring for the client.
7. Demonstrate correct technique when obtaining vital signs.
8. Recognize variations in vital signs that affect client care.
9. Demonstrate documentation of vital signs in EHR.

Required Reading:

Taylor, Lynn, & Bartlett: **Chapter 5, pp. 642-690**
Chapter 39, pp. 1489, Table 39-1; pp. 1524-1528

Visual Aids:

Watch and Learn Videos (CoursePoint+):

Measuring Oral Temperature
Radial Pulse
Respiratory Rate
Blood Pressure

SKILLS LAB OBJECTIVES

Activity/Exercise and Use of Restraints

Activity/Exercise:

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

Use of Restraints:

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

Required Reading:

Taylor, Lynn, & Bartlett: **Chapter 27, pp. 772-776, pp. 786-789.**
Chapter 33, pp. 1129-1197.

Visual Aid:

Watch and Learn Videos (CoursePoint+):

Providing Range of Motion Exercises

SKILLS LAB OBJECTIVES

Intake and Output (I&O) Monitoring

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

<u>Required Reading:</u>

Taylor, Lynn, & Bartlett:	**Chapter 37, pp. 1349-1351** **Chapter 38, pp. 1422-1423** **Chapter 40, pp. 1569, 1571**

SKILLS LAB OBJECTIVES

Non-Parenteral Medication Administration

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

Required Reading:

Taylor, Lynn, & Bartlett: **Chapter 29, pp. 831-845, 857-861, 864, 874-880.**

Visual Aid:

Patient Safety Video - Lewis Blackman: Discussion

Watch and Learn Videos (CoursePoint+):

The Three Checks and the Rights of Medication Administration
Preparing Unit-Dose Packaged Medications
Administering Oral Medications
Administering Eye Drops
Administering Ear Drops.

SKILLS COMPETENCY RUBRIC

Medication Administration

All criteria must be satisfactory to pass the Skills Competency.

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

SKILLS LAB OBJECTIVES

Personal Hygiene/Bed Making

PERSONAL HYGIENE

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

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

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

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

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

6. Respect client by ensuring privacy during procedure.

7. Discuss healthcare facilities' protocol on personal hygiene.

8. Demonstrate documentation of personal hygiene procedures in EHR.

BED MAKING

1. Discuss the clinical guidelines for safe bed making.

2. Demonstrate the following bed making skills:
   - occupied and unoccupied bed making

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

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

5. Demonstrate documentation of bed making procedure in EHR.

Required Reading:

Taylor, Lynn, & Bartlett: Chapter 31, pp. 984-1040

Visual Aid:

Watch and Learn Videos (CoursePoint+):

Providing a Bed Bath and Making an Occupied Bed.

SKILLS LAB OBJECTIVES

Parenteral Medication Administration

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

Required Reading:

Taylor, Lynn, & Bartlett: **Chapter 29, pp. 845-856**
Skills 29-2 and 29-3 pp.880-886
Skills 29-5 and 29-6 pp. 890-904.

Visual Aid:

Watch and Learn Videos (CoursePoint+):

Administering Subcutaneous Injections
Administering an Intramuscular Injection.

SKILLS LAB OBJECTIVES

Surgical Asepsis

1. Define terms commonly used with surgical asepsis.

2. Differentiate between concepts of cleaning, disinfecting and sterilization.

3. Discuss four (4) common methods of sterilization.

4. Discuss the basic principles of surgical asepsis.

5. List three (3) situations where surgical asepsis is used.

6. Recognize client's needs and readiness prior to procedure.

7. Demonstrate use of surgical asepsis principles when completing the following procedures in the skills laboratory or in the clinical environment:

    a. opening sterile field
    b. adding supplies to a sterile field
    c. donning sterile gloves
    d. completing the following types of dressing changes:

        1) dry dressing.
        2) wet to moist dressing change.
        3) irrigation of a wound and applying dressings.

8. Demonstrate correct removal of a dressing.

9. Demonstrate documentation of procedure in EHR.

<u>Required Reading:</u>

Taylor, Lynn, & Bartlett:	**Chapter 24, Skills 24-3 and 24-4 pp. 628-637** **Chapter 32, pp. 1070-1077** **Skills 32-2 and 32-3 pp. 1096-1105**

<u>Visual Aid:</u>

Watch and Learn Videos (CoursePoint+):

Irrigating a Wound Using Sterile Technique

SKILLS COMPETENCY RUBRIC

Sterile Dressing

All criteria must be satisfactory to pass the Skills Competency.

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

SKILLS LAB OBJECTIVES

Laboratory Values

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

<u>Reference:</u>

Lippincott Advisor for Education (CoursePoint+): Diagnostic Tests

- Review Labs written in Clinical Worksheet using Lippincott Advisor:

- Potassium
- Sodium
- Glucose
- Red Blood Cell Count
- Hemoglobin
- Hematocrit
- White Blood Cell Count
- Platelet
- Blood Urea Nitrogen (BUN)
- Creatinine

SKILLS LAB OBJECTIVES

Oxygenation

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

Required Reading:

Taylor, Lynn, & Bartlett:	**Chapter 39, Pulmonary Function Studies pp. 1496** **Pulse Oximetry pp.1497** **Providing Humidified Air… pp.1503-1504** **Administering Inhaled Medications, pp. 1506-1514** **Using Pulse Oximeter Skill 39-1 pp. 1524-1528** **Administering Oxygen Skill 39-3 and Skill 39-4 pp. 1532-1538.**

SKILLS LAB OBJECTIVES

Physical Assessment

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

Required Reading:

Taylor, Lynn, & Bartlett: **Chapter 19, pp. 453-483; Chapter 26, pp. 691-750.**

Visual Aid:

Watch and Learn Videos (CoursePoint+):

10-Minute Head-to-Toe Assessment

SKILLS COMPETENCY RUBRIC

Physical Assessment

All criteria must be satisfactory to pass the Skills Competency.

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

SKILLS LAB OBJECTIVES

Intravenous Therapy

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

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

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

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

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

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

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

8. Demonstrate correct documentation related to intravenous therapy.

<u>Required Reading:</u>

Taylor, Lynn, & Bartlett: **Chapter 40, pp. 1579-1593.**

<u>Visual Aid:</u>

Watch and Learn Videos (CoursePoint+):

Changing and IV Solution Container and Administration Set
Monitoring an IV Site and Infusion.

SKILLS COMPETENCY RUBRIC

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

All criteria must be satisfactory to pass the Skills Competency.

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

N113L WRITTEN COMPETENCY

Clinical Judgment
Competency Category(s): Recognize Cues
Analyze Cues
Prioritize Hypotheses
Generate Solution
Take Action
Evaluate Outcomes

Learning Objectives: N113L Clinical Written Competency is aimed to evaluate student's fundamental medical/surgical nursing theoretical and clinical knowledge in preparation for Next Generation NCLEX-RN. The student needs to review the client scenario for medical diagnosis, laboratory results, medications, and other details. The student should utilize nursing responsibilities for topics discussed in Semester 1 as well as recognize cues, analyze cues, prioritize problems, desired outcome, and interventions, and evaluate outcomes for the client.

Written Competency: 90 minutes to complete competency
Passing score is 70% or greater
Only two attempts are allowed. If a student is unsuccessful in passing the written competency, it will result in an unsatisfactory grade in the course. The exam may have a combination (but not limited to) of the following types of questions:

- Multiple choice
- Paragraph
- True / False
- Matching
- Fill-in the blanks

Recommendations on how to prepare for the written competency:

1. Knowledge of abbreviations and medical terminologies
2. Recognize vital signs (normal / abnormal) and their implications
3. Comprehend laboratory values (normal / abnormal) and their implications
4. Recognize abnormal physical assessment findings
5. Apply nursing process
6. Appropriate client teaching regarding medication, safety, mobility, etc.
7. Prioritize patient problems and their interventions.

WRITTEN COMPETENCY RUBRIC

Criteria	Possible Score	Earned Score
Recognize Cues Accurately identified important and relevant information from the patient scenario given.	**3**	
Analyze Cues Accurately analyzed client conditions that are consistent with the recognized cues from the patient's clinical presentation.	**11**	
Prioritize Hypotheses Evaluated and prioritized patient problems according to the priority (urgency, risk, difficulty, etc.).	**9**	
Generate Solution Identified expected outcomes to the priority problems and generated a set of interventions for the expected outcomes.	**11**	
Take Action Implemented the solution(s)/interventions that addresses the highest priority problem.	**13**	
Evaluate Outcomes Compared observed outcomes against expected outcomes.	**3**	
TOTAL POINTS	**50**	

CLINICAL WORKSHEET RUBRIC

Section	Description	Satisfactory	Unsatisfactory/Needs Improvement
Records from Charts	Information collected pre- clinical (client dx, hx) is complete. Chief complaint that brought client to hospital, use "OLD CART" format.		
Pathophysiology	Comprehensive discussion of current primary diagnosis. Secondary diagnosis(es), brief discussion only.		
Medical Information and Vital Signs	Complete list of medical information including vital signs.		
Organizational Plan	Identify planned activities throughout the shift.		
Pertinent Data	Identify significance of lab value to your client's disease process and nursing interventions specific to your client. Trend if applicable.		
Summary of Medications	Follow the guidelines for medication preparation.		
Patient Problems	Appropriate prioritization of patient problems.		
Assessment Data	Include pertinent assessment data to support patient problem.		
Disease Process	Include disease process causing assessment findings.		
Desired Outcome	Desired Outcome must be specific, measurable, attainable, realistic and time bound (SMART).		
Interventions	Appropriate, independent nursing intervention plan for patient problems. Utilize assess, do, & teach.		
Rationale	Each intervention should have a rationale.		
Implementation	Independent nursing intervention plan has been implemented. Client's response or result is listed per intervention.		
Evaluation	Desired Outcome is met/partially met/unmet. If desired outcome is not met or partially met, follow-up revision plan is clearly written.		

Instructor's Comments:

Instructor's Signature: _____ Date: _____

NURSING CARE PLAN RUBRIC

Section	Description	Satisfactory	Unsatisfactory/Needs Improvement	Revision(s) as Needed
Medical Information	• Chief Complaint			
	• Medical History			
	• Medical Diagnoses			
	• Providers Orders (Active orders only) o Chronological order			
Pathophysiology	• Comprehensive discussion of current primary diagnosis			
	• Briefly discussed and integrate secondary diagnosis (es).			
	• Reference source (s) in APA format			
Diagnostic tests	• Identify all laboratory values			
	• Identify all diagnostic test result			
	• Correlate the laboratory values to the clinical condition of the patient and provide appropriate independent nursing interventions			
	• If applicable, identify laboratory/diagnostic trends			
Physical Assessment	• Detailed Physical assessment (refer to the N113L Assessment Documentation Guide)			
Prioritization	• List priority patient problems			
	• Actual or risk patient problem			
	• Must be in listed in order of priority			
Nursing Care Plan	• One priority nursing care plan			

Section	Description	Satisfactory	Unsatisfactory/Needs Improvement	Revision(s) as Needed
a. Assessment	• Accurate objective and subjective data • Objective data must be from laboratory/diagnostic/assessment			
b. Analysis	• Appropriate analysis/utilization of patient problems.			
c. Planning	• SMART Desired Outcome: ○ Specific ○ Measurable ○ Attainable ○ Realistic ○ Time Bound • Completed Independent nursing intervention ○ Assessment ○ Do#1 ○ Do #2 ○ Teach • Rationale provided for each intervention			
d. Implementation	• Implemented independent nursing intervention • Client's response or result written per intervention			
e. Evaluation	• Desired outcome was met/partially met/unmet • If desired outcome was not met or partially met, follow up revision plan was briefly discussed			
Spelling, Grammar and Format	• Paper was neatly written with correct grammar and spelling. • Prescribed format was followed.			

Comments:

Instructor's Signature:_____ Date:_____