Old RN Sequencing.

Nursing, Registered

Allied Health, Business and Public Safety

Dean
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DEGREE
A.S. - Nursing, Registered

Web site
www.mccd.edu/alliedhealth/

Program Description
All individuals who meet minimum enrollment requirements are eligible to apply to the nursing programs. Criteria and complete information on the selection process as well as the philosophy and objectives of each program are described in the Nursing Application Handbook which is available in the Merced College Bookstore and online. The handbook is extensive and may contain additional information to the following brief program outline.

Completion of the Registered Nursing Program at Merced College and all requirements of the A.S. Degree qualify students to take the *National Council Licensure Examination for Registered Nurses (NCLEX-RN). (It is the student's responsibility to meet all requirements to sit for the NCLEX-RN exam.)

*BRN-Board of Registered Nursing;
1625 North Market Blvd; Suite N217; Sacramento, CA 95834-1924;
www.rn.ca.gov

Highlights
The Allied Health Center houses a complete Registered Nursing Skills Lab, large computer lab, conference rooms, study rooms and multiple large and small classrooms. The Registered Nursing Program has state-of-the-art equipment and software that assist students with learning current procedures.

Mission Statement
The mission of the Merced College Registered Nursing Program is to prepare our students for careers as professional Registered Nurses by providing a continually-improving educational program which is accredited by the CA Board of Registered Nursing and by instilling in our students a commitment to continued professional growth and lifelong learning.

Nursing, Registered
The Registered Nursing Program at Merced College prepares students to take the National Council Licensure Examination for Registered Nurses (NCLEX-RN), leading to licensure as a Registered Nurse (RN) and is designed to prepare competent nurses for service in the community. The Registered Nursing Program requires two academic years beyond the completion of the prerequisite courses and non-nursing breadth requirements. Graduates will earn the Associate of Science Degree upon completion of designated courses and competency requirements.

Program Application
Applications are available from the division's web site and the college bookstore. It is the applicant's responsibility to submit all required paperwork within the specified dates and times. Applications will be accepted during March, specifically during a 2-3 day window. Specific dates and times will be noted on the web site.

Selection Process
The Merced College RN Program uses the California Community College chancellor's model for selection of program applicants. The selection procedure will be a blended combination of random selection and multi-criteria screening process. Details are available online at www.mccd.edu/alliedhealth/.

Using the merit-based selection process above, those applicants scoring 80% or higher will be included in a merit-based selection pool. Randomized selection will be used to select an incoming class of students from this merit-based selection pool. These students will be sequentially numbered from one to the maximum allowed for the incoming class, including a predetermined number of alternate students.

Depending on the number of qualified applicants and constraints of the Chancellor's Office Merit-based selection model, the merit-based selection pool will vary in size for each application period.

Multiple Applications
There is no waiting list maintained for entrance into the RN Program. Applicants applying to the program a second time must reactivate their application and are responsible for updating their information to comply with local and/or state requirements. It is possible to be accepted into the qualified merit-based selection pool more than one selection period.

If an applicant has applied to the program more than once **consecutively** as a fully qualified applicant, the applicant's name will be added to the application pool an additional time for each such application.

Applicants who are selected and then declined **OR** are not successful completing the first semester may apply again but **will not** be recognized as a "consecutive" applicant. Applicants may only be accepted to the program a maximum

of two times.

Requirements for Accepted Applicants Only
The following must be completed prior to starting the first course in the RN Program:
Health clearance (including necessary immunizations)
Criminal background check (requires proof of valid social security number)
CPR certification
Drug screening

Preassessment Testing Requirement
Students selected into the RN Program must pass an assessment test (currently using TEAS). Applicants who do not meet the established score of 62 must attend a remediation program within one year in order to be considered for enrollment in the next RN class. Study materials are available in the Allied Health Office. Students may submit a copy of a previous TEAS test score in lieu of taking the test again.

Note to Transfer Students
SECTION 1. Section 66055.8 of the Education Code is amended to read:

66055.8 Notwithstanding any other provision of law, a campus of the California State University or the California Community Colleges that operates a registered nursing program shall not require a student who has been admitted to that registered nursing program and who has already earned a baccalaureate or higher degree from a regionally accredited institution of higher education to undertake any coursework other than the coursework that is unique and exclusively required to earn a nursing degree from that institution.

The System Office is interpreting this amendment to the Education Code as follows:

To obtain an associate degree in nursing, students who have baccalaureate or higher degrees are only required to complete the course work required for completion of the registered nursing program, including prerequisites and nursing course work. These students are not to be required to complete any other courses required by the college for an associate degree.

Program Student Learning Outcomes
A. A student will be able to customize nursing interventions utilizing a decision making process based upon their knowledge of pathophysiology, mathematical principles, critical thinking, patient developmental levels and cultural differences.
B. A student will be able to collaborate with an interdisciplinary health care team to demonstrate and utilize therapeutic communication techniques during interactions with their clients (as well as to obtain needed information during the phases of the nursing process).
C. A student will be able to utilize critical thinking an problem solving during the phases of the nursing process.
D. A student will exhibit an (internalized) individual code of ethics consistent with nursing professional standards and apply this code solving ethical dilemmas of patient/ family care while acting as a patient advocate.
E. A student will exhibit leadership and management skills while providing entry level competent, culturally sensitive quality care.

DEGREE (2/07)
A.S. - Nursing, Registered (12500.AS)

Prerequisite courses:		**Units**
BIOL-16**	General Human Anatomy	4
BIOL-18**	Principles of Physiology	4
BIOL-20**	Microbiology	4
CHEM-02A	Introductory Chemistry	4
ENGL-01A	College Composition and Reading	4

**It is highly recommended that once enrolled in these classes, students do not drop them. Program applicants need to understand that multiple attempts to improve grades earned in these classes can negatively affect their eligibility.

Required courses (non-nursing) which also fulfil A.S. Breadt requirements:		
ANTH-02	Cultural Anthropology	3
or		
SOC-01	Introduction to Sociology	3
COMM-01	Fundamentals of Speech	3
or		
COMM-05	Interpersonal Communication	3
CLDV-09***	Human Development (Also Psyc-09)	3
HIST-17A	Political and Social History of the United States	3
or		
HIST-17B	Political and Social History of the United States	3
or		
POSC-01	Essentials of the American Political System	3
HUM	Any Humanities A.S. Breadth Area C (see catalog)	3
PHED	Any activity	2

***Must be completed prior to or concurrently with REGN-25.

Required courses (nursing):		
First Semester		
REGN-15	Nursing in Health and Illness I	9
REGN-16	Pharmacology I	2
REGN-17	Nursing Skills Simulation I	1
Second Semester		
REGN-25	Nursing in Health and Illness II	9
REGN-26	Pharmacology II	2
REGN-27	Nursing Skills Simulation II	
Third Semester		
REGN-35	Nursing in Health and Illness III	9
REGN-36	Pharmacology III	1
REGN-37	Nursing Skills Simulation III	1

REGN-38	Professional Relationships and Responsibilities I	1

Fourth Semester

REGN-45	Nursing in Health and Illness IV	9
REGN-46	Pharmacology IV	1
REGN-47	Nursing Skills Simulation IV	1
REGN-48	Professional Relationships and Responsibilities II	1
		65

Competencies as required by Merced College for graduation:
Writing: Met by completion of ENGL-01A within program prerequisites.
Math: Met by MATH-C or higher level math course.
Reading: Met by completion of A.S. Breadth courses with "C" grade or better.

[Completion of the Registered Nursing Program at Merced College satisfies CILC areas A through G.]

LVN to RN Pathway

The pathway for California Licensed Vocational Nurses requires one academic year beyond completion of the prerequisite courses, non-nursing breadth requirements, and competencies. LVN to RN students enter into the third semester of the RN curriculum identified above after completion of REGN-01 and all other prerequisites. Applicants submit an application found on the Allied Health web site. Graduates will earn the Associate in Science Degree on completion of designated courses and competency requirements. Communication, natural and social science, and nursing courses must be completed with a grade of "C" or better to be eligible for licensure requirements of the State Board of Nursing.

Enrollment eligibility to the LVN to RN pathway requires the completion of previously identified prerequisite courses. Applicants must meet the same selection requirements as generic RN students entering the program in the first semester. In addition, CLDV-09/PSYC-09 are prerequisites for the LVN to RN applicant who has already met the selection criteria. Randomized selection is used to select a cohort from the pool of qualified applicants according to available seats.

LVN to RN applicants are notified of eligibility approximately two months prior to the next semester. The LVN-RN application period remains open. To progress into the RN program, students must successfully complete the REGN-01 LVN to RN transition class which is offered when a sufficient number of qualified applicants exist.

Space in the RN program is determined based on the number of RN students progressing from the second semester to the third semester.

Applicants selected from the pool must complete the assessment test (currently using TEAS). A score less than 67 requires the applicant to complete the same remediation requirements as all other generic RN students before admission into the program. Only those students formally accepted into the program may register for courses identified as Registered Nursing Curriculum. Students may, however, enroll in other courses designated as non-nursing program requirements while awaiting selection into the program.

Third Semester

REGN-02****	Clinical Skills Transition - LVN to RN	1
REGN-35	Nursing in Health and Illness III	9
REGN-36	Pharmacology III	1
REGN-37	Nursing Skills Simulation III	1
REGN-38	Professional Relationships and Responsibilities I	1

Fourth Semester

REGN-45	Nursing in Health and Illness IV	9
REGN-46	Pharmacology IV	1
REGN-47	Nursing Skills Simulation IV	1
REGN-48	Professional Relationships and Responsibilities II	1
		25

****Required for LVN's who have met admission selection criteria, have successfully completed REGN-01 and have been accepted into the Registered Nursing Program's third semester.

Transfer
Credits earned in the Merced College Registered Nursing Program may be transferable to California State Universities. Since prerequisite science and social science courses vary at each institution, students are advised to consult the catalog of their intended transfer school and establish a transfer plan with the Allied Health Counselor.

REGISTERED NURSING (REGN)

REGN-01 TRANSITION LVN TO RN
2 units: 1 hour lecture, 3 hours lab.
Limitation on enrollment: California VN license . Prerequisites: BIOL 16; BIOL-20; CHEM-02A; ENGL-01A; BIOL-18. One-way corequisite: CLDV-09/PSYC-09
The series of lectures and discussions will provide concepts and principles necessary to facilitate transition of the LVN to the changing role of the registered nurse. Emphasis will be placed upon the registered nurse as a decision-making member of the health team, and of responsibilities to be assumed by such a practitioner. (10/06)

REGN-02 CLINICAL SKILLS TRANSITION - LVN TO RN
1 unit: 3 hours lab.
Limitation on enrollment: California VN license, enrolled in REGN Program 3rd semester. Prerequisites: REGN-01. One-way corequisite: REGN-35.
This course consists of practice in the clinical setting with skills and principles necessary to facilitate transition of the LVN to the changing role of the registered nurse. Clinical hours must be initiated in the first week of the semester enrolled. Emphasis is placed on nursing skills related to first year RN nursing concepts in clinical practice. (1/08)

REGN-15 NURSING IN HEALTH AND ILLNESS I
[CILC Area B,C,D,E,F,G]
9 units: 4 hours lecture, 15 hours lab.
Limitation on enrollment: 1) Enrollment in the REGN program, 2) CPR card Module AC, 3) physical within past 6 months, 4) negative TB screening test within past 6 months or negative chest x-ray within past year, 5) proof of current immunizations, 6) criminal background clearance, 7) proof of current malpractice insurance, and 8) drug screening. Prerequisites: BIOL-16, BIOL-18, BIOL-20; CHEM-02A; ENGL-01A. Two-way corequisites: REGN-16, REGN-17. Advisory: REGN-50.
This course presents basic concepts that provide the foundation upon which homeostasis is maintained in adults and/or children. Common threads integrated throughout the program are initiated: nursing process, nutrition, pharmacology, developmental levels, cultural diversity, communication, and professional role. (1/09)

REGN-16 PHARMACOLOGY I
2 units: 2 hours lecture.
Limitation on enrollment: Enrollment in the REGN Program. Two-way corequisite: REGN-15. Advisory: VOCN-46A.
This course presents introductory concepts of pharmacology and drug administration with focus on laxatives/antidiarrheageal, hypoglycemics, and analgesics/anti-inflammatory agents and basic math. (1/09)

REGN-17 NURSING SKILLS SIMULATION I
[CILC Area A]
1 unit: 3 hours lab.
Limitation on enrollment: Enrollment in the REGN program. Two-way corequisite: REGN-15.
This course includes instruction/demonstration and return demonstration of nursing skills related to the first year nursing concepts. This course emphasizes skills and knowledge applications. (11/08)

REGN-25 NURSING IN HEALTH AND ILLNESS II
9 units: 4 hours lecture, 15 hours lab.
Limitation on enrollment: Enrollment in the REGN program 2nd semester. Prerequisites: REGN-15, REGN-16. One-way corequisite: CLDV-09/PSYC-09, Two-way corequisite: REGN-26, REGN-27.
This course enlarges upon the concepts presented in REGN-15, introducing principles of care to maintain and restore normal homeostatic mechanisms in patients of all ages; study of the family unit throughout the life cycle is included, with emphasis on preventive care. (1/09)

REGN-26 PHARMACOLOGY II
2 units: 2 hours lecture.
Limitation on enrollment: Enrollment in the REGN program 2nd semester. Prerequisites: REGN-16. Two-way corequisite: REGN-25 Advisory: VOCN-46A
This course presents introductory concepts of pharmacology and mediation for infectious diseases, hypertension, anemias, family/OB. (1/09)

REGN-27 NURSING SKILLS SIMULATION II
1 unit: 3 hours lab.
Limitation on enrollment: Enrollment in the REGN program 2nd semester. Prerequisites: REGN-17. Two-way corequisite: REGN-25.
This course includes instruction/demonstration and return demonstration of nursing skills related to the first year nursing concepts. This course emphasizes skills and knowledge applications. (11/08)

REGN-35 NURSING IN HEALTH AND ILLNESS III
9 units: 4 hours lecture, 15 hours lab.
Limitation on enrollment: 1) Enrollment in the REGN program 3rd semester, 2) CPR card Module AC, 3) physical within past 6 months, 4) negative TB screening test within past 6 months or negative chest x-ray within past year, 5) proof of current immunizations, 6) criminal background clearance, 7) drug screening, and 8) proof of current malpractice insurance. Prerequisites: CLDV-09/PSYC-09; REGN-25 or REGN-01. One-way corequisite: REGN-38. Two-way corequisite: REGN-36, REGN-37.
This course enlarges upon the concepts presented in REGN-15 and REGN-25 by introducing principles of care to maintain and/or restore homeostatic mechanisms in acute health problems. Prototype disease processes associated with each concept are studied in relation to preventive and restorative nursing care. Concurrent practice in the college laboratory and clinical experience in community facilities are required. (1/09)

REGN-36 PHARMACOLOGY III
1 unit: 1 hour lecture.
Limitation on enrollment: Enrollment in the REGN program 3RD semester. Prerequisite: REGN-26. Two-way corequisite: REGN-35.
This course presents ongoing concepts of pharmacology compatible with respiratory, cardiac/vascular, cancer, DMARDs and immunosuppressant therapies for adults and children. (1/09)

REGN-37 NURSING SKILLS SIMULATION III
1 unit: 3 hours lab.
Limitation on enrollment: Enrollment in the REGN program 3rd semester. Prerequisite: REGN-27. Two-way corequisite: REGN-35.
This course presents demonstration of higher-level nursing concepts related to second-year nursing courses. The third-semester student will assume the facilitator role with other nursing students in skill check-offs. (11/08)

REGN-38 PROFESSIONAL RELATIONSHIPS AND RESPONSIBILITIES I
1 unit: 1 hour lecture.
Limitation on enrollment: Enrollment in the REGN program 3rd semester. One-way corequisite: REGN-35.
The course introduces the student to the professional role of the registered nurse: its status, its responsibilities, and inherent problems as influenced by historical and social change. The focus is on the individual nurse and on the profession as a whole. (1/09)

REGN-45 NURSING IN HEALTH AND ILLNESS IV
9 units: 4 hours lecture, 15 hours lab.
Limitation on enrollment: Enrollment in the REGN program 4 semester. Prerequisites: REGN-35. One-way corequisite: REGN-48. Two-way corequisite: REGN-46, REGN-47.
This course presents advanced concepts and skills in caring for the client with critical or multiple health problems. It emphasizes rehabilitation and adaptation to a compromised and/or declining health status. Concurrent practice in the college lab and clinical experience in community health facility is required. (1/09)

REGN-46 PHARMACOLOGY IV
1 unit: 1 hour lecture.
Limitation on enrollment: Enrollment in the REGN program 4th semester. Prerequisites: REGN-36. Two-way corequisite: REGN-45.
This course presents ongoing concepts of pharmacology for psychiatric (adult/teenagers), shock, cardiac arrhythmias, neurological and neuromuscular, and endocrine conditions. (01/09)

REGN-47 NURSING SKILLS SIMULATION IV
1 unit: 3 hours lab.
Limitation on enrollment: Enrollment in the REGN program 4th semester. Prerequisite: REGN-37. Two-way corequisite: REGN-45.
This course presents instruction and demonstration of higher level nursing concepts related to second-year nursing courses. The second-year student will assume a facilitator role with other nursing students in nursing care planning. (10/06)

REGN-48 PROFESSIONAL RELATIONSHIPS AND RESPONSIBILITIES II
1 unit: 1 hour lecture.
Limitation on enrollment: Enrollment in the REGN program 4th semester. Prerequisite: REGN-38. One-way corequisite: REGN-45.
This course is an introduction to leadership and management principl applied to the health care field. Discussions will include leadership and management theories, organizational structure, problem-solving, decision-making, conflict management, effective communication, change process, planning process, motivational theories, and performance appraisal. (10/06)

REGN-49A-ZZ SPECIAL TOPICS IN NURSING
.5-3 units: .5-3 hours lecture, 0-6 hours lab.
Limitation on enrollment: Enrollment in an accredited nursing program, or a graduate from an accredited nursing program, or possession of a valid nursing license.
This course is designed to address special topics in nursing to meet the current needs of students. It will provide students access to instruction that will assist them in acquiring the most up-to-date information possible in order to cope with the rapidly changing health care environment. (2/08)

REGN-50 NURSING CAREER SEMINAR
.25 unit: 4.5 total hours lecture.
Prerequisite/Advisory: None.
This course introduces students to the various roles and responsibilities of nursing practitioners, including knowledge of educational levels as well as behaviors and skills. Merced College nursing programs are described, including admission requirements and procedures. Students are graded on credit/no credit basis. May be repeated once. (10/06)

New RN Sequencing.

Nursing, Registered

ALLIED HEALTH, BUSINESS AND PUBLIC SAFETY

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DEGREE
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Depending on the number of qualified applicants and constraints of the Chancellor's Office Merit-based selection model, the merit-based selection pool will vary in size for each application period.

Multiple Applications
There is no waiting list maintained for entrance into the RN Program. Applicants applying to the program a second time must reactivate their application and are responsible for updating their information to comply with local and/or state requirements. It is possible to be accepted into the qualified merit-based selection pool more than one selection period.

If an applicant has applied to the program more than once **consecutively** as a fully qualified applicant, the applicant's name will be added to the application pool an additional time for each such application.

Applicants who are selected and then declined **OR** are not successful completing the first semester may apply again but **will not** be recognized as a "consecutive" applicant. Applicants may only be accepted to the program a maximum

of two times.

Requirements for Accepted Applicants Only
The following must be completed prior to starting the first course in the RN Program:
Health clearance (including necessary immunizations)
Criminal background check (requires proof of valid social security number)
CPR certification
Drug screening

Preassessment Testing Requirement
Students selected into the RN Program must pass an assessment test (currently using TEAS). Applicants who do not meet the established score of 62 must attend a remediation program within one year in order to be considered for enrollment in the next RN class. Study materials are available in the Allied Health Office. Students may submit a copy of a previous TEAS test score in lieu of taking the test again.

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The System Office is interpreting this amendment to the Education Code as follows:

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DEGREE (2/13)

A.S. - Nursing, Registered (12500.AS)

The Registered Nursing Program at Merced College prepares students to take the National Council Licensure examination for Registered Nurses (NCLEX-RN), leading to licensure as a Registered Nurse (RN) and is designed to prepare competent nurses for service in the community. The Registered Nursing Program requires two academic years beyond the completion of the prerequisite courses and non-nursing breadth requirements. Graduates will earn the Associate in Science Degree upon completion of designated courses and competency requirements.

Program Student Learning Outcomes
A. Provide quality, safe, patient-center nursing care through evidence-based practice.
B. Participate in collaborative relationships with members of the interdisciplinary team to provide and improve patient care.
C. Engage in critical thinking skills and strategies and clinical reasoning necessary to provide quality patient care.
D. Provide leadership in a variety of healthcare settings for diverse patient populations.
E. Use information technology to communicate, manage knowledge, mitigate error, and support decision-making.
F. Function as a competent nurse assimilating all professional, ethical, and legal principles.

Prerequisite courses:		**Units**
BIOL-16**	General Human Anatomy (meets Area B2)	4
BIOL-18**	Principles of Physiology	4
BIOL-20**	Microbiology	4
ENGL-01A	College Composition and Reading (meets Area A1)	4
MATH-C	Intermediate Algebra	4

**It is highly recommended that once enrolled in these classes, students do not drop them. Program applicants need to understand that multiple attempts to improve grades earned in these classes can negatively affect their eligibility.

Required courses (non-nursing) which also fulfil A.S. Breadth requirements:		
COMM-01	Fundamentals of Speech (meets area A2)	3
or		
COMM-01H	Honors Fundamentals of Speech (3)	
or		
COMM-04	Small Group Discussion & Problem Solving (3)	
or		
COMM-05	Interpersonal Communication (3)	
Area B1	Physical Science (CHEM-02A recommended)	3
Area C	Humanities	3
Area D1	Behavioral Science (ANTH-02 recommended)	3
Area D2	Social Science	3
Area E1	Integrated Organism	3
Area E2	Activity	2

Required courses (nursing):		
First Semester		
REGN-15	Foundations of Nursing	9
REGN-18	Pharmacology In Nursing Practice	3
Second Semester		
REGN-24	Acute Medical/Surgical and Nursing of the Childbearing Family	10
Third Semester		
REGN-34	Advanced Medical/Surgical Nursing and Pediatric Nursing	10
Fourth Semester		
REGN-44	Acute Medical/Surgical Nursing and Mental Health Nursing	9
		81

Competencies as required by Merced College for graduation:
Writing: Met by completion of ENGL-01A within program prerequisites.
Math: Met by MATH-C or higher level math course.
Reading: Met by completion of A.S. Breadth courses with "C" grade or better.

[Completion of the Registered Nursing Program at Merced College satisfies CILC areas A through G.]

LVN TO RN PATHWAY

The pathway for California Licensed Vocational Nurses requires one academic year beyond completion of the prerequisite courses, non-nursing breadth requirements, and competencies. LVN to RN students enter into the third semester of the RN curriculum identified above after completion of REGN-01 and all other prerequisites. Applicants submit an application found on the Allied Health web site. Graduates will earn the Associate in Science Degree on completion of designated courses and competency requirements. Communication, natural and social science, and nursing courses must be completed with a grade of "C" or better to be eligible for licensure requirements of the State Board of Nursing.

Enrollment eligibility to the LVN to RN pathway requires the completion of previously identified prerequisite courses. Applicants must meet the same selection requirements as generic RN students entering the program in the first semester. In addition, CLDV-09/PSYC-09 are prerequisites for the LVN to RN applicant who has already met the selection criteria. Randomized selection is used to select a cohort from the pool of qualified applicants according to available seats.

LVN to RN applicants are notified of eligibility approximately two months prior to the next semester. The LVN-RN application period remains open. To progress into the RN program, students must successfully complete the REGN-01 LVN to RN transition class which is offered when a sufficient number of qualified applicants exist.

Space in the RN program is determined based on the number of RN students progressing from the second semester to the third semester.

Applicants selected from the pool must complete the assessment test (currently using TEAS). A score less than 67 requires the applicant to complete the same remediation requirements as all other generic RN students before admission into the program. Only those students formally accepted into the program may register for courses identified as Registered Nursing Curriculum. Students may, however, enroll in other courses designated as non-nursing program requirements while awaiting selection into the program.

Second Semester

REGN-01	Transition LVN to RN	2

Third Semester

REGN-02****	Clinical Skills Transition - LVN to RN	1
REGN-34	Advanced Medical/Surgical Nursing and Pediatric Nursing	10

Fourth Semester

REGN-44	Acute Medical/Surgical Nursing and Mental Health Nursing	9
		22

****Required for LVN's who have met admission selection criteria, have successfully completed REGN-01 and have been accepted into the Registered Nursing Program's third semester.

Transfer

Credits earned in the Merced College Registered Nursing Program may be transferable to California State Universities. Since prerequisite science and social science courses vary at each institution, students are advised to consult the catalog of their intended transfer school and establish a transfer plan with the Allied Health Counselor.

REGISTERED NURSING (REGN)

REGN-01 TRANSITION LVN TO RN

2 units: 1 hour lecture, 3 hours lab.
Limitation on enrollment: California VN license . Prerequisites: BIOL 16; BIOL-20; CHEM-02A; ENGL-01A; BIOL-18. One-way corequisite: CLDV-09/PSYC-09

The series of lectures and discussions will provide concepts and principles necessary to facilitate transition of the LVN to the changing role of the registered nurse. Emphasis will be placed upon the registered nurse as a decision-making member of the health team, and of responsibilities to be assumed by such a practitioner. (10/06)

REGN-02 CLINICAL SKILLS TRANSITION - LVN TO RN

1 unit: 3 hours lab.
Limitation on enrollment: California VN license, enrolled in REGN Program 3rd semester. Prerequisites: REGN-01. One-way corequisite: REGN-35.

This course consists of practice in the clinical setting with skills and principles necessary to facilitate transition of the LVN to the changing role of the registered nurse. Clinical hours must be initiated in the first week of the semester enrolled. Emphasis is placed on nursing skills related to first year RN nursing concepts in clinical practice. (1/08)

REGN-15 FOUNDATIONS OF NURSING

[CILC Area B,C,D,E,F,G]
9 units: 4 hours lecture, 15 hours lab TBA.
Limitation on enrollment: 1) Enrollment in the REGN program, 2) CPR card Module AC, 3) physical within past 6 months, 4) negative TB screening test within past 6 months or negative chest x-ray within past year, 5) proof of current immunizations, 6) criminal background clearance, 7) drug screening. Prerequisites: BIOL-16, BIOL-18, BIOL-20; ENGL-01A; MATH-C. Two-way corequisites: REGN-18.

Registered Nursing 15 (Foundations of Nursing) focuses on foundational concepts necessary for safe, patient-centered nursing care to a diverse patient population while integrating legal and ethical responsibilities of the nurse. Introduces critical thinking applied to nursing, the nursing process, diversity, and communication techniques used when interacting with patients and members of the interdisciplinary team, and applies evidence-based nursing practice. Includes acquisition of basic nursing skills. Application of knowledge and skills occurs in the nursing skills laboratory and a variety of acute and long-term care clinical settings. (2/13)

REGN-17 NURSING SKILLS SIMULATION I

[CILC Area A]
1 unit: 3 hours lab.
Limitation on enrollment: Enrollment in the REGN program. Two-way corequisite: REGN-15.

This course includes instruction/demonstration and return demonstration of nursing skills related to the first year nursing concepts. This course emphasizes skills and knowledge applications. (11/08)

REGN-18 PHARMACOLOGY IN NURSING PRACTICE

3 units: 3 hours lecture.
Limitation on enrollment: Enrollment in the REGN Program. Two-way corequisite: REGN-15. Advisory: VOCN-46A.

Registered Nursing 18, Pharmacology in Nursing Practice, presents an overview of the basic principles of pharmacology including major drug classifications and prototypes. Principles of medication administration include all aspects of best practice for safe, quality, patient-centered care including developmentally and culturally appropriate interventions. Includes dosage calculations. (2/13)

REGN-24 ACUTE MEDICAL/SURGICAL AND NURSING OF THE CHILDBEARING FAMILY

10 units: 5 hours lecture, 15 hours lab TBA.
Limitation on enrollment: Enrollment in the REGN program 2nd semester. Prerequisite: REGN-15, REGN-18.

Registered Nursing 24 provides for the acquisition and application of nursing theory, communication, collaboration, and critical thinking skills necessary for safe, patient-centered nursing care to a developmentally and culturally diverse patient populations experiencing various common medical/surgical interventions and to the childbearing family. Incorporates best practices, professional standards, and legal and ethical responsibilities of the professional nurse as applied in various healthcare settings. Includes acquisition of nursing skills required in acute care and childbearing family settings. Application of knowledge and skills occurs in the nursing skills laboratory and clinical settings. (2/13)

REGN-25 NURSING IN HEALTH AND ILLNESS II

9 units: 4 hours lecture, 15 hours lab.
Limitation on enrollment: Enrollment in the REGN program 2nd semester. Prerequisites: REGN-15, REGN-18. One-way corequisite: CLDV-09/PSYC-09, Two-way corequisite: REGN-26, REGN-27.
This course enlarges upon the concepts presented in REGN-15, introducing principles of care to maintain and restore normal homeostatic mechanisms in patients of all ages; study of the family unit throughout the life cycle is included, with emphasis on preventive care. (1/09)

REGN-26 PHARMACOLOGY II
2 units: 2 hours lecture.
Limitation on enrollment: Enrollment in the REGN program 2nd semester. Prerequisites: REGN-18. Two-way corequisite: REGN-25
Advisory: VOCN-46A
This course presents introductory concepts of pharmacology and mediation for infectious diseases, hypertension, anemias, family/OB. (1/09)

REGN-27 NURSING SKILLS SIMULATION II
1 unit: 3 hours lab.
Limitation on enrollment: Enrollment in the REGN program 2nd semester. Prerequisites: REGN-17. Two-way corequisite: REGN-25.
This course includes instruction/demonstration and return demonstration of nursing skills related to the first year nursing concepts. This course emphasizes skills and knowledge applications. (11/08)

REGN-34 ADVANCED MEDICAL/SURGICAL NURSING AND PEDIATRIC NURSING
10 units: 5 hours lecture, 15 hours lab TBA.
Limitation on enrollment: Enrollment in the REGN program 3rd semester; CPR card Module AC; physical within past 6 months; negative TB screening test within past 6 months or negative chest x-ray within past year; proof of current immunizations; criminal background clearance; drug screening. Prerequisite: REGN-01 or REGN-24.
This course enlarges upon the concepts presented in REGN-15 and REGN-24 by introducing principles of care to maintain and/or restore homeostatic mechanisms in acute health problems. Prototype disease processes associated with each concept are studied in relation to preventive and restorative nursing care. Concurrent practice in the college laboratory and clinical experience in community facilities are required. (2/13)

REGN-35 NURSING IN HEALTH AND ILLNESS III
9 units: 4 hours lecture, 15 hours lab.
Limitation on enrollment: 1) Enrollment in the REGN program 3rd semester, 2) CPR card Module AC, 3) physical within past 6 months, 4) negative TB screening test within past 6 months or negative chest x-ray within past year, 5) proof of current immunizations, 6) criminal background clearance, 7) drug screening, and 8) proof of current malpractice insurance. Prerequisites: CLDV-09/PSYC-09; REGN-25 or REGN-01. One-way corequisite: REGN-38. Two-way corequisite: REGN-36, REGN-37.
This course enlarges upon the concepts presented in REGN-15 and REGN-25 by introducing principles of care to maintain and/or restore homeostatic mechanisms in acute health problems. Prototype disease processes associated with each concept are studied in relation to preventive and restorative nursing care. Concurrent practice in the college laboratory and clinical experience in community facilities are required. (1/09)

REGN-36 PHARMACOLOGY III
1 unit: 1 hour lecture.
Limitation on enrollment: Enrollment in the REGN program 3RD semester. Prerequisite: REGN-26. Two-way corequisite: REGN-35.
This course presents ongoing concepts of pharmacology compatible with respiratory, cardiac/vascular, cancer, DMARDs and immunosuppressant therapies for adults and children. (1/09)

REGN-37 NURSING SKILLS SIMULATION III
1 unit: 3 hours lab.
Limitation on enrollment: Enrollment in the REGN program 3rd semester. Prerequisite: REGN-27. Two-way corequisite: REGN-35.
This course presents demonstration of higher-level nursing concepts related to second-year nursing courses. The third-semester student will assume the facilitator role with other nursing students in skill check-offs. (11/08)

REGN-38 PROFESSIONAL RELATIONSHIPS AND RESPONSIBILITIES I
1 unit: 1 hour lecture.
Limitation on enrollment: Enrollment in the REGN program 3rd semester. One-way corequisite: REGN-35.
The course introduces the student to the professional role of the registered nurse: its status, its responsibilities, and inherent problems as influenced by historical and social change. The focus is on the individual nurse and on the profession as a whole. (1/09)

REGN-44 ACUTE MEDICAL/SURGICAL NURSING AND MENTAL HEALTH NURSING
9 units: 4 hours lecture, 15 hours lab.
Limitation on enrollment: Enrollment in the REGN program 4th semester. Prerequisite: REGN-34.
Registered Nursing 44 builds on REGN-34, focusing on complex medical/surgical conditions of the high acuity patient and the patient at various levels of mental health promotion and mental illness management. Builds on nursing theory, communication, collaboration, and critical thinking skills necessary for safe, patient-centered nursing care to developmentally and culturally diverse patient populations. Incorporates best practices, professional standards, and legal and ethical responsibilities of the professional nurse as applied in the acute care and mental health settings incorporating all aspects of the professional nurse. Application of knowledge and skills occurs in the acute care and community settings to facilitate an effective transition from student to registered nurse. (2/13)

REGN-45 NURSING IN HEALTH AND ILLNESS IV
9 units: 4 hours lecture, 15 hours lab.
Limitation on enrollment: Enrollment in the REGN program 4th semester. Prerequisites: REGN-35. One-way corequisite: REGN-48. Two-way corequisite: REGN-46, REGN-47.
This course presents advanced concepts and skills in caring for the client with critical or multiple health problems. It emphasizes rehabilitation and adaptation to a compromised and/or declining health status. Concurrent practice in the college lab and clinical experience in community health facility is required. (1/09)

REGN-46 PHARMACOLOGY IV
1 unit: 1 hour lecture.
Limitation on enrollment: Enrollment in the REGN program 4th semester. Prerequisites: REGN-36. Two-way corequisite: REGN-45.
This course presents ongoing concepts of pharmacology for psychiatric (adult/teenagers), shock, cardiac arrhythmias, neurological and neuromuscular, and endocrine conditions. (1/09)

REGN-47 NURSING SKILLS SIMULATION IV
1 unit: 3 hours lab.
Limitation on enrollment: Enrollment in the REGN program 4th semester. Prerequisite: REGN-37. Two-way corequisite: REGN-45.
This course presents instruction and demonstration of higher level nursing concepts related to second-year nursing courses. The second-year student will assume a facilitator role with other nursing students in nursing care planning. (10/06)

REGN-48 PROFESSIONAL RELATIONSHIPS AND RESPONSIBILITIES II
1 unit: 1 hour lecture.
Limitation on enrollment: Enrollment in the REGN program 4th semester. Prerequisite: REGN-38. One-way corequisite: REGN-45.
This course is an introduction to leadership and management principles applied to the health care field. Discussions will include leadership and management theories, organizational structure, problem-solving, decision-making, conflict management, effective communication, change process, planning process, motivational theories, and performance appraisal. (10/06)

Merced College

REGN 15

Foundations of Nursing

Fall 2013

Wanda Schindler, RN, MSNEd
Dan Smith, RN, MSN, FNP

Merced College
REGN 15
Foundations of Nursing
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If you have a verified physical, medical, psychological, or learning disability or perhaps you feel you may have one of these disabilities which impact your ability to carry out assigned course work, please contact the Disabled Student Services (DSS) office. DSS staff will review your needs and determine what accommodations are necessary and appropriate. All information and documentation is confidential. DSS is located in the Lesher Student Services Bldg. Room 234, phone 384-6155. In Los Banos, DSS is located in Building A, phone 381-6423.

Merced College
Instructor Information

Instructor:	Wanda Schindler, RN, MSNEd
Phone:	209-384-6128
Pager:	388-2788 (for clinical use only)

Instructor:	Dan Smith, RN, MSN, FNP
Phone:	209-384-6127

Instructor reserves the right to modify the syllabus in response to changing student or pedagogical needs.

Merced College
1st Semester Syllabus (REGN 15)

Using This Syllabus in Your Learning
This syllabus is divided into specific parts of learning objectives. You should utilize what has been included in this syllabus to facilitate your learning. As a nursing student you are expected to be actively involved in your learning. This syllabus is an adjunct to the lectures, theory in textbooks, and clinical experience. Some suggestions to assist you are:

I. Read the assigned parts of the textbook as listed in the syllabus.
II. Read assigned portions of the syllabus.
III. Read the objectives and write an answer/explanation for each one. Be sure that you understand them. Try them yourself first, after reading the assigned readings, and then talk about them with your study group.
IV. Download lecture note pages for taking notes during reading and lectures.
V. Read the principles as provided; think of them as guidelines to the required theory.
VI. Complete as many pre-tests and post-tests as you can using the skills lab resources.

Attendance Policy
Class participation is expected and will be assigned a grade through quizzes, presentations, and participation in discussion. Another measure of participation comes from evidence of progress toward completion. This is evaluated through timely submissions of assignments.

Academic Honesty
Cheating and plagiarism are acts of academic dishonesty. They refer to the use of unauthorized books, notes, or otherwise securing help in a test; copying tests, assignments, reports, or term papers; representing the work of another as one's own; collaborating, without authority with another student during an examination or in preparing academic work; partial or complete use of another's work without giving proper credit; or otherwise practicing scholastic dishonesty. All students are expected to follow Merced College Academic Honesty Procedure. Each student is expected to refrain from acts of academic dishonesty and refuse to aid or abet any form of academic dishonesty. Refer to the RN Student Handbook for actions that may be taken.

Academic Help
Assistance is available in various areas of concentration including math, writing skills, and study habits through the http://www.mccd.edu/academics/resourses/help.html. Students are encouraged to seek assistance early in the semester.

Accommodation in the Classroom
If you have a verified physical, medical, psychological, or learning disability or perhaps you feel you may have one of these disabilities which impacts your ability to carry out assigned course work, please contact the Disabled Student Services (DSS) office. DSS staff will review your needs and determine what accommodations are necessary and appropriate. All information and documentation is confidential. DSS is located in the Lesher Student Services Bldg. Room 234, phone 384-6155. In Los Banos, DSS is located in Building A, phone 381-6423.

Introduction to the RN Program

Reference:
RN Student Handbook

Objectives:
In the classroom, clinical, and/or lab the student will:

- Differentiate the role of learner from the role of teacher and relate those roles to student behavior
  - ✓ With the instructor
  - ✓ With the client

- Explain the significance of health teaching and describe the student nurse as a "role mode" in the learning of health behaviors by clients.
- Describe the philosophy and purpose of the Merced College R.N. program.
- Explain the purpose and procedure of Student Grievance Policy.
- Explain the concept of proactive learning and develop a process for becoming a proactive learner.
- Discuss the integrative nature of the RN classes:
  - ✓ Nursing in Health & Illness I (REGN 15)
  - ✓ Pharmacology in Nursing Practice (REGN 18)
- Discuss location of resources on websites
  - ✓ Clinical forms
    http://www.mccd.edu/alliedhealth/REGN/Forms.htm

- Specific Clinical Skills Objectives
  - ✓ Confirmed written order
  - ✓ Handwashing
  - ✓ Necessary equipment gathered
  - ✓ Allergies checked
  - ✓ Identification of Patient (must have armband, Allergy band, & patient number)
  - ✓ Appropriate communication & clear explanation of procedure to patient
  - ✓ Preparation for patient & unit
  - ✓ Patient privacy maintained
  - ✓ Proper positioning of patient, nurse, bed
  - ✓ Gloves worn and/or proper isolation technique maintained
  - ✓ Correct administration of medication or treatment
  - ✓ Patient positioning for comfort & safety
  - ✓ Correct collection, labeling and handling of specimens
  - ✓ Accurate charting

August 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
11	12 RN-15 Skills 0800-1600 AHC- 131	13 RN-15 Skills 0800-1600 AHC-140	14 Theory 0800-1000 AHC-124 History of nursing/ Nursing Education ATI- Critical Thinking Test/ Blackboard 1000-1100 Computer Lab	15 Theory 0800-1000 AHC-124 Professionalism/ Standards of Practice RN-15 Skills 1300-1600 AHC- 140	16	17
18	19 RN-15 Skills 0800-1600 AHC- 131	20 RN-15 Skills 0800-1600 AHC-140	21 Theory 0800-1000 Legal/Ethical AHC-124 Math Test #1 AHC-124	22 Theory 0800-1000 AHC- 124 Culture/ Ethnicity RN-15 Skills 1300-1600 AHC-140	23	24
25	26 RN-15 Skills 0800-1600 AHC- 131	27 RN-15 Skills 0800-1600 AHC-140	28 Theory 0800-1000 AHC-124 Spirituality	29 Theory 0800-1000 AHC-124 Growth and Development RN-15 Skills 1300-1600 AHC-140	30	31

September 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2 Holiday	3 RN-15 Skills 0800-1600 AHC-140	4 Theory 0800-1000 AHC-124 Exam # 1 Math Test # 2 AHC-124	5 Theory 0800-1000 AHC-124 Documentation/ Communication/SBAR RN-15 Skills 1300-1600 AHC- 140	6	7
8	9 RN-15 Skills 0800-1600 AHC-140	10 RN-15 Skills 0800-1600 AHC-140	11 Theory 0800-1000 AHC-124 Nursing Informatics	12 Theory 0800-1000 AHC-124 Information Literacy **Practical Skills Examination** AHC-140 (sign ups provided)	13	14
15	16 RN-15 Skills 0800-1600 AHC-140	17 RN-15 Skills 0800-1600 AHC-140	18 Theory 0800-1000 AHC-124 Nursing Process Math Test # 3 AHC-124 1000-1100	19 Theory 0800-1000 AHC-124 Critical Thinking/ Reasoning RN-15 Skills 1300-1600 AHC-140	20	21
22	23 RN-15 Skills 0800-1600 AHC-140	24 RN-15 Skills 0800-1600 AHC-140	25 Theory 0800-1000 AHC-124 Health Assessment/ Physical Assessment	26 Theory 0800-1000 AHC-124 Exam # 2 RN-15 Skills 1300-1600 AHC-140	27	28
29	30 RN-15 Skills 0800-1600 AHC-140					

October 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 RN-15 Skills 0800-1600 AHC-140	2 Theory 0800-1000 AHC-124 Safety	3 Theory 0800-1000 AHC-124 Personal Hygiene/ Asepsis/ Universal Precautions RN-15 Skills 1300-1600 AHC-140	4	5
6	7	8	9 Theory 0800-1000 AHC-124 Patient Education Post-Conference 1000-1300	10 Theory 0800-1000 AHC-124 Sensory perception/pain	11 Clinical- Mercy/ Anberry/ Los Banos 0630-1700	12
13	14	15	16 Theory 0800-1000 AHC-124 Activity/ Exercise Post-Conference 1000-1300	17 Theory 0800-1000 AHC-124 Nutrition	18 Clinical- Mercy/ Anberry/ Los Banos 0630-1700	19
20	21	22	23 Theory 0800-1000 AHC-124 Oxygenation Post-Conference 1000-1300	24 Theory 0800-1000 AHC-124 Exam # 3	25 Clinical- Mercy/ Anberry/ Los Banos 0630-1700	26
27	28	29	30 Theory 0800-1000 AHC-124 Bowel Elimination Math Test # 4 AHC- 124 Post-Conference 1000-1300	31 Theory 0800-1000 AHC-124 Urinary Elimination		

November 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1 Clinical- Mercy/ Anberry/ Los Banos 0630-1700	2
3	4	5	6 Theory 0800-1000 AHC-124 Fluids Post-Conference 1000-1300	7 Theory 0800-1000 AHC-124 Electrolytes	8 Clinical- Mercy/ Anberry/ Los Banos 0630-1700	9
10	11	12	13 Theory 0800-1000 AHC-124 Acid-base balance Post-Conference 1000-1300	14 Theory 0800-1000 AHC-124 Exam # 4	15 Clinical- Mercy/ Anberry/ Los Banos 0630-1700	16
17	18	19	20 Theory 0800-1000 AHC-124 Psychosocial health and illness Post-Conference 1000-1300	21 Theory 0800-1000 AHC-124 Loss, Grief, Dying	22 Clinical- Mercy/ Anberry/ Los Banos 0630-1700	23
24	25	26	27 Theory 0800-1000 AHC-124 Stress and Adaptation Post- Conference 1000-1300	28 Holiday	29 Holiday	30

December 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4 Theory 0800-1000 AHC-124 Sleep and Rest Post-Conference 1000-1300	5 Theory 0800-1000 AHC-124 Exam # 5 ATI- Fundamentals Testing 1000-1100 Computer Lab	6 No Class/ Start of Finals Week	7
8	9 Theory 0800-1000 AHC-124 FINAL EXAM	10 FINALS	11 FINALS	12 FINALS	13 FINALS	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Week 1 – Monday, Tuesday, Wednesday, Thursday

Monday – 8/12

I & O Charting

Abbreviations – Handout

PPE

Hand washing

Tuesday – 8/13

V/S

Bed making

Restraints

Bathing/Pericare/Shaving

Oral Hygiene

Wednesday-8/14

ATI Critical Thinking

Thursday – 8/15

Oral suction

ROM/Positioning

Week 2 – Monday, Tuesday, Thursday

Monday – 8/19

Transfers

Hot/Cold Application

Ostomy care

Ace wrap/Abdominal binder

Enemas

Tuesday – 8/20

Ace wrap/Abdominal binder

Oral Airway, Oxygen mask & cannula, Ambu bag

D/C IV

LPAT, KATZ & Mini mental

Thursday – 8/22

Glucoscan

Foley insertion/condom cath

Week 3 – Monday, Tuesday, Thursday

Monday – 8/26

Medication administration PO & topical

NG tube suction maintenance, G-tube feedings, G-tube Medications

SC: withdrawing from vial mixing insulin, syringe safety, Lovenox/Heparin

Tuesday – 8/27

Intradermal injections

D/C foley

Catheter care

Clean/Sterile urine specimen

Thursday – 8/29

Medication administration IM

Medication Administration – Nasal & Inhalers

Week 4 – Tuesday, Thursday (Monday – Holiday)

Tuesday – 9/3

Medication administration IM

Medication Administration – Nasal & Inhalers

Medication administration – Otic, Optic, Rectal, Vaginal

Dry sterile dressing/wet-dry dressing

Thursday – 9/5

Discuss clinical paperwork

Week 5 – Monday, Tuesday, Thursday

Monday – 9/9

Check-off/orientation

Tuesday – 9/10

Check-off/orientation

Thursday – 9/12

Practical Examination

Merced College
REGN - 15
Course Description

Credit: 9 units
2-Way Co-requisite: *REGN-18*
This course presents basic concepts that provide the foundations upon which homeostasis is maintained in adults and/or children. Common threads integrated throughout the program are initiated: Nursing Process, Nutrition, Pharmacology, Developmental Levels, Cultural Diversity, Communication, and Professional Role.

Required Text
As indicated in text list located in the RN website.

Course Pedagogy
Students are guided through lessons using a combination of PowerPoint presentations, brief audio and/or video, activities, assignments, quizzes, exams, and readings (text, website, articles, etc.). Topics are explored through weekly instructor and/or student-led discussions.

Method of Evaluation
Students are evaluated through assignments, presentations, quizzes, and exams. ***Assignments*** are due by the beginning of class on the date due. Late work receives a 10% deduction. ***Quizzes*** are unannounced and intended to explore the student's grasp of main topics. ***Exams*** are divided into four unit review exams. Exam items are primarily multiple choice with some multiple select, matching, diagram selection and short answer questions. Students have 50 minutes in which to complete the exams. Missed exams receive 10% reduction in score. Students are required to schedule a make-up time for a missed exams with the Allied Health Office within one week or forfeit points for that exam.. A ***final exam*** is administered covering the content of the semester. Following each of the four unit exams, students are divided into small groups to repeat the exam for a group score. This process allows students an opportunity to discuss the material and develop a deeper understanding.
*ATI Nurse logics must be completed prior to first examination.

Evaluation	**Percent**	Grading is as follows: 90 - 100=A, 80 - 89=B, Assignments and
Quizzes/ATI Nurse logics	5	75 -79=C, 74 - 60=D, <60=F
Exams (5)	75	
Final Exam	20	Students must achieve 75% or greater to pass
Total Points	**100**	this course in the RN Program.

Tentative Schedule
The schedule provided is intended to give you a guideline for study. Actual times may vary according to the needs of the class and any unforeseen problems. Assignment dates are provided in advance to allow students to work ahead and identify problems in advance of the due dates.

Clinical Principles

1. The student nurse is held to the same level of accountability as a professional nurse in the performance of nursing duties.
2. A high degree of personal maturity is a prerequisite for the nurse before she/he practices nursing.
3. The health team has representation from all practitioner groups, and its members work interdependently and collaboratively in offering services distinctive to its profession.
4. Due to the expanding professional role from one of direct and limited care of the ill patients to involving extensive planning and coordination of total patient care, the nurse is increasingly more vulnerable to legal action.
5. Each nursing practitioner is expected to uphold and adhere to the code of their professional society.
6. Nurses enter into partnerships with patients (nurse-patient relationship) and as such, exist to assist the patient in meeting the needs as defined by the patient. Nurses are concerned primarily with the health of the individual rather than disease.

Confidentiality

- Confidentially is the duty to respect privileged information.
- It is a basic ethical principle that ensures a client's privacy.
- You are **legally** bound to keep client information confidential.
- It is grounds for dismissal from the program to not adhere to confidentiality.
- Read you RN Student Handbook!
- Avoid discussing the client's condition with anyone who is not involved in the case.
- Do not share patient's records with anyone outside of the hospital.
- Do not tell information the client does not want told, even if you think others have the right to know. (e.g., patient with AIDS and family does not know but will be caring for the patient). You can't tell the family, just encourage patient to discuss it with them.
- Be careful walking in hallways, not talking about patients.
- If you have a question about your duty/ethical responsibility with a patient, please ask the instructors!

Course Student Learning Outcomes and Competencies

The following course student learning outcomes and competencies represent the overall behaviors the student is to accomplish by the end of the course. They will build throughout the program to culminate in the program student learning outcomes and competencies. The individual weeky units taught in the classroom specify the specific content to be taught. As that content is taught it should be connected to the course student learning outcomes and competencies; this puts the weekly "lesson" content into the bigger perspective of your curriculum strucuture. The same is true for the clinical experience. Therefore, the clinical evaluation tool (CET) is developed based on these course student learning outcomes and competencies. Included with the CET are clinical activities for each competency that provide students an opportunity to demonstrate their ability to achieve that particular competency. This provides validity to the CET. Grading rubrics are used for each activity so all faculty are grading students using the same criteria and all students are aware of the criteria used to grade them. This provides reliability to the CET. Grading rubrics are included, but faculty should review these and revise if they believe the expected level of behaviors should be higher or lower than indicated.

Students keep all the activities for the course in a 3-ring binder known as a clinical activity portfolio. Each of the 6 course outcomes can be divided into sections with a page divider then all the activities for the competencies for each of the outcomes are contained in the section for each that outcome. Some of the activities may be completed as students provide traditional patient care. However, some of them may be carried out as the only assignment for the day. Often two students work together on an activity then discuss their findings in postconference.

It is most helpful to complete these clinical activities during clinical time with feedback from the faculty during clinical time. This promotes active learning in the context of the environment and the patient. Students can be asked to correct any errors while still in the environment where the information resides and with the faculty available for feedback and discussion.

Please feel free to add, delete, or revise any of the clinical portfolio activities.

Nursing 15: Foundations of Nursing

Registered Nursing 15 (Foundations of Nursing) focuses on foundational concepts necessary for safe, patient-centered nursing care to a diverse patient population while integrating legal and ethical responsibilities of the nurse. Introduces critical thinking applied to nursing, the nursing process, diversity, and communication techniques used when interacting with patients and members of the interdisciplinary team, and applies evidence-based nursing practice. Includes acquisition of basic nursing skills. Application of knowledge and skills occurs in the nursing skills laboratory and a variety of acute and long-term care clinical settings.

Registered Nursing 15 Course Outcomes

1. Provide quality, safe, patient-centered nursing care at the basic level.
2. Identify the nurse's role in collaborative relationships with members of the interdisciplinary team.
3. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.
4. Identify the role of leadership for the purpose of providing and improving patient care.
5. Identify simple examples of information management and how they are used in the clinical environment.
6. Explain how professional standards, and legal and ethical principles apply to safe, quality, patient-centered nursing care.

Registered Nursing 15 Course Competencies

1. Provide quality, safe, patient-centered nursing care at the basic level.

- Conduct at a basic level a comprehensive and focused physical, behavioral, psychological, spiritual assessment eliciting patient values, experiences, and expressed needs.
- Plan at a fundamental level holistic, patient-centered care that reflects psychosocial integrity, physiological integrity, and health promotion and maintenance within a variety of healthcare systems.
- Deliver compassionate, patient-centered, evidence-based care that respects patient and family preferences.
- Demonstrate at a fundamental level the application of psychomotor skills for the efficient, safe, and compassionate delivery of patient care.
- Deliver care within expected timeframe.
- Monitor at a fundamental level patient outcomes, including interpretation of assessment data and appropriate follow-up, to evaluate the effectiveness of nursing interventions.
- Identify quality measures when evaluating effects of nursing interventions appropriate to the care environment.
- Describe factors that create a culture of caring for the patient and the patient's support network.
- Communicate effectively with the patient and the patient's support network.
- Communicate effectively when reporting care provided and evaluation data including appropriate handoff reports.

- Provide at a fundamental level appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.
- Evaluate effectiveness of patient teaching.

2. Identify the nurse's role in collaborative relationships with members of the interdisciplinary team.
- Explain effective communication techniques that produce positive professional working relations.
- Interact with members of the healthcare team to plan patient care and evaluate progress toward patient outcomes.
- Identify the nurse's role in decision making related to patient care.
- Identify examples of conflict resolution.
- Identify own role as a member of the interdisciplinary healthcare team.
- Describe ways in which team functioning impacts safety and quality improvement.

3. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.
- Identify how critical thinking/clinical reasoning is used to approach patient care.
- Demonstrate at a fundamental level tolerance for ambiguity and unpredictability and its effect on patient care.
- Interpret and correctly implement physician and interprofessional orders.
- At the fundamental level anticipate risks and predict and manage potential complications.
- Use the nursing process to make decisions about patient care.

4. Identify the role of leadership for the purpose of providing and improving patient care.
- Identify how the delegation process is used in the healthcare setting.
- Describe how the individualized plan of care is implemented in the healthcare setting.
- Describe the differences in the provision of patient care among various healthcare settings.
- Describe the effect of the nursing leadership in the healthcare setting.
- At the fundamental level, describe the quality improvement processes in the clinical setting used to effectively implement patient safety initiatives and monitor performance measures.
- Apply the National Patient Safety Goals to patients in the clinical setting and identify any areas in need of improvement.

5. Identify simple examples of information management and how they are used in the clinical environment.
- Maintain organizational and client confidentiality.
- Discuss skills used in the clinical area to implement clinical information systems for safe nursing practice.
- Explain the role of information technology in improving patient care outcomes and creating a safe care environment.

6. Explain how professional standards, and legal and ethical principles apply to safe, quality, patient-centered nursing care.

- Apply rules and regulations that authorize and define professional nursing practice.
- Demonstrate professional standards of moral, ethical, and legal conduct.
- Assume accountability for own behaviors, including a recognition for when to ask for assistance.
- Practice within the parameters of individual knowledge and experience.
- Identify limits and boundaries of therapeutic, patient-centered care.

Nursing 15: Foundations of Nursing: Mid-term and Final Clinical Evaluation Tool – Scoring Sheet

Student: _____ **Clinical Faculty:** _____

S = Satisfactory **NI = Needs Improvement** **U = Unsatisfactory (Must be Satisfactory by final evaluation)**

Course Outcome	Midterm Grade			Final Grade		Evaluation Tool
	S	NI	U	S	U	
1. Provide quality, safe, patient-centered nursing care at the basic level. a. Conduct at a basic level a comprehensive and focused physical, behavioral, psychological, spiritual assessment eliciting patient values, experiences, and expressed needs. b. Plan at a fundamental level holistic, patient-centered care that reflects psychosocial integrity, physiological integrity, and health promotion and maintenance within a variety of healthcare systems. c. Deliver compassionate, patient-centered, evidence-based care that respects patient and family preferences. d. Demonstrate at a fundamental level the application of psychomotor skills for the efficient, safe, and compassionate delivery of patient care. e. Deliver care within expected timeframe. f. Monitor at a fundamental level patient outcomes, including interpretation of assessment data and appropriate follow-up, to evaluate the effectiveness of nursing interventions. g. Identify quality measures when evaluating effects of nursing interventions appropriate to the care environment. h. Describe factors that create a culture of caring for the patient and the patient's support network. i. Communicate effectively with the patient and the patient's support network. j. Communicate effectively when reporting care provided and evaluation data including appropriate handoff reports. k. Provide at a fundamental level appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.						a, b. Concept Map c. Patient Preferences Tool d. Psychmotor Skills Reflect Sheet e. No tool for this competency; faculty observation. f. Signs and Symptoms Critic Thinking Tool g. Quality Measures h. Patient-Centered Care and Caring i. Patient Interaction Sheet j. SBAR patient report k, l. Patient Teaching Tool

l. Evaluate effectiveness of patient teaching.						
2. Identify the nurse's role in collaborative relationships with members of the interdisciplinary team. a. Explain effective communication techniques that produce positive professional working relations. b. Interact with members of the healthcare team to plan patient care and evaluate progress toward patient outcomes. c. Identify the nurse's role in decision making related to patient care. d. Identify examples of conflict resolution. e. Identify own role as a member of the interdisciplinary healthcare team. f. Describe ways in which team functioning impacts safety and quality improvement.						a. Interprofessional Communicatin Interaction Sheet c. Basis for Making Decisions b, e, f: Teamwork Impacting Safety and Quality Improvement Measures d. Conflict Resolution on the Clinical Unit
3. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds. a. Identify how critical thinking/clinical reasoning is used to approach patient care. b. Demonstrate at a fundamental level tolerance for ambiguity and unpredictability and its effect on patient care. c. Interpret and correctly implement physician and interprofessional orders. d. At the fundamental level anticipate risks and predict and manage potential complications. e. Use the nursing process to make decisions about patient care.						a, c, e: Patient Care/Nursing Process Critical Thinking Activity b. Parameters for Patient Care d. Predict and Manage Potential Complications
4. Identify the role of leadership for the purpose of providing and improving patient care. a. Identify how the delegation process is used in the healthcare setting. b. Describe how the individualized plan of care is implemented in the healthcare setting. c. Describe the differences in the provision of patient care among various healthcare settings. d. Describe the effect of the nursing leadership in the healthcare setting. e. At the fundamental level, describe the quality improvement processes in the clinical setting used to effectively implement patient safety initiatives and monitor performance measures. f. Apply the National Patient Safety Goals to patients in the clinical setting and identify any areas in need of improvement.						a. Identifying Delegation Responsibilities b, c. Implementing the Individualized Plan of Care d. Nursing Leadership and Safe, Quality Patient Care e. Tool for 1, g: Quality Measures f. National Patient Safety Goal Activity
5. Identify simple examples of information management and how they are used in the clinical environment.						a. Organizational and Patient Confidentiality Observation

a. Maintain organizational and client confidentiality. b. Discuss skills used in the clinical area to implement clinical information systems for safe nursing practice. c. Explain the role of information technology in improving patient care outcomes and creating a safe care environment.						Rubric b, c. Technology is More than Charting
6. Explain how professional standards, and legal and ethical principles apply to safe, quality, patient-centered nursing care. a. Apply rules and regulations that authorize and define professional nursing practice. b. Demonstrate professional standards of moral, ethical, and legal conduct. c. Assume accountability for own behaviors, including a recognition for when to ask for assistance. d. Practice within the parameters of individual knowledge and experience. e. Identify limits and boundaries of therapeutic, patient-centered care.						a, b, e. Moral, Ethical, Legal, and Professional Standards Observation Rubric c, d. Accountability Observation Rubric

Additional Comments:

Signatures:

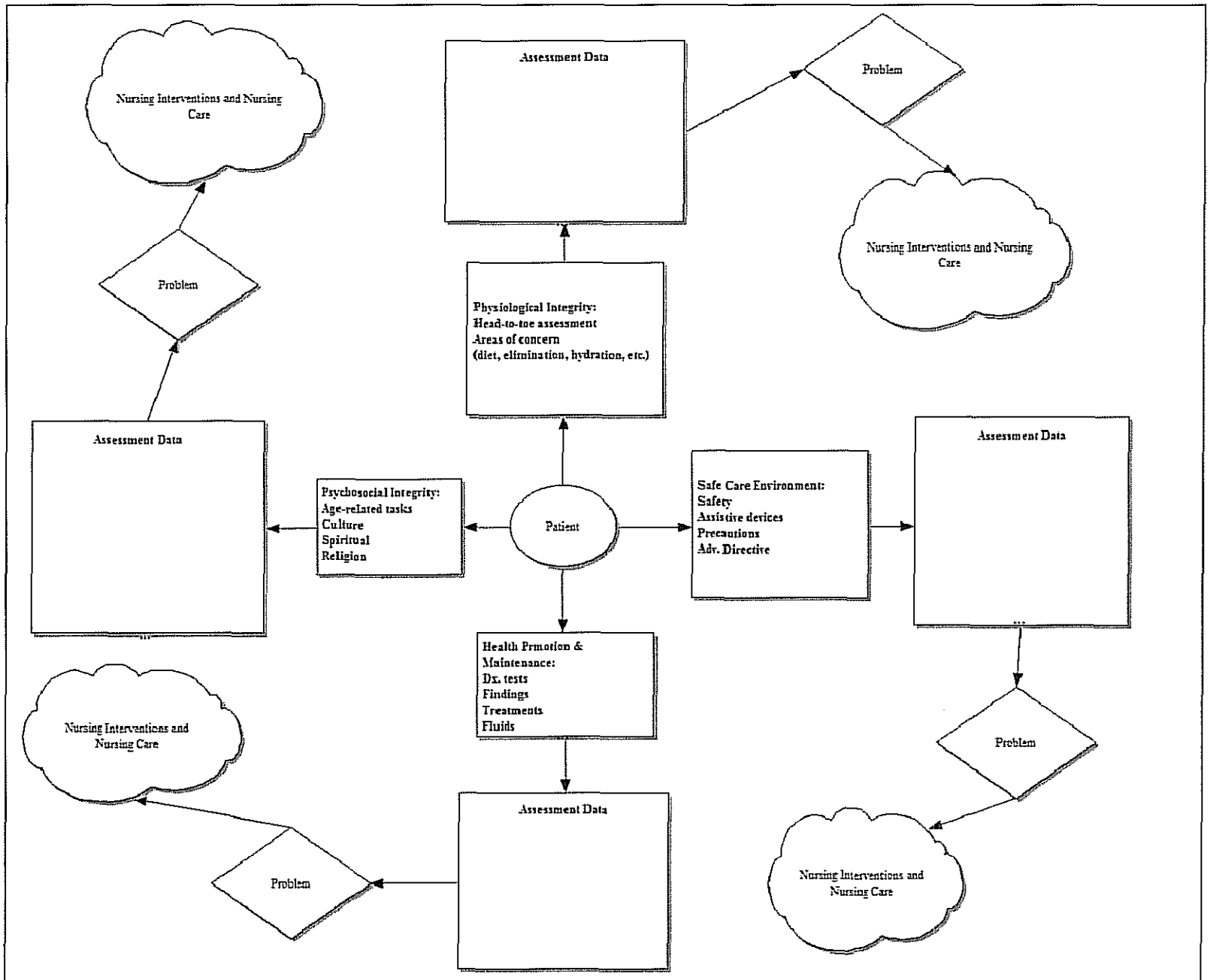
Midterm Evaluation **Date:** _____
Student _____
Faculty _____

Final Evaluation **Date:** _____
Student _____
Faculty _____

The following pages contain the Clinical Activity Portfolio Tools for Foundations of Nursing , Course Student Learning Outcome #1.

Course Student Learning Outcome #1, Competencies:
a. Conduct at a basic level a comprehensive and focused physical, behavioral, psychological, spiritual assessment eliciting patient values, experiences, and expressed needs.
b. Plan at a fundamental level holistic, patient-centered care that reflects psychosocial integrity, physiological integrity, and health promotion and maintenance within a variety of healthcare systems.

Tool:
Concept Map


Nursing Interventions and Nursing Care
Assessment Data
Problem
Problem
Nursing Interventions and Nursing Care
Physiological Integrity:
Head-to-toe assessment
Areas of concern
(diet, elimination, hydration, etc.)
Assessment Data
Psychosocial Integrity:
Age-related tasks
Culture
Spiritual
Religion
Patient
Safe Care Environment:
Safety
Assistive devices
Precautions
Adv. Directive
Assessment Data
Health Promotion & Maintenance:
Dx. tests
Findings
Treatments
Fluids
Nursing Interventions and Nursing Care
Problem
Assessment Data
Problem
Nursing Interventions and Nursing Care

Grading Rubric for the Concept Map

Performance Level	S	NI	U
Lists collected data in appropriate section of concept map.	Identifies ≥ 5 objective/subjective data within each appropriate areas	Identifies 3-4 objective/subjective data within each appropriate area	Identify less than 2 objective/subjective data within each appropriate basic need
Identifies nursing interventions specific to each area	Writes ≥ 3 nursing interventions specific to each area	Writes ≥ 1 nursing intervention specific to each area	Unable to identify nursing interventions for all areas

Course Student Learning Outcome #1, Competency:

c. Deliver compassionate, patient-centered, evidence-based care that respects patient and family preferences.

Tool: Patient Preferences Tool

Use own textbook and agency guidelines to compare and contrast care provided versus text and agency recommendations.
Activity:

- Access your textbook.
- Access any available agency source for clinical guidelines regarding your patient's condition.
- Review the patient's chart to see how closely the care prescribed relates to that in your textbook and in the agency's clinical guidelines.
- Note if there are variances and find our why there are variances.

Key recommendations of guidelines	**Comparison to textbook: Adherence or variation?**	**Adherence to agency guidelines or variation**	**Reasons for variance (Pt preference, physical or other conditions)**
Medications: Tests/Lab work Activity/Health behaviors			

Grading Rubric for Patient Preferences Tool

Performance Level	S	NI	U
Compares care to textbook and agency guidelines.	Clearly compares care to textbook and agency guidelines.	Scant comparison of care with that in the textbook and agency guidelines.	Unable to compare care to textbook and agency guidelines.
Identifies variances based on patient preferences.	Clearly identifies variances based on patient preferences.	Scantly identifies variances based on patient preferences.	Unable to identify variances based on patient preferences.

Course Student Learning Outcome #1, Competency:

d. Demonstrate at a fundamental level the application of psychomotor skills for the efficient, safe, and compassionate delivery of patient care.

Psychomotor Skills Reflection Sheet

Date	Skill	How I believe I performed.	Ways I can improve.

Rubric for the Psychomotor Skills Tool

Performance Criteria	S	NI	U
Psychomotor Skills Tool: Demonstrates competent and safe nursing care.	Clearly describes how the psychomotor skill was performed, evaluates self performance, and offers 2 ways for improvement.	Able to describe how the psychomotor skills was performed but with limited insight to problems on self performance. Offers one way to improve performance.	Descriptions of performance of psychomotor skills are scant and unorganized. Does not offer ways to improve future performance.

Faculty Notes Related to Acceptable Performance of Psychomotor Skill:

Course Student Learning Outcome #1, Competency:

f. Monitor at a fundamental level patient outcomes, including interpretation of assessment data and appropriate follow-up, to evaluate the effectiveness of nursing interventions.

Signs and Symptoms Critical Thinking Tool

Lists the **signs and symptoms** you noted on your assessment of your patient.

What **diagnostics tests** were completed relative to these manifestations?

What **medical treatments/interventions** were implemented to treat these manifestations? (Include medications.)

What **nursing interventions** were implemented to treat these manifestations?

Any **manifestations** not being addressed? What will you do about them?

Which of the above indicate the interventions were/were not effective?

Signs and Symptoms Grading Rubric

Performance Level	S	NI	U
1. Identifies signs/symptoms and laboratory information related to the patient's condition including the medical and nursing treatments for the disease.	In depth explanation of the signs/symptoms and laboratory information related to the patient's condition including the medical and nursing treatments for the disease.	Explanation includes some but not all of the signs/symptoms and laboratory information related to the patient's condition including the medical and nursing treatments for the disease.	Brief explanation of the signs/symptoms and laboratory information related to the patient's condition including the medical and nursing treatments for the disease.
2. Identify manifestations not addressed by present nursing and/or medical interventions.	In depth explanation of manifestations not addressed by present nursing and/or medical interventions.	Explanation includes some but not all of the manifestations not addressed by present nursing and/or medical interventions.	Brief explanation of the manifestations not addressed by present nursing and/or medical interventions.
3. Identifies patient evaluation data used to determine if interventions were/were not effective.	In depth explanation of patient evaluation data used to determine if interventions were/were not effective.	Explanation includes some but not all of the patient evaluation data used to determine if interventions were/were not effective.	Brief explanation of the patient evaluation data used to determine if interventions were/were not effective.

Course Student Learning Outcome #1 Competency:

g. Identify quality measures when evaluating effects of nursing interventions appropriate to the care environment.

Quality Measures

The quality measures for this assignment include safety and fall risks.

60 Second Assessment for Fall Risks

The overall purpose of this assignment is to:

- Assess safety and fall risks each time student enters a patient's room
- Identify safety hazards in the patient environment that will cause harm or could potentially lead to harm
- Perform risk factor interventions when applicable

Directions- Enter the patient's room and observe the patient and the environment for up to 60 seconds while reviewing the following questions. After the 60 second assessment, discuss your findings with your clinical instructor and perform interventions (when applicable) to reduce fall risks.

Tubes and Lines Does the patient have any tubes or an IV? Does the patient need these tubes or IV, if so, why? Are the tubes tangled or crossing along the patient?	**Your Findings**
Equipment • If an IV pole is present, is the stand steady and easy to maneuver? • Are the side rails up? Does the upper or all four need to be raised up?	**Your Findings**

• Is the height of the bed in the lowest position? • Are the bed brakes on? • Is the call light within reach? • Are any bed/exit alarms on? Why or why not?	
Environmental Is the bed side table and patient's immediate belongings/essentials within reach of the patient? Is the floor wet or is clutter or debris present? What else about the environment could lead to a problem for the patient?	**Your Findings**
Patient Safety Survey Does the patient have non-skid slippers on? Has the patient previously been identified as a fall risks? Does the patient have a fall risks identification armband on? Is a fall risk sign and/or symbol on the patient's door or at the bedside? Is the patient confused, disoriented, or visually impaired?	**Your Findings**
Overall, what are your safety concerns with this patient? Do you need to report any risks factors or problems? If so, to whom? How would you manage the risk factors and problems, if any?	**Your Findings**

After your 60 second assessment is complete answer the following questions: What are the tools used for fall risk measurement on this unit?	

Grading Rubric for the 60 Second Safety Assessment

Performance Level	S	NI	U
Safety and fall risk assessment	Thoroughly conducts a safety and fall risk assessment.	Explanation includes some but not a complete safety and fall risk assessment.	Brief explanation of a safety and fall risk assessment.
Identified safety hazards	Identifies all potential and actual safety hazards.	Explanation includes some but not all potential and actual safety hazards.	Scant list of potential and actual safety hazards.
Identified interventions to prevent harm to patient	Identifies all interventions to prevent harm to patient.	Identifies some but not all interventions to prevent harm to patient.	Scant list of interventions to prevent harm to patient.

Course Student Learning Outcome #1 Competency:

h. Describe factors that create a culture of caring for the patient and the patient's support network.

QSEN Activity Related to Patient-Centered Care and Caring

Caring Model

- Introduce yourself and explain your role in the patient's care for the day
- Call the patient by his or her preferred name; talk with the patient's support network if members are present.
- Sit with the patient for at least five minutes per shift to discuss the day's care and milestones to cross (best done at the beginning of the shift)
- Use touch, such as a handshake or touch on the arm, or exhibit a caring behavior that is unique to your own personality and approach
- Most important, demonstrate commitment to the care and improvement of the patient's life and hospital stay.

The following sample interview questions will provide the patient with an opportunity to express their agenda, concerns and lead to more patient centered care.

Questions for patient (5 minute sit down)

1. What would you like to see happen today?
2. How would you describe your hospitalization? Is there anything that could be done to make it better?
3. What should nursing students know about what it's like being a patient in the hospital?

After Your "Sit down":

Discuss what happened during your sit down with the patient/patient's support network.

_____

_____

_____

Describe factors from your time with the patient/patient's support network that demonstrate a culture of caring.

_____

_____

_____

_____

Grading Rubric for the Caring Activity

Performance Level	S	NI	U
Able to discuss what happened during sit down.	Thoroughly discusses what happened during sit down.	Explanation includes some but not a complete account of what happened during sit down.	Scant explanation of what happened during sit down.
Able to relate factors from sit down that demonstrated a culture of caring.	Thorough discussion of factors from sit down that demonstrated a culture of caring.	Explanation includes some but not all factors from sit down that demonstrated a culture of caring.	Scant explanation of factors from sit down that demonstrated a culture of caring.

Course Student Learning Outcome #1 Competency:

i. Communicate effectively with the patient and the patient's support network.

Patient Interaction Sheet

Date	Communication Techniques Used with Patient	How the Communication was Effective	How the Communication was Ineffective	Ways I can improve.

Rubric for Patient Interactions Sheet

Performance Criteria	S	NI	U
Identify effective communication skills to use when interacting with patients, significant others, and health care team members.	Clearly describes communication between self and patient. Identifies non therapeutic communication used. Offers at two ways to improve future interactions listing specific therapeutic communication techniques.	Describes communication between self and patient. Identifies non therapeutic communication used. Offers only one way to improve future interactions listing specific therapeutic communication techniques.	Descriptions of communication between self and patient are scant and unorganized. Does not offer ways to improve future interactions.

Course Student Learning Outcome #1 Competency:

j. Communicate effectively when reporting care provided and evaluation data including appropriate handoff reports.

Tool: SBAR patient report

Situation Include basic demographics about your patient; name, ethnicity. age, gender, and pertinent information about the patient's condition/situation. Include patient preferences.	Patient Name: Code Status: VS: Outputs: IVs/fluids: Abnormal/concerns:
Background patient's admitting diagnosis, hospital day, medical history that might complicate her current admission, any data about what has led up to any problems the patient is currently experiencing.	Pertinent background information affecting the patient's current condition. Other history that is also present and may or may not affect current condition but needs to be considered.
Assessment Signs and symptoms that are related to patient's diagnosis, including	Mental Status: Alert and oriented Confused Cooperative or non-cooperative Agitated or combative

vital signs, O2 Sats, and any other pertinent assessment data. Should correlate with the information on the signs and symptoms tools.	Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimuli Skin: Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm Patient is or is not on oxygen: L/min or oxygen for min(hrs) Pulse ox reading What you think the problem is: The pt is Stable, unstable, getting worse
Recommendations Include what you have done and the patient's response.	I suggest that you: Any diagnostic labs/test needed/pending: Need to notify the physician, primary healthcare provider:

SBAR Communication Rubric

Performance Criteria	S	NI	U
Informs responsible staff member of patient status	Clearly completes the SBAR report for a patient. All criteria are documented on and are easy to understand and follow.	Clearly completes portions of the SBAR report for a patient. Some criteria do not have documentation and/or and are not easy to read.	The SBAR report is scant and/or unorganized. It is difficult to understand.

Course Student Learning Outcome #1 Competency:

k. Provide at a fundamental level appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.

l. Evaluate effectiveness of patient teaching.

Patient Teaching Tool (Fundamentals)

Refer to your signs and symptoms tool.

What **teaching** needs to be completed regarding any of the concerns noted on the signs and symptoms tool?

_____
_____
_____
_____
_____

What modifications will you need to make related to your **teaching** methods based on the patient's developmental stage, age, culture, preferences, and level of health literacy?

_____
_____
_____
_____
_____
_____

Was your teaching effective? If so, how do you know? If no, how do you know and what will you do?

Signs and Symptoms Grading Rubric

Performance Level	S	NI	U
Identifies teaching needs.	In depth explanation of patient's learning needs.	Explanation includes some but not all of patient's learning needs.	Brief explanation of patient's learning needs.
Explains modifications to teaching based on patient's developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.	In depth explanation of necessary modifications to teaching based on patient's developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.	Explanation includes some but not all necessary modifications to teaching based on patient's developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.	Brief explanation of necessary modifications to teaching based on patient's developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.
Evaluates effectiveness of teaching.	In depth explanation of effectiveness of teaching.	Explanation includes some but not all issues related to the effectiveness of teaching.	Brief explanation of the issues related to the effectiveness of teaching.

Course Student Learning Outcome #2: Identify the nurse's role in collaborative relationships with members of the interdisciplinary team.

The following pages contain the Clinical Activity Portfolio Tools for Foundations of Nursing , Course Student Learning Outcome #2.

Course Outcome #2 Competency:

a. Explain effective communication techniques that produce positive professional working relations.

Tool: Interprofessional Communication Interaction Sheet

Date	Today I talked with _____ members of the healthcare team.	Information Collected to Evaluate Progress Toward Achievement of Patient Outcomes	Communication Techniques Used that were Effective	Communication Techniques Used that were Ineffective	Ways I can improve to Produce Positive Professional Working Relations.
	Healthcare team member:				
	Healthcare team member:				
	Healthcare team member:				

Rubric for Interprofessional Communication Interaction Sheet

Performance Criteria	S	NI	U
Identify effective and ineffective communication skills to use when interacting with members of the healthcare team.	Clearly describes communication between self and a member of the healthcare team. Identifies effective and ineffective communication techniques used. Offers at two ways to improve future interactions listing specific techniques.	Describes communication between self and a member of the healthcare team. Identifies effective and ineffective communication techniques used. Offers only one way to improve future interactions.	Descriptions of communication between self and other healthcare providers are scant and unorganized. Does not offer ways to improve future interactions.
Information collected related to evaluation of achievement of patient outcomes.	Able to identify patient outcomes and how collected information relates.	Identifies some but not all patient outcomes and able to relate some collected information to them.	Unable to identify patient outcomes and how collected information relates.

Course Outcome #2 Competency:

c. Identify the nurse's role in decision making related to patient care.

Basis for Making Decisions

Activity:
Locate the staff job description for the RN.
Review the California Board of Registered Nursing's scope of practice
Review the ANA's Standards of Practice

Identifies how these three documents relate to the nurse's role in making decisions related to patient care.

Complete the following:

RN Job Description related to decision making for patient care.	Describe the RN's role from the Nurse Practice Act related to decision making for patient care.	Describe the RN's role as outlined in the ANA's Standards of Practice related to decision making for patient care.	Decision making by me or the RN based on professional standards.

Rubric for Basis for Making Decisions

Performance Criteria	S	NI	U
Describe the basis for decision making for the RN based on the job description, nurse practice act, and the ANA Standards of practice.	Clearly describes basis for decision making for the RN based on the job description, nurse practice act, and the ANA Standards of practice.	Provides a superficial description for the basis for decision making for the RN based on the job description, nurse practice act, and the ANA Standards of practice.	Unable to describe the basis for decision making for the RN based on the job description, nurse practice act, and the ANA Standards of practice.
Relates decisions made in patient care to the job description, nurse practice act, and the ANA Standards of practice.	Clearly relates decisions made in patient care to the job description, nurse practice act, and the ANA Standards of practice.	Provides a superficial relationship for decisions made in patient care to the job description, nurse practice act, and the ANA Standards of practice.	Unable to relate decisions made in patient care to the job description, nurse practice act, and the ANA Standards of practice.

Course Outcome #2 Competency:

d. Identify examples of conflict resolution.

Tool: Conflict Resolution on the Clinical Unit

Interview a Nurse and One Other Healthcare Provider to Identify An Area of Conflict on the Unit	Ask Healthcare Professional How the Conflict was Resolved	Observe the Interactions of all the Healthcare Professionals on the Unit	What Conflicts did you Observe and How were they Handled or Not Handled

Two students can spend one day completing the above then reporting in postconference.

Once the postconference activity occurs, students will complete the below each day:

Identify a conflict on the unit and how it was resolved. What did you learn? Discuss with faculty or in postconference.

Rubric for Conflict Resolution

Performance Criteria	S	NI	U
Conflict identified on the unit.	Clearly describes a conflict on the unit.	Description of a conflict on the unit are vague and unclear.	Unable to describe any conflicts on the unit.
Suggestions for how to resolve the conflict.	Clearly and accurately describes solutions for resolving the identified conflict.	Identifies some but not all possible solutions for resolving the identified conflict.	Unable to describe solutions for resolving the identified conflict.

Course Outcome #2 Competencies:

b. Interact with members of the healthcare team to plan patient care and evaluate progress toward patient outcomes.
e. Identify own role as a member of the interdisciplinary healthcare team.
f. Describe ways in which team functioning impacts safety and quality improvement.

Tool: Teamwork Impacting Safety and Quality Improvement Measures

What nursing sensitive quality indicators are used on the unit?	How are unit falls and pressure ulcers tracked?	How are patients identified as being "at risk for falls" & "at risk for skin breakdown"?	What screening tools are used?	What prevention measures and precautions are implemented for those identified as "at risk"?	What is your role as a member of the interdisciplinary healthcare team related to these safety and quality improvement measures?	How does team functioning impact patient outcomes related to these safety and quality improvement measures?

Two students will complete this activity in lieu of a patient care assignment, then report in postconference. After this postconference presentation all students will incorporate this activity into their daily patient care assignments by answering the following questions each day:

1. The prevention measures and precautions I'll implement include:

2. My role on the interdisciplinary team related to these measures.
3. How team functioning impacts patient outcomes related to these safety and quality improvement measures.

Rubric for Teamwork Impacting Safety and Quality Improvement Measures

Performance Criteria	S	NI	U
Identifies prevention and precaution measures.	Clearly describes prevention and precaution measures.	Description of prevention and precaution measures are vague and unclear.	Unable to describe any prevention and precaution measures.
Identifies the nurse's role on the interdisciplinary team related to quality and safety measures.	Clearly and accurately describes the nurse's role on the interdisciplinary team related to quality and safety measures	Identifies some but not all roles of the nurse on the interdisciplinary team related to quality and safety measures	Unable to describe the nurse's role on the interdisciplinary team related to quality and safety measures
Describes how team functioning impacts patient outcomes related to these safety and quality improvement measures.	Clearly and accurately describes how team functioning impacts patient outcomes related to these safety and quality improvement measures.	Identifies some but not all ways team functioning impacts patient outcomes related to these safety and quality improvement measures.	Unable to describe how team functioning impacts patient outcomes related to these safety and quality improvement measures.

Course Student Learning Outcome #3: Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.

The following pages contain the Clinical Activity Portfolio Tools for Foundations of Nursing, Course Student Learning Outcome #3.

Course Outcome #3 Competencies:
a. Identify how critical thinking/clinical reasoning is used to approach patient care.
c. Interpret and correctly implement physician and interprofessional orders.
e. Use the nursing process to make decisions about patient care.

Tool: Patient Care/Nursing Process Critical Thinking Activity

Note: Two students work through this activity over and over on one clinical day in place of a traditional patient care assignment.

Patient Care Critical Thinking Activity

Answer the following:
1. Patient information:
   - Age:
   - Reason for admission:
   - Date of admission:
   - Diagnostic Procedures:
   - Surgical procedure:
   - Diet:
   - Activity:
2. Medications:
   - Drug:
   - Reason why it was prescribed:
   - Therapeutic effects expected:
   - Adverse effects to monitor:

(Complete for all medications prescribed.)
3. Patient history:
   - Important information from history:
   - From the history, the most important data impacting this hospitalization is:
4. Diagnostic tests:
   - Name of test:
   - Why was this test ordered?
   - (Complete for each test ordered.)
5. Problems occurring for this patient during the preceding 24 hours:
   - How were the above problems handled?

Patient Care Critical Thinking Activity

On a separate sheet of paper, answer the following:

6. What specific physician/healthcare provider orders relate to your care today and how will you implement those orders?

7. Was the physician called for any reason? If so, why?
   - What information was gathered prior to notifying the physician?
   - What actions were taken?
8. Potential problems that could occur for this patient:
   - Interventions to prevent the potential problems:
9. Look at the patient's nursing care plan:
   - List the nursing diagnoses:
   - **Prioritize the nursing diagnoses:**
   - How did you determine the order of prioritization of the nursing diagnoses?
   - What are the interventions for the top two nursing diagnoses?
   - **Prioritize those interventions:**
   - Which of these interventions can you delegate to an unlicensed person?
10. Look at the shift report sheets for the past 24 hours. Based on those report sheets, what is the MOST IMPORTANT nursing intervention for you to carry out this shift?
11. Visit the patient and perform a two-minute head-to-toe assessment.
12. Based on your assessment **reprioritize** your nursing diagnoses and interventions if needed. If not, state why they remain the same.
13. If the physician came in at this moment and discharged this patient, what are the most important teaching instructions for this patient?
14. What if.....

(Ask me to complete this question for you to answer.)
Here the teacher poses a "What if" question based on the information the student collected.

Reflection:

Answer the following:

1. What did you learn from this experience?
2. How will you use those lessons learned when caring for patients in the future?

Once the above activity is completed and discussed in postconference, each week students will complete the activity when planning care for their assigned patients and answer the above reflection questions.

Rubric for Patient Care/Nursing Process Critical Thinking Activity

Performance Criteria	S	NI	U
Completes all sections of the tool.	Accurately completes all sections of the tool.	Able to complete some, but not all, all sections of the tool.	Unable to complete all sections of the tool.
Identifies lessons learned from the patient care tool.	Clearly identifies lessons learned from the patient care tool.	Description of lessons learned from the patient care tool are scant.	Unable to describe any lessons learned from the patient care tool.
Discusses ways to use the lessons learned when caring for patients in the future.	Clearly discusses ways to use the lessons learned when caring for patients in the future.	Superficially discusses ways to use the lessons learned when caring for patients in the future.	Unable to discuss ways to use the lessons learned when caring for patients in the future.

Course Outcome #3 Competency:

b. Demonstrate at a fundamental level tolerance for ambiguity and unpredictability and its effect on patient care.

Tool: Parameters for Patient Care

What are the patient's vital signs:
Blood pressure:
Pulse:
Respirations:
Temperature:

What were the highs and lows for the past 24 hours?

What is the patient's activity level?

What medications is the patient taking that affect the vital sign readings?

What medical/nursing interventions is the patient experiencing that may affect the patient's vital signs?

What other factors are influencing this patient's vital sign readings?

How low can each of the readings go before you would intervene? Give your rationale.

How high can each of the readings go before you would intervene? Give your rationale.

Rubric for Parameters for Patient Care

Performance Criteria	S	NI	U
Able to identify all factors influencing the patient's vital signs.	Clearly identifies all factors influencing the patient's vital signs.	Description of all factors influencing the patient's vital signs is scant.	Unable to identify all factors influencing the patient's vital signs.
Able to identify reasonable parameters for vital signs and rationales.	Clearly identifies reasonable parameters for vital signs and rationales.	Superficially discusses reasonable parameters for vital signs and rationales.	Unable to discuss reasonable parameters for vital signs and rationales

Course Outcome #3 Competency:

d. At the fundamental level anticipate risks, and predict and manage potential complications.

Tool: Predict and Manage Potential Complications

For each patient answer these questions based on the nursing theory presented to date:

1. What are you on alert for today with this patient?

2. What are the important assessments to make?

3. What complications may occur? What could go wrong?

4. What interventions will prevent complications?

Students will use this same activity as they go through the program clinical courses. Faculty can then compare their answers from course to course to provide evidence of higher level thinking.

Rubric for Predict and Manage Potential Complications

Performance Criteria	S	NI	U
Based on the nursing theory presented to date able to identify complications that may occur with patient's condition.	Clearly identifies complications that may occur with patient's condition.	Description of complications that may occur with patient's condition is scant.	Unable to identify complications that may occur with patient's condition.
Based on the nursing theory presented to date able to identify interventions to prevent complications.	Clearly identifies interventions to prevent complications.	Superficially discusses interventions to prevent complications.	Unable to discuss interventions to prevent complications.

Course Student Learning Outcome #4: Identify the role of leadership for the purpose of providing and improving patient care.

The following pages contain the Clinical Activity Portfolio Tools for Foundations of Nursing, Course Student Learning Outcome #4.

Course Outcome #4 Competency:

a. Identify how the delegation process is used in the healthcare setting.
Tool: Identifying Delegation Responsibilities

Locate the staff job descriptions for the RN, LVN, and certified nursing assistant.
Bring a copy of the California Nurse Practice Act

Complete the following: **Job Descriptions/Comparison**

Job Title	Job Responsibilities Related to the Delegation Process	Comparison with the California Practice Act	Observations about the Process of Delegation at this Agency

One group of two students will complete this activity in lieu of a patient care assignment. Once the assignment is discussed in postconference all students will answer the following questions each day they care for patients:

1. What activities that you performed today could you delegate and to whom? Explain.

2. Did the RN delegate those activities? Why or why not?

Rubric for Identifying Delegation Responsibilities

Performance Criteria	S	NI	U
Explanation of the patient care activities performed that can be delegated to whom and rationale why.	Clearly explains patient care activities performed that can be delegated to whom and rationale why.	Description of patient care activities performed that can be delegated to whom and rationale why is scant.	Unable to explain patient care activities performed that can be delegated to whom and rationale why.
Explanation about what the RN delegated and did not delegate.	Clearly explains what the RN delegated and did not delegate and why.	Superficially discusses what the RN delegated and did not delegate and why.	Unable to discuss what the RN delegated and did not delegate and why.

Course Outcome #4 Competencies:

b. Describe how the individualized plan of care is implemented in the healthcare setting.
c. Describe the differences in the provision of patient care among various healthcare settings.

Tool: Implementing the Individualized Plan of Care

Complete the following:

Members of the Nursing Care Team	Job Responsibilities Related to Implementing the Individualized Plan of Care	Comparison with Other Healthcare Settings	Observations about the Process of Providing Individualized Care in this Healthcare Setting.

Rubric for Implementing the Individualized Plan of Care

Performance Criteria	S	NI	U
Explanation of implementation of the individualized plan of care.	Clearly explains how the individualized plan of care is implemented.	Description of how the individualized plan of care is implemented is scant.	Unable to explain how the individualized plan of care is implemented .
Comparison with other healthcare settings.	Able to compare the implementation of the individualized plan of care with the process in another healthcare setting.	Superficially discusses the individualized plan of care with the process in another healthcare setting.	Unable to discuss the individualized plan of care with the process in another healthcare setting.

Course Outcome #4 Competency:

d. Describe the effect of the nursing leadership in the healthcare setting.

Tool: Nursing leadership and safe, quality patient care

Read about the different types of nursing leadership styles in your fundamentals book. Identify the nursing leadership positions in the institution. Observe the interactions of the nurse leaders on the unit then complete the table.

Activity:

1. Identify the nursing leadership positions in the institution.
2. Locate the job descriptions for those positions.
3. Observe the interactions of the nurse leaders on the unit then complete the table.
4. This table can be completed over the course of a few weeks.

Complete the following:

Job Title	Major Responsibilities	Observed Interactions with Others: (list, ie, RN, CNA, etc.)	Explain the effect of nursing leadership on improved patient safety and quality care.

Rubric for Nursing Leadership and Safe, Quality Patient Care

Performance Criteria	S	NI	U
Provides accurate observations about the interaction of the nursing staff.	Clearly provides accurate observations about the interactions of the nursing staff.	Explanation of observations about the interactions of the nursing staff is scant.	Unable to explain interactions of the nursing staff.
Explain the effect of nursing leadership on improved patient safety and quality care.	Able to explain the effect of nursing leadership on improved patient safety and quality care.	Superficially discusses the effect of nursing leadership on improved patient safety and quality care.	Unable to discuss the effect of nursing leadership on improved patient safety and quality care.

Course Outcome #4 Competency:

e. At the fundamental level, describe the quality improvement processes in the clinical setting used to effectively implement patient safety initiatives and monitor performance measures.

Tool: See tool for Outcome 1, Competency g. Identify quality measures when evaluating effects of nursing interventions appropriate to the care environment.

Quality Measures

Course Outcome #4 Competency:

f. Describe the use of National Patient Safety Goals in the clinical setting to maintain a safe environment for all patients.

Tool: National Patient Safety Goal Activity

Two students spend one day assessing the environment and at least 3 patients.
Their goal is to look at the environment and these patients from the perspective of the Joint Commission's Patient Safety Goals.
Answer the following questions. Students may use additional paper for each patient.
Report in postconference and discuss with fellow students.

1. What precautions should the nurse take relative to each safety goal for each patient?

2. For each patient, is there a safety goal that is the most important for each of these patients?

3. What information about each of these patients is most important to communicate to the nurse on the next shift?

4. Can the SBAR form be used for this environment or should it be revised? If so, how would you revise it?

5. What factors about the environment indicate these safety goals are being met?

6. Gap Analysis: What factors about the environment indicate a need for change so the safety goals can be met?

Once students have completed this assignment, they incorporate this information into their daily care of patients and answer these questions:
1. What NPSG most applied to this patient?
2. Are the safety goals being met? If not, what will you do to correct the situation?

Rubric for National Patient Safety Goal Activity

Performance Criteria	S	NI	U
Identifies the NPSG most applicable to this patient.	Clearly identifies the NPSG most applicable to this patient.	Scantly identifies the NPSG most applicable to this patient.	Unable to identify the NPSG most applicable to this patient.
Explains if the safety goals are being met, and if not, explains what to do to correct the situation.	Able to explain if the safety goals are being met, and if not, explains what to do to correct the situation.	Superficially explains if the safety goals are being met, and if not, superficially explains what to do to correct the situation.	Unable to explain if the safety goals are being met, and if not, explains what to do to correct the situation.

Course Student Learning Outcome #5: Identify simple examples of information management and how they are used in the clinical environment.

The following pages contain the Clinical Activity Portfolio Tools for Foundations of Nursing, Course Student Learning Outcome #5.

Course Outcome #5 Competency:
a. Maintain organizational and patient confidentiality.

Tool: Organizational and Patient Confidentiality Observation Rubric

Read the agency's policy related to organizational and patient confidentiality.

Observation Rubric

Behavior	Satisfactory	Needs Improvement	Unsatisfactory
Demonstrates adherence to agency policy related to organizational and patient confidentiality.	Applies the agency policy in the care setting with no supporting (verbal/physical) cues.	Requires supporting cues when applying the agency's policy.	Unable to apply the agency's policy in the clinical setting.

Provide examples of how you satisfactorily met this competency each day you cared for patients:

Day 1:

Day 2:

Day 3:

Day 4:

Day 5:

Day 6:

Course Outcome #5 Competencies:

b. Discuss skills used in the clinical area to implement clinical information systems for safe nursing practice.
c. Explain the role of information technology in improving patient care outcomes and creating a safe care environment.

Tool: Technology is more than Charting

This informatics worksheet relates to technology used on the unit including computer charting, but all other types of technology as well.

Type of Technology (list all technology used: computer charting, IV pumps, pulse oximeters, etc.)	**How the Technology is Used**	**Who Accesses the Technology**	**How does the technology contribute to safe, quality care?**

Reflections:
1. Summarize your impression of the importance of technology in patient care.
2. How will you use technology to provide safe patient care?

Rubric for Technology is More than Charting

Performance Criteria	S	NI	U
Summarize your impression of the importance of technology in patient care.	Summary reflects information gathered on the tool.	Scantly summarizes information gathered on the tool.	Unable to summarize information gathered on the tool.
Discuss how will you use technology to provide safe patient care.	Able to discuss how technology is used to provide safe patient care.	Superficially discusses how technology is used to provide safe patient care.	Unable to discuss how technology is used to provide safe patient care.

Course Student Learning Outcome #6: Explain how professional standards, and legal and ethical principles apply to safe, quality, patient-centered nursing care.

The following pages contain the Clinical Activity Portfolio Tools for Foundations of Nursing, Course Student Learning Outcome #6.

Course Outcome #6 Competencies:

a. Apply rules and regulations that authorize and define professional nursing practice.
b Demonstrate professional standards of moral, ethical, and legal conduct.
e. Identify limits and boundaries of therapeutic, patient-centered care.

Tool: Moral, ethical, legal, and professional standards observation rubric
This tool is used to demonstrate application of and moral, ethical, legal, and professional conduct in the care of aging patients in the long-term care setting.

Observation Rubric

Behavior	Satisfactory	Needs Improvement	Unsatisfactory
Demonstrates application of the professional standards of moral, ethical, and legal conduct in the care of patients.	Applies professional standards and moral, ethical, and legal conduct in the care of patients with no supporting (verbal/physical) cues.	Applies some but not all professional standards and moral, ethical, and legal conduct in the care of patients and requires supporting (verbal/physical) cues.	Unable to apply professional standards and moral, ethical, and legal conduct in the care of patients.

Provide examples of how you satisfactorily met these competencies each day you cared for patients:

Day 1:

Day 2:

Day 3:

Day 4:

Day 5:

Day 6:

Course Outcome #6 Competencies:
c. Assume accountability for own behaviors, including a recognition for when to ask for assistance.
d. Practice within the parameters of individual knowledge and experience.

Tool: Accountability Observation Rubric

Behavior	Satisfactory	Needs Improvement	Unsatisfactory
Assumes accountability for personal and professional behaviors, including a recognition of when to ask for assistance and recognizing limits of own individual knowledge and experience.	Assumes accountability for personal and professional behaviors, including a recognition of when to ask for assistance and recognizing limits of own individual knowledge and experience with no supporting (verbal/physical) cues.	Assumes some accountability for personal and professional behaviors, including a recognition of when to ask for assistance and recognizing limits of own individual knowledge and experience requires supporting (verbal/physical) cues.	Unable to assume accountability for personal and professional behaviors, including a recognition of when to ask for assistance and unable to identify limits of knowledge and experience.

Provide examples of how you satisfactorily met these competencies each day you cared for patients:

Day 1:

Day 2:

Day 3:

Day 4:

Day 5:

Merced College
Associate Degree Nursing Program

Registered Nursing 15: Foundations of Nursing

Course Syllabus

4 hours lecture, 15 hours skills lab/clinical

Registered Nursing 15 (Foundations of Nursing) focuses on foundational concepts necessary for safe, patient-centered nursing care to a diverse patient population while integrating legal and ethical responsibilities of the nurse. Introduces critical thinking applied to nursing, the nursing process, diversity, and communication techniques used when interacting with patients and members of the interdisciplinary team, and applies evidence-based nursing practice. Includes acquisition of basic nursing skills. Application of knowledge and skills occurs in the nursing skills laboratory and a variety of acute and long-term care clinical settings.

Registered Nursing 15 Course Outcomes

1. Provide quality, safe, patient-centered nursing care at the basic level.
2. Identify the nurse's role in collaborative relationships with members of the interdisciplinary team.
3. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.
4. Identify the role of leadership for the purpose of providing and improving patient care.
5. Identify simple examples of information management and how they are used in the clinical environment.
6. Explain how professional standards and legal and ethical principles apply to safe, quality, patient-centered nursing care.

Registered Nursing 15 Course Competencies

1. Provide quality, safe, patient-centered nursing care at the basic level.

- Conducts at a basic level a comprehensive and focused physical, behavioral, psychological, spiritual assessment eliciting patient values, experiences, and expressed needs.
- Plans at a fundamental level holistic, patient-centered care that reflects psychosocial integrity, physiological integrity, and health promotion and maintenance within a variety of healthcare systems.
- Delivers compassionate, patient-centered, evidence-based care that respects patient and family preferences.
- Demonstrates at a fundamental level the application of psychomotor skills for the efficient, safe, and compassionate delivery of patient care.
- Delivers care within expected timeframe.

- Monitors at a fundamental level patient outcomes, including interpretation of assessment data and appropriate follow-up, to evaluate the effectiveness of nursing interventions.
- Identifies quality measures when evaluating effects of nursing interventions appropriate to the care environment.
- Describes factors that create a culture of caring for the patient and the patient's support network.
- Communicates effectively with the patient and the patient's support network.
- Communicates effectively when reporting care provided and evaluation data including appropriate handoff reports.
- Provides at a fundamental level appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.
- Evaluates effectiveness of patient teaching.

2. Identify the nurse's role in collaborative relationships with members of the interdisciplinary team.

- Explains effective communication techniques that produce positive professional working relations.
- Interacts with members of the healthcare team to plan patient care and evaluate progress toward patient outcomes.
- Identify the nurse's role in decision making related to patient care.
- Identifies examples of conflict resolution.
- Identifies own role as a member of the interdisciplinary healthcare team.
- Describes ways in which team functioning impacts safety and quality improvement.

3. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.

- Identifies how critical thinking/clinical reasoning is used to approach patient care.
- Demonstrates at a fundamental level tolerance for ambiguity and unpredictability and its effect on patient care.
- Interprets and correctly implements physician and interprofessional orders.
- At the fundamental level anticipates risks and predicts and manages potential complications.
- Uses the nursing process to make decisions about patient care.

4. Identify the role of leadership for the purpose of providing and improving patient care.

- Identifies how the delegation process is used in the healthcare setting.
- Describes how the individualized plan of care is implemented in the healthcare setting.
- Describes the differences in the provision of patient care among various healthcare settings.
- Describes the effect of the nursing leadership in the healthcare setting.
- At the fundamental level, describes the quality improvement processes in the clinical setting used to effectively implement patient safety initiatives and monitor performance measures.

- Applies the National Patient Safety Goals to patients in the clinical setting and identifies any areas in need of improvement.

5. Identify simple examples of information management and how they are used in the clinical environment.
- Maintains organizational and client confidentiality.
- Discusses skills used in the clinical area to implement clinical information systems for safe nursing practice.
- Explains the role of information technology in improving patient care outcomes and creating a safe care environment.

6. Explain how professional standards and legal and ethical principles apply to safe, quality, patient-centered nursing care.
- Applies rules and regulations that authorize and define professional nursing practice.
- Demonstrates professional standards of moral, ethical, and legal conduct.
- Assume accountability for own behaviors, including a recognition for when to ask for assistance.
- Practices within the parameters of individual knowledge and experience.
- Identifies limits and boundaries of therapeutic, patient-centered care.

Registered Nursing 15 Topical Outline

1. Fundamental concepts of quality, safe, patient-centered, evidence-based nursing care
2. Collaboration and communication techniques in nursing practice
3. Critical thinking and clinical reasoning applied to nursing practice
4. Introduction to leadership and management concepts/principles
5. Introduction to information technology
6. Introduction to professionalism and standards of practice

This topical outline will be applied to weekly content.

Required Texts

Deglin, J. & Vallerand, A. (2009). *Davis's drug guide for nurses,* (11th ed.). Philadelphia: FA Davis.

Dillon, P. M. (2007). *Nursing health assessment: Clinical pocket guide*, (2nd ed.). Philadelphia: F. A. Davis.

Malarkey, L. & McMorrow, M. E. (2005). *Saunder's nursing guide to laboratory & diagnostic tests*. St. Louis: Elsevier Saunders.

Potter, P.A., & Perry, A.G. (2013). *Fundamentals of Nursing.* (8th ed.). St. Louis: Elsevier

Whitehead, D. K., Weiss, S. A., & Tappen, R. M. (2010). *Essentials of nursing leadership and management.* (5th ed.). Philadelphia: F. A. Davis.

Unit 1
Introduction to Nursing

Purpose:
This unit introduces the student to the profession of nursing, professional guidelines, and what a nurse does in practice. Basic nursing care is the foundation for all of nursing. Important topics include measuring vital signs, implementing standard precautions, meeting hygiene needs, evidence-based practice, quality improvement, caring, and collaboration. The one major area that all nurses and other healthcare professionals must be always mindful of is safety. Safety is also discussed in this unit and the student is introduced to the National Patient Safety Goals used in healthcare environments.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Provide quality, safe, patient-centered nursing care at the basic level.
2. Identify the nurse's role in collaborative relationships with members of the interdisciplinary team.
3. Identify the role of leadership for the purpose of providing and improving patient care.
4. Identify simple examples of information management and how they are used in the clinical environment.
5. Explain how professional standards and legal and ethical principles apply to safe, quality, patient-centered nursing care.

Unit 1: Major Topics

1. Professional nursing practice
    a. History of nursing and nursing education (Ch 1-5)
    b. Legal and ethical responsibilities (Ch 22 & 23)
    c. Professionalism and standards of practice (Ch 1-5)
2. Diversity
    a. Culture and ethnicity (Ch 9)
    b. Spirituality (Ch 35)
    c. Growth & development (Ch 11-14)
3. Communication in nursing, collaboration, teamwork (Ch 24 & 26)
    a. Documentation
    b. Handoff communication/SBAR reporting
4. Nursing informatics – an introduction
    a. Computers in healthcare
        a. Review of computers as tools, various application types for productivity
        b. Ethical/legal/social issues around computer use
    b. Clinical Paperwork

c. Information Literacy

1) Accessing health resources on the Internet

2) Evaluating web sites and resources as primary and secondary, popular vs. scholarly

3) Electronic databases

Nursing Skills Laboratory

The student will spend the week's laboratory time in the nursing lab at the college. Basic nursing skills will be discussed, demonstrated, and practiced. These skills include:

1. Hand washing
2. Universal precautions
3. Sterile Equipment & Sterile Gloving
4. Vital signs
5. Measuring intake and output
6. Charting I&O and vital signs
7. Practice documentation

Practice the above skills in the nursing skills laboratory.
Return demonstration for vital signs.

Required Reading

1. Potter & Perry, Chapters 1-5; 9; 11-14; 22-26; 35.
2. http://www.qsen.org/news.php#joint-commission-tackles-miscommunication-among-caregivers
3. http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm
4. Sections of the California Nurse Practice Act that governs nursing practice.

Unit 2
The Nursing Process, Critical Thinking
Health History and Physical Assessment

Purpose:
This unit begins with the nursing process. Then, the first step of the nursing process, assessment, is considered in more depth with an overview of taking a health history and conducting a physical assessment. The student will continue to build skill in assessment by addressing in more depth both the history and the physical with each unit in Nursing 15 and all subsequent nursing course throughout the nursing program. Evidence-based nursing practice is also introduced.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Provide quality, safe, patient-centered nursing care at the basic level.
2. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.

Unit 2: Major Topics

1. The Nursing Process (Ch 16-20)
    a. Evidence-based nursing practice (Ch 5)
2. Critical thinking; clinical reasoning (Ch 15)
3. Health assessment (Ch 16 & 30)
    a. Taking a health history
    b. Conducting a physical assessment

Nursing Skills Laboratory

1. Taking a health history
2. Basic physical assessment

Required Reading

1. Potter & Perry, Chapters 5; 15-20; 30.

Unit 3
Safety
Personal Hygiene
Patient Teaching

Purpose:
Safety has become a primary focus of healthcare institutions. It is also a major concept in the nursing curriculum at Merced College. This unit covers basic information about ensuring safety when providing quality patient care. The second major area of content relates asepsis and universal precautions, both important safety measures, when learning about providing personal hygiene. Inherent in all nursing care is patient teaching. Patient teaching is both formal and informal.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Provide quality, safe, patient-centered care.
2. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.
3. Explain professional standards, and legal and ethical principles as they relate to safe, quality, patient-centered nursing care

Unit 3: Major Topics

1. Safety in the environment (Ch 27-29)
2. Personal Hygiene/Asepsis/Universal Precautions (Ch 39)
3. Patient Teaching (Ch 25)

Nursing Skills Laboratory

1. Sterile Equipment & Sterile Gloving
2. Bed making
3. Positioning
4. Bed Bathing
5. Transfers
6. Lifts

Required Reading

- Potter & Perry, Chapters 25; 27-29; 39.
- The Joint Commission's website on National Patient Safety Goals for acute care and long-term care settings: http://www.jointcommission.org/standards_information/npsgs.aspx
- Quality and Safety Education for Nurses: qsen.org

Unit 4
Supporting Physiological Functioning:
Sensory Perception
Pain
Movement

Purpose:
This unit is the first of several that discusses the nurse's role in supporting physiological functioning by introducing the student to three major areas of patient need – sensory perception, pain, and movement. Problems with any of these three can place the patient at risk for injury; therefore, safety is a primary concern when studying sensory perception, pain, and movement.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Provide quality, safe, patient-centered nursing care at the basic level.
2. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.
3. Explain how professional standards and legal and ethical principles apply to safe, quality, patient-centered nursing care.

Unit 4: Major Topics

1. Sensory perception (Ch 49)
2. Pain (Ch 43)
3. Activity and exercise (Ch 38 & 47)

Nursing Skills Laboratory:

1. Mobility
2. Ambulation
3. Wheelchair
4. Gurney
5. ROM
6. Restraints

Required Reading

- Potter & Perry, Chapters 38; 43; 47; 49.

Unit 5
Supporting Physiological Functioning:
Nutrition, Oxygenation, Elimination, Fluids, Electrolytes, and Acid-Base Balance

Purpose:
This unit continues the discussion of supporting normal physiological functioning addressing nutrition, oxygenation, elimination, fluids, electrolytes, and acid-base balance. These discussions provide a framework and basis for higher level courses that discuss the nurse's role in caring for patients with alterations in these physiological processes.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Provide quality, safe, patient-centered nursing care at the basic level.
2. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.
3. Explain how professional standards and legal and ethical principles apply to safe, quality, patient-centered nursing care.

Unit 5: Major Topics

1. Nutrition/Diet Therapy (Ch 44)
2. Oxygenation (Ch 40)
3. Bowel Elimination (Ch 46)
4. Urinary Elimination (Ch 45)
5. Fluids (Ch 41)
6. Electrolytes (Ch 41)
7. Acid-base balance (Ch 41)

Nursing Skills Laboratory

1. Catheterization
2. Gavage, lavage NG Feedings
3. Enemas
4. O2 Therapy
5. Airways
6. Suctioning (non-sterile)

Required Reading

- Potter & Perry, Chapters 40-41; 44-46.

Unit 6
Supporting Psychosocial Functioning

Purpose:
This unit discusses the nurse's role in supporting psychosocial functioning by introducing the student to major factors affecting psychosocial health. Support systems are also introduced in this unit as a means for assisting patients to cope psychologically with various illnesses and situations they encounter. Problems with, or lack of, these support systems can place the patient at risk for illness and injury.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Provide quality, safe, patient-centered nursing care at the basic level.
2. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.
3. Explain how professional standards and legal and ethical principles apply to safe, quality, patient-centered nursing care.

Unit 6: Major Topics

1. Psychosocial health and illness (Ch 6; 10; 33)
2. Loss, grief, and dying (Ch 36)
3. Stress and adaptation (Ch 37)
4. Sleep and rest (Ch 42)

Nursing Skills Laboratory

1. IV Monitoring, IV DC, Tube Maintenance
2. Application of Heat and Cold

Required Reading

- Potter & Perry, Chapters 6; 10; 33; 36-37; 42.

Unit 7
Wound Care
Advanced Concepts of Nursing

Purpose:
This unit addresses the final physiological topics for the course, that of wound care and first aid then health promotion. It then turns the student's attention to higher level concepts of nursing theory and research, leadership and management, delegation, and quality improvement.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Provide quality, safe, patient-centered nursing care at the basic level.
2. Identify the nurse's role in collaborative relationships with members of the interdisciplinary team.
3. Demonstrate critical thinking/clinical reasoning when providing basic nursing care to patients from diverse backgrounds.
4. Identify the role of leadership for the purpose of providing and improving patient care.

Unit 7: Major Topics

1. Wound Care and First Aid Measures (Ch 48)
2. Nursing theory and research; evidence-based nursing (Ch 4-5)
3. Leadership and management (Ch 21)
4. Quality improvement (Ch 6)

Nursing Skills Laboratory:

1. Bandages
2. TEDS
3. Binders & Dressings

Required Reading

- Potter & Perry, Chapters 4-6; 21; 48.
- Whitehead, Weiss, & Tappen, Chapters 9, and 10
- http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/PatientSafetyQuality/Research-Measurement/The-National-Database/Nursing-Sensitive-Indicators_1.aspx

Student Clinical Objectives

I. **Nursing Process**

Assessment

- Establish preparation following review of chart, care plan, and textbooks. Be able to convey the information in both verbal and written formats.**
- Be able to explain with assistance: **
  - ✓ the relationship between the client's course of treatment and nursing care needs.
  - ✓ nursing implications of normal lab, and diagnostic tests.
  - ✓ oral medications and nursing implications.

Nursing Diagnosis

- Select nursing diagnoses on the basis of data collection.

Planning

- Collaborate with staff, client, and faculty in establishing short-term client goals and interventions utilizing standardized care plans.

Implementation

- Implement interventions in response to client needs.
- Demonstrate 1st semester nursing skills. **
- Complete skills check requirements (green) for semester. **
- Administer medications competently. **

Evaluation

- Determine the effects of nursing interventions on the status of the client.

II. **Leadership & Teamwork**

- Establish priorities in planning, organizing, and completing basic care according to the needs of one assigned client. **

III. **Communication**

- Communicate verbally and in writing, assessments and client responses to care. **
- Report promptly abnormal or unclear information to appropriate health care team member and instructor. This includes absences. **

IV. **Client Education**

- Demonstrate basic interviewing skills when informing the client about his health status.
- Assess clients understanding of course of treatment and nursing care.

V. **Professional Accountability**

- Is prepared for clinical activities and aware of objectives to be accomplished. **
- Utilize and integrate theoretical knowledge in delivering client care. **
- Demonstrate the ability to problem solve and use the nursing process. **
- Practice within the ethical and legal framework of nursing, including client confidentiality. **
- Work within established school/agency goals and policies. **
- Recognizes own interactive behavior and use constructive criticism and suggestions for improving nursing practice. **
- Provide for physical and psychological safety of client. **

** **Critical Elements**

Critical Elements Level I

A. **Overriding Critical Elements** – Failure of an overrding area will result in termination and failure of the particular skill being tested. This criterion is applied to every skill.
   1. Adherence to agency and Merced College RN Student Policy. (Merced College RN Student Policy is primary).
      a. Standard Precautions:
         1) Applies standard/universal precautions to all procedures.
         2) Recognizes appropriate barrier precautions for potential exposure.
         3) Physical Well-being: Any action or inaction on the part of the student which threatens the client's physical well-being.
         4) Checks the physician's order when applicable.
         5) Identifies the client.
         6) Maintains a safe environment.
         7) Assessment and reassessment of client.
         8) Uses equipment safely and appropriately.
         9) Knows emergency procedures and equipment in clinical setting.
   2. Emotional Well-being: Any action or inaction on the part of the student which fosters the client's emotional well-being;
      a. Introduces self.
      b. Explains procedure and client's role.
      c. Provides privacy.
      d. Maintains professional caring role, i.e., communication.
   3. Medical Asepsis:
      a. Protects self from contamination (i.e., personal protective equipment).
      b. Protects client from contamination (i.e., handwashing).
      c. Disposes of contaminated material in designated containers.
      d. Confines contaminated material to contaminated area.
   4. Documentation:
      a. Documents nursing action and client response in a timely manner.
   5. Teaching Learning:
      a. Assesses barriers to learning.
      b. Provides teaching based on client learning needs.
      c. Evaluates client response and documents.

B. Application of the Nursing Process Incorporating Nursing Judgment
   1. Assesses the client on an ongoing basis using a systematic data collection approach to determine the client's current health status and evaluate present and post coping patterns.
   2. Prepares in advance for each clinical experience.
   3. Completes a physical assessment on all clients across the lifespan.
   4. Plans client care needs based on assessment findings and care priorities.
   5. Develops a written care plan on each client.
   6. Implements client care.
   7. Evaluates client response to care.

C. **Skill Specific Critical Elements** – Failure of a skill specific critical element will result in termination and failure of a particular skill being evaluated.
   1. Charting:
      a. Observes legal requirements of charting.
      b. Applies the nursing process in charting.
      c. Records information pertinent to the client's condition and nursing care.
   2. Medication Administration: The administration of drugs by any route.
      a. Identifies drug incompatibilities and allergies.
      b. Identifies correct landmarks.
      c. Follows the Rights:
         1) Right patient;
         2) Right drug;
         3) Right route;
         4) Right time;
         5) Right dose;
         6) Right documentation;
         7) Right action/purpose;
         8) Right form;
         9) Right response;
         10) Verifies allergies.
      d. Verbalizes precautionary measures before administration, including anticipated side effects, drug interactions, and nursing implications.
      e. Performs appropriate assessments and reassessments.
      f. Uses equipment safely and appropriately.
      g. States rationale for correct antidote.
      h. Assesses client knowledge of medication and provides appropriate instruction.
   3. Neuro Check:
      a. Assesses and reassesses level of consciousness and orientation.
      b. Evaluates motor response.
      c. Evaluates sensory response.
   4. Fluid Assessment:
      a. Follows the elements in item C2 for medication administration.
      b. Site Care:
         1) Insures patency.
         2) Follows agency policy for site care.
         3) IV Site Assessment every hour and prn..
         4) Documents site care.
   5. Intake and Output:
      a. Monitors, records, and reports intake and output.
   6. Mobility:
      a. When moving or positioning client, maintains proper body alignment and self and client.
      b. Observes safety regarding equipment when moving or positioning client.
      c. Evaluates nerve and blood supply to affected area (e.g., neuro-circulation checks).
   7. NG Tube/Gastrostomy Tube:
      a. Feeding
         1) Assesses and reassesses for correct placement.
         2) Checks residuals every 2 – 4 hours and prn.
         3) Secures tube.

4) Flushes tube before and after medication administration.

b. Skin Care:
   1) Assesses and Reassesses skin integrity.
   2) Washes with soap and water unless contraindicated.
   3) Rinses and dries all areas.

c. Decompression
   1) Assesses and reassesses correct placement.
   2) Assures correct suction level.
   3) Assures the patency of the NG Tube.

d. Irrigation: The introduction and return of irrigant.
   1) Uses correct solution at appropriate temperature.
   2) Controls flow (rate and volume) of solution.

8. Oxygenation:
   a. Positions client to facilitate respirations.
   b. Assures correct oxygen delivery.
   c. Skin Care:
      1) Assesses and reassesses skin integrity.
      2) Washes with soap and water unless contraindicated.
      3) Rinses and dries all areas.
9. Surgical Asepsis-Sterile Technique:
   a. Maintains sterile field.
   b. Applies principles of sterile technique throughout the procedure.
10. Urinary Catheter:
   a. Applies Sterile Technique:
      1) Maintains sterile field.
      2) Applies principles of sterile technique throughout the procedure.
   b. Assesses and reassesses proper placement.
11. Vital Signs:
   a. Measures records and reports accurately:
      1) +/-0.2 degrees for temperature
      2) +/-2 mm Hg for blood pressure
      3) +/-2 beats/minute for apical pulse
      4) +/-1 respirations/minute
12. Wound Care:
   a. Maintains medical asepsis
   b. Maintains surgical asepsis-sterile technique
13. Blood Glucose Monitoring:
   a. Uses equipment correctly and efficiently.
   b. Cleanses client's finger per policy.
   c. Dons clean gloves.
   d. Collects adequate blood sample and assure homeostasis.
14. Written Care Plan:
   a. Every client will have a care plan based on the nursing process. The student will develop and/or update the care plan based on client data and assessment.
15. Pain Management:
      a. Assesses the client's pain on a scale of 1-10 (0 = no pain, 10 = pain).
      b. Informs the client of possible pharmaceutical and non-pharmaceutical methods of pain control.
      c. Encourages client to participate in goal setting of pain management.
      d. Evaluates and documents interventions and client's ongoing response.

16. Subcutaneous Medication Administration:
    a. Follows all the guidelines set forth in item C2.
17. Intramuscular Medication Administration:
    a. Follows all the guidelines set forth in item C2.
18. Surgical Asepsis/Sterile Technique:
    a. Maintains sterile field.
19. Naso-pharyngeal and oropharyngeal suction:
    a. Provides adequate oxygenation.
    b. Verifies patency of suction and appropriate level of suction.
    c. Inserts catheter only to pharyngeal area.
    d. Maintains a patent airway.
    e. Fosters physical well-being.
20. Ostomy Care:
    a. Assess and reassesses skin integrity.
    b. Cleans skin and changes pouch when leaking.
    c. Applies bag and wafer correctly.
    d. Maintains integrity of the system by emptying when 1/3 – 2 full, and or client request.
    e. Monitors output.
    f. Assesses and reassesses stoma.
    g. Monitors input and output.

Important Student's Note

Please **Do Not Expect** to perform a return demonstration unless you have viewed the associated videos and CD's and practiced the assigned skill several times to the point of mastery. You and another student will practice and sign off each other's checklist indicating successful practice of this skill. **You will be expected to perform the skills with a level of expertise and competency equal to that performed by employable RN's.** You and your instructors are **Legally Liable** for the level-of-care given to patients in the clinical setting.

After successfully completing the objectives of the return demonstration, the instructor or mentor will sign and date your performance checklist and initial your performance checklist and initial your check-off book. These cards are used by your clinical instructors each week prior to assignments of patients. For example: if you have completed **Hand Washing, Bed Making,** but have not yet completed **Bed Bath**, you would be assigned a patient who is not ambulatory so assistance will be needed in bathing. **You will not be assigned, nor should you accept an assignment that requires care beyond the level of procedures that you have completed in simulated in lab return demonstrations.** Each time you perform a skill in the clinical area, you should document on your skill book and have your clinical instructor initial. When your instructors feel you are proficient in the skill, they will date and sign the far right column. With your instructors' permission, you may then be allowed to perform those skills independently.

If you are unable to complete the objectives of the return demonstration satisfactorily, you will not be allowed to retest the same day. Open skills lab time is available each week for practice. Retesting will be done the following week as time allows, after the current week's skill has been completed. Retesting may be done by the lab instructor. Skills may not be performed in the clinical setting until competency is established in the lab.

To summarize:

Utilization of Simulated Lag for Return Demonstrations

1) View required media and/or instructor video demonstration and lecture (see syllabus for requirements).

2) Read pertinent theory for applicable principles.

3) Assemble equipment (bring skills supply bag) needed in laboratory and practice the procedure to master (either individually or with other students). Seek feedback from lab instructor if assistance is needed for clarification.

4) When you have successfully accomplished the demonstration, the instructor or mentor will sign and date your performance checklist and initial skills book.

5) If your return demonstration was not satisfactory, you will need to review specific areas (skills and/or knowledge) and then repeat the return demonstration with the instructor the following week.

6) There may be mini quizzes throughout the semester. Your grade will be based on criteria identified in your syllabus. Patient safety is deemed essential for each

and every procedure; any activity which places a patient in any kind of jeopardy, whether it is physical or psychological, is considered unsatisfactory or failing. The following ground rules will be mutually acknowledged by the student and the mentor during the lab practicum:

a. The burden of "proof of competency" rests with the student, not the evaluator.
b. It is the student's responsibility to make ***overt*** and ***explicit*** points being demonstrated. The mentor/instructor is not to cue, prompt, question, or remind the student during the demonstration.
c. A mistake or error in performance may be corrected with penalty if:
    - The student recognizes and describes the error without prompting or cues and appropriately solves the problem.
    - The subsequent action is appropriate.
    - It is the student's responsibility to make sure that the mentor/instructor sees and hears the points the student is demonstrating or verbalizing.

Feedback on Performance

They suggest these guidelines:

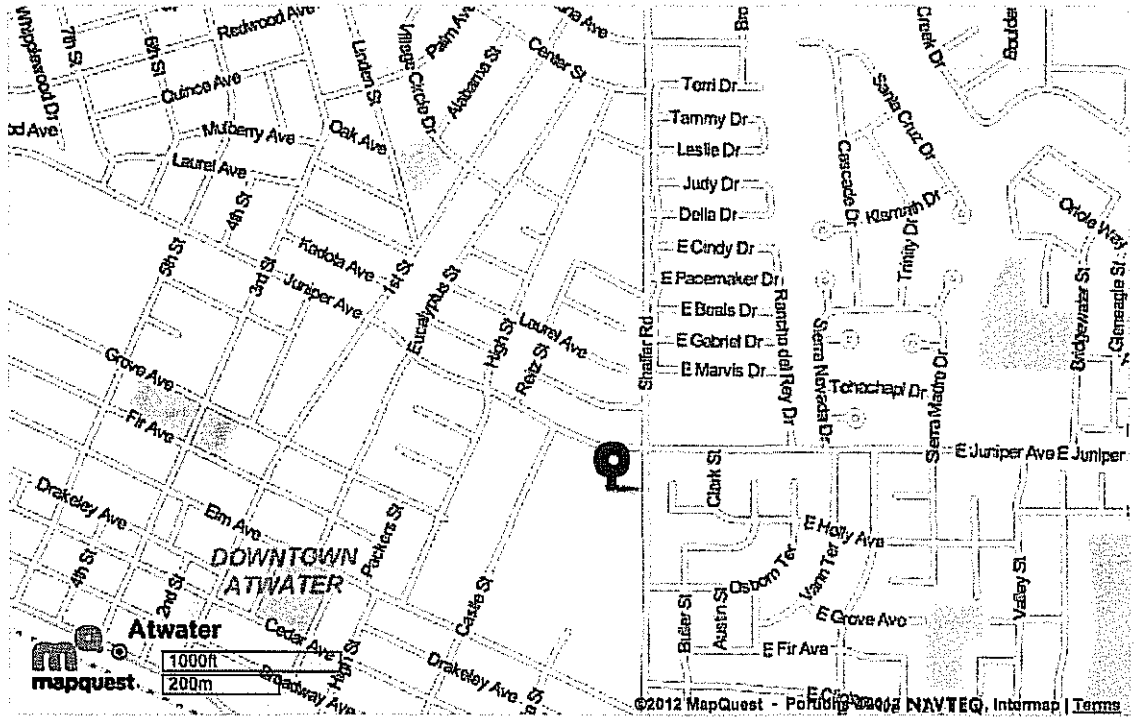
1. *Feedback is a gift.* Consider others' reactions to be a gift, requiring a commitment and effort from the giver.
2. *Giving feedback is a risk.* So thank and reassure the giver.
3. *Perception is a reality.* Accept the impact of your behavior as the other's reality. You don't have to agree with it.
4. *Distinguish impact and intent.* Focus on being curious about your impact, not defensive about your presumed intent.
5. *Lock for the "germ of truth".* Adopt a "what can I learn from this?" posture.
6. *Check your understanding.* Paraphrase to verify what you hear and clarify anything you're unsure about.
7. *Put the message in perspective.* The feedback relates to just one aspect of your behavior, not your worth as a person.
8. *Assume good intent.* Assume the giver values and wants to improve your relationship, even if the feedback expresses temporary dissatisfaction.
9. *Separate consideration from action.* Take time to think about what's been said before reacting.
10. *Be responsible for yourself.* You decide how much you can take, at what rate, and what you will do with the information.
11. *First impressions are valid.* Don't dismiss first impressions from new people because "they don't really know you yet". First impressions are important, and they provide some useful data you wouldn't otherwise have.

Written and Practice Skills Exam

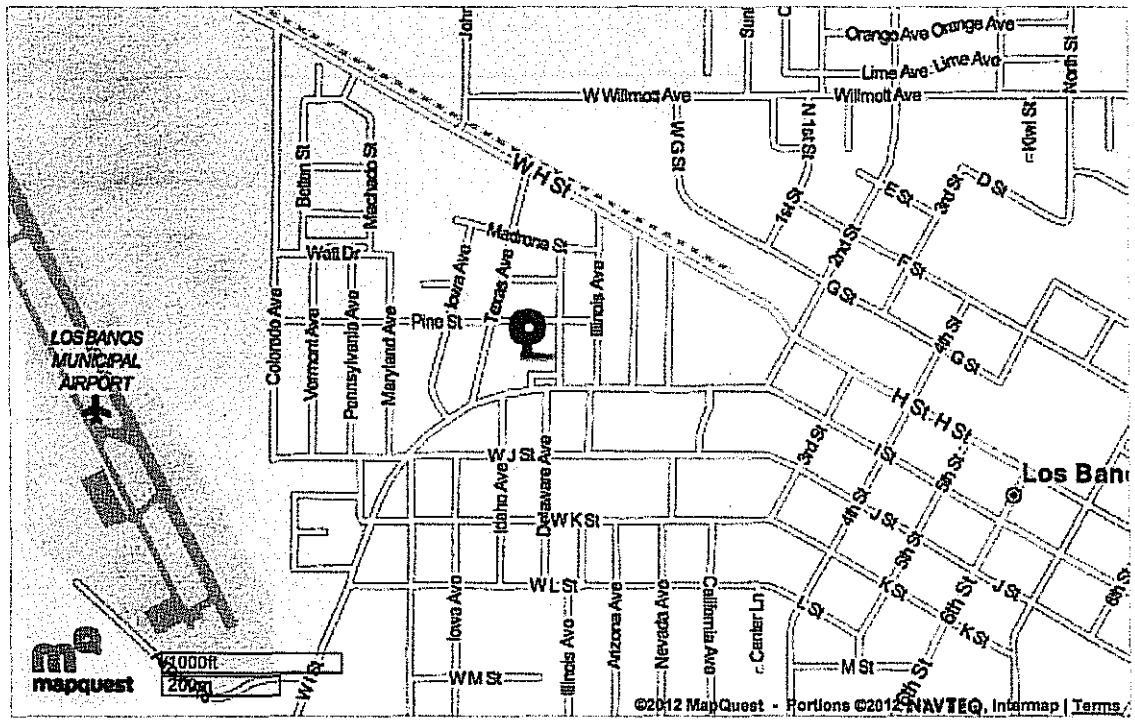
There is one Practical Skills Exam at week 5 prior to going to clinical. Students must pass Skills Exam with a minimum of **75%. Failure of the student to pass the Skills Exam with a minimum of 75% will result in the student not being permitted in the clinical area and MAY result in probation and/or dismissal from the RN Program.**

Clinical Site Maps

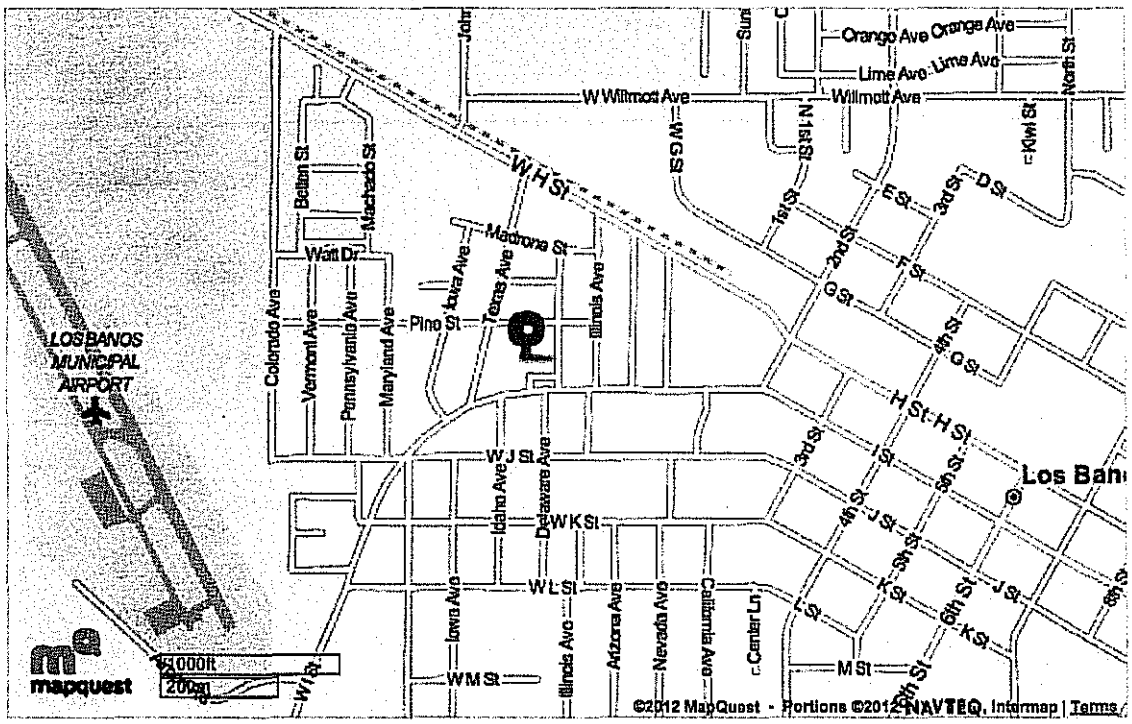
Annberry Rehabilitation Hospital
1685 Shaffer Rd.
Atwater, CA 95301
209-357-3420



Mercy Medical Center
333 Mercy Ave.
Merced, CA 95340
209-564-5000



Memorial Hospital Los Banos
520 West "I" St.
Los Banos, CA 93635
209-826-0591



Clinical Guidelines

I. Your clinical prep varies based on the clinical site. After the fifth week, you will select your patient based on established criteria.

II. After obtaining your patient assignment, you are to research the information you need in order to complete a nursing care plan for your client. ***When researching, you are to dress in business dress with a white lab coat and your name tag visible.*** You must come prepared to clinical with the following: Patient Care Plan Pages 1 & 2 researched thoroughly and Signs & Symptoms with the primary and secondary diagnoses. To organize your thought for AM report you are to complete the AM Report. For each clinical day you **MUST** bring your Skills Booklet with you to be considered prepared for the clinical day. Failure to bring the Skills Booklet requires that you return home to get it or forfeit your clinical day and make up the time in the skills lab if possible.

III. In the morning of each clinical day you must be prepared to give a morning report on your client from all the data you have gathered from your assessment. This report is not to exceed 5 minutes and consist of the clients name, age, sex, code, status, allergies, past medical history, current medical diagnosis, ADL status, nursing interventions for the signs and symptoms of the medical diagnosis, chosen NANDA nursing diagnoses in relation to signs and symptoms from the primary and/or secondary diagnoses, and relevant laboratory findings and diagnostic study.

IV. You must be prepared to perform nursing procedures for which you have been checked off. These are recorded in your Skills Booklet. Skills will be performed in front of your clinical instructor. Under no circumstances are you to perform any skills, unless under the supervision of your clinical instructor/clinical assistant, until you are signed off as being proficient to perform without supervision or as indicated by your instructor. Even after being signed off as proficient, no skill is to be performed without notifying your instructor/assistant first.

V. Each clinical day you are to perform a daily LPAT assessment. during the semester, your LPAT is to be observed by the instructor/assistant just as the other skills to be checked off as proficient.

VI. Your clinical instructor is available to supervise procedures.

VII. REGN 15 – See Course Description, Student Learning Outcomes and Competencies, Clinical Evaluation Tool and Clinical Activities Portfolio for assignments.

Quick Chart Review

Face sheet – age, sex, marital; status/significant other, religion, occupation, residence, next of kin and address, allergies, and insurance status.

Physician's orders – admitting diagnosis, date of admission, current orders regarding: diet, activity, frequency of vital signs, daily weights, treatments, medications, diagnostic test ordered, IV therapy, and therapies ordered, i.e., -PT, OT, Respiratory.

Nurse's notes – status during last 24 hours.

Physician's progress notes – findings of last few days; status of problems.

Graphic Sheet – Temperature, pulse, respiration, & blood pressure patterns, weight, I & O record, bowel pattern, $Pa0_2$ patterns, pain level

Medication Administration Record (MAR) – medications given, frequency of PRN medications and allergies.

Physician's patient history and physical – current complaint, chronic problems, physical finding abnormalities, allergies, impressions, and plan for treatment.

Surgery operative report – procedure done; organs removed; type of incision, drains or equipment in place, blood loss, and problems during surgery.

Discharge summary – summary of the problems the patient had, how they were resolved, and plan of care after discharge.

Pathology report – presence of malignancy or infection.

Current diagnostic test – check for abnormal findings: CBC, UA, blood chemistries, x-ray films, culture and sensitivity, EKG, and other tests.

Nursing admission history and assessment – reason for hospitalization, smoking status, alcohol consumption status, last BM, special dietary requirements, use of aids or prostheses (hearing aid, glasses, artificial limb), medications taken regularly, identification of significant other, previous surgeries or hospitalizations, baseline vital signs, and physical abnormalities.

Nursing care plan or problem list – patient's nursing diagnoses and interventions.

Laboratory Data – Results of blood tests

Radiology/X-Ray – Impressions and interpretations of radiological procedures

Consultations, Etc. – Impressions and treatment plans of physicians invited to contribute to a special condition or problem.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Objective: Apply the principles of confidentiality in the provision of care.

Overview:

- *First federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers*
- *Effective April 14, 2003*
- *Developed by the Department of Health and Human Services (DHS)*
- *Provide patients with access to their medical records and more control over how their personal health information is used and disclosed*
- *Designed to encourage electronic transactions and also required new safeguards to protect the security and confidentiality of health information*

Patient Protections

- **Access to Medical Records**. Able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes. Access to be provided within 30 days of the request & may include charges for the cost of copying and sending the records.
- **Notice of Privacy Practices**. Covered entities must provide notice to patients how they may use personal medical information & their rights under the new privacy regulation. This is usually handled with a disclosure statement signed by the patient.
- **Limits on Use of Personal Medical Information**. Personal health information generally may not be used for purposes not related to health care & covered entities may use or share only the minimum amount of protected information needed for a particular purpose. A specific authorization is required before a covered entity could release medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to health care.
- **Prohibition on Marketing**. Covered entities must obtain an individual's specific authorization before disclosing their patient information for marketing. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.
- **Stronger State Laws**. The federal law provides a baseline for privacy & is superseded by stricter state laws when in place. When a state law requires a certain disclosure – such as reporting an infectious disease outbreak to the public health authorities – the federal privacy regulations would not preempt the state law.
- **Confidential communications** – Patients can request that doctors, health plans and other covered entities take reasonable steps to ensure that communications with them are confidential.
- **Complaints**. Complaints can be made to the covered provider or health plan or HHS' Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation. Information about filing complaints should be included in each covered entity's notice of privacy practices.

Health Plans and Providers

- **Written Privacy Procedures**. Must have written privacy procedures, including a description of staff that has access to protected information, how it will be used and when it may be disclosed. Covered entities generally must take steps to ensure that any business associates who have access to protected information agree to the same limitations on the use and disclosure of that information.
- **Employee Training and Privacy Officer**. Covered entities must train employees in their privacy procedures & must designate an individual responsible for ensuring the procedures are followed. If violated the entity must take appropriate disciplinary action.
- **Public Responsibilities**. Permitted disclosures include: emergency circumstances identification of the body of a deceased person, or the cause of death; public health needs; research that involves limited data or has been independently approved by an institutional Review Board or privacy board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; & activities related to national defense and security. The rule generally establishes safeguards & limits on these disclosures.
- **Equivalent Requirements for Government**. Rules generally apply equally to private sector and public sector covered entities.

Enforcement

- **Civil and Criminal Penalties.**
    - Civil violations of the standards:
        - Penalties up to $100 per violation, up to $25,000 per year, for each requirement or prohibition violated.
    - Criminal penalties:
        - Apply for certain actions such as knowingly obtaining protected health information in violation of the law.
        - Up to $50,000 & one year in prison for certain offenses; up to $100,000 & up to five years in prison if the offenses are committed under "false pretenses"
        - Up to $250,000 & up to 10 years in prison if the offenses are committed with the intent to sell, transfer or use protected health information for commercial advantage, personal gain or malicious harm.

To learn more visit: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

Last revised: April 14, 2003

U.S. Department of Health & Human Services – 200 Independence Ave., S.W. – Washington, D.C., 20201

Confidentiality

- ✓ Confidentiality is the duty to respect privileged information.
- ✓ it is a basic ethical principle that ensures a client's privacy.
- ✓ You are <u>legally</u> bound to keep client information confidential.
- ✓ **It is ground for dismissal from the program to not adhere to confidentiality.**
- ✓ Read your RN Handbook!
- ✓ Avoid discussing the client's condition with anyone who is not involved in the case.
- ✓ Do not share client's records with anyone outside of the hospital.
- ✓ Do not tell information the client does not want told: even if you think others have the right to know. (e.g. clients with AIDS and family does not know but will be caring for client. You can't tell the client's family, just encourage the client to discuss it with them).
- ✓ Use client's initials **<u>ONLY</u>** on your paperwork.
- ✓ No calling up other students in class and telling them about your patient.
- ✓ Be careful walking in hallways, no talking about patients.
- ✓ If you have a question about your duty/ethical responsibility with a client., please ask the instructors!

Geriatric Experiences – Resident Rights

You have the right to exercise your rights, free of interference and coercion, discrimination, and reprisal.

You have the right to be informed of all rules and regulations governing resident conduct, care and responsibilities during your stay in the facility.

You have the right to manage your financial affairs.

You have the right to choose your physician and to be informed about your care.

You have the right to personal privacy and confidentiality.

You have the right to voice grievances without discrimination or reprisal.

You have the right to examine the most recent State Survey.

You have the right to refuse to perform services for the facility.

You have the right to send and promptly receive mail that is unopened.

The facility must provide reasonable access to you by an entity or individual that provides health, social, legal or other services.

You have the right to reasonable access tot the use of a telephone.

You have the right to maintain and use your personal possessions.

You have the right to share your room with your spouse.

You may self-administer your medications, if this practice has been determined safe.

You have the right to be notified of transfers and discharges.

You have the right to be free from any physical and chemical restraints not required for your medical condition.

You have the right to be fee from verbal, sexual, physical and mental abuse.

You have the right to choose your activity schedules, and to interact with members of the community.

You have the right to participate in social, religious, and community activities.

An Old Lady's Poem

What do you see, nurses, what do you see?
What are you thinking when you're looking at me?
A crabby old woman, not very wise,
Uncertain of habit, with faraway eyes?
Who dribbles her food and makes no reply
When you say in a loud voice, "I do wish you'd try!"

Who seems not to notice the things that you do,
And forever is losing a stocking or shoe....
Who, resisting or not, lets you do as you will,
With bahting and feeding, the long day to fill....
Is that what you're thinking? Is that what you see?
Then open your eyes, nurse; you're not looking at me.

I'll tell you who I am as I sit here so still,
As I do at your bidding, as I eat at your will.
I'm a small child of ten...with a father and mother,
Brothers and sisters, who love one another.
A young girl of sixteen, with wings on her feet,
Dreaming that soon now a lover she'll meet!

A bride soon at twenty – my heart gives a leap,
Remembering the vows that I promised to keep.
At twenty–five now, I have young of my own,
Who need me to guide and a secure happy home.
A woman of thirty, my young now grown fast,
Bound to each other with ties that should last.

At forty, my young sons have grown and are gone,
But my man's beside me to see I don't mourn.
At fifty once more, babies play around my knees,
Again we know children, my loved one and me.
Dark days are upon me, my husband is dead;
I look at the future, I shudder with dread.

For my young are all rearing young of their own,
And I think of the years and the love that I've known.
I'm now and old woman....and nature is cruel;
'Tis just to make old age look like a fool.
The body, the crumbles, grace and vigor depart,
There is now a stone where I once had a heart.

But inside this old carcass a young girl still dwells,
And now and again my battered heart swells.
I remember the joys, I remember the pain,
And I'm loving and living life over again.
I think of the years....all too few, gone to fast,
And accept the stark fact that nothing can last.

So open your eyes, nurses, open and see.
Not a crabby old woman; look closer....see ME!

Anonymous

Vital Signs

Skill of the Week Objectives and Activities
• Identify when vital signs should be taken. • Explain the principles and mechanisms of thermoregulation. • Identify steps used to assess oral, rectal, axillary, and tympanic membrane temperature. • Explain the physiology for normal regulation of TPR and BP (values from text). • Identify steps used to assess TPR and BP. • Identify normal vital sign values for an adult. • Accurately obtain and record vital sign measurements. • Be able to show the following pulse points: corotid, apical, brachial, radial, ulnar, femoral, popliteal, dorsalis pedis, posterior tibial.

Temperature
Normal range_____ to _____
Assess activities prior to taking temperature (what actions may affect result)

_____

_____

_____

Pulse Characteristics
Assess activities prior to taking pulse (what actions may affect result)

_____

_____

_____

Quality	Rate	Volume	Rhythm
Feel, it's rhythm and forcefulness Good-fair-bad	Normal_____-_____ bpm Bardycardia<_____bpm Tachycardia>_____bpm Pulse deficit: apical>radial	Force exerted by the ejected blood against the arterial wall with each contraction 0 Absent 1+ weak and thready 2+ normal 3+ bounding	Regular or irregular Dysrhythmia/ arrhythmia: irregular heart beat

Respirations
Normal range_____ to _____
Assess activities prior to taking respirations (what actions may affect result)

_____

_____

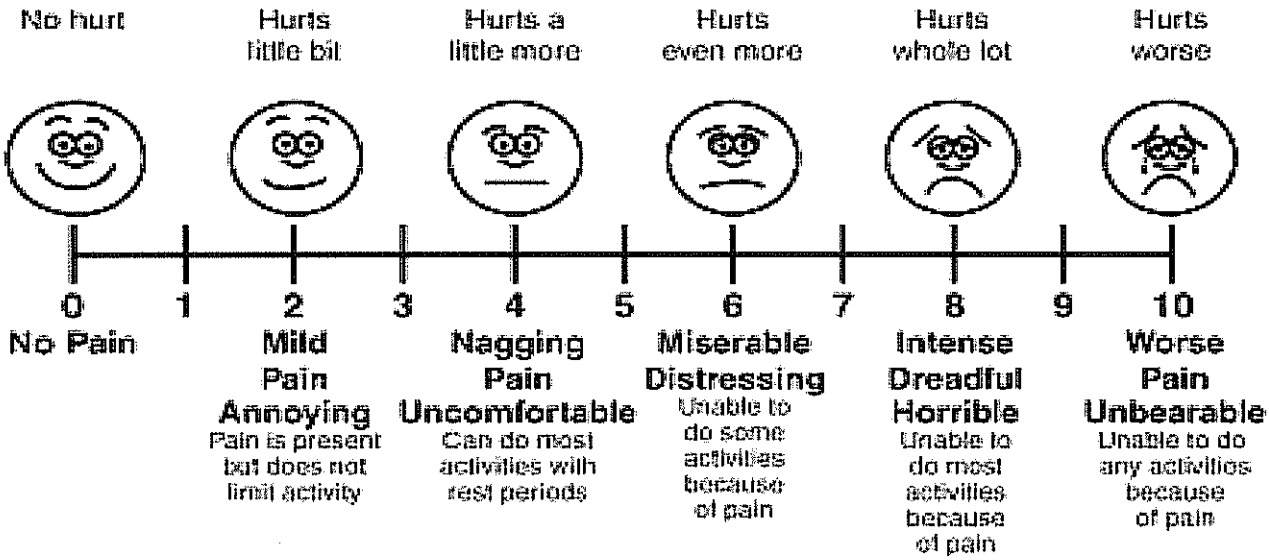
_____

Blood Pressure Characteristics
Assess activities prior to taking pulse (what actions may affect result)
Normal: _____Systolic/ _____Diastolic _____

_____

Basic Pain Assessment

- Acute Pain: Sudden onset and short duration (≤ 6 months)
- Chronic Pain
  -Long-term (≥ 6 months)
  -Persistent, constant, or recurring pain that produces negative changes in life
- Pain assessment Tool (0 – 10)
- Wong-Baker pain tool
- Key questions to ask: Intensity, location, onset, duration, variation, quality



Procedure Checklist
Assessing Body Temperature

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Selects the appropriate site and thermometer type.			
2. Inserts the thermometer in the sheath or uses a thermometer designated only for patient.			
3. Inserts in chosen route/sit. a. *Axillary*: Dries axilla; places the thermometer tip in the middle of the axilla; lowers patient's arm.			
b. *Oral*: Places the thermometer tip under the tongue in the posterior sublingual pocket (right or left of frenulum). Asks patient to keep lips closed.			
c. *Rectal*: Dons procedure gloves; lubricates thermometer; uses rectal thermometer; inserts 2.5-3.7 cm (1-1.5 in.) in an adult; 2.5 cm (0.9 in.) for a child, and 1.5 cm (0.5 in.) for an infant. Holds rectal thermometer securely in place; does not leave patient unattended.			
d. *Tympanic membrane*: Positions patient's head to one side and straightens the ear canal. Unless manufacturer directs otherwise: 1) For an adult, pulls the pinna up and back. 2) For a child, pulls the pinna down and back.			
4. Leaves an electronic thermometer until it beeps.			
5. Reads the temperature. (For a glass thermometer, wipes with tissue before reading; reads at eye level).			
6. Stores in recharging unit (electronic) or safe container (glass).			

Procedure Steps	Yes	No	Comments

*Mercury-containing thermometers are not recommended. Use only glass thermometers filled with galinstan or alcohol.

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Assessing for an Apical-Radial Pulse Deficit

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Cleanses the stethoscope before examining patient.			
2. Obtains another nurse to assist.			
3. Nurse 1 correctly locates and palpates the apical site (5th intercostal space at the midclavicular line).			
4. Places the watch so it is visible to both nurses.			
5. Nurse 2 palpates the radial pulse; nurse 1 uses diaphragm of stethoscope to auscultate the apex. Correctly locates sites.			
6. Nurse 2 calls "start" to begin counting and "stop" to end the count.			
7. Counts for 60 seconds.			
8. Notes rate, rhythm, and quality of radial pulse.			
9. Identifies S_1 and S_2 heart sounds.			
10. Correctly obtains pulse deficit (apical rate minus radial rate).			
Variation: When performing this procedure without a second nurse to assist, holds the stethoscope in place with one hand while palpating the radial pulse with the hand wearing the watch. If it is not possible to count both rates, at least reports whether there are any differences between the apical and radial rates.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Assessing Peripheral Pulses

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Note: You can use this checklist to evaluate on peripheral pulse, or to evaluate the student's ability to locate all the peripheral pulses			
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
Circle the site used: Radial, brachial, carotid, dorsalis pedis, femoral, popliteal, posterior tibial, temporal			
1. Selects, correctly locates, and palpates the site.			
2. Uses fingers (not thumb) to palpate.			
3. Counts for 30 seconds if regular; 60 seconds if irregular.			
4. Notes rate, rhythm, and quality.			
5. Compares bilaterally.			
6. Carotid pulse: Palpates only on one side at a time.			
7. Correctly locates the following sites: a. Radial			
b. Brachial			
c. Carotid			
d. Dorsalis pedis			
e. Femoral			
f. Posterior tibial			
g. Popliteal			
h. Femoral			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Assessing Respirations

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Flexes patient's arm and places patient's forearm across his chest, or otherwise counts unobtrusively.			
2. Counts for 30 seconds if respirations are regular; 60 seconds if irregular.			
3. Observes rate, rhythm, and depth.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Assessing the Apical Pulse

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Assists patient to a supine or sitting position.			
2. Cleans the stethoscope with a 70% alcohol or benzalkonium chloride wipe before using.			
3. Selects, correctly locates, and palpates the apical site (5th intercostal space at the midclavicular line).			
4. Warms the stethoscope in the hands for 10 seconds.			
5. Uses the diaphragm of stethoscope over the PMI (Point of Maximum Impulse).			
6. Counts for 60 seconds.			
7. Notes rate, rhythm, and quality.			
8. Identifies S_1 and S_2 heart sounds.			
9. Again, cleans the stethoscope with a 70% alcohol or benzalkonium chloride wipe before using.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Assessing the Blood Pressure

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Note: This checklist describes using the brachial artery in the upper arm; however, the checklist can also be used to assess lower arm, calf, and thigh blood pressures.			
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Cleans the stethoscope before beginning the procedure.			
2. Measures blood pressure after patient has been inactive for 5 minutes.			
3. If possible, positions patient sitting, feet on flood, legs uncrossed; alternatively, lying down.			
4. Exposes an arm (does not auscultate through clothing).			
5. Supports patient's arm at the level of the heart.			
6. Uses appropriately sized cuff. (The width of the bladder of a properly fitting cuff will cover approximately 2/3 of the length of the upper arm for an adult, and the entire upper arm for a child. Alternatively, the length of the bladder encircles 80% to 100% of the arm in adults).			
7. Positions the cuff correctly; wraps snugly.			
8. Palpates the brachial artery. a. Closes the sphygmomanometer valve.			
b. Inflates the cuff rapidly to about 80 mm Hg.			
c. While palpating the pulse, continues inflating 10 mm Hg increments until the pulse is no longer felt.			
d. Notes the pressure at which the pulse disappears.			
e. Continues inflating for 20-30 mm Hg more.			
9. **Alternate to Step 8.** Palpates the brachial artery: a. Closes the sphygmomanometer valve.			
b. Inflates the cuff rapidly to about 80 mm Hg.			
c. While palpating the pulse, continues inflating in 10 mm Hg increments until the pulse is no longer felt.			
d. Notes the pressure at which the pulse disappears.			
e. Deflates the cuff rapidly.			
f. Waits 2 minutes, then places the stethoscope over the brachial artery and inflates the cuff to a pressure that is 20-30 mm Hg above the level previously palpated.			

Procedure Steps	Yes	No	Comments
10. Places the stethoscope over the brachial artery, ensuring that: a. The stethoscope is not touching anything (e.g., clothing).			
b. The diaphragm is not tucked under the edge of the BP cuff.			
11. Releases pressure at 2-3 mm Hg/second.			
12. Records at least systolic and diastolic readings (first and last sounds heart – e.g., 110/80). Records level of muffling, if possible.			
13. If necessary to remeasure, waits at least 2 minutes.			
14. **Variation**. If a mercury manometer must be used, reads the scale at eye level.			
15. **Variation. If an automatic blood pressure device is used:** a. Follows the same guidelines as for taking a manual blood pressure (e.g., cuff size and placement, patient position).			
b. Turns on the machine, making sure the cuff is deflated.			
c. Applies the cuff; presses the button to start the measurement.			
d. At the tone, reads the digital measurement.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Monitoring Pulse Oximetry (Arterial Oxygen Saturation)

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Chooses a sensor appropriate for patient's age, size, and weight; and the desired location.			
2. If patient is allergic to adhesive, uses a clip-on probe sensor. Uses a nasal sensor if patient's peripheral circulation is compromised.			
3. Prepares the site by cleansing and drying.			
4. If the finger is the desired monitoring location, removes nail polish or an acrylic nail, if present.			
5. Removes the protective backing if using a disposable probe sensor that contains adhesive.			
6. Attaches the probe sensor to the chosen site. Makes sure that the photodetector and light-emitting diodes on the probe sensor face each other.			
7. If a clip-on probe sensor is used, warns patient that he may feel a pinching sensation.			
8. Connects the sensor probe to the oximeter and turns it on. Makes sure the oximeter is plugged into an electrical socket.			
9. Checks the pulse rate displayed on the oximeter to see if it correlates with patient's radial pulse.			
10. Reads the Sao_2 measurement on the digital display when it reaches a constant value, usually in 10-30 seconds.			
11. Sets and turns on the alarm limits for Sao_2 and pulse rate, according to the manufacturer's instructions, patient condition, and agency policy, if continuous monitoring is necessary.			
12. Obtains readings as ordered or indicated by patient's respiratory status.			
13. Rotates the probe site every 4 hours for an adhesive probe sensor and every 2 hours for a clip-on probe sensor, if continuous monitoring is indicated.			
14. Removes the probe sensor and turns off the oximeter when monitoring is no longer necessary.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

APPENDIX M – Medical Abbreviations and Symbols List

Welcome to the new abbreviation and symbol list. This is not a complete listing of medical abbreviations or symbols, but contains commonly found abbreviations used in Adult Care Home and In Home Service settings.

Abbreviation	Meaning
$\overline{a}$	before
ac	before meals
abd	abdomen
AD	Alzheimer's disease; right ear
ADL	activities of daily living
ad lib	as desired
AKA	above the knee amputation
amb	ambulation (walk)
ama, AMA	against medical advice, American Medical Assoc.
AMI	acute myocardial infarction
ANS	autonomic nervous system
appt	appointment
ARDS	adult respiratory distress
AROM	active range of motion
AS	left ear; aortic stenosis
AVR	aortic valve replacement
AV	atrioventricular (heart)
ASAP	as soon as possible
ASHD	arterisosclerotic heart disease
BID, bid	twice in the day
BKA	below knee amputation
BM	bowel movement
BP	blood pressure
BPH	benign prostatic hypertrophy (enlarged prostate gland)
BR or br	bath room
BSC	bed side commode, a "portable potty chair"
BUN	blood urea nitrogen (a lab test)
Bx or BX	biopsy
$\overline{c}$	with
c/o	complaints of
C1 , C2	refers to cervical vertebra #1, #2, a location in the spine
Ca, CA	cancer
caps	capsule with medication in it
CAD	coronary artery disease (heart disease)
CAT or CT scan	computerized axial tomography (CAT scan of the body)
cath	catheter (a tube used to drain out body fluid)

CABG	coronary arterial bypass graft
CBC	complete blood count (a blood test)
CC	chief complaint; cardiac catheterization
CCU	coronary care unit
CHD	coronary heart disease
CHF	congestive heart failure
CNS	central nervous system
cont.	continued
COPD	chronic obstructive pulmonary disease
CO_2	carbon dioxide
CPR	cardiopulmonary resuscitation
CXR	chest xray
CRF	chronic renal failure (kidney failure)
CVA	cerebral vascular accident
CVD	cardiovascular disease
CVS	cardiovascular system
cysto	cystoscopy
/d	per day
DC or D/C	discharge
dc	discontinue
decub	decubitus ulcer (pressure sore, bedsore)
DJD	degenerative joint disease (osteoarthritis)
DM	diabetes mellitus (diabetes)
DOA	date of admission; dead on arrival
DOB	date of birth
Dx	diagnosis
drsg	dressing
DSD	dry sterile dressing
DT, DTs	delirium tremens ("the shakes" from alcohol withdrawal)
ECG, EKG	electrocardiogram
EEG	electroencephalogram (measurement of electric brain activity)
e.g.	example
ENT	ears, nose, throat
ERT	estrogen replacement therapy
est, EST	estimate; electroshock therapy
ETOH	ethanol (alcohol)
FBS	fasting blood sugar (a lab test)
F/U FU	follow up
FUO	fever of unknown origin
Fx	fracture
G tube	gastric tube (a tube in the stomach)
GB	gall bladder
GBS	gall bladder series (a type of xray of the gut)

GC	gonorrhea
GERD	gastroesophageal reflux disease (a severe recurrent heartburn disorder)
GU	genitourinary
gtts	drops
gyn	gynecology
hgb hct	hemoglobin, hematocrit, (both are blood cell measurements)
HHA	home health agency; or home health aide
H_2O	water
HS, hs	hour of sleep, or at bedtime
ht	height
Hx hx	history
I & O	intake and output (amount of fluid taken in and urine output)
ICF	intermediate care facility
ICU	intensive care unit
ID	incision and drainage (when a scalpel is used to cut & drain a boil)
IDDM	insulin dependent diabetes mellitus
IM	intramuscular
inj	injection
IV	intravenous
IVP	intravenous pyelogram (a type of xray of the kidneys and bladder)
L lft lt	left
L1, L2, L3	refers to the lumbar section of the spine
lab	laboratory
liq	liquid
LLQ	left lower quadrant
LP	lumbar puncture (spinal tap)
LPN	licensed practical nurse
LRQ	lower right quadrant
LUQ	left upper quadrant
LV	left ventricle
max	maximum
meds	medications
MI	myocardial infarction (heart attack)
mod	moderate
MRI	magnetic resonance imaging
MS	mitral stenosis; multiple sclerosis; musculoskeletal
MVR	mitral valve replacement
N/C	no complaints
NG, NGT	nasogastric (tube)

NIDDM	non-insulin dependent diabetes mellitus
noc	night
norm	normal
NPO	nothing by mouth
NSAID	nonsteroidal anti-inflammatory drug
nsg	nursing
OA	osteoarthritis
OBS	organic brain syndrome
occ	occasional
OD	right eye; overdose
OOB	out of bed
OS	left eye
OU	both eyes
orth ortho	orthopedic
os	bone; opening; mouth
OV	office visit
O_2	oxygen
$\overline{p}$	after
P	pulse
PA	physician assistant
Pap	pap smear (a lab test)
path	pathology
pc, p.c.	after meals
PDR	physician's desk reference (a drug handbook)
PE pe	physical exam
prn, p.r.n.	as needed or required
PROM	passive range of motion
PO po	my mouth
pt	patient
PVC	premature ventricular contraction
PVD	peripheral vascular disease
ph pH	hydrogen ion concentration (a measure of the acidity of a substance)
q	every
qam	every am
qd	every day
qod	every other day
qh	every hour
q2h, q3h, q4h	every 2 hours, every 3 hours, every 4 hours
qhs	every night (hour of sleep)
qid	four times a day
quad	quadriplegic (arms and legs paralyzed)
R, rt	right

RA	right atrium
re:	about or regarding
rbc, RBC	red blood cell
reg	regular
resp	respiration or breaths
RLQ	right lower quadrant
RN	registered nurse
R/O, r/o	rule out
ROM	range of motion
RUQ	right upper quadrant
RV	right ventricle
Rx, RX	treatment
$\bar{s}$	without
SA	sinoatrial node
sl	sublingual meaning under the tongue
sm	small
SOB	short of breath
S/P, s/p	status post (status post an "event" , s/p MI, s/p CVA, s/p GI bleed)
spec	specimen
spec grav, sp gr	specific gravity (urine test)
s & s, s/s	signs and symptoms
staph	staphylococcus
stat	immediately
STD	sexually transmitted disease
strep	streptococcus
subq, subc	subcutaneous
symp, Sx	symptom
T	temperature
T1, T2, T3	refers to the thoracic section of the spine
tab	tablet, a tablet of medication, a round pill
TB	tuberculosis
THR	total hip replacement
TIA	transient ischemic attack
tid	three times a day
TKR	total knee replacement
T/O, t/o	telephone order
TPR	temperature, pulse, respiration (the measurement of these 3 things)
tsp	teaspoon measurement
TUR, TURP	transurethral resection (prostate gland surgery in men)
Tx	treatment
U/A, u/a	urine analysis

URI	upper respiratory infection
UTI	urinary tract infection
VD	venereal disease
VO, v/o	verbal order
vs, VS, v/s	vital signs (temperature, pulse and respiration measurements)
WBC, wbc	white blood cell
W/C	wheel chair
WNL	within normal limits
w/o	without
wt	weight
w/u	work up
x	times
y/o	years old
yr	year

Commonly Used Symbols

↑	increase	↓	decrease
~	approximately	#	number
@	at	o	degree
>	greater than	<	less than
+	positive	-	negative
+, &	and	Ø	nothing, not, none
=	equal to	≠	not equal to
♂	male	♀	female
$\dot{1}$	one of something	$\ddot{11}$, $\dddot{111}$	2, 3 of something

(dss.abrvlist/98)

Guidelines for Documentation

Factual

1. Objective, direct observations; See, Feel, Hear, Smell
2. Subjective information needs factual support. "Quotes" if the person says it.

Accurate

3. Specific measurements: Use only approved abbreviations; spell out if confusing term.
4. Only correct spelling and legible handwriting. Chart only for yourself. The chart is a legal document.
5. Ink. No erasing, correction fluid or skipping lines. Correct errors promptly. One line through.

Example:

> 1500 – c/o RLQ abd pain x30 min states 6 on 1-10 scale, medicated with Demerol 50 mg IM--Lyn Nurse, SN

6. Avoid phrases like "Had a nice night".
7. Record clarification of orders. Never make critical remarks about staff in the chart.

Concise

The whole focus is the client, so there's no need to repeatedly say "the client" or "the patient" unless those words are necessary to clarify. Leave out the, a, an, if the words aren't needed for clarification. Begin each statement with a capital letter and end with a period.

Current

Chart as soon as reasonable after the event. Charting ahead of time is not acceptable. Time each entry. Military time must be understood.

Confidential

Notes not open to public view. Illegal to share confidential info.

✻ ✻

You will need to review different types of charting. At the clinical facilities we use for first semester, you'll find many charting methods/forms.

Procedure Checklist
Hand Washing

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Pushes up the sleeves; removes jewelry and watch.			
2. Adjusts water temperature to warm.			
3. Wets hands and wrists under running water, keeping hands lower than wrists and forearms.			
4. Avoids splashing water onto clothing.			
5. Avoids touching inside of the sink.			
6. Applies 3-5 mL liquid soap.			
7. Rubs soap over all surfaces of hands.			
8. Rubs hands vigorously together for at least 15 seconds.			
9. Lathers all surfaces of the hands and fingers.			
10. Cleans under fingernails, if nails are dirty.			
11. Rinses thoroughly, keeping hands lower than forearms.			
12. Dries hands thoroughly: moves from fingers up forearms; blots with paper towel.			
13. Turns off faucet with paper towel.			
14. Applies non-petroleum-based hand lotion or skin protectant.			
Using alcohol-Based Handrub:			
1. If hands are soiled, washes them with soap and water.			
2. Removes jewelry, bares arms, and so on, as with the soap-and-water procedure.			
3. Applies a sufficient quantity of antiseptic solution to cover the hands and wrists.			
4. Rubs solution on all surfaces of fingers and hands.			
5. Continues rubbing until hands are dry, or as recommend by the manufacturer or agency policy.			

Procedure Steps	Yes	No	Comments

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Hand Hygiene

Skill of the Week Objective and Activities	
• Successfully perform proper procedures for hand washing.	
Rational: • Prevent and control transmissions of infections • Instant alcohol hand antiseptic before and after care • Hand washing with soap and water -When hands visibly soiled -When performing surgical scrub **Other option:** • Use alcohol-based waterless antiseptic when hands not soiled • Apply ample amount to palm • Rub hands together • Cover all surfaces • Rub hands together until alcohol is dry • Use lotion as needed	**Procedure** • Inspect for breaks or cuts • Remove rings, watch, clothing from wrists • Turn on water; avoid splashing • Wet hands and forearms lower then elbows • Wash with soap and water -Friction is important -15 sec. between pts. -One minute: -Before a procedure -When arriving to work -When leaving the floor • Clean nails – **no artificial nails** • Dry from fingers to elbows • Turn off faucet with dry paper towel • Apply lotion as needed

Intravenous Infusions

Skill of the Week Objective and Activities
• Demonstrate safe discontinue of an IV in lab or clinical setting.
• Demonstrate safe monitoring of an IV site in lab or clinical setting.

Complication:

- **Infiltration** (IV fluids in SubQ space … swelling, pallor, pain)
  - ✓ **Nursing Action**: Discontinue IV, elevate affected extremity, restart IV in alternate site if fluids still needed.
- **Phlebitis** (inflammation of vein … pain, heat over vein, redness)
  - ✓ **Nursing Action**: Discontinue IV, apply moist, warm compress to inflamed area for comfort, restart IV if fluids are needed.
- **Fluid overload** (too rapid an administration)
  - ✓ **Nursing Action**: Reduce IV flow rate, notify MD
- **Bleeding** (around venipuncture site, usually an oozing)
  - ✓ **Nursing Action**: Monitor IV closely, if catheter is in the vein, apply dry dressing. Will eventually have to be restarted if continued therapy needed.

Monitoring

- Assess the site every hour & document findings.
- Note amount in bag as you come on shift and do initial assessment.
- Note amount in bag as you leave shift. The difference is the amount that the patient received. Caution: new bags added, fluid wasted, piggyback or blood or medications added.
- IV bag (main IV solution ordered by the physician, such as D5W, 0.9 NaCl, or Lactated Ringers)
- Piggyback bag (smaller IV bag, usually 50-100 ml, which contains some medication that is administered intermittently, such as an antibiotic, and is delivered over 30-60 minutes)
- IV tubing (goes from the IV bag to the patient, be sure to check the drip rate on the box)
- Extension Tubing (makes the IV tubing longer, from main IV tubing to the patient)
- Drip chamber (the bubble-like chamber located near the bag to assess flow)
- Drip regulator (this can either be a roller clamp, or some other mechanical means of controlling the rate of flow of the IV solution. Check the doctor's order for flow rates)

Removal of IV	Documentation
• Reasons -Complications -Infiltration -Phlebitis: mechanical or chemical -Bleeding/bruising -Cellulitis -Extravasation -IV treatment completed	• Identify which I.V. site • Describe the I.V. site • If cannula is intact or not • Any complications (hematoma, bleeding, skin tear) • Client tolerance and comfort

Charting that you have discontinued an IV site can be simple. You need to watch your:

- Spelling (look it up if you are unsure
- Handwriting (neat, legible, in black ink)
- Terminology (use appropriate abbreviations, etc.)
- Completeness (contains time, page is dated, all the issues below are addressed, signed with your first initial, last name, title)
- Accuracy (correct chart)

First state which IV site is being addressed by its specific location & why the IV was DC'd (complications or completed therapy), then describe the site using terms like **reddened, swollen, painful, warm to the touch,** and **bleeding.**

Next document the condition of the cannula (intact or not). Include any complications such as excessive bleeding when the IV was removed & what was done (e.g., "pressure held to area x5 minutes with no further bleeding").

Finally address comfort & safety issues. Document how the patient tolerated the procedure, and that you left them in a safe environment (bed down, side rails up x 2, call bell in reach).

An example of the above would be:

1615 IV site L antecubital reddened, leaking clear fluid, swollen, and painful. IV removed, cannula intact patient tol procedure well. Bed in low position, side rails up x2, call bell in reach. J. Doe, RN notified at 1620, states she will restart IV.....H.Smith, SN

Student Name:_____ Date:_____

Activity	Date	Instructor
Administering IV Fluid Therapy – Mosby CD/Advanced (all parts)		
Skill Check off: Discontinuing an IV	**S**	**Comments**
1. Determine appropriateness, verify orders, gather equipment, wash hands, ID client, provide privacy, & explain procedure.		
2. Prepare supplies, apply gloves. Stop IV solution if present.		
3. Loosen tape & occlusive dressing, pull toward site.		
4. Place 2 x 2 or other dressing over IV site and pull IV catheter out even with the skin. Apply pressure over site. Examine catheter for intactness.		
5. Remove gloves & dispose of IV equipment. Perform hand hygiene. Document actions/findings.		

Check off by:_____ Check off by:_____
Student Evaluator

Date:_____ Date:_____

Restraints

Skill of the Week Objectives and Activities
List guidelines and rationales for the use of restraints Be able to state your legal obligations when applying restraints to clients Successfully and safely apply wrist/ankle, and jacket/vest restraints

Classifications

- Chemical: Use of medications to control patient behavior
- Physical: Decreases patient movement through the application of a device

Restraint Types

1. Jacket: Vest with straps that cross in front or in the back of the client and are ties to the bed frame or chair
2. Belt: Straps or belts applied across the client to secure to the stretcher, bed or wheelchair.
3. Mitten or hand: Enclosed cloth material applied over the clients hand to prevent injury from scratching.
4. Elbow: A combination of fabric and plastic or wooden tongue blades that immobilized the elbow to prevent flexion.
5. Limb or extremity wrist: Cloth devices that immobilize one or all limbs by securely tying the restraint to the bed frame or chair.
6. Mummy: A blanket or sheet that is folded around the client to limit movement.

The Controversy

- Vest restraints banned in Nursing Homes.
- Estimated 50 - 100 deaths/yr from restraints.
- Use contributes to increase in infection, anger, nosocomial infections, pressure ulcers.

Guideline

- Physician's order MUST be obtained and renewed every 24 hours w/justified documentation
- Nurses:
  -MUST be knowledgeable of and follow hospital procedure accurately
  -May be held liable if there is evidence that standards of practice ignored/violated
  -Documentation MUST include client's precipitation behavior for use of restraint
  -Use quick release knots, insert 2 fingers under restraint to keep from being too tight

Safety

- Release q2 hrs for 30 minutes and check CMS and provide ROM
- Assist client to the bathroom q 2 hours
- Stay with client or provide other safety measures while out of restraints

Procedure Checklist
Using Restraints

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Follows agency policy, state laws, and Medicare standards for using restraints, as applicable.			
2. Tries alternative interventions first (e.g., bed alarm, patient sitter).			
3. Uses least invasive method of restraint that is likely to be effective.			
4. Determines that one of the following applies. Patient: a. Is a danger to self or others.			
b. Must be immobilized temporarily to perform a procedure.			
5. Obtains a medical order before restraining, except in an emergency.			
6. Notifies the family.			
7. Obtains written consent.			
Applying Restraints:			
8. Obtains the properly sized retraint.			
9. Pads bony prominences before applying the restraint.			
10. Secures straps in a way that allows for quick release.			
11. Does not tie restraints to the bed rail; ties to the bed frame or chair frame.			
12. Adjusts restraint to maintain good body alignment, comfort, and safety.			
13. Assesses that restraints are snug enough to prevent them from slipping off, but not tight enough to impair blood circulation or skin integrity (e.g., should be able to slide two fingers under a wrist or ankle restraint).			
Caring for a Patient in Restraints:			
14. Checks restraints every 30 minutes.			
15. Checks that a prescriber reassess and reorders restraints every 24 hours.			

Procedure Steps	Yes	No	Comments
16. Releases restraints and assesses every 2 hours (more often for behavioral restraints); provides skin care, range of motion, ambulation, and toileting.			
17. At least every 2 hours, assesses circulation, skin integrity, and need for continuing restraint.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Universal Precautions/Protective Equipment

Universal Precautions/Protective Equipment

Skill of the Week Objectives & Activities
• Compare body substance isolation with universal blood and body fluid precautions • Successfully perform putting on cove gown (non-sterile), gloves & mask/shield for protection

Wash hands (plain soap)
- After touching blood , body fluids, secretions, excretions & contaminated items
- Wash immediately after gloves removed & before & after client contact

Wear gloves
- When touching blood, body fluids, secretions, excretions & contaminated items
- Clean gloves just before touching mucous membranes & non-intact skin
- Change between tasks & procedures on same client when likelihood of touching contaminated surfaces
- Remove promptly upon completion of use, before touching non-contaminated items, environmental surfaces, before going to another client, wash hand immediately

Wear mask & eye protection or face shield
- whenever likelihood of activities that generate a splash or spay of blood, body fluids, secretions or excretions

Client care equipment
- Use appropriate protection against contaminating yourself while handling soiled equipment
- ensure all reusable equipment is disinfected before reuse

Environmental control
- Follow established facility policies for routine care & cleaning of clients rooms

Linen
- Handle all used linen in a manner that avoids transfer of microorganisms to self & others

Occupational Health & Blood Borne Pathogens
- Prevent injuries when using, cleaning or disposing of needles scalpel or other sharp instruments
- Never recap needles
- Never bend or manipulate needles, blades, scalpels or other sharp object
- Use resuscitation devices as an alternative to mouth-to-mouth resuscitation

Client Placement
- Use a private room for clients contaminated or for those who are unable to assist in maintaining appropriate hygiene or environmental control
- consult the infection control nurse for assistance

Procedure Checklist
Donning Personal Protective Equipment (PPE)

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Assesses the need for personal protective equipment. *Gloves:* When the nurse may be exposed to potentially infectious secretions or materials. *Gowns*: When the nurse's uniform may become exposed to potentially infectious secretions. *Face shield or eye goggles*: When splashing may occur and potentially contaminate the nurse's eyes. *N-95 respirator*: When caring for patients infected with airborne microorganism. *Hair cover*: When there is potential for splashes or sprays of body fluids. *Shoe cover*: When there is potential for contaminating shoes with body fluids.			
2. Determines availability of appropriate PPE.			
3. Dons gown first. a. Picks up the gown by the shoulders; allows to fall open without touching any contaminated surface.			
b. Slips arms into the sleeves; fastens ties at the neck.			
c. If the gown does not completely cover clothing, wears two gowns. Places the first gown on with the opening in the front and then places the second gown over the first with the opening in the back.			
4. Dons a face mask. Identifies the top edge of the mask by locating the thin metal strip that goes over the bridge of the nose. a. Picks up the mask with the top ties or ear loops.			
b. Places the metal strip over the bridge of the nose and ties upper ties or slips loops around the ears.			
c. Places the lower edge of the mask below the chin and ties lower ties.			
d. Presses the metal strip so it conforms to the bridge of the nose.			
5. Dons the face shield by placing the shield over the eyes, adjusting metal strip over bridge of nose, and tucking the lower edge below the chin. Secures straps behind head.			
6. If using safety glasses or goggles, dons them by setting them over the top edge of the face mask.			

Procedure Steps	Yes	No	Comments
7. Dons hair cover (as indicated).			
8. Dons shoe covers (as indicated).			
9. Dons gloves. Selects the appropriate size.			
10. If wearing a gown, makes sure that the glove cuff extends over the cuff of the gown.			
11. If there is not complete coverage, tapes the glove cuff to the gown.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Removing Personal Protective Equipment (PPE)

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
Removes PPE in the following order:			
1. If wearing a gown that is tied in front, unties waist ties.			
2. Removes gloves. (If gown is tied in back, removes gloves first). a. Removes one glove by grasping the cuff of the glove and pulling down so the glove turns inside out. Holds the glove removed in the remaining gloved hand.			
b. Slips the fingers of the ungloved hand inside the cuff of the other glove; pulls glove off inside out, turning it over to enclose the first glove. Does not touch self with the contaminated surface of either glove.			
c. Holds the contaminated gloves away from the body.			
d. Disposes of gloves in a designated waste receptacle.			
3. Removes gown. a. Releases neck ties of gown, allowing the gown to fall forward.			
b. Places the metal strip over the bridge of the nose and ties upper ties or slips loops around the ears.			
c. Reaches inside to pull off the cuff and remove the arm from the sleeve, one arm at a time.			
d. Holding the gown away from body, folds inside-out and discards. Does not contaminate clothing with the dirty gown.			
(Note: If wearing two gowns, second gown is removed now).			
4. Removes goggles before the mask. Grasps by ear pieces.			
5. Removes the mask or face shield by untying lower ties first; unties upper ties next; disposes in designated waste receptacle. Does not touch the front of the mask.			
6. Removes hair covering. Slips fingers under the edge of the hair cover; does not touch the outside of it. Disposes of hair cover properly.			
7. Washes hands before leaving the room.			
8. Closes the door on leaving.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Transmission Based Isolation Precautions

	Airborne	Droplet	Contact	Neutropenic
Diseases	• TB (known or suspected) • Measles (Rubeola) • Chickenpox (Varicella) • Disseminated Herpes Zoster	• Meningococcal Disease • Pertussis • Acute influenza • Mumps • Rubella • Strep pharyngitis (status pre 24 hr tx)	•MRSA, VRE, other multi-drug resistant organisms •RSV (respiratory syncytial virus) •Pediculosis, scabies (status pre 24 hr. effective tx) •Major wounds (unable to contain drainage with dressing •Infectious diarrhea when difficult to contain (ex: C difficile)	• Immunosuppressed • Absolute neutrophil count < 500
Private Room	Yes	Yes	Yes	Yes Flowers – ask MD
Negative Pressure	Yes	No	No	No
Closed Door	Yes	No	No	No
Hand washing	Yes, upon entering & exit & when likely contaminated	Yes, upon entering & exit & when likely contaminated	Yes, upon entering & imperative on exit	Yes, upon entering & exit
Gloves	Yes when contact with body fluids likely	Yes when contact with body fluids likely	Yes when entering the room. Avoid touching surfaces when gloves are contaminated. Remove in the room & wash hands, do not touch surfaces with clean hands.	Yes when contact with body fluids likely
Mask	Yes, fit tested.	Yes, surgical mask when within 3 feet of client	No, unless splashing is likely	No, unless ordered by MD
Gown	Yes, when clothing may become soiled with body fluids	Yes, when clothing may become soiled with body fluids	Yes, with direct care or contact with surfaces or equipment	Yes, when clothing may become soiled with body fluids
Equipment	Disinfect when soiled with body fluids	Disinfect when soiled with body fluids	Dedicate BP cuff, stethoscope, glucose monitor, thermometer & wheelchair or walker to client room. Disinfect when removed from room.	Disinfect when soiled with body fluids
Transportation	Client wears surgical mask, staff wears respirator mask	Client wears surgical mask	Client with clean gown & linen. Drainage must be contained. Client may ambulate in hall.	Consult with MD. Client to mask when around others.
D/C Precautions	MD, Infection control nurse. County Public Health Dept aware of discharges	MD, Infection control nurse	MD, infection control nurse	MD
Visitors	Respirator masks, isolation instructions, hand washing	Isolation instructions, surgical mask if within 3 feet of client, hand washing	Isolation instructions, gloves if contact with secretions likely, hand washing	Evaluate for communicable illness. Isolation instructions, hand washing

Procedure Checklist
Making an Occupied Bed

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Note: This checklist is designed to evaluate making an occupied bed separately from giving a bed bath. If linen change is done at the time as the bed bath, some of these steps will vary.			
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Prepares the environment as needed: a. Moves furniture to allow access to the bed.			
b. Positions the linen hamper for easy access.			
2. Dons protective gloves and other gear if necessary.			
3. Positions the bed flat if possible, and raises to the appropriate working height. Lowers the side rail nearest the nurse.			
4. Disconnects the call device and removes patient's personal items from the bed.			
5. Checks that no tubes are entangled in the bed linens.			
6. Leaves the side rail down only on the side of the bed where the nurse is standing. Does not walk to the other side with the rail still down.			
7. Removes blanket and/or bedspread; if clean, folds and places on a clean area. Does not place clean linen on another patient's bed or furniture.			
8. Covers patient with a bath blanket, if available, or leaves the top sheet over patient.			
9. Positions patient: a. Slides patient to the far side of the bed; places in a side-lying position facing the side rail.			
b. Places a pillow under patient's head; if needed, places a pillow between patient and the side rail.			
10. Rolls or tightly fan-folds the soiled linens toward patient's back; tucks the roll slightly under patient.			
11. Covers any moist areas of the soiled linen with a waterproof pad.			
12. Removes soiled gloves; performs hand hygiene; and dons clean procedure gloves.			
13. Places a clean bottom sheet and drawsheet on near side of the mattress, with the center vertical fold at the center of the bed.			

Procedure Steps	Yes	No	Comments
14. Fanfolds the half of the clean linen that is to be used on the far side, folding it as close to patient as possible and tucking it under the dirty linen.			
15. Tucks the lower edges of clean linen under the mattress. Smoothes out all wrinkles.			
16. Explains to patient that he will be rolling over a "lump".			
17. Rolls patient over dirty linen and gently pulls patient toward the nurse so patient rolls onto the clean linen.			
18. Raises the side rail on the clean side of the bed.			
19. Moves to opposite side of bed; lowers the bed rail.			
20. Pulls soiled linen away from patient. Removes from the bed and places in a laundry bag or hamper without contaminating the uniform.			
21. Does not put soiled linen on the floor or other surfaces.			
22. Moves pillows to the clean side of the bed; positions patient side-lying near the bed rail on the clean side.			
23. Removes soiled gloves, performs hand hygiene, and dons clean procedure gloves.			
24. Pulls clean linens through to the unmade side of the bed, and tucks them in.			
25. Pulls linens taut, starting with the middle section.			
26. Assists patient to a supine position close to the center of the mattress.			
27. Places the top sheet and bedspread along one side of the mattress; removes the bath blanket.			
28. Tucks sheet and blanket in at the same time, then moves to the opposite side of the bed.			
29. After making both sides of the bed, at the head of the bed, folds sheet down over the bedspread.			
30. At the foot of the bed, makes a small toe pleat in the top sheet and bedspread; then tucks in the bottom of the sheet and bedspread at the same time.			
31. Miters corners neatly.			
32. Changes pillowcases: Turns inside out; grasps the middle of the closed end of the pillowcase; reaches through the pillowcase and grasps the end of the pillow; pulls the pillow back through the pillowcase. Does not hold the pillow under an arm or the chin.			
33. Returns the bed to a low position, raises side rails, and attaches the call light within patient's reach.			

Procedure Steps	Yes	No	Comments
34. Positions the bedside table and overbed table within patient's reach.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Making an Unoccupied Bed

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Assists patient to the chair; provides a robe/blanket if needed.			
2. Prepares the environment: a. Positions the bed flat, raises to working height, and lowers side rails			
b. Moves furniture as needed.			
c. Places the linen hamper for convenient access.			
3. Dons gloves and protective gear if necessary.			
4. Loosens all bedding.			
5. Folds and places clean bedspread and/or blanket on clean area. Does not place clean linen on another patient's bed or furniture.			
6. Removes all sheets and pillowcases; places in a laundry bag or hamper without contaminating uniform. a. Does not shake or "fan" linens.			
b. Does not place linens on the floor.			
c. Removes and replaces linens on one side of the bed at a time, to save steps.			
7. For a flat bottom sheet, allows at least 10 inches to hang over at tope and side for tuck-in.			
8. Smoothes wrinkles from the bottom sheet.			
9. If there is a draw sheet, tucks it and draws it tight.			
10. Replaces the waterproof pad if one is being used.			
11. Places the top sheet and bedspread along one side of the mattress; unfolds.			
12. Makes a small pleat in the top sheet and bedspread, at the foot of the bed.			
13. Tucks the top sheet and bedspread in at the same time, using a mitered corner. Then moves to the opposite side of the bed.			

Procedure Steps	Yes	No	Comments
14. After making both sides of the bed, at the head of the bed, folds the sheet down over the bedspread.			
15. Fanfolds the top sheet and bedspread back to the foot of the bed.			
16. Changes pillowcases: a. Turns the pillowcase wrong side out.			
b. Grasps the middle of the closed end of the pillowcase.			
c. Reaches through the pillowcase and grasps the end of the pillow.			
d. Pulls the pillow back through the pillowcase.			
e. Does not hold the pillow under an arm or the chin.			
17. Assists patient back to bed.			
18. Places the call signal within reach; puts the bed in a low position.			
19. Places the bedside table and overbed table so they are accessible to patient.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Providing Oral Care for an Unconscious Patient

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Determines whether patient has dentures or partial plate; access the gag reflex.			
2. Positions patient in a side-lying position with head turned to the side, if possible, and with head of bed down (slightly dependent, if possible).			
3. Dons procedure gloves, eye goggles, and any other protective gear needed.			
4. Places waterproof pad and then towel under patient's cheek and chin.			
5. Sets up suction: Attaches tubing and tonsil-tip suction, checks suction.			
6. Brushes patient's teeth: a. Uses a padded tongue blade or bit-block to hold the mouth open.			
b. Places an emesis basin under patient's cheek.			
c. Moistens a toothbrush and applies a small amount of toothpaste.			
d. Brushes teeth, holding bristles at a 45^0 angle to the gum line.			
e. Uses short, circular motions.			
f. Gently brushes the inner and outer surfaces of the teeth, including the gum line.			
g. Brushes the biting surface of the back teeth by holding the toothbrush perpendicular to the teeth and brushing back and forth.			
h. Brushes patient's tongue.			
i. Performs oral suctioning when fluid accumulates in the mouth.			
7. Draws about 10 mL of water or mouthwash (e.g., dilute hydrogen peroxide) into a syringe; ejects it gently into the side of the mouth. Allows the fluid to drain out into the basin; or suctions as needed.			

Procedure Steps	Yes	No	Comments
8. Cleans the tissues in the oral cavity according to agency policy. a. Uses foam swabs or moistened gauze square wrapped around a tongue blade.			
b. Uses a clean swab for each area of the mouth: cheeks, tongue, roof of the mouth, and so forth.			
9. Removes the basin, dries face and mouth, applies water-soluble lip moisturizer.			
10. Removes the waterproof pad and towel.			
11. Turns off suction equipment.			
12. Discards gloves and used supplies.			
13. Repositions patient as needed.			
14. Cleans and stores reusable oral hygiene tools in clean containers, separate from other articles of personal hygiene.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Providing Denture Care

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Dons procedure gloves.			
2. Removes the upper denture before the lower denture.			
3. To remove the upper denture, with a gauze pad, grasps the denture with a thumb and forefinger and moves gently up and down. Tilts the denture slightly to one side to remove it without stretching the lips.			
4. To remove lower denture, uses thumbs to gently push up on denture at gum line to release from lower jaw. Grasps the denture with thumb and forefinger and tilts to remove the patient's mouth.			
5. Places each denture in a denture cup after removing.			
6. Places a towel or basin of water in the sink to prevent damage to dentures.			
7. Cleanses the dentures under cool running water.			
8. Applies a small amount of toothpaste to stiff-bristled toothbrush; brushes all surfaces of each denture; rinses thoroughly with cool water. *Obtain hospital policy **Alternatively**, soaks stained dentures in a commercial cleaner, following the manufacturer's instructions.			
9. Inspects dentures for rough, worn, or sharp edges before replacing.			
10. Inspects the mouth under the dentures for redness, irritation, lesions, or infection before replacing dentures.			
11. Applies denture adhesive as needed or as desired by patient.			
12. Replaces the upper denture before the lower denture.			
13. Moistens the upper denture, if dry; inserts at a slight tilt, and presses it up against the roof of the mouth.			
14. Moistens the bottom denture, if dry; inserts the denture, rotating as it is placed in patient's mouth.			
15. If patient does not wish to wear the dentures, covers them with water in a denture container with a lid. Labels the container with patient's name and agency identifying number.			

Procedure Steps	Yes	No	Comments
16. Offers mouthwash.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Oral & Denture Care

Oral & Denture Care

Skill of the Week Objectives & Activities
• Discuss measures to provide oral hygiene. • Demonstrate correct denture care in lab setting. • Assist with/provide oral hygiene to classmate. • Be able to demonstrate mouth care for an unconscious client. • Correctly setup and demonstrate use of a Yankauer catheter in suctioning oral secretions. • Practice feeding another student.

Non-Sterile Suctioning:

- Remember not to suction more than 15 seconds, as no oxygen gets to the lungs during suctioning.
- Use oropharyngeal/nasopharyngeal suctioning when pt. can cough but not able to clear secretions. Have patient cough first.

Bathing & Pericare

Skill of the Week Objectives & Activities
• Successfully perform proper technique in performing a complete bed bath (come prepared for lab with swimsuit, shorts, or other attire that will allow students to bathe each other--also bring towel, wash cloth, and toothbrush) • Describe factors that influence personal hygienic practices • Accurately document ADL's and basic care on form provided in lab and/or clinical.

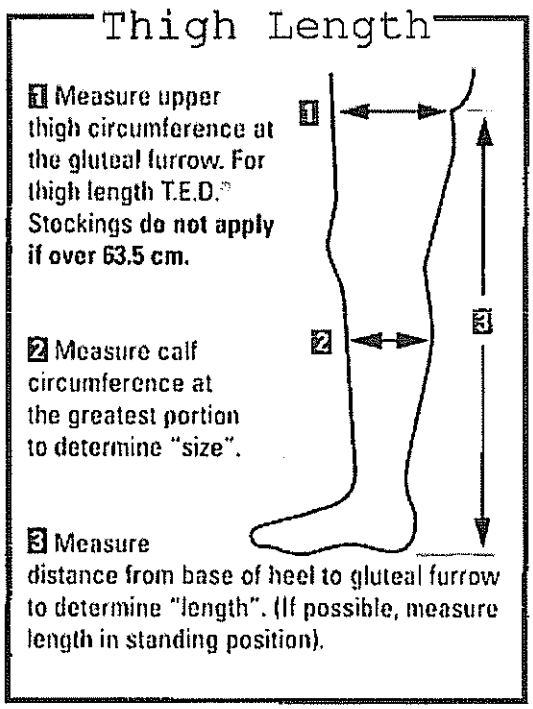
Shaving Considerations

If possible, use an electric shaver. Before shaving any client with a blade there are things you must do first. Because clients with clotting problems can bleed severely if shaved, the first thing you need to do is determine that the patient's clotting times are adequate.

√ Check labs (found on chart) for the following tests:

1. PT (Prothrombin Time, Protime) normal 9-12 seconds
2. APPT (Activated Partial Thromboplastin Time) normal 27-38 seconds
3. Platelet count 130,000-400,000 mm^3
4. Also, check the client for signs of bleeding such as oozing around IV site, bruising, etc.
5. If you can't find the labs, call your instructor before shaving the client.

Antiembolism Stockings & Sequential Compression Devices (SCD)



Patients with limited movement or a risk for developing a deep vein thrombosis (DVT) may have an order for Antiembolism stockings and/or sequential compression devices. If stockings are ordered they must be measured correctly to avoid constriction. They are worn continuously to promote circulation through venous return. Apply prior to ambulation while limited edema is present. Stockings are removed every 8 hours for about 1 hour. If SCDs are used they are worn at all times while the patient is in bed. They may be applied to the full leg, lower leg, or just the feet. The SCD works by rhythmic compression and release

Procedure Checklist
Providing Perineal Care

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Assists with elimination as needed.			
2. Fills the basin or perineal wash bottle with warm water (temperature should be approximately 105^{0}F [41^{0}C]			
3. Positions patient supine.			
4. Places waterproof pads under patient.			
5. Drapes patient for privacy: a. Female patient: Drapes legs and perineum using triangular-folded sheet or bath blanket.			
b. Male patient: Drapes chest with towel; drapes upper legs with another towel; leaves bed linens over lower legs. Exposes only perineum.			
6. If the perineum is grossly soiled, places patient on a bedpan or portable sitz tub.			
7. Removes any fecal material with toilet paper.			
8. Moistens a washcloth with water in the basin or sprays perineum with the perineal wash bottle.			
9. For females: a. Washes the perineum from front to back.			
b. Uses a clean portion of the washcloth for each stroke.			
c. Cleanses the labial folds and around the urinary catheter if one is in place.			
10. For males: a. Retracts the foreskin, if present.			
b. Cleanses the head of the penis using a circular motion.			
c. Replaces foreskin and finishes washing the shaft of the penis, using firm strokes.			
d. Washes the scrotum, using a clean portion of the cloth with each stroke.			
e. Handles the scrotum gently to avoid discomfort.			
11. Cleanses skin folds thoroughly, rinses, and pats dry.			

Procedure Steps	Yes	No	Comments
12. If perineal care is not being done as part of the bath, also cleans the anal area by asking the patient to turn to the side and washing, rinsing, and drying the area as needed.			
13. Applies skin protectants as needed. Use powder only if patient requests it.			
14. If patient has an indwelling catheter, provides special catheter care as prescribe by agency policy. Dons clean gloves before special catheter care.			
15. Repositions and covers patient.			
16. Removes and appropriately discards soiled gloves.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Bathing: Providing a Complete Bed Bath

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics, and documentation.			
1. Uses warm, not hot, water (approximately 105^0F [41^0C]).			
2. Changes water before cleansing the perineum and whenever the water becomes dirty or cool.			
3. Adjusts the bed to working height.			
4. Positions patient supine.			
5. Drapes patient to provide privacy and prevent chilling.			
6. Removes soiled linens without exposing patient.			
7. Removes the patient's gown without exposing patient; exposes just the part of the body being bathed.			
8. If patient has an IV, removes the gown first from the arm without the IV; replaces gown on the affected arm first; does not disconnect the IV tubing; keeps IV container above level of patient's arm.			
9. Modifies the procedure or stops temporarily if patient becomes tired.			
10. Follows principle of "head to toe".			
11. Follows principle of "clean to dirty".			
12. Washes extremities from distal to proximal.			
13. While bathing patient, keeps loose ends of washcloth from dragging across the skin and wrings out excess water.			
14. Supports joints when bathing.			
15. Rinses well if using soap.			
16. Pats dry to protect the skin.			
17. Dries thoroughly between skinfolds.			
18. Changes water and uses a clean washcloth to wash the perineal area.			
19. Dons procedure gloves to wash the rectal area; removes any fecal matter with tissues before using a washcloth.			
20. Applies deodorant, lotion, and/or powder as desired or as needed.			
21. Provides a back rub if not contraindicated.			

Procedure Steps	Yes	No	Comments
22. When finished, repositions patient and changes bed linen as needed.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Range of Motion

Skill of the Week Objectives & Activities
• Be able to demonstrate and define flexion, extension, hyper extension, pronation, supination, abduction, abduction, internal rotation, external rotation, eversion, inversion, dorsi flexion, and plantar flexion. • Successfully perform range of motion for each of the following: elbow, knee, hip, wrist, ankle, shoulder, neck, fingers.

Why?

- To prevent joint contractures and muscle atrophy due to immobility
- To prepare an immobile client for ambulation
- To maintain circulation, helping to prevent deep vein thrombosis

Who?

Anyone who is incapacitated, either by illness or operative procedures, who can't move around at least two hours every twenty-four.

Types

- ACTIVE – exercises the client can perform independently
- ACTIVE-ASSISTED – exercises performed with some assistance
- PASSIVE – exercises the client is dependent upon someone else to perform for them

Method

- ***Always*** be methodical and organized, don't jump from one part of the body to another, it'll confuse you and your client!
- ***Never*** force a limb beyond what is comfortable!
- Enjoy time with your client!

To provide Passive ROM:

1. Verify orders, assess client for contraindications
2. Utilize correct body mechanics to avoid muscle strain to yourself and to your client including positioning the bed at correct height.
3. To protect client privacy expose only the limb being exercised.
4. Support the client's limb above and below the joint being exercised.
5. Move the body parts smoothly, slowly, rhythmically. Each exercise is usually done five times, twice a day.
6. Each exercise is done to the point of **SLIGHT** resistance, **NOT** to the point of pain.

Student Name:_____ Date:_____

Activity	Date	Instructor
Exercises/Joint Motion – Mosby CD/Basic/Body Mechanics & Exercise		
Skill Check off: Passive Range of Motion Exercises	**S**	**Comments**
1. Determine any restrictions for passive range-of-motion exercises.		Plan time for exercises to be done several times a day.
2. Wash hands, check pt. ID, provide privacy & explain procedure to client.		
3. Elevate the bed and place the client in semi Fowlers position.		
4. Start at head and do exercises down each side of body. Repeat each exercise five times, supporting the appropriate joints. **Head:** Turn side to side; tilt chin toward sternum, then turn to normal position; tilt head upward (occiput toward spine); tilt each ear to shoulder.		
Neck: Rotate neck in semicircle.		
Truck: Bend trunk forward straighten, and extend slightly backward; turn shoulders forward, then relax; tip trunk to left, then right.		
Arm: Extend arm to head, then along side; extend toward midline (adduction) and away from midline (abduction).		
Shoulder: Bend elbow at 90^0 angle, keeping upper arm parallel to shoulder; move lower arm upward and downward.		
Elbow: Flex and extend elbow; move hand in palm up then palm down position.		
Wrist: Flex and extend wrist; Turn wrist to right, then left, rotate wrist in circular motion.		
Hand: Flex and extend fingers; spread fingers apart, then together; . touch each finger with tip of thumb.		
Thumb: Rotate thumb in circular motion.		
Hip and leg: Flex leg toward chest, then extend; move extended leg away from body (abduction/adduction).		
Knee: Flex and extend knee.		
Ankle: Flex and extend ankle.		
Foot: Spread toes apart; then together; extend toes upward, then downward.		
5. Provide safety & positioning. Perform hand hygiene.		
6. Evaluate client tolerance & document procedure in medical record per agency policy.		Complete within 15 minutes.

Check off by:_____ Check off by:_____
Student Evaluator

Date:_____ Date:_____

Positioning, Transfer & Ambulation

Skill of the Week Objectives & Activities
• Describe the procedures for assisting a client to move up in bed, reposition a helpless client, assisting a client to a sitting position, and transferring a client from a bed to a chair, wheelchair, or commode. • Perform proper positioning: supine, prone, Fowlers (high, semi), lateral, Sims. • Perform proper transfer from bed to chair/wheelchair • Assist with ambulation in lab/clinical setting using gait belt & mechanical lift - unilateral and generalized weakness • Demonstrate appropriate technique for crutch walking (2 point, 3 point, 4 point, swing thru)

Back Safety & Transfer Training

Introduction:

1. Everyone experiences back pain at some time in their lives, especially health care workers.
2. Starts with improper lifting and moving, leading to unnecessary stress to the back, injury, and chronic pain. Most are preventable.
3. Once injured, re-injury much more likely.
4. Visit www.osha.gov for more guidelines and details.

Risks:

1. Depends on knowledge of back anatomy, body mechanics, transfer training, and self-care.
2. Ask, do I...
   ...maintain the natural spinal curves?
   ...know which muscles are needed for transferring and moving?
   ...use my body weight to transfer, not my back?
   ...keep my clients close to my center of gravity?
   ...ask for help?
   ...get organized to know what to do as I begin transferring?
   ...understand my client's special needs?
   ...know how to use assistive devices?
   ...exercise regularly?
   ...keep healthy and physically fit?
   ...take regular breaks?
   ...take care of myself?

General Guidelines (Michelle Preston-Smith, MS, PT)

1. Assess the client before lifting or moving.
2. Eliminate or reduce manual lifting and moving of clients.
3. Have client help as much as possible, giving clear and simple instructions, allowing for adequate time for response.
4. Get help whenever possible.
    a. Use teamwork, make sure your team members are adequately trained, understand proper lifting technique and use timing.
5. Plan and prepare.
6. Set up surfaces to keep work tasks, equipment, and supplies close and at the correct height – between waist and shoulders.
7. Make sure brakes are working properly, and make sure you apply them firmly.
8. Use upright, neutral postures and proper body mechanics.
    a. Bend legs, not back.
    b. Don't twist. Pick up feet and pivot whole body.
    c. Always face the load, and pull it toward your center of gravity.
    d. Use the "ugly – butt" and do not curve your back.

Assistive Devices

1. Draw Sheets – Make sure the client is supported from thigh to shoulder. Used to protect client's skin by reducing friction.
2. Trapezes – Allow client to assist with moving in bed. Adjust the length of the chain so that the client's elbows are slightly bent when grasping the bar.
3. Slide Boards – Scoot enough of the board under the client; ensure client's skin is protected.
    a. Sitting slide boards – client must have fair sitting balance. Must use gait belt to assist client and for safety.
    b. Supine slide boards – use when client unable to tolerate sitting board.
    c. Plastic bags – large plastic bags over the boards make a smoother surface. **Be aware this makes the surface very slippery!**
4. Gait Belts – Make sure the belt fits snuggly around the client's waist. Be aware of G-tubes, colostomy bags, surgical sites, fractured ribs, etc.
5. Mechanical Lifts – Use with clients who are unable to assist with the transfer or are obese. Be sure that the sling is properly supporting the client, that you understand how to use the lift, and that you have at least one other person to assist.

Special Needs Clients

1. Frail – Remember to use smooth, slow, and controlled movements. Talk through the transfer so the client knows what to expect.
2. Obese – Because of their size, these clients are harder to move and put you at higher risk for injury. Have the client help as much as possible, use double sheets as a precaution or use a mechanical lift.
3. Paralyzed – Protect paralyzed extremities, because often the client is unable to do so. Move body by parts or sections, i.e. body-on-body rolling.
4. Tubes – Check every client for tubes. Place tubes, catheter bags, IV poles, etc. in the direction of the move to avoid pulling or tangling.

5. Casts – Remember that casts add extra weight to transfers and the client is often unable to lift the part. Get help to move the cast and use an over bed trapeze.
6. Traction – Movement is often painful, use slow, controlled movements to minimize discomfort. Leave the traction unit intact, do not lift the weights.

Lifting

- Use upright, neutral working postures and proper body mechanics.
- Keep client, equipment, and supplies close to the body with handholds between the waist and shoulders.
- Move the client towards you, not away from you.
- Use slides and lateral transfers instead of manual lifting.
- Use a wide, balanced stance with one foot slightly ahead of the other.
- Lower the client slowly by bending your legs, not your back. Return to and erect position as soon as possible.
- Use smooth movements and do not jerk. When lifting with others, coordinate lift by counting down and synchronizing the lift.

Lateral Transfers

- Position surfaces as close as possible to each other. Surfaces should be at approximately waist height, with the receiving surface slightly lower to take advantage of gravity.
- Lower side rails on both surfaces.
- Use draw sheets or incontinence pads in combination with other friction reducing devices (slide boards, sheets, plastic bags, etc.)
- Get a good hand-hold by rolling up draw sheets and incontinence pads or use devices with handles.
- Kneel on the bed or gurney to avoid extended reaches and bending the back.

Have team members on both sides of the surfaces. Count down and synchronize the lift. Use a smooth, coordinated push-pull motion. Do not reach across the person being moved.

Gait Belts

- Keep the client as close as possible.
- Avoid bending, reaching or twisting you back when:
- Attaching or removing belts
- Lowering the client down
- Assisting with ambulation
- Pivot with your feet to turn
- Use a gentle rocking motion to take advantage of momentum.

Stand Pivot Transfer – Bed to Chair

Assess:

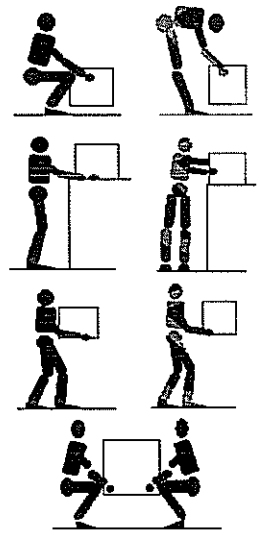
Strength
Joint mobility
Orthostatic hypotension
Activity tolerance
Level of comfort
VS
Sensory status
Motivation
Previous mode of transfer
Risk for falling
Client's ability to assist - If unable – get help!

Guidelines for Transporting Clients and Equipment

- Decrease load or weight of carts, instrument trays, etc.
- Store items and equipment between waist and shoulder height.
- Use sliding motions or lateral transfers instead of lifting.
- Push, don't pull. Keep loads close to your body. Use an upright, neutral posture and push with your whole body, not just your arms.
- Move down the center of corridors to prevent collisions.
- Watch out for door handles and high thresholds which can cause abrupt stops.

Principles of Body Mechanics

1. Use your LEGS
2. Keep your BACK STRAIGHT
3. DON'T TWIST
4. Move your feet; FACE THE LOAD
5. Keep the load CLOSE
6. SIZE UP the load
7. Ask for HELP if the load can't be managed alone



Degrees of Assistance Defined

Independent	Client able to begin & complete tasks without physical assistance & without verbal cues. a. Dressing – client must be able to retrieve clothes safely and independently. b. Bathing – client must be able to set up own bath.
Modified Independent	Adaptive devices ensuring independence should be documented, i.e. client independent with dressing using long handled shoe horn.
Supervised	Client able to begin and complete task without physical assistance. May require verbal cues for sequencing or safety. Care provider is in close proximity.
Standby Assistance	Client able to begin and complete task without physical assistance. May require verbal cues for sequencing or safety. Care provider stands next to the client for assistance.
Contact Guarding	Client able to begin and complete the task but requires light "hands on" assistance, i.e. light touch on shoulder to bring body forward when changing from sitting to standing.
Minimal Assistance	Client able to contribute most of the effort to accomplish tasks and requires constant physical assistance (75% done by client, 25% done with assistance).
Moderate Assistance	Client able to contribute half of the effort to accomplish the task and requires constant physical assistance.
Maximal Assistance	Client may or may not be able to contribute minimal effort to initiate and/or complete tasks and requires the majority of physical effort by others or with the use of mechanical assistance (25% effort by client).

Precautions for Total Hip Arthroplasty

1. NO hip flexion greater than 90 degrees (lifting knee toward chest or bending over)
2. NO internal rotation (knees facing each other, or pigeon-toed position)
3. NO hip adduction past neutral (crossing legs, or side-lying with legs moving past midline)

Procedure Checklist
Transferring a Patient from Bed to Chair

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Determine the need for transferring the patient from a bed to a chair			
2. Wash hands			
3. Positions the chair next to the bed and near the head of the bed. If possible, locks the chair			
4. Puts nonskid footwear on the patient			
5. Applies transfer belt			
6. Places the bed in low position			
7. Assists patient to dangle at bedside			
8. Faces the patient; brace feet and knees against patient's feet and knees. Pays particular attention to any weaknesses			
9. Bends hips and knees; holds onto the transfer belt. If two nurses are available, one nurse should be on each side of the patient			
10. Instructs patient to place his or her arms around the nurse between the shoulders and waist (the exact location depends on the height of the nurse and the patient)			
11. Asks the patient to stand as the nurse moves to an upright position by straightening her legs and hips			
12. Allows the patient to steady his or herself for a moment			
13. Instructs the patient to pivot and turn with the nurse toward the chair			
14. Asks the patient to flex her hips and knees as she lowers his or herself to the chair. Guides her motion while maintaining a firm hold of the patient			
15. Assists the patient to comfortable position in the chair. Provides blanket, if needed			
16. Provide patient with call light			
17. Wash hands			
18. Document procedure			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Use of a Patient Mechanical Lift

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Determine the patient's need for the use of the mechanical lift			
2. Wash hands			
3. Gather supplies (including the mechanical lift)			
4. Wash hands upon entering patient room			
5. I.D. patient			
6. Explain procedure			
7. Provide for privacy			
8. Places patient in a comfortable position that provides efficient use of the mechanical lift			
9. Dons clean gloves			
10. Raise bed to a level that will not place strain on the nurse's back			
11. Roll the patient onto his or her side and position the sling underneath patient			The sling should extend from behind the knees to beyond the patient's head
12. Smooth out the sling material and roll the patient onto his or her back			
13. Get mechanical lift ready by pushing the base of the mechanical lift under the bed			
14. Press lever down to lock base of the mechanical. Mechanical lift must be in a locked position when in use			
15. Lower bed and side rails			
16. Attach sling to lift by hooking the four sling straps to the four hooks on the cradle			
17. Slightly raise the patient until his or her body clears the bed			
18. Unlock the mechanical lift and move the lifted patient			
19. Position the sling of the mechanical lift over a chair or wheelchair (center the sling over the chair or wheelchair).			The sling should be positioned in a way that the patient should end up in a sitting position in the wheelchair

Procedure Steps	Yes	No	Comments
20. Open the control valve on the mechanical lift to lower the patient into the chair or wheelchair			
21. Have one nurse guide the patient's body into the wheelchair while the second nurse is controlling the movement of the mechanical lift			
22. Make sure that the breaks are applied on the wheelchair prior to lowering the patient into it			
23. When the patient is positioned correctly in the chair or wheelchair, disconnect the straps from the lift, leaving the sling under the patient			
24. Move the mechanical lift to a safe place for use later			
25. Provide comfort measures			
26. Provide patient with call light			
27. Wash hands			
28. Document procedure			

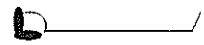
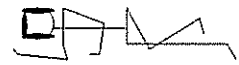
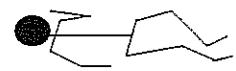
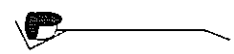
Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Student:_____ Date:_____

Activity	Date	Instructor
Body Mechanics & Exercise - Mosby CD/Basic		

Skill Check off: Positioning a Client in Bed	S	Comments
1. Determine appropriate position & assistance needed. Gather appropriate equipment.		Draw sheet, pillows.
2. Wash hands ID client, provide privacy, & explain procedure.		
3. Elevate bed to working height & place draw sheet under client's back (shoulder to knees)		
Fowler's Position • Hips even with the middle of the bed, place bed at a 45° to 90° angle. • Small pillow at small of back, pillow under ankles, arms, & head		 Semi-Fowlers 45-60 High-Fowlers 60-90
Supine Position • Bed flat. Small pillow at small of back, pillow under head & ankles.		 Assess heels for redness
Side-Lying Position • Roll client to side. Place pillow under head, behind back, between legs, and tucked by abdomen. Move dependent shoulder forward.		
Sims Position • Roll client toward abdomen with dependent shoulder, arm, hip & leg pulled back. Place pillow under head, tucked under abdomen, under top leg, & under top arm		
Prone Position • Client on abdomen. Place small pillow under head. Turn head to side. Extend arms near side or flex toward head. Place pillow under ankles or allow toes to rest between foot of bed & mattress.		
4. Assess client for comfort. Lower the bed & elevate side rails. Evaluate frequency of repositioning.		At least every 2 hours
5. Document actions/findings/client tolerance:		Complete within 15 minutes.

Check off by:_____ Check off by:_____
Student Evaluator

Date:_____ Date:_____

Urine Sample – Foley (Sterile), Clean Catch

Skill of the Week Objectives & Activities
• Demonstrate sterile urine sample collection from Foley catheter • State patient instructions to safely obtain clean catch urine sample for a male & female • Describe safe/effective handling, storage and correct amounts of urine samples • State normal urine appearance pH, specific gravity, glucose, acetone

Urinalysis – clean catch

First voided spec in am if possible to ensure uniform concentration of constituents

Nurse can do quick screening with reagent strips

What is measured?

- Specific Gravity (N=1.010-1.025)
  - ⇒ Substance concentration compared to equal volume of water
  - ⇒ Aids in determination of fluid balance:
  - ⇒ High-concentrated – dehydration
  - ⇒ Low-dilute – over hydration
- pH (N=4.6 – 8)
  - ⇒ Acid pH protects against bacteria
- Protein (N=up to 8mg/100ml)
  - ⇒ Damage to glomeruli or tubules (Renal Failure) allows protein to enter urine
- Glucose (N=0)
  - ⇒ Inability of tubules to reabsorb high glucose concentrations (diabetes)
  - ⇒ Seen in healthy with heavy ingestion of glucose
- Ketones (N=0)
  - ⇒ End product of fat metabolism
  - ⇒ Seen in dehydration, starvation, excessive use of aspirin
- Blood (RBC - N=0; WBC – N=0-4)
  - ⇒ Renal damage, trauma, disease, surgery, UTI
- Bacteria (N=none)
  - ⇒ UTI

Procedure Checklist
Obtaining a Clean-Catch Urine Specimen

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, body mechanics.			
Note: If patient can do self-care, instructs patient in the following steps. If not, performs them for patient.			
1. Dons clean procedure gloves.			
2. Opens the prepackaged gloves.			
3. Washes hands and don clean procedure gloves.			
4. Cleanses, or instruct patient to cleanse, around the urinary meatus. Allow the area to dry.			
Variation: For Women:			
a. Washes the perineal area with warm water and mild soap if soiled. Otherwise, instructs use of an antiseptic towelette.			
b. Opens the antiseptic towelette provided in the prepackaged kit. If there is no kit, pour the antiseptic solution over the cotton balls. Wipes down one side of the meatus using one pad and discard it. Then wipes the other side with a second pad. Wipes down center over the urinary meatus with the third pad; then discard it. Cleans the perineal area at least twice. Uses each towelette or cotton ball only once.			
Variation: For Men:			
c. If the penis is uncircumcised, retracts the foreskin back from the end of the penis.			
d. Uses the towelette provided in the prepackaged kit or pour antiseptic solution over cotton balls or a 2 in. x 2 in. gauze pad soaked with povidone-iodine, if patient is not allergic to iodine.			
e. With one hand, grasps the penis gently. With the other hand, cleanses the meatus in a circular motion from the meatus outward, and cleanses for a few inches down the shaft of the penis. Cleanses around the meatus at least twice, using each towelette or cotton ball only once. Repeats the cleansing three times, each time with a fresh 2 in. x 2 in. gauze pad, towelette, or cotton ball.			
5. Removes gloves. Washes hands, and dons the second pair of clean procedures gloves.			

Procedure Steps	Yes	No	Comments
6. Opens the sterile specimen container, being careful not to touch the inside of the lid or container.			
7. Holding the container near the meatus, instructs patient to begin voiding into the container. Holds the female labia apart during this step (or teaching self-care patients to do so). For the male patient who is unable to assist, holds the penis during voiding.			
8. Allows a small stream of urine to pass; and then without stopping the urine stream, places the specimen container into the stream, collecting approximately 30-60 mL.			
9. Removes the container from the stream, and allows patient to finish emptying his bladder. *Note*: If the penis is uncircumcised, replaces the foreskin over the glans when the procedure is finished.			
10. Carefully replaces the container lid, touching only the outside of the cap and container. Avoids touching the rim of the cup to the genital area. Does not get toilet paper feces, pubic hair, menstrual blood, or anything else in the urine sample.			
11. Labels the container with the correct patient information (in many institutions, labels are preprinted or bar-coded). Places the container in a facility-specific carrier (usually a plastic bag) for transport to the lab.			
12. Removes gloves and washes hands. If the specimen has been obtained from a patient on a bedpan, leaves gloves on until it is removed, emptied, and stored properly.			
13. Assists patient back to bed, or removes the bedpan, if applicable. (See Procedure 28-2 for removing a bedpan).			
14. Transports the specimen to the lab in a timely manner.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Check List
Obtaining A Sterile Specimen From A Foley Catheter

Student Name:_____ Date:_____

	Skill Check off: Positioning a Client in Bed	S	Comments
1.	Determine appropriateness, verify orders.		
2.	Gather appropriate equipment: Gloves, clamp, sterile specimen cup, Biohazard bag, label, lab requisition, alcohol wipes, 10 ml syringe		Access to the closed system is by needleless port.
3.	Wash hands, ID client, provide privacy, explain procedure.		
4.	Manipulate the drainage tubing so that urine in tubing goes into bag. Clamp tubing below aspiration port for 15-30 minutes.		
5.	Prepare specimen cup & remove cap. Apply gloves. Cleanse aspiration port with antiseptic solution and let dry. Secure syringe to access port, aspirate 10 ml of urine.		
6.	Transfer urine to labeled container, seal, and place in biohazard bag. Place syringe in sharps container or designated biohazard container. Remove clamp & gloves and wash hands.		
7.	Evaluate patency of closed urinary drainage system before leaving client's room.		
8.	Document actions/findings/client tolerance:		Specimen must be transported to lab with 15 minutes or refrigerate. Complete within 10 minutes.

Check off by:_____ Check off by:_____
Student Evaluator

Date:_____ Date:_____

Hot & Cold Applications

Skill of the Week Objectives & Activities
• Understand normal body responses to local temperature variation • Know local effects of heat and cold • List conditions that increase risk from heat and cold application • List therapeutic effects of heat and cold application • Determine how to assess for temperature tolerance • List safety factors for applying heat or cold • Compare/contrast moist and dry application methods • Demonstrate how to apply warm soaks, ice packs, and use thermal pads safely

Risks

- Impaired circulation: Diabetes, peripheral vascular disease (PVD), arteriosclerosis
- Decreased ability to note discomfort: age, confusion, unconsciousness, spinal cord injury

Safety Factors

- Check skin for breaks, stomas, edema, scar formation, impaired circulation
- Assess for alertness, cooperation, sensation
- Equipment safety

Moist/Dry Application Methods

- Moist: Compress/pack, soaks, sitz bath, K pad
- Dry: blower, heat lamp, commercial hot packs

Effects

- Warm soaks: cause vasodilation & increase tissue blood flow
- Ice packs: cause vasoconstriction, local anesthetic, blood coagulation

Thermal pads: electronic method for administering hot or cold

Student Name:_____ Date:_____

Skill Check off: Hot/Cold Applications	S	Comments
1. Verify orders, determine appropriateness & gather equipment.		Assess for sensation, color, tissue damage, bleeding.
2. Wash hands, ID client, provide privacy & explain procedure.		
3. Assess site for skin integrity, circulation, movement, sensation		Apply gloves if skin not intact
Cold Applications • Prepare cold pack & cover with towel or cover sleeve • Apply to affected area.		Fill bag or collar 2/3 full with ice and expel air. Activate pack. Temperature about 59°F.
• Place pack over affected area & secure.		
• Leave pack in place for 20-30 minutes if client tolerates.		Check periodically to ensure tolerance.
Hot Applications • Prepare warm pack (moist or dry) & cover with towel.		Temperature about 105-113°F.
• Place over affected area for no more than 30 minutes.		Assess client tolerance periodically.
K-Pad Applications • Prepare warm or cold application using k-pad. (dry or moist).		Verify adequate distilled water Set temperature
4. Reassess after 5 minutes		
5. Remove after no more than 30 minutes, reassess		
6. Dispose of single use items, assess site, remove/clean equipment & perform hand hygiene.		
7. Document actions/findings/client tolerance: Identify hazards of using hot & cold therapies. What patients are at risk?		

Check off by:_____ Check off by:_____
Student Evaluator

Date:_____ Date:_____

Blood Glucose Testing & Monitoring

Skill of the Week Objectives & Activities
• Identify steps for safe nursing care when clients need blood glucose testing. • Demonstrate accurate blood glucose testing. • Describe appropriate interventions once blood glucose levels have been determined.

(Blood Sugar, Fasting Sugar (FBS)

Normal Value

Child-2 years to adult:

80-120 mg/dl

Critical Value

<40 and >400 mg/dl

Clinical Priorities

- Serum glucose levels must be evaluated according to the time of day they are obtained. Increased levels follow a recent meal.
- Glucose determinations must be performed frequently in new diabetic patients to determine appropriate insulin therapy. Finger stick blood glucose determinations are often performed before meals and at bedtime.
- Many forms of stress can cause increased serum glucose levels. Trauma, general anesthesia, infection, burns, myocardial infarction.
- Many drugs affect glucose levels.
  - ↑ antidepressants (tricyclics), beta-adrenergic blocking agents, corticosteroids, caffeine, IV fluids contain dextrose, which is quickly converted to glucose
  - ↓ acetaminophen, alcohol, insulin, popranolol
- Many pregnant women experience some degree of glucose intolerance. If significant it is called gestational diabetes.

Procedure Checklist
Checking Fingerstick (Capillary) Blood Glucose Levels

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Instructs patient to wash her hands with soap and warm water, if she is able. Dries completely.			
2. Turns on the glucose meter. Calibrates according to the manufacturer's instructions.			
3. Checks the expiration date on the container of reagent strips.			
4. Checks that the reagent strip is the correct type for the monitor being used.			
5. Dons procedure gloves.			
6. Removes the reagent strip from container; tightly seals the container.			
7. Places reagent strip into the glucose meter.			
8. Selects a puncture site on the lateral aspect of a finger (heel or great toe for an infant) and cleans the site with alcohol pad (according to facility policy). Lets dry completely.			
9. Uses a different site each time glucose is checked.			
10. Positions the finger in a dependent position and massages toward the fingertip.			
11. For infants, older adults, and people with poor circulation, places a warm cloth on the site for about 10 minutes before obtaining the blood sample.			
12. Performs fingerstick: a. Engages the sterile injector and removes the cover.			
b. Places a disposable lancet firmly in the end of injector.			
c. Places the back of the hand on the table, or otherwise secures the finger so it does not move when pricked.			
d. Positions the injector firmly against the skin, perpendicular to the puncture site. Pushes the release switch, allowing the needle to pierce the skin.			
e. If there is no injector, uses a darting motion to prick the site with the lancet.			
13. Lightly squeezes patient's finger above the puncture site until a droplet of blood has collected.			

Procedure Steps	Yes	No	Comments
14. Places a reagent strip test patch close to the drop of blood. Allows contact between the drop of blood and the test patch until blood cover the entire patch. Does not "smear" the blood over the reagent strip.			
15. Places the reagent strip into the glucose meter, if not already inserted. (Follows individual manufacturer instructions).			
16. Allows the blood sample to remain in contact with the reagent strip for the amount of time specified by the manufacturer.			
17. Using a gauze pad, gently applies pressure to the puncture site.			
18. After the meter signals, reads the blood glucose level indicated on the digital display.			
19. Turns off the meter and disposes of the reagent strip, cotton ball, gauze pad, paper towel, alcohol pad, and lancet in the proper containers.			
20. Removes the procedure gloves and disposes of them in the proper container.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Oxygenation, Airways, Nasal Cannulas, Masks

Skill of the Week Objectives & Activities
• Correctly identify, and apply mask, re-breather mask, and nasal cannula • Correctly define pulse oximetry and its purpose. • Demonstrate oral/nasal airway insertion. • Demonstrate correct use of ambu bag.

Oxygenation:

Oxygen ordered by physician. At times there may be a range ordered according to oxygenation saturations or a unit/facility protocol.

Too high an oxygen flow rate in any patient can stimulate changes in the lung tissue causing a decrease in diffusion, check your oxygen flow meters and orders for each patient.

Patients with COPD are used to high $PaCO_2$ levels in their blood. Too much oxygen (over 1-2 L/min) can take away their drive to breath, as a lack of oxygen has become their breathing trigger rather than a high CO_2 level.

Oxygen can be ordered by the liters per minute (L/min) or by the % of oxygen in inspired air. In normal room air breathing 21% oxygen reaches the lungs.

Airways:

- Choose oral or nasal & measure from the tip of nose (nasal) or corner of mouth (oral) to the earlobe

Nasal Cannulas:

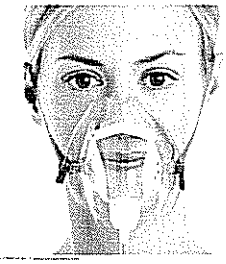
- Is effective for mouth breathers because oxygen is heavier than room air.
- Can accommodate oxygen up to 6 L/min. Flow rates > 4L/min rarely used because they dry out the mucosa and do not increase the actual oxygen concentration inspired.
- Need to humidify the oxygen with sterile distilled water. Check the humidifier when you check the oxygen and replace as needed.

Masks:

Oxygen masks are used to administer oxygen, humidity, or heated humidity.

Simple Face Mask

- For short term oxygen therapy
- Not a good idea to use these with CO_2 retention patients (COPD)



- Provide 30-60% oxygen

Re-breather Mask - Can provide 70% oxygen when used at 10 L/min

Reservoir/Non-re-breather Mask - 80-90% oxygen at 10 L/min

Venturi Mask

- The percentage of oxygen depends on the flow rate attached to it.
- Highest is 55% (14 L/min), lowest 24-30% (2-3 L/min)

Student Name:_____ Date:_____

Activity	Date	Instructor
Oxygenation - Mosby CD/Intermediate		

Skill Check off: Oxygen Administration (Airway/Ambu/Nasal/Mask)	S	Comments
1. Determine appropriateness of administration type, verify orders, & perform hand hygiene. Gather appropriate equipment. Wash hands, ID client, provide privacy, & explain procedure.		
Oral/Nasal Airway 2. Select appropriate type/size (nasal/oral); Insert into mouth/nares correctly		
Ambu Bag 3. Attach to O2 source & mask; Administers breaths		
Nasal Cannula 4. Attach nasal cannula to humidified oxygen source & adjust oxygen flow to prescribed rate.		
5. Place tips of cannula into nares & adjust until cannula fits snugly and comfortably. Perform hand hygiene.		
Mask 6. Select correct size & apply correctly, adjust for fit		
7. Document actions/findings/client tolerance:		
Follow up Assessment • Check oxygen flow rate and physician's orders every 8 hours. • Inspect client for relief of symptoms. • Observe nares and superior surface of ears for skin breakdown. • Assess pulse oximetry readings with VS or as ordered.		

Check off by:_____ Check off by:_____
Student Evaluator

Date:_____ Date:_____

Enemas

Skill of the Week Objectives & Activities
• Explain what an enema is and its purpose • State the suggested maximum volume for an enema in an adult • State procedure and rationale for cleansing enema, tap water enema, oil retention enema, Harris flush, and medicated enemas • Assemble correct equipment, position client correctly, and follow procedure for administering a cleansing enema • Correctly place client on a bedpan after enema administration • Correctly document the administration of, effect and results of a cleansing enema

Types:

Cleansing
- tap water
- normal saline
- soap solutions (1 tsp castile per 1000 cc)
- Low volume hypertonic (fleets)

Oil Retention

Carminative
- MGW or 1-2-3 (30 ml magnesium, 60 ml glycerine, 90 cc water)
- Return flow–Harris flush

Medicated
- Kayexalate
- Neomycin

Administration:

Note: tip insertion on adult is 3-4 inches
Height of container is 12-18 inches for high enema
Height of container is 12 inches or less for a low enema
Maximum volumes for an adult are 750-1000 cc

Enemas till clear - indicates no more fecal matter, not that water is clear.
No more than three or less if patient not tolerating

Patient who is unable to contract the external sphincter: put on bedpan, but never administer an enema on commode or toilet.

Digital removal of stool: check hospital policy, use caution, watch for bleeding.

Procedure Checklist
Administering an Enema

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Determines patient's ability to retain the enema solution.			
2. Places a bedpan or bedside commode nearby for patient with limited mobility.			
3. Opens the enema kit or obtains supplies.			
4. Warms the solution to 105^0-110^0F (40^0-43^0C), not in a microwave. Checks temperature with bath thermometer.			
5. Attaches tubing to the enema bucket if a bucket is being used (the 1-L enema bag comes with preconnected tubing).			
6. Closes the clamp on the tubing and fills the container with 500-1100 mL of warm solution (40-150 mL for infants; 250-350 mL for toddlers; 300-500 mL for school-age children.)			
7. Adds castile soap or soap solution used by the facility, if a soapsuds enema was prescribed.			
8. Hangs the container on the IV pole.			
9. Holding the end of the tubing over a sink or waste can, opens the clamp and slowly allows the tubing to prime (fill) with solution. Reclamps when filled.			
10. Dons clean procedure gloves.			
11. Asks patient to turn or assists to turn to a left side-lying position with the right knee flexed. (Elevates head of the bed very slightly for patients who have shortness of breath).			
12. Places a waterproof pad under patient's buttocks/hips.			
13. Drapes patient with bath blanket, leaving only the buttocks and rectum exposed.			
14. Places the bedpan flat on the bed directly beneath the rectum, up against patient's buttocks; or places the bedside commode near the bed.			
15. Generously lubricates the tip of the enema tubing.			
16. If necessary, lefts the superior buttock to expose the anus.			
17. Slowly and gently inserts tip of the tubing approximately 7-10 cm (3-4 in.) into rectum; asks patient to take slow, deep breaths during this step.			
18. If tube does not pass with ease, does not force, allows a small amount of fluid to infuse and then tries again.			

Procedure Steps	Yes	No	Comments
19. Removes the container from the IV pole and holds it at the level of patient's hips. Begins instilling the solution.			
20. Slowly raises the level of the container so that it is 30-45 cm (12-18 in.) above the level of the hips. Adjusts the IV pole and rehangs the container.			
21. Continues a slow, steady instillation of the enema solution.			
22. Continuously monitors patient for pain or discomfort. If pain occurs or resistance is met at any time during the procedure, stops and consults with the primary care provider.			
23. Assesses ability to retain the solution. If patient has difficulty with retention, lowers the level of the container, stops the flow for 15-30 seconds, and then resumes the procedure.			
24. When the correct amount of solution has been instilled, clamps the tubing and slowly removes the tubing from the rectum.			
25. If there is stool on the tubing, wraps the end of the tubing in a washcloth or toilet tissue until it can be rinsed or disposed of.			
26. Cleanses patient's rectal area.			
27. Re-covers patient.			
28. Instructs patient to hold the enema solution for 5-15 minutes.			
29. Places the call light within reach.			
30. Disposes of enema supplies or, if reusable, cleans and stores in an appropriate location in patient's room.			
31. Removes gloves; washes hands.			
32. Depending on patient's mobility status, assists onto the bedpan, to the bedside commode, or to the toilet when she feels compelled to defecate.			
33. After patient has defecated, inspects the stool for color, consistency, and quantity.			

Procedure Checklist
Administering an Enema (continued)

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Prepackaged Enemas:			
1. Determines patient's ability to retain the enema solution.			
2. Places a bedpan or bedside commode nearby for patient with limited mobility.			
3. Warms the solution-not in a microwave.			
4. Dons clean procedure gloves.			
5. Asks patient to turn or assists to turn to a left side-lying position with the right knee flexed. (Elevates head of the bed very slightly for patients who have shortness of breath).			
6. Places a waterproof pad under patient's buttocks/hips.			
7. Drapes patient with bath blanket, leaving only the buttocks and rectum exposed.			
8. Opens prepackaged enema. Removes the plastic cap from the container. The tip of the prepackaged enema container comes prelubricated. Adds extra lubricant as needed.			
9. If necessary, lifts the superior buttock to expose the anus.			
10. Slowly and gently inserts tip of the tubing approximately 7-10 cm (3-4 in.) into rectum; asks patient to take slow, deep breaths during this step.			
11. If tube does not insert with ease, does not force; removes, relubricates, and retries.			
12. Tilts container slightly and slowly rolls and squeezes the container until all of the solution is instilled.			
13. Withdraws container tip from the rectum; wipes the area with a washcloth or toilet tissue.			
14. Cleans patient's rectal area, re-covers patient and instructs to hold the enema solution for approximately 5-10 minutes.			
15. Removes gloves; washes hands.			
16. Places the call light within reach.			
17. Disposes of the empty container.			
18. Depending on patient's mobility status, assists onto the bedpan, to the bedside commode, or to the toilet when she feels compelled to defecate.			
Return-Flow Enemas:			
1. Obtains rectal tube and solution container.			

Procedure Steps	Yes	No	Comments
2. Places a bedpan or bedside commode nearby for patient with limited mobility.			
3. Prepares 100 to 200 mL tap water or saline. Warms the solution to 105^0-110^0F (40^0-43^0C), not in a microwave. Checks temperature with bath thermometer.			
4. Attaches tubing to the enema container and primes the tubing.			
5. Dons clean procedure gloves.			
6. Asks patient to turn or assists to turn to a left side-lying position with the right knee flexed. (Elevates head of the bed very slightly for patients who have shortness of breath).			
7. Places a waterproof pad under patient's buttocks/hips.			
8. Drapes patient with bath blanket, leaving only the buttocks and rectum exposed.			
9. Generously lubricates the tip of the enema tubing.			
10. If necessary, lifts the superior buttock to expose the anus.			
11. Slowly and gently inserts tip of the tubing approximately 7-10 cm (3-4 in.) into rectum; asks patient to take slow, deep breaths during this step.			
12. If tube does not insert with ease, does not force; allows a small amount of fluid to infuse and then tries again.			
13. Holds the container at the level of patient's hips. Begins instilling the solution.			
14. Slowly raises the level of the container so that it is 30-45 cm (12-18 in.) above the level of the hips.			
15. Continues a slow, steady instillation of the enema solution.			
16. Instills all the solution into patient's rectum.			
17. When the correct amount of solution has been Lowers the tube and container below the level of the rectum and allows the solution to flow back into the container.			
18. Repeats instillation and return several times or until distention is relieved.			
19. Withdraws container tip from the rectum; wipes the area with a washcloth or toiler tissue.			
20. If there is stool on the tubing, wraps the end of the tubing in a washcloth or toilet tissue until it can be rinsed or disposed of.			
21. Removes gloves; washes hands.			
22. Places the call light within reach.			
23. Disposes of the empty container.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Physical Assessment (LPAT)

Skill of the Week Objectives & Activities
• List the purposes of physical assessment • Define inspection, palpation, percussion, auscultation • List techniques used to promote the client's physical and psychological comfort during an exam • List normal physical findings in an adult • Demonstrate placement of stethoscope for auscultation of breath sounds, bowel sounds, apical heart rate • Be aware of anterior, lateral, and posterior position of lung lobes in relation to anatomical landmarks LPAT & KATZ Mini-mental forms available on website

Student Name:_____ Date:_____

Skill Check off: LPAT	S	Comments
1. Neurological		
2. HEENT		
3. Respiratory		show proper placement of stethoscope for auscultation of all lobes (anterior & posterior) Explain/demonstrate the most effective method for auscultation.
4. Cardiovascular		show proper placement of stethoscope for PMI
5. Gastrointestinal		show proper placement of stethoscope and order for bowel sounds Explain hyper, hypo, and absent bowel sounds
6. Genitourinary		How much urine is normal for an hourly average?
7. Musculoskeletal		
8. Psychosocial		Complete within 15 minutes

Check off by:_____ Check off by:_____
Student Evaluator

Date:_____ Date:_____

Merced College
Registered Nursing –REG 15

Leveled Physical Assessment Tool (LPAT)
1st semester - Inspection & Auscultation

Pt. ID: _____ Room #: _____ Date: _____ height: _____ weight: _____ BMI: _____

Vital Signs: T _____ P _____ R ____ BP _____ O2 sat. _____% Pain ____/ 10
T _____ P _____ R ____ BP _____ O2 sat. _____% Pain ____/ 10
T _____ P _____ R ____ BP _____ O2 sat. _____% Pain ____/ 10

NEUROLOGIC

Level of Consciousness (LOC):	Alert	Lethargic / Stuporous / Comatose
Level of Orientation:	x 4	Person / Place / Time / Purpose
Pain:	none	present (location): _____
Sleep pattern:	normal for self	abnormal (describe): _____

HEENT (head, eyes, ears, nose, and throat)

Head: shape	normocephalic	asymmetrical
Hair:	clean / shiny	dirty / dull / fine / coarse
Eyebrows / Eyelashes:	present	absent
Eyes : sclera	white	red / yellow / brown
vision	normal	glasses / contacts
Ears: hearing	normal (low voice)	HOH / Deaf or Hearing aid: AD AS AU
Nose: nares	patent	non-patent / deviated septum / bloody
Mouth: lips	intact	cracked / swollen
tongue	clean	coated
mucous membranes	moist	dry
dentition	good	poor / loose / edentulous / dentures: upper / lower / both
Throat: swallowing	smooth	dysphagia
speech	clear	aphasia

RESPIRATORY

Rhythm / Depth / Quality :	reg. / nml. / unlabored	irregular / deep / shallow / labored
Chest shape (AP diameter):	normal (AP<transverse)	asymmetrical
Lung sounds: anterior	clear	RUL LUL RML LLL RLL
posterior	clear	RUL LUL LLL RLL
Cough:	none	non-productive / productive (sputum color): _____
Supplemental Oxygen:	none	present at _____ Liters per: nasal cannula / mask PRN

CARDIOVASCULAR

Skin: Color	robust	pale / jaundice / cyanotic / other: _____
Temp. / moisture	warm / dry	cold / moist / oily
Turgor	good (non-tenting)	poor (tenting)
Integrity	intact	broken / wound (location): _____
Fingernails & Toenails:	normal	yellow / thick
capillary refill:	normal (<3 sec.)	delayed @ _____ sec.
Pulses: Apical	strong	weak / unable to auscultate
Radial	strong / equal	weak / unequal / absent on R L side
Pedal	strong / equal	weak / unequal / absent on R L side
Heart: Rhythm	regular	irregular
Quality	strong	weak
IV / Heplock:	N/A or present	Solution: _____ Rate: _____ Site: _____ Appearance: _____
Central line / PICC line:	N/A or present	Site: _____ Appearance: _____

GASTROINTESTINAL

Abdomen: size / shape	round / flat	protuberant (obese) / scaphoid (very thin)
bowel sounds	present x 4 / borborygmi	hypoactive / hyperactive / absent / (location): _____
Appetite:	good	poor / nausea / emesis (color): _____
Nasogastric tube (NG):	none	R L nares / drainage color : _____
Fluid intake:	good	poor / fluid restriction @ _____ mls/ hr
Bowel movement:	yes	no / LBM (date): _____
BM characteristics:	soft / medium brown	liquid / hard (pellets) / small / copious / blood / green / pain

GENITOURINARY

Urine: color / clarity	yellow / clear	dk. amber / bloody / cloudy / burning / incontinent
catheter	none	foley / condom / in & out
Fluid Output:	good	poor / type & amount: _____
Discharge:	none	vagina / penis (description): _____

MUSCULOSKELETAL

Muscle: tone	good	poor
Muscle strength: hand grips	strong / equal	weak / unequal / absent: _____
foot pushes	strong / equal	weak / unequal / absent: _____
Joints:	normal	enlarged / painful
Range of Motion (ROM):	full	limited / location: _____
Gait:	steady	unsteady
CMS (If in cast / sling / traction):	good	poor / limited / location: _____
Amputations:	no	yes (location): _____

PSYCHOSOCIAL

Behavior:	cooperative / pleasant	uncooperative / withdrawn / combative / other: _____
Family:	present	absent / waiting
Restraint: wrist / ankle	N/A	released (times): _____
skin problem	no	yes (describe): _____

Comments (OK to list anything here that was unique or different than any of the above choices)
- Also a place to do a narrative charting on any procedure or finding -

_____

_____

_____

_____

_____

_____

_____

_____

Time: _____ Signature / title: _____ Initial: _____

Intake and Output: Charting

Skill of the Week Objectives & Activities
• Be able to convert ounces to mL's and determine how many mL's are in the following: a six ounce coffee cup, a four ounce juice glass, a six ounce soup bowl, a eight ounce glass • Be able to use a graduate measuring device to measure a quantity of liquid (output) • Successfully perform the recording of intake and output on a standard I&O sheet

Measuring and recording all liquid intake and output during a 24-hour period provides assessment data for fluid, electrolyte, and acid-base balance.

Intake

- Oral-all liquids taken by mouth, on tray, foods that are liquid at room temperature, soup, gelatin, ice cream, juice, water in pitcher, liquid medications (Maalox, Metamucil, etc.)
- Via NG or gastrostomy tube
- Parenterally-IV fluids, blood or blood products
- Types of irrigation-liquid instilled into the body with corresponding output drainage recorded in the output

Output

- Urine, voided-emptied from a bedpan, hat, or urinal or catheter-emptied hourly or q 8 hours
- Diarrhea
- Vomitus
- Gastric suction
- Drainage from post surgical tubes (drains)
- Drainage from dressings-large amounts
- Diaphoresis-in the case of fever, extreme heat
- Respiratory

Routinely measured for clients after surgery, who are unstable, have a fever, are on fluid restriction, are receiving fluids by IV therapy, or are on diuretics. Especially heart and kidney patients. No doctor's order is needed.

Requires help from the client and family. Nurse explains reason for measurement. Client to notify nurse after voiding.

Fluid Content of Selected Foods

Food	Fluid (ml)	Food	Fluid (ml)
Broth (6 oz.)	180	Juice (4 oz)	120
Coffee/tea	240	Milk (carton)	240
Creamer	15	Popsicle	90
Cup, Styrofoam (6 oz) = 4 oz liquid	120	Fruited ice	120
Ice cream, sherbet	90	Soda (can)	360
Gelatin, plain	120	Soup, cream (puree)	180
Gelatin, fruited	80	Soup, chowder or split pea	90

Equivalents:						
	1 cup	=	240 ml	1/4 cup	=	60 ml
	½ cup	=	120 ml	1 Tbsp	=	15 ml
	1/3 cup	=	80 ml	1 oz	=	30 ml

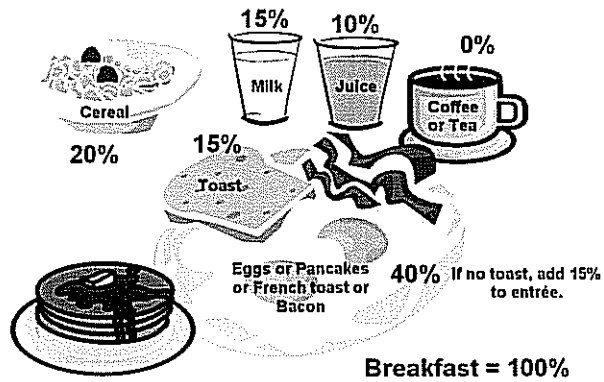
Normal Fluid Intake & Output

Intake 1500-2500 ml/24 hr (Remember! A kg gained is a liter retained.)

Output 1500-2500 ml/24 hr (Minimum urine output is 30 ml/hr!)

Insensible loss 500-1000 ml/day

Breakfast Measurements



Student Name:_____Date: _____

All videos, CD's and/or worksheets must be complete before the student may be checked off by an instructor. Additionally, the student must have the signature of another student verifying the student has successfully performed the skill before him/her.

Activity	Date	Instructor
Intake & Output - Mosby CD/Basic/Measurements		

Skill Check off: Intake & Output	S	Comments
Correctly measures items from set up		

Check off by:_____
Evaluator

Date:_____

I & O Sheet

Student Name:_____ Date:_____

Date Started (7 AM): 12 hour Intake & Output Record

Intravenous Fluid Administration				Oral Intake			Fluid Output				
Time	Type of Fluid and Medication Added	ML in Bag	ML Infused	Time	Type	Amount	Time	Urine	Emesis	Drain	B.M.
Day Shift Summary (All Columns 7 AM – 7 PM)		12° Total		12° Total			12° Total				

Catheter Care & Discontinue

Skill of the Week Objectives & Activities
• Demonstrate proper care for clients with indwelling foley catheters • Demonstrate safe discontinue of a foley catheter.

Indwelling Foley Catheter

- For accurate intake and output
- For urine retention problems
- For surgical patients
- Foley catheter may stay in for a few days to a month

Catheter Care

- Female: retract labia and keep hand in position during cleansing
- Male: retract foreskin
- Assess meatus and surrounding tissue
- Cleanse pubis from front to back using a new area of the cloth with each wipe
- Cleanse at catheter site first and then down the length of the catheter

Assessment Questions

- Able to void without difficulty prior to insertion?
- Prone to urinary tract infection?
- Taking in fluids well enough to promote urine productions?
- Able to walk to the bathroom?
- Prone to skin problems?

Removal

- Assess client hx for urinary problems & need for specimen
- Explain:
  - Reason for removal
  - Usually does not hurt during removal, but you will feel the catheter coming out
  - Client to take deep breaths during removal for relaxation
  - Client may experience a little burning & blood in urine at first void
  - Client to void into specified container for measuring
  - Inform nurse at first void & if burning does not go away
- DO NOT CUT THE PORT!
- STOP IF RESISTANCE FELT!
- Inspect the balloon and catheter for intactness

Documentation

- Client tolerance of the procedure
- Balloon & foley catheter size & condition (intact)
- Time foley removed & amount on I&O
- Post first void document: Time, color, amount

Procedure Checklist
Removing an Indwelling Catheter

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
Note: If patient can do self-care, instructs patient in the following steps. If not, performs them for patient.			
1. Dons clean procedure gloves.			
2. Instructs patient to assume a supine position.			
3. Places the catheter receptacle near patient (e.g., on the bed).			
4. Places a towel or waterproof drape between patient's legs and up by the urethral meatus.			
5. Obtains a sterile specimen (see Procedure 27-2B), if needed. Some agencies require a culture and sensitivity test of the urine when an indwelling catheter is removed.			
6. Removes the tape securing the catheter to patient.			
7. Deflates the balloon completely by inserting a syringe into the balloon valve and aspirating the fluid. Verifies that the total fluid volume has been removed by checking the balloon size written on the valve port.			
8. If unable aspirate all the fluid, does not pull on the catheter.			
9. Instructs patient to relax and take a few deep breaths as the nurse slowly withdraws the catheter from the urethra.			
10. Wraps the catheter in the towel or drape.			
11. Uses warm water and a washcloth to cleanse the perineal area. Rinses well.			
12. Measures the urine and then empties it in the toilet; discards the catheter, drainage tube, and collection bag in the biohazard waste receptacle.			
13. Explains to patient the need to monitor the first few voids after catheter removal. If patient toilets independently, ask him to notify the nurse when he voids and to save the urine.			
14. Places a receptacle in the toilet or bedside commode if patient toilets independently.			
15. Encourages patient to increase fluid intake if not contraindicated by other health conditions.			
16. Removes and discards gloves; washes hands.			

Procedure Steps	Yes	No	Comments
17. Records the date and time of the procedure; the volume, color, and clarity of the urine; and patient teaching.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Sterile Field, Open Gloving, Dressings & Bandages

Skill of the Week Objectives & Activities
• Be familiar with steps and rationale for open sterile gloving • State the function of sterile gloves know how to determine proper glove size • Successfully and properly perform sterile gloving • Be familiar with steps and rationales for preparing a sterile field and opening sterile packages • Successfully and properly perform setting up a sterile field and opening a sterile package • List seven purposes of dressings • List the CDC guidelines for preparing for, & changing a dressing • Maintain sterile technique during dry dressing change • Properly apply abdominal binder & elastic bandages

Definition:

- Medical Asepsis-absence of pathogenic organisms
- Surgical Asepsis-absence of all organisms and spores

Surgical Asepsis Principles

- Sterile objects remain sterile only when touched by another sterile object
  Sterile + sterile = sterile Sterile + contaminated = contaminated
  Sterile + clean = contaminated Sterile + questionable = contaminated
- Only sterile objects may be placed on a sterile field
- The package or container holding a sterile object must be intact and dry
  - A package torn, punctured, wet, or open is unsterile
- Sterile object or field out of the range of vision, or an object held below a person's waist is contaminated because it cannot be viewed at all times
- A sterile object or field becomes contaminated by prolonged exposure to the air
  - Avoid activities that create air currents after a sterile object or field becomes exposed
- Do not reach over a sterile field for microorganisms can fall on the sterile items
- A sterile object or field becomes contaminated by capillary action when a sterile surface comes in contact with a wet contaminated surface
  - Spilling solution over a sterile drape contaminates the field unless the drape cannot be penetrated by moisture
  - Because fluid flows in the direction of gravity, a sterile object becomes contaminated if gravity causes a contaminated liquid to flow over the objects surface
  - Hold your hands up while drying
- Edges of a sterile field or container are contaminated (1 inch border)
- Poured sterile liquid:
  - First pour small amount & discard
  - Washes away any microorganisms on the bottle lip
  - Second pour fills a container with the desired amount of solution

Seven purposes of dressings:

1. **Protecting a wound from microorganism contamination** - acts as a barrier between wound and outside microorganism
2. **Aiding hemostasis** - pressure dressings prevent bleeding of wound site; make sure pressure dressing is not too tight (check distal pulse)
3. **Promoting healing by absorbing drainage and debriding a wound** - absorbs drainage, exudate attaches to dressing; dressings act as a wick to pull moisture away from wound; don't pull dressings off...moisten with sterile normal saline if stuck; if for debridement, expect that it will stick as that is the purpose
4. **Supporting or splinting the wound site** - minimizes movement of the wound; can immobilize a body part
5. **Protecting the client from seeing the wound** (if perceived as unpleasant - physical barrier from viewing wound
6. **Promoting thermal insulation to the wound surface** - keeps wound from elements
7. **Providing maintenance of high humidity between the wound and dressing** - keeps wound moist and with high humidity

Identify the most common type of dressing, and its benefits:

Gauze dressings: most common; do not interact with wound tissues thus causes little wound irritation; available in different textures, shapes, and forms (pads, rolls)

Transparent dressing: superficial wounds such as abrasions; acts as second temporary skin

Wet dressing: often ordered as "wet to dry"; cleanses infection & dead cells

Non-adherent gauze dressing: Telfa; shiny, non-adherent surface that does not stick to incisions or wound openings

List the CDC guidelines for preparing for & changing a dressing:

- Wash your hands well before & after dressing change
- Do not directly touch wound without wearing sterile gloves
- Change dressings when they are wet, or if you detect signs of infection

Drainage Descriptions

- Sanguinous – bloody, clots (red)
- Serosanguinous – clear, blood-tinged (pinkish)
- Serous – clear, watery, may be slightly yellow tinged (plasma)
- Purulent – (AKA pus) – yellow/greenish, thick lumpy, may be odorous

Packing/Irrigation Principles

- A wound may be packed with gauze primarily to protect an open wound from contamination, absorb drainage, protect from mechanical injury, fill dead space, and debride the wound
- Be sure all the surface area to be debrided is covered with gauze
- Do not pack wound tightly for it will impair circulation and prevent healing
- If packing tunneled areas, always leave a piece of gauze visible for easy removal
- If wet-to-dry, do not apply NS to remoisten -> it is intended to debride
- If wet-to-dry, you may apply NS to remove it if it sticks to the wound
- Wet solutions penetrating the dry cover dressing cause wicking allowing pathogens access
- If absorbing drainage, fluff the gauze prior to packing

Procedure Checklist
Applying Sterile Gloves (Open Method)

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Determines correct glove size.			
2. Assesses glove package for intactness and expiration date.			
3. Creates a clean space for opening the package.			
4. Opens the outer wrapper and places the glove package on a clean, dry surface.			
5. Opens the inner package so that glove cuffs are nearest to the nurse.			
6. Fully opens the package flaps so they do not fold back over and contaminate the gloves.			
7. Takes care to not touch anything else on the sterile field, with the nondominant hand grasping the inner surface of the glove for the dominant hand and lifting up and away from the table.			
8. Slides the dominant hand into the glove, keeping the hand and fingers above the waist and away from the body.			
9. Slides gloved fingers under the cuff of the glove for the nondominant hand.			
10. Lifts the glove up and away from the table and away from the body.			
11. Slides the nondominant hand into the glove, avoiding contact with the gloved hand.			
12. Adjusts both gloves to fit the fingers and so that there is no excess at the fingertips.			
13. Keep hands between shoulder and waist level.			
(**Note:** to remove gloves, refers to the procedure for removing PPE).			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Preparing and Maintaining a Sterile Field

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Assesses the sterility of all packages and equipment.			
2. Positions patient before setting up a sterile field.			
Preparing a Sterile Field with Commercial Package:			
3. Places the sterile package on a clean, dry surface.			
4. Opens the flaps in this order to create a sterile field: a. Opens the flap farthest from own body.			
b. Opens side flaps.			
c. Opens flap nearest body.			
5. Treats as unsterile the area 1 inch from all edges of the wrapper, and any area hanging over the edge of the table.			
Preparing a Sterile Field with Fabric or Paper-Wrapped Package:			
6. Checks and removes the chemical indicator strip.			
7. Removes the outer wrapper and places the inner package on a clean, dry surface.			
8. Opens the inner wrapper following the same technique described in step 4 above.			
Preparing a Sterile Drape:			
9. Places the package on a clean, dry surface.			
10. Holds the edge of the package flap down toward the table and grasps the top edge of the package and peels back.			
11. Picks up the sterile drape by the corner and allows it to fall open without touching unsterile surfaces.			
12. Places drape on a clean, dry surface, touching only the edge of the drape.			
13. Does not fan the drape.			
Adding Supplies to a Sterile Field:			
14. Using the nondominant hand, peels back the wrapper in which the item is wrapped, creating a sterile barrier field with the inside of the wrapper.			
15. Holding the contents through the wrapper, several inches above the field, allows the supplies to drop onto the field inside the 1-inch border of the sterile field.			

Procedure Steps	Yes	No	Comments
16. Does not let arms pass over the sterile field; does not touch supplies with nonsterile hands.			
17. Disposes of the wrapper and continues opening any needed supplies for the procedure.			
Adding Sterile Solutions to a Sterile Field			
18. If the sterile field is fabric or otherwise at risk for strikethrough, uses a sterile bowl or receptacle. It may be added to the field by unwrapping as described in the preceding section.			
19. Places a sterile bowl near the edge of the sterile field.			
20. Checks that the sterile solution is correct and not expired.			
21. Removes the cap off the solution bottle by lifting directly up.			
22. If the cap will be reused, sets it upside down on a clean area.			
23. Holds the bottle of solution 4-6 inches above the bowl to pour needed amount into the bowl.			
Other:			
24. Does not leave a sterile field unattended or outside the field of vision.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Applying and Removing Dry Dressings

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order for Procedure			
2. Wash hands			
3. Gather supplies			
4. Wash hands upon entering patient room			
5. I.D. patient			
6. Explain procedure			
7. Provide privacy			
8. Places patient in a comfortable position that provides easy access to wound			
9. Dons clean gloves			
10. Loosens the edges of the tape of the old dressing. Stabilizes the skin with one hand while pulling the tape in the opposite direction			
11. Beginning at the edges of the dressing, lifts the dressing toward the center of the wound			
12. Discards gloves and soiled gauze into a biohazard bag.			
13. If dressing sticks, moisten it with 0.9% (normal) saline before completely removing it			
14. Assess the type and amount of drainage present on the soiled dressing			
15. Assess wound for size, color of tissue present, amount and type of exudate and color			
16. Disposes of soiled dressing and gloves in a biohazard receptacle			
Applying the Dry Dressing			
1. Washes hands			
2. Opens sterile packages on a clean, dry surface			
3. Dons sterile gloves			
4. Applies a layer of dry dressings over the wound; if drainage is expected, uses an additional layer of dressings			
5. Applies tape; box technique			
6. Removes gloves, turning them inside out, and discards in a biohazard receptacle			
7. Positions patient for comfort			

Procedure Steps	Yes	No	Comments
8. Raise side rails on bed; place bed in low position			
9. Provide patient with call light			
10. Wash hands			
11. Document procedure			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Applying and Removing Wet-to-Damp Dressings

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order for Procedure			
2. Wash hands			
3. Gather Supplies			
4. Wash hands upon entering patient room			
5. I.D. patient			
6. Explain procedure			
7. Provide for privacy			
8. Places patient in a comfortable position that provides easy access to wound			
9. Dons clean gloves			
10. Loosens the edges of the tape of the old dressing. Stabilizes the skin with one hand while pulling the tape in the opposite direction			
11. Beginning at the edges of the dressing, lifts the dressing towards the center of the wound			
12. If dressing sticks, moisten it with 0.9% 9normal) saline before completely removing it			
13. Continues to remove layers until the entire dressing is removed			
14. Assesses the type and amount of drainage present on the soiled dressing			
15. Assesses wound for size, color of tissue present, amount and type of exudate and color			
16. Disposes of soiled dressing and gloves in a biohazard receptacle			
Applying the Wet-to-Dry Dressing			
1. Washes hands			
2. Establishes a sterile field, using a sterile impermeable barrier			
3. Opens sterile supplies onto a sterile field. The amount of gauze used will depend on the size of the wound			
4. Opens sterile containers (saline, nugauze, gauze tub, etc.)			
5. Dons one sterile glove			
6. Remove dry 4X4s and places onto sterile field from 4X4 gauze tub			

Procedure Steps	Yes	No	Comments
7. Pours a portion of saline into trash can to sterile lip of container			
8. Pours saline into 4X4 gauze tub			
9. Don second sterile glove			
10. Uses sterile scissors and forceps to cut nugauze and places on sterile gauze in gauze tub			
11. Irrigates or cleans wound (per MD order)			
12. Pack nugauze into wound using sterile cotton-tipped applicator			
13. Apply wet gauze onto wound bed			
14. Apply dry gauze on top of wet gauze			
15. Apply ABD (outer portion of dressing)			
16. Applies tape; box technique			
17. Removes gloves, turning them inside out, and discards in a biohazard receptacle			
18. Positions patient for comfort			
19. Provide patient with call light			
20. Raise side rails on bed; place bed in low position			
21. Wash hands			
22. Document procedure			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Applying Binders

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Choose a binder of the proper size. Measures.			
2. Washes hands. Dons gloves.			
3. Thoroughly cleans and dries the part to be covered.			
4. Places the body part in its natural, comfortable position (e.g., with the joint slightly flexed), whenever possible.			
5. Pads between skin surfaces (e.g., under the axilla) and over bony prominences.			
6. Fastens from the bottom up.			
7. Changes binders whenever they become soiled or wet.			
Applying an Abdominal Binder:			
8. Measures patient for the abdominal binder. a. Places patient in supine position.			
b. With a disposable measuring tape, encircles the abdomen at the level of the umbilicus. Note the measurement. This is the length of the binder.			
c. Measures the distance from the costal margin to the top of the iliac crests. This is the width of the binder.			
d. Disposes of gloves and measuring tape, and washes hands.			
e. Based on the measurements, obtains an abdominal binder.			
9. Assists patient to roll to one side. Rolls one end of the binder to the center mark. Places the rolled section of the abdominal binder underneath patient. Positions the binder appropriately between the costal margin and iliac crest.			
10. Makes sure the binder does not slip upward or downward.			
11. Assists patient to turn to the other side while unrolling the binder from underneath him.			

Procedure Steps	Yes	No	Comments
12. With the dominant hand, grasps the end of the binder on the side furthest from self, and steadily pulls toward the center of patient's abdomen. With the nondominant hand, grasps the end of binder closest to self, and pulls toward the center. Overlaps the ends of the binder so that the Velcro® enclosures meet.			
13. Removes the abdominal binder every 2 hours, and assess the underlying skin and dressings. Changes wound dressings if they are soiled, or as prescribed.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Skills Check Off

Elastic Bandage

Skill Check Off: Elastic Bandage	S	Comments
1. Gather appropriate equipment		
2. Wash hands, ID client, provide privacy, & explain procedure		
3. Assess client's skin integrity and circulation		
4. Help client to comfortable, correct position		
5. With roll of bandage in dominate hand, hold beginning of bandage at distal body part with other hand. Continue transferring bandage properly as it is wrapped.		Demonstrate spiral, reverse spiral, & figure 8
6. Document actions/findings/client tolerance: Explain the purposes of each type of application.		Complete within 5 minutes.
7. Evaluate distal circulation after application is completed and at least twice during 8-hour period.		

Check off by:_____
Student

Check off by:_____
Evaluator

Date:_____

Date:_____

Urinary Catheters

Skill of the Week Objectives & Activities
• Name the three types of urinary catheters • Define catheterization • List two possible complications of catheterization • Name two forms of catheter insertion • Describe the use and be able to identify the parts of a triple-lumen foley catheter • Recognize the differences between a foley catheter and a straight catheter • List the indications for catheterizations • Successfully and properly insert a urinary catheter • Correctly apply a condom catheter

Skill Goal

- Maintain sterility & properly insert a urinary catheter
- Utilize proper technique in the application of a condom catheter

Complications

- Sepsis
  - Sterile technique critical to avoid bacteria entering tract
  - Organisms may move up the catheter lumen or the space between the catheter & the urethral wall
  - Most clients with an indwelling catheter in place for more than 4 weeks develop bacteriuria (UTI)
- Trauma
  - Male urethra is especially vulnerable due to its length
  - Insertion with force can lacerate the urethral wall
  - Inflating the balloon while still in the urethra can rupture the urethra wall

Condom Catheter

- Alternative to indwelling catheter for the male client
- Applied externally to the penis
- Connected to leg bag during the day & drainage bag during the night
- Always follow manufacturer's instructions for applying the condom
- Apply secure enough to prevent leakage, yet not so tight as to constrict the blood vessels in the area
- Keep the tip of the tubing 1-2 inches away from the tip of the penis to prevent irritation
- Maintain free urinary drainage, no kinks, for the ammonia in the urine can excoriate the glans penis

Procedure Checklist
Inserting an Indwelling Urinary Catheter (Female)

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Takes an extra pair of sterile gloves and an extra sterile catheter into the room.			
2. Ensures good lighting.			
3. Dons procedure gloves.			
4. Works on the right side of the bed if right-handed; the left side, if left-handed.			
5. Places patient dorsal recumbent position (supine). a. Asks her to flex her knees and place her feet flat on the bed.			
b. Instructs patient to relax her thighs and allow them to rotate externally.			
6. If patient is confused or unable to follow directions, obtains help.			
7. Drapes patient. Covers upper body with blanket. Folds the blanket in a diamond shape, wrapping the corners around the patient's legs and folding the upper corner down over the perineum.			
8. Lifts the corner of the privacy drape to expose the perineum.			
9. Washes the perineal area with soap and water. Lets it dry. At the same time, visualizes and locates the urinary meatus.			
10. Folds the corner of the privacy drape down over the perineum.			
11. Removes and discards gloves.			
12. Washes hands.			
13. Organizes the work area: a. Bedside or overbed table within nurse's reach.			
b. Opens the sterile catheter kit and places on the bedside table, without contaminating the inside of the wrap.			
c. Positions a plastic bag or other trash receptacle so that nurse does not have to reach across the sterile field (e.g., near patient's feet); or places a trash can on the floor beside the bed.			

Procedure Steps	Yes	No	Comments
14. Applies a sterile drape(s) and underpad. **Variation: Waterproof Underpad Packed as Top Item in the Kit:** a. Removes the waterproof underpad from the kit before donning sterile gloves. Does not touch other kit items with bare hands.			
b. Allows the drape to fall open as it is removed from the kit. Touching only the corners and shiny side, places the drape shiny side down under the patient's buttocks.			
c. Dons sterile gloves (from the kit). (Touching only the glove package, removes it from the sterile kit before donning the gloves.)			
d. Picks up the fenestrated drape; allows it to unfold without touching other objects; places the hole over the labia.			
Variation: Sterile Gloves Packed as Top Item in the Kit:			
Uses the following steps instead of steps 14 a-d: e. Removes gloves from package, being careful not to touch anything else in the package with a bare hand.			
f. Grasps the edges of the sterile underpad and places it shiny side down under the patient's buttocks.			
g. Places fenestrated drape: Picks it up, allowing it to unfold without touching any other objects. Keeps gloves sterile.			
h. Places the fenestrated drape so that the hold is over the penis.			
15. Organizes kit supplies on the sterile field and prepares the supplies in the kit, maintaining sterility. a. Opens the antiseptic packet; pours solution over the cotton balls. (Some kits contain sterile antiseptic swabs; if so, opens the "stick" end of the packet.)			
b. Lays forceps near cotton balls (omits step if using swabs).			
c. Opens the specimen container if a specimen is to be collected.			
d. Removes any unneeded supplies (e.g., specimen container) from the field.			
e. If there is a plastic covering on the catheter, removes it.			
f. Now, squeezes the sterile lubricant into the kit tray. Rolls the catheter slowly in the lubricant, being sure to lubricate the first 2.5 – 5 cm (1 – 2 in.) of the catheter. Allow the catheter tip to stay in the sterile lubricant or on the sterile field until ready to use.			

Procedure Steps	Yes	No	Comments
g. Attaches the saline-filled syringe to the side port of the catheter. Leaves the syringe attached to the catheter.			
16. Touching only the kit or inside of the wrapping, places the sterile catheter kit down onto the sterile field between patient's legs.			
17. If the drainage bag is preconnected to the catheter, leaves the bag on the sterile field until after the catheter is inserted.			
18. Places the nondominant hand on the labia, and with the thumb and forefinger, spreads patient's labia, pulling up at the same time to expose the urinary meatus. Uses firm pressure to hold this position throughout the procedure.			
19. If the labia accidentally slip back over the meatus, repeats the procedure.			
20. Continuing to spread the labia with the nondominant hand, holds forceps in the dominant hand and picks up a cotton ball.			
21. Wipes from the clitoris to the anus, wiping in the order of: far labium majora, near labium majora, inside far labium, inside near labium, and directly down the center over the urinary meatus. Uses only one stroke and a new cotton ball for each area. **Note**: If the kit has only three cotton balls, cleanses only the inside far labium minora, and the inside near labium minora, and down the center of the urethral meatus.			
22. With the dominant hand, holds the catheter 3 – 5 cm (1 – 2 in.) from the proximal end, with the remainder of the catheter coiled in the palm of the hand.			
23. Asks patient to bear down as though trying to void; slowly inserts the end of the catheter into the meatus. Asks patient to take slow deep breaths until the initial discomfort has passed.			
24. Continues gentle insertion of catheter until urine flows. This is about 5 – 7.5 cm (2 – 3 in.) in a woman. Then inserts the catheter another 2.5 – 5 cm (1 to 2 in.)			
25. If resistance is felt, withdraws the catheter; does not force the catheter.			
26. After urine flows, stabilizes the catheter's position in the urethra with nondominant hand; uses the dominant hand to pick up saline-filled syringe and inflate catheter balloon.			
27. If patient complains of severe pain upon inflation of the balloon, the balloon is probably in the urethra. Allows the water to drain out of the balloon, and advances the catheter 2.5 cm (1 in.) farther into the bladder.			
28. If it is not preconnected, connects the drainage bag to the end of the catheter.			

Procedure Steps	Yes	No	Comments
29. Hangs the drainage bag on the side of the bed below the level of the bladder.			
30. Using hypoallergenic, medical tape or a catheter strap, secures the catheter to the thigh or the abdomen.			
31. Cleanses patient's perineal area as needed, and dries.			
32. Discards supplies in a biohazard receptacle.			
33. Removes gloves; washes hands.			
34. Returns patient to a position of comfort.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Inserting an Indwelling Urinary Catheter (Male)

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Takes an extra pair of sterile gloves and an extra sterile catheter into the room.			
2. Selects a catheter kit that contains lubricant, if available.			
3. Ensures good lighting.			
4. Works on the right side of the bed if right-handed; the left side, if left-handed.			
5. Places patient supine, legs straight and slightly apart.			
6. If patient is confused or unable to follow directions, obtains help.			
7. Drapes patient. Covers upper body with blanket; folds linens down to expose the penis.			
8. Dons clean procedure gloves and washes the penis and perineal area with soap and water.			
9. If using 2% Xylocaine gel for the procedure, uses a syringe and inserts it into the urethra.			
10. Removes and discards gloves.			
11. Washes hands.			
12. Organizes the work area: a. Bedside or overbed table within nurse's reach.			
b. Opens the sterile catheter kit and places on the bedside table, without contaminating the inside of the wrap.			
c. Positions a plastic bag or other trash receptacle so that nurse does not have to reach across the sterile field (e.g., near patient's feet); or places a trash can on the floor beside the bed.			
13. Applies sterile drape(s) and underpad. **Variation: Waterproof Underpad Packed as the Top Item in the Kit:** a. Removes the waterproof underpad from the kit before donning sterile gloves. Does not touch other kit items with bare hands. Allows the drape to fall open as it is removed from the kit.			

Procedure Steps	Yes	No	Comments
b. Allows the drape to fall open as it is removed from the kit. Touching only the corners and shiny side, places the drape shiny side down across top of patient's thighs.			
c. Dons sterile gloves (from kit). (Touching only the glove package, removes it from the sterile kit before donning the gloves.)			
d. Picks up the fenestrated drape; allows it to unfold without touching other objects; places the hold over the penis.			
Variation: Sterile Gloves Packed as Top Item in the Kit:			
Uses the following steps instead of steps 13 a – d: e. Removes the gloves from the package, being careful not to touch anything else in the package with a bare hand. Dons gloves.			
f. Grasps the edges of the sterile underpad and places it shiny side down across the top of patient's thighs.			
g. Places the fenestrated drape: Picks it up, allowing it to unfold without touching any other objects. Keeps gloves sterile.			
h. Places the fenestrated drape so that the hole is over the penis.			
14. Organizes kit supplies on the sterile field and prepares the supplies in the kit, maintaining sterility. a. Opens the antiseptic packet; pours solution over the cotton balls. (Some kits contain sterile antiseptic swabs; if so, opens the "stick" end of the packet.)			
b. Lays forceps near cotton balls (omits step if using swabs).			
c. Opens the specimen container if a specimen is to be collected.			
d. Removes any unneeded supplies (e.g., specimen container) from the field.			
e. Expresses a small amount of sterile lubricant into the kit tray; lubricates the first 2.5 – 5 cm (1 – 2 in.) of the catheter by rolling it in the lubricant. Does not lubricate the catheter if Xylocaine gel has already been inserted into the urethra, or if lubricant will be inserted via syringe into the urethra.			
f. Attaches the saline-filled syringe to the side port of the catheter. Leaves the syringe attached to the catheter.			
15. Touching only the kit or inside of the wrapping, places the sterile catheter kit down onto the sterile field between or on top of patient's thighs.			

Procedure Steps	Yes	No	Comments
16. If the drainage bag is preconnected to the catheter, leaves the bag on the sterile field until after the catheter is inserted.			
17. With the nondominant hand, reaches through the opening in the fenestrated drape and grasps the penis, taking care not to contaminate the surrounding drape. If the penis is uncircumcised, retracts foreskin to expose the meatus.			
18. If the foreskin accidentally falls back over the meatus, or if the nurse drops the penis during cleansing, repeats the procedure.			
19. Continuing to hold the penis with the nondominant hand, holds forceps in the dominant hand and picks up a cotton ball.			
20. Beginning at the meatus, cleanses the glans in a circular motion in ever-widening circles and partially down the shaft of the penis.			
21. Repeats with at least one more cotton ball.			
22. Discards cotton balls or swabs as they are used; does not move them across the open, sterile kit and field.			
23. Using the nondominant hand, holds the penis gently but firmly at a 90^0 angle to the body, exerting gentle traction.			
24. Gently inserts the tip of the prefilled syringe into the urethra and instill the lubricant. (If the kit contains only a single packet of lubricant and if no other kits are available, then lubricates 12.5 – 17.7 cm (5 – 7 in.) of the catheter. This is not the technique of choice, however.)			
25. With the dominant hand, holds the catheter 7.5 cm (3 in.) from the proximal end, with the remainder of the catheter coiled in the palm of the hand.			
26. Asks patient to bear down as though trying to void; slowly inserts the end of the catheter into the meatus. Instructs patient to take slow deep breaths until the initial discomfort has passed.			
27. Continues gentle insertion of catheter until urine flows. This is about 17 – 22.5 cm (7 – 9 in.) in a man. Then inserts the catheter another 2.5 – 5 cm (1 to 2 in.)			
28. If resistance is felt, withdraws the catheter; does not force the catheter.			
29. After urine flows, stabilizes the catheter's position in the urethra with nondominant hand; uses the dominant hand to pick up saline-filled syringe and inflate catheter balloon.			
30. If patient complains of severe pain upon inflation of the balloon, the balloon is probably in the urethra. Allows the water to drain out of the balloon, and advances the catheter 2.5 cm (1 in.) farther into the bladder.			

Procedure Steps	Yes	No	Comments
31. If it is not preconnected, connects the drainage bag to the end of the catheter.			
32. Hangs the drainage bag on the side of the bed below the level of the bladder.			
33. Using tape or a catheter strap, secures the catheter to the thigh or the abdomen.			
34. Cleanses patient's penis and perineal area as needed, and dries. Ensures that foreskin is no longer retracted.			
35. Removes gloves; washes hands.			
36. Returns patient to a position of comfort.			
37. Discards supplies in the appropriate receptacle.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Applying a Condom Catheter (Male)

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Dons clean, procedure gloves.			
2. Measures the circumference of the penis using a disposable paper tape for correct catheter fit.			
3. Washes hands and don clean procedure gloves.			
4. Drapes patient for privacy.			
5. Organizes supplies and prepares the bedside drainage bag for attachment to the condom catheter.			
6. Washes hands and dons clean, procedure gloves.			
7. Positions patient supine.			
8. Folds down the bedcovers to expose the penis, and drape patient using the bath blanket.			
9. Gently cleanses the penis with soap and water. Rinses and dries it thoroughly. If patient is uncircumcised, retracts the foreskin, cleanse the glans, and replaces the foreskin. If patient has excess hair along the shaft of the penis carefully clips it with the scissors.			
10. Washes hands and changes procedure gloves.			
11. Applies skin prep to the penis and allows it to dry.			
12. Holds the penis in the nondominant hand. With the dominant hand, places the condom catheter at the end of the penis, and slowly unrolls it along the shaft toward patient's body. Leaves 2.5 – 5 cm (1 – 2 in.) between the end of the penis and the drainage tube on the catheter.			
13. Secures the condom catheter in place on the penis.			
14. Assesses the proximal end of the condom catheter.			
15. Secures the drainage tubing to the patient's thigh using tape or a commercial leg strap (following facility protocol).			
16. Covers patient. Removes gloves, and washes hands.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Changing an Ostomy Appliance

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics.			
1. Washes hands and dons clean procedure gloves.			
2. Folds down the linens to expose the ostomy site; places a clean towel across patient's abdomen under the existing pouch.			
3. Positions patient so that no skin folds occur along the line of the stoma.			
4. If the pouch is drainable, opens it by removing the clamp and unrolling it at the bottom.			
5. Empties the existing ostomy pouch into a bedpan.			
6. Saves the clamp for reuse (note that some pouches cannot be drained).			
7. Using a silicone-based adhesive remover with one hand, uses the other hand to gently remove the old wafer from the skin, beginning at the top and proceeding in a downward direction.			
8. Places the old pouch and wafer in a plastic bag for disposal. If the pouch is nondrainable, disposes of it according to agency protocol.			
9. Inspects stoma and peristomal skin.			
10. Uses warm water or skin cleansing agent with a pH of 5.5 to cleanse stoma and surrounding skin.			
11. Allows the area to dry.			
12. Reports excess bleeding to the physician.			
13. Measures the size of the stoma in one of the following ways: a. Using a standard stoma measuring guide placed over the stoma.			
b. Reusing a previously cut template.			
c. Measuring the stoma from side to side (approximating the circumference)			
14. Places a clean 4 in. x 4 in. gauze pad over the stoma.			
15. Removes gloves and washes hands.			

Procedure Steps	Yes	No	Comments
16. Traces the size of the opening obtained in Step 13 onto the paper on the back of the new wafer; cuts the opening. Wafer opening is approximately 1.5 – 3 cm (1/16 – 1/8 in.) larger than the circumference of the stoma.			
17. Peels the paper off the wafer.			
18. **Note:** Some ostomy wafers come with an outer ring of tape attached. If so, does not remove the backing on this tape until the wafer is securely positioned (steps 22 – 24).			
19. Dons clean procedure gloves.			
20. If ostomy skin care products are to be used, applies them at this time (e.g., wipes around stoma with skin-prep, applies skin barrier powder or paste, applies extra adhesive paste).			
21. Removes the gauze. Centers the wafer opening around the stoma and gently presses down. Presses hand firmly against the newly applied wafer and holds it for 30 – 60 seconds. a. *If using a one-piece pouch*, makes sure the bag is pointed toward patient's feet.			
b. *If using a two-piece system*, places the wafer on first. When the seal is complete, attaches the bag following manufacturer's instructions.			
c. *for an open-ended pouch*, folds the end of the pouch over the clamp and closes the clamp, listening for a "click" to ensure it is secure.			
22. Removes gloves and washes hands.			
23. Returns patient to a comfortable position.			
24. Disposes of used ostomy pouch following agency policy for biohazardous waste.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Clinical Guidelines for Administering Medications

- Nurses who administer medications are ***responsible*** for their own actions. Question any order that you consider incorrect.
- Be knowledgeable about the medications you administer.
- Federal laws govern the uses of narcotics and barbiturates. Keep these medications in a locked place.
- Use only medications that are in a ***clearly labeled*** container.
- Return liquid medications that are cloudy or have changed color to the pharmacy.
- Before administering a medication, identify the client correctly using the appropriate means of identification, e.g., identification bracelet and/or asking clients to state their names.
- Do not leave medication at the bedside, with certain exceptions, e.g., nitroglycerine, cough syrup. Determine agency policy.
- If a client vomits after taking an oral medication, report this to the nurse in charge.
- Take special precautions when administering certain medications; for example, have another nurse check the dosages of anticoagulants, insulin, and certain IV preparations.
- Most hospitals require new orders from the physician for the client's post-surgery care.
- When a medication is omitted for any reason, record the fact together with the reason.
- When a medication error is made, report it immediately to the nurse in charge.

RIGHTS of Drug Administration

RIGHT

Client	• Have client say his/her name & date of birth, ✓ armband each time you give a med
Drug	• Check the order against MAR then the MAR to drug X 3
Dosage	• Calculate dosages correctly
Route	• Know route abbreviations: PO, IV, IVP, OU, OD, OS, etc.
Time	• Check MAR, know when last given, check to see if any contraindications to being given at time on MAR, such as if other meds are being given which would enhance or reduce effectiveness of drug
Purpose	• Know why this med is being given
Documentation	• On MAR, on nurses notes if PRN medication, and any VS as indicated by type of med given, also sign out on narcotic sheet if it is a narcotic
Expiration Date	

- Look all meds up before giving. Use your med sheet as a work sheet which prompts you to check for certain labs, vital signs, etc. You will be asked what drug is given for, side effects, and other information. Know your meds!

Preparing Medications

- Let your primary nurse know that you are giving medications.
- Remember your Green card. You cannot pass medications unless checked off in skills lab and an average score of 90% on math exams.
- Before your instructor arrives verify the drugs are in the cart/med room, that you were able to locate the orders & allergies. Be prepared to explain and correlate medications to labs and patient assessment data. Call your instructor when ready and between the 30 minutes before to 30 minutes after the scheduled hour
    - o ✓ your order against the MAR, also allergies & pertinent labs
    - o ✓ medication **three times**
        1. ✓ label against MAR when getting it out of drawer, verify expiration date
        2. ✓ label against MAR when preparing medication for administration
        3. ✓ label against MAR when putting unused items in drawer or just before administration
- Never take MAR into isolation rooms (get a label from the chart for checking patient ID)
- Do not rest MAR on surfaces in the patient's room, keep in your pocket after verifying ID and discussing meds with the patient.

Common Nursing Actions Before Administering

	Example Medications	***What to Check***
Anticoagulants	Coumadin Lovenox Heparin	Check for bleeding esp. the gums, check PT/INR, PTT, hold according to MD guidelines
Heart meds.	Digoxin Quinidine Procanamide	Check electrolytes (K, BUN, Creat etc.) Dig level, AHR (at time of administration), check VS trends, I & O, weight
Antihypertensives	Aldomet HCTZ	Check AHR & BP-hold if sys < 90 or according to protocol or MD order & trends, I&O trend, daily weights, electrolytes
Diuretics	Lasix Bumex	Check BP-hold if sys < 90 or according to protocol or MD order & trends, I & O trend, daily wts, K+
Antibiotics		C&S, VS trends, what organism, purpose
Hormone Replacement	Levothyroxin	Check AHR

These are guidelines only. Check with the facility policy, MD orders, and drug book for variances. Remember, there will be more as time goes on.

Allergies: *NKDA*

Date: *9/12/XX* Time: *1000* If Generic Equivalent not acceptable check here ☐	1 ADDRESSOGRAPH My Patient ID
Admit to Merced College Hospital	
Diagnosis: CHF, Arthritis, Gastric Ulcer, Diabetes	
1. BRP č assistance	
2. Get permit for angiogram	
3. ↓ sodium diet	
4. Labs: U/A, CBC, Lytes	
5. Medications:	1
Kclor 40meq po daily	
Nitro Patch 80mg daily	
Fevite 1 tab po daily at noon	
Hydrochlorothiazide 100 mg po bid	
Doxy 100 mg po daily Noted	
Procainamide HCI 500 mg po q6h (12-6-12-6) M. Jones RN	
Empco 30 1 tab po q4h prn for pain 9-12-XX 1030	
Physician Signature: *Dr. A. Smith*	
Date: *9/12/XX* Time: *1200* If Generic Equivalent not acceptable check here ☐	
Floxin 3% solution 2 gtts As daily	
Humorsol Ocumeter 0.125% 1 gtt OD @1000 daily	
Neosporin ophthalmic ointment OS q4h	
Rhinall 25% 1 gtt each nostril daily	
Combivent 1 puff q6h Noted	
Advair 100/50 inhaled daily M. Jones RN 9-12-xx 1220	
Physician Signature: *Dr. A. Smith*	

Allergies: *NKDA*

Date: *9/13/XX* Time: *1200* If Generic Equivalent not acceptable check here ☐

A and D ointment to wound on left arm

apply liberally bid

Start IV: D5W 1000ml@ 42ml/min

Demerol 50 mg with Vistaril 25 mg IM q6h prn pain

Noted
M. Jones RN
9-13-xx
1300

Physician Signature: *Dr. A. Smith*

Date: *9/14/XX* Time: *0200* If Generic Equivalent not acceptable check here ☐

Heparin 2500 units subq daily @ 0700

Insulin regular 7 units/NPH 15 units subq daily ac

Lovenox 80 mg subq daily @0700

Noted
S. Smith RN
9-14-xx
0215

Physician Signature: *Dr. C. Jackson*

Date: *9/15/XX* Time: *1000* If Generic Equivalent not acceptable check here ☐

Cleocin vaginal cream 1 applicator full daily

Anusol supp per rectum bid

PPD today

Noted
M. Jones RN
9-15-xx
1030

Physician Signature: *Dr. C. Jackson*

1

ADDRESSOGRAPH

My Patient ID

My Patient ID Allergic: NKDA	Diagnosis Block Page 1 of 2	**Merced College Registered Nursing** **Medication Administration Record**

START	STOP	MEDICATION	0001 TO 1200	1201 TO 2400
9/12/xx		Kclor 20 meq/10 ml (Potassium Chloride) dose: 40meq po daily	0900	
9/12/xx		Nitro-Patch 0.4mg/hr (Nitroglycerin) dose: 80mg daily	0900	
9/12/xx		Fevite (B complex with iron, Vit E, C) dose: 1 tab po daily	1200	
9/12/xx		Hydro 50 mg (hydrochlorothiazide) dose: 100 mg po bid	0900	2100
9/12/xx		Doxy 100 mg (doxycycline monohydrate) dose: 100 mg po daily	0900	
9/12/xx		Procana 500 mg (procainamide HCl) dose: 500mg po q 6hr	0600 1200	1800 2400
9/12/xx		Floxin 3% (ofloxacin) dose: 2 gtt AS daily	1000	
9/12/xx		Humorsol Ocumeter 0.125% (demecarium bromide ophthalmic) dose: 2 gtt OD daily	1000	
9/12/xx		Neosporin 3.5g (Neosporin ophthalmic ointment) dose: daily OS q4h	0200 0600 1000	1400 1800 2200
9/12/xx		Combivent (ipratropium bromide / albuterol sulfate) dose: 1 puff Q6^0	0300 1100	1300 2100
9/15/xx		PPD skin test (Purified Protein Derivative) Dose: 0.1 ml ID (today)		

INITIALS	NAME & PROFESSIONAL DESIGNATION	INITIALS	NAME & PROFESSIONAL DESIGNATION	INITIALS	NAME & PROFESSIONAL DESIGNATION

My Patient ID Allergic: NKDA	Diagnosis Block Page 2 of 2	**Merced College Registered Nursing** **Medication Administration Record**

START	STOP	MEDICATION	0001 TO 1200	1201 TO 2400
9/12/xx		Advair Diskus 100/50 (fluticasone propionate / salmeterol) dose: inhaled daily	1100	
9/12/xx		Rhinall 25% (Phenylephrine Hydrochloride) dose: 2 gtts each nostril	1100	
9/13/xx		A&D ointment (Vitamin A & D) dose: Apply liberally to left arm wound bid	0900	2100
9/14/xx		Heparin 10,000 units/ml (Heparin Sodium Injection) dose: 2500 units subcutaneous daily	0700	
9/14/xx		Lovenox 80 mg/0.8 ml (Enoxaparin Sodium) dose: 80mg subcutaneous daily	0700	
9/14/xx		Regular Insulin 100 units/ml / NPH 100 units/ml (Humulin R/Humulin N) dose: Regular 7 units / NPH 15 units subcutaneous	0700	
9/15/xx		Cleocin vaginal cream 2% (clindamycin phosphate) dose: 1 applicator full daily	1000	
9/15/xx		Anusol suppository 1% (hydrocortisone) dose: 1 rectally bid	1000	2200
9/12/xx		Empco 30 (aspirin/codeine 30 mg) Dose: 1 tab po q4hr prn pain		
9/13/xx		Demerol 50 mg (meperidine) Dose: 50 mg give with Vistaril Im q6h prn		
9/13/xx		Vistaril 50 mg (hydroxyzine) Dose: 25 mg give with Demerol IM q6h prn		

INITIALS	NAME & PROFESSIONAL DESIGNATION	INITIALS	NAME & PROFESSIONAL DESIGNATION	INITIALS	NAME & PROFESSIONAL DESIGNATION

Oral & Topical Medication

Skill of the Week Objectives & Activities
• Identify the nurses legal responsibility in drug administration • Correctly calculate drug dosages as supplied by instructors • Utilize the 'rights' of drug administration - lab and clinical setting • List the advantages and disadvantages of the oral route of medication administration (stat, now, routine, prn) • Utilize the rights of drug administration for topical medications • List the advantages and disadvantages of topical medications.

Note: Less than 90% average math exams and you will not be able to give medication until your next math exam average is greater than or equal to 90%.

PO Medication Preparation:

- Check for fluid restriction, etc.
- Wash hands after handling chart, etc. **BEFORE** pouring meds.
- Do not touch medications with your bare hands. Wear gloves.
- Have meds sorted in a small cup in drawer before instructor arrives (your first check-don't forget expiration dates). If a narcotic, wait to sign out of drawer until instructor there, but get narcotic keys from charge nurse or med nurse.
- If liquid-pour away from label. (Called palming the label)
- If must cut pills, check to be sure scored, have pill cutter available.
- Put somewhere on your med sheet what color pills are, etc-so if patients asks "what does this blue pill do?" you can answer correctly.
- Don't turn your back on medications. If you need to get water, etc. for patient, take the pill cup with you.
- **Stay until all meds swallowed, return in 30 minutes to evaluate patient.**

Topical Medication Preparation:

- Prepare lotions, creams, pastes, ointments before entering room by placing small amount in cup for application in room. Use measuring guide for nitroglycerin ointment.
- Always wear gloves to apply.
- **Lotion** – contains an insoluble powder suspended in water or an emulsion. When applied it leaves a uniform layer of powder in a film on the patient's skin. Use cotton balls or 2x2 to apply.
- **Cream** – is an oil-in-water emulsion in a semisolid form. It lubricates the skin and acts as a barrier. Use cotton balls or 2x2 to apply.
- **Ointment** – is a semisolid substance that when applied to the skin, helps to retain body heat and provides prolonged contact between the skin and the drug. Use tongue blade, cotton tipped swab or gloved hand to apply.
- **Paste** - is a stiff mixture of powder and ointment. It provides a uniform coat to reduce and repel moisture. Use tongue blade, cotton tipped swab, gloved hand or application paper to apply.

Patient Teaching for Topical Drugs

1. Instruct patient to wash hands before and after applying the topical medication.
2. Teach how to apply the medication.
3. Be sure to stress that skin should be clean and dry before applying medication.
4. Instruct to apply only to affected area.
5. Teach how to avoid contaminating the lid or cap of the container.
6. Instruct patient to stop using the medication and to call M.D. if develops a skin irritation, ulcers, signs and symptoms of infection or a worsening skin reaction.
7. Provide written instructions.

Transdermal Drug Types

- Nitroglycerin to control angina
- Scopolamine to treat motion sickness
- Estrogen to provide hormone replacement after menopause
- Clonidine to treat hypertension
- Fentanyl to control chronic pain
- The appropriate form ointment or patch depends largely on the desired deliver time – a patch usually delivers the drug for a longer period of time.

Patient Teaching for Transdermal drugs

1. Review drug specific precautions the patient needs to know and adverse side effects to watch for. Review when to notify the doctor.
2. Make sure patient knows how to choose an appropriate site for application of drug.
3. Instruct patient not to get any Transdermal ointment on his hands and to wash before and after applying drug.
4. Keep area around patch as dry as possible.
5. Provide written instructions.

Procedure Checklist
Medication Guidelines:
Steps to Follow for All Medications, Regardless of Type or Route

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics, and documentation.			
1. *First Check*: checks medication order on MAR against physicians' prescription (patient name, patient identifier, mediation, dose, route, time, and allergies.)			
2. Follows agency policies for medication administration, including the time frame for medication administration. Most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR.			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications.			
4. Determines if medication dosage is appropriate for patient's age and weight.			
5. Identifies any special considerations for medication preparation and administration, such as whether medication should be administered with food or on an empty stomach.			
6. Checks expiration date of medication.			
7. *Second Check*: When preparing medication, verifies correct medication, dose, time, route, and expiration date. Checks for patient drug allergies.			
8. Calculates dosage accurately.			
9. Locks medication cart after removing medication.			
10. Identifies patient by two methods, following agency policy.			
11. *Third Check*: At the bedside, verifies correct patient (using two methods of identification, including armband), medication, expiration date, dose, route, time and presence of drug allergies.			
12. Performs any assessments that are related to the medication to be given, such as checking the pulse or blood pressure.			
13. Remains with the patient until sure he has taken the medication.			
14. Does not leave medication unattended at bedside.			

Procedure Steps	Yes	No	Comments
15. Reassesses for therapeutic and side effects.			
16. Teaches patient about the medication as needed.			
17. Documents the medication given in the patient medication record.			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administering Oral Medications

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR).			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Attains medication from medication cart/computer			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Calculates dosage accurately			
10. Washes hands upon entering patient's room			
11. Identifies patient by two methods			
12. Provides for privacy			
13. Explains procedure			
14. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
15. Opens medication and places in medication cup without touching medication (if liquids, shake medication and pour into cup from the side of the container away from the label)			
16. If sublingual, administer under tongue. If buccal, administer between cheek and teeth			
17. Performs any assessments that are related to the medication to be given, such as checking the pulse and blood pressure			
18. Remains with the patient until sure patient has taken the medication			
19. Does not leave medication unattended at bedside			

Procedure Steps	Yes	No	Comments
20. Reassesses for therapeutic and side effects			
21. Teaches patient about the medication			
22. Washes hands			
23. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administering Topical Medications

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration including supplies needed			
6. Attains medication from medication cart/computer/cabinet			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Washes hands upon entering patient's room			
10. Identifies patient by two methods			
11. Provides for privacy			
12. Explains procedure			
13. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
14. Don clean gloves			
15. Cleanses the skin with soap and water and pats dry before applying to enhance absorption			
16. Opens medication and uses gloves or an applicator to apply and spread the medication evenly, following the direction of hair growth when coating the area			
17. When treating skin disease or skin wound infections, rub medication into the skin until the medication is no longer visible			
Powders			
18. Spreads apart skinfolds, and applies a very thin layer			

Procedure Steps	Yes	No	Comments
19. Applies the powder to clean, dry skin. Is careful that patient does not inhale powder			
Transdermal Medication			
20. Removes previous patch, folding the medicated side to the inside			
21. Disposes of the old patch carefully in an appropriate receptacle			
22. Cleanses skin area of traces of remaining medication. Allows skin to dry			
23. Removes patch from packaging			
24. Write date and time on the patch			
25. Applies patch to skin (application sites must be rotated)			
26. Avoid skin areas with lesions and hair			
27. Teaches patient not to use heating pads over the patch			
28. Removes gloves			
All Topicals			
29. Reassesses for therapeutic and side effects			
30. Teaches patient about the medication			
31. Bed in low position, side rails up, provide patient with call light			
32. Removes gloves and washes hands			
33. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

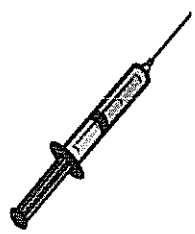
Instructor:_____ Date:_____

Administration of Injections (Subcutaneous Intradermal & Intramuscular)

Skill of the Week Objectives & Activities
• Correctly calculate prescribed drug dosages. • Describe factors to consider when choosing routes for parenteral drug administration. • Correctly prepare and administer subcutaneous, intradermal and intramuscular injections. • Correctly mix medications a) Tubex & ampule b) Tubex & vial c) Tubex & tubex d) Reconstitution of medications • Correctly identify all landmarks for subcutaneous, intradermal & intramuscular injections. **Insulin Injections** • Identify safe locations for administration of subcutaneous insulin injections. • Verify dose with another RN who must sign the MAR • Verbally explain relationship of pertinent labs and point of care testing. **Heparin & Lovenox Injections** • Correctly calculate prescribed dosage of heparin and/or Lovenox • Verify dose with another RN who must sign the MAR • Describe factors to consider when administering parenterally • Identify safe locations for administration of heparin • Correctly prepare and administer heparin • Verbally explain relationship of pertinent labs

Syringe Safety

- Use syringes with safety features
- Plan safe handling and disposal before beginning any procedure using needles
- Avoid recapping needles & then only if the needle has not been used
- Dispose of used syringes promptly in appropriate sharps disposal containers
- Report all sharp related injuries promptly to your supervisor



An estimated 800,000 needlestick injuries occur among health care workers annually

To protect yourself and coworkers, be aware of the hazards posed by needlestick injuries

Insulin Syringes

U-100 insulins are measured using U-100 calibrated syringes.

The smallest capacity syringe possible is used for ease & accuracy.

Premixed Insulins

Humulin 70/30 & Novolin 70/30

Novolog Mix 70/30: 70% aspart protamine/ 30% aspart

Humalog Mix 75/25: 75% lispro protamine/25% lispro

Never mix these with other insulin products.

Do not give IV!

Onset/Peak/Duration

Insulin	*Onset*	*Peak*	*Duration*
Rapid Acting (Lispro; Aspart)	15 min	1 hour	2 – 4 hours
Short Acting (Regular)	30 min	2 – 4 hours	6 – 8 hours
Intermediate Acting (NPH; Lente)	1 – 4 hours	6 – 12 hours	18 – 28 hours
Long Acting (Glargine; Ultralente)	1 – 8 hours	NONE	24 – 36 hours
Combinations (Regular +)	30 min	4 – 8 hours	24 hours

For Regular insulin think "Cheer" 2, 4, 6, 8:

Symptoms of Hypoglycemia (Cold & Wet):
Increased anxiety, blurred vision, chilly sensation, cold diaphoresis, pallor, confusion, drowsiness, headache, increased pulse rate, shakiness, increased weakness, increased appetite.

Symptoms of Hyperglycemia (Hot & Dry):
Drowsiness, red and dry skin, fruity breath odor, anorexia, polyuria, rapid and deep breathing, thirst, weight loss, nausea, vomiting, dry mouth.

Procedure Checklist
Administration of a Subcutaneous Injection of Heparin

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medication to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration (i.e.: PTT results & signs and symptoms of excessive bleeding)			
6. Selects the appropriate syringe and needle. In addition to considering the amount of adipose tissue			
7. For Heparin volumes <1ml, uses a tuberculin (TB) syringe with a 25-27 gauge, 3/8 – 5/8 inch needle			
8. Attains medication from medication cart/computer			
9. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
10. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
11. Washes hands upon entering patient's room			
12. Identifies patient by two methods			
13. Provides for privacy			
14. Explains procedure			
15. Teaches patient about the Heparin including signs and symptoms of excessive bleeding			
16. Asks patient about allergies			
17. Takes cap off needle. Holds cap in hand or places cap on clean surface away from opening			
18. Cleans top of vial with alcohol wipe			
19. Draws up air in syringe (same amount as prescribed Heparin dose)			

Procedure Steps	Yes	No	Comments
20. Injects air in Heparin vial			
21. Inverts syringe and draws up prescribed Heparin dose in syringe			
22. Double checks heparin dose with 2nd licensed nurse			
23. Removes needle from Heparin vial			
24. Recaps needle with the scope-method (the only time that the needle is recapped)			
25. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug			
26. Dons procedure gloves			
27. Selects appropriate site for Heparin administration			
28. Opens alcohol wipe and 2x2 packages			
29. Cleans injection site with alcohol wipe			
30. Allows alcohol to dry			
31. Holding the syringe between thumb and index finger of the dominant hand like a pencil or dart, inserts needle at a 45-90^0 angle; depending on the amount of adipose tissue. May also "pinch" adipose tissue depending on the amount of adipose tissue			
32. Stabilizes the syringe with the fingers of the nondominant hand			
33. Removes needle along the line of the insertion. Does not recap needle			
34. Engages the needle safety device or places uncapped syringe and needle directly in the sharps container			
35. Applies 2x2 over injection site. **Does Not Massage Site**			
36. Reassesses for therapeutic and side effects			
37. Places bed in low position			
38. Makes sure side rails are up on bed			
39. Makes patient comfortable			
40. Washes hands			
41. Documents the medication given in the patients record			

Lovenox Subcutaneous Injection (Differences from Heparin Injection)			
1. Identifies that Lovenox is packaged in a pre-filled syringe			
2. Does not remove air from syringe			
3. For dosage adjustments, syringe must be held with the needle pointing downward			
4. Correct site selection (Anterolateral, Posterolateral and lateral abdomen) "love handles"			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Heparin/Lovenox Administration

Sodium Heparin Injection, USP

- Used to interrupt the clotting process.
- May be given in therapeutic doses or in small diluted doses to maintain the patency of IV or arterial lines.
- Is usually administered deep subcutaneous or IV. Never give IM, causes hematoma and pain, or never given orally as it is inactive.
- Orders are individualized and based on lab studies. Heparin comes in various strengths, including 5000, 10,000, 20,000 and 50,000 Units/mL. Heparin also comes in 10 and 100 Units/ml as intravenous patency flushes.
- When multidose vials are available, choose the strength that will ensure that less than 1 ml will be injected subcutaneous. Have a registered nurse check the order, dose, vial, and amount before administering. The second nurse initials the MAR as well as a witness.
- Heparin is fast acting and counteracted with protamine sulfate. Check lab values for clotting times before administering heparin.

  APTT (Activated Partial Thromboplastin Time) *usually done in Merced

  Normal 25 - 38 seconds (FDA)

  Therapeutic range 1 ½ to 2 ½ times normal = 37.5 - 95 seconds

  Preferred therapeutic range is 60 - 80 seconds

  PTT (Partial Thromboplastin Time)

  Normal 60 - 90 seconds (FDA)

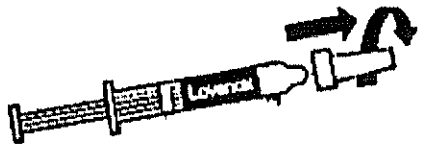
  Therapeutic range 1 ½ to 2 times normal = 90 - 180 seconds
- Watch for symptoms of overdose including nosebleed, tarry stools, petechiae, and easy bruising.
- For administration, always use TB syringe. Add 0.02 mL air to syringe to ensure all med is administered and prevent tracking. Give subcutaneous without aspirating.

Enoxaparin (Lovenox)

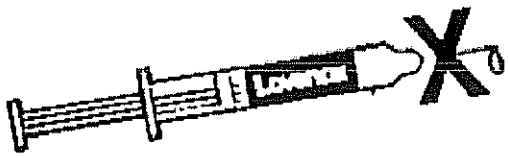
- Low molecular weight heparin used especially for prevention of Deep Vein Thrombosis (DVT) following knee replacement or hip replacement. Has fewer adverse effects than heparin. Daily coagulation studies are not needed. Assess platelet count occasionally.
- Administered in a fixed dose, usually 30 mg BID within 12 to 24 hours after surgery provided hemostasis has occurred. Usually given for 7 to 10 days. Administer subcutaneously in "love handles" (costal margins & iliac crest)
- No lab tests are required.

Lovenox (enoxaparin sodium) Injection

LOVENOX is available in prefilled disposable syringes of 30 mg each.

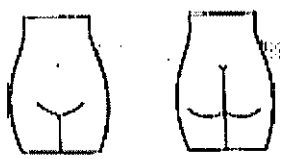


2. To remove protective covering, pull it lengthwise away from the needle with a slight rotating motion.

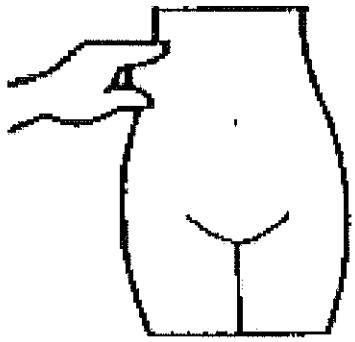


3. Do not expel air out of syringe.

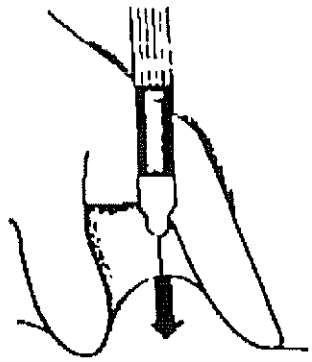
4. Always administer the subcutaneous injection when the patient is lying down. LOVENOX must not be administered by intramuscular injection.



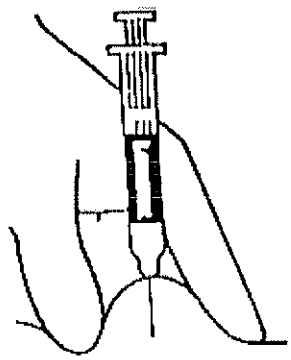
5. The ideal site for injection is the cell mass under the skin of the anterolateral and posterolateral abdominal wall. Alternate injections between right and left anterolateral and posterolateral sides.



6. Pinch skin between thumb and index finger to make a skin fold.



7. Insert full length of needle vertically into skin fold.



8. Inject LOVENOX slowly; be sure to hold the skin fold throughout the injection.

Procedure Checklist
Administration of a Subcutaneous Injection of Mixed Insulin

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medication to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Selects the appropriate syringe and needle. In addition to considering the amount of adipose tissue.			
7. Use an insulin syringe – typically 0.3, 0.5 or 1.0ml. Most insulin needles are 28-31 gauge. Needle length is often 3/16 – 1 inch			
8. Attains medication from medication cart/computer			
9. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date) for both insulins			
10. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date) for both insulins			
11. Washes hands upon entering patient's room			
12. Identifies patient by two methods			
13. Provides for privacy			
14. Explains procedure			
15. Teaches patient about the medication including signs and symptoms of hypoglycemia			
16. Asks patient about allergies			
17. Rolls NPH (cloudy) insulin vial in hands			
18. Takes cap off needle. Holds cap in hand or places cap on clean surface away from opening			
19. Cleans tops of both vials with alcohol wipe			

Procedure Steps	Yes	No	Comments
20. Draws up air in syringe for the same amount of NPH insulin			
21. Injects air in NPH Insulin vial			
22. Draws up air in syringe for the same amount of Regular insulin			
23. Injects air into Regular insulin vial			
24. Inverts Regular Insulin vial and draws up the prescribed amount of Regular insulin			
25. Double checks Regular insulin dose with 2nd licensed nurse			
26. Removes needle from Regular insulin vial			
27. Inserts needle into NPH insulin syringe			
28. Draws up the prescribed amount of NPH insulin; being careful to draw up the correct dose with going over			
29. Double checks combined insulin dose with 2nd licensed nurse			
30. Removes needle from NPH insulin vial			
31. Recaps needle with the scope-method (the only time that the needle is recapped)			
32. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies (for both insulins)			
33. Dons procedure gloves			
34. Selects appropriate site for insulin administration			
35. Opens alcohol wipe and 2x2 packages			
36. Cleans injection site with alcohol wipe			
37. Allows alcohol to dry			
38. Holding the syringe between thumb and index finger of the dominant hand like a pencil or dart, inserts needle at a 45-90^0 angle; depending on the amount of adipose tissue			
39. Stabilizes the syringe with the fingers of the nondominant hand			
40. Using the thumb of the dominant hand, presses the plunger slowly injecting the medication			
41. Removes needle smoothly along the line of insertion. Does not recap needle			
42. Engages the needle safety device or places uncapped syringe directly in the sharps container			
43. Applies 2x2 over injection site. Does not massage injection site			

Procedure Steps	Yes	No	Comments
44. Disposes of sharps safely			
45. Reassesses for therapeutic and side effects			
46. Places bed in low position			
47. Makes sure side rails are up on bed			
48. Makes patient comfortable			
49. Washes hands			
50. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administration of Intradermal Injections

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Selects the appropriate syringe and needle. Uses a tuberculin (TB) syringe with a 25-27 gauge, 3/8 – 5/8 inch needle			
5. Attains medication from medication cart/computer			
6. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
7. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. Washes hands upon entering patient's room			
9. Identifies patient by two methods			
10. Provides for privacy			
11. Explains procedure			
12. Teaches patient about Purified Protein Derivative (PPD) and the expectations of the test			
13. Asks patient about allergies			
14. Takes cap off needle. Holds cap in hand or places cap on clean surface away from opening			
15. Cleans top of vial with alcohol wipe			
16. Draws up air in syringe (same amount as prescribed medication dose)			
17. Injects air into vial			
18. Inverts syringe and draws up prescribed medication dose in syringe			
19. Removes needle from vial			
20. Recaps needle with the scope-method (the only time that the needle is recapped)			
21. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug			

Procedure Steps	Yes	No	Comments
22. Dons procedure gloves			
23. Selects and correctly locates the site for injection. Usual sites are the ventral surface of the forearm and upper back. The upper chest may also be used			
24. Assists patient to a comfortable position. If using a forearm, instructs patient to extend and supinate arm on a flat surface. If using the upper back, instructs patient to a prone position or a prone position or to lean forward over a table or the back of a chair			
25. Opens alcohol wipe and 2x2 packages			
26. Cleans injection site with alcohol wipe			
27. Allows alcohol to dry			
28. Holds syringe between the thumb and index finger of the dominant hand parallel to skin			
29. With the non-dominant hand, holds skin taut by on the following methods:			
a. If using a forearm, may be able to place a hand under the arm and pull the skin tight with thumb and fingers			
b. Stretching skin between thumb and finger			
c. Pulling the skin toward the wrist or down with one finger			
30. While holding the skin taut with the non-dominant hand, holds syringe in the dominant hand with the bevel up and parallel to patient's skin at a 5^0 to 15^0 angle			
31. Inserts needle slowly and advances approximately 3mm (1/8 inch) so that the entire bevel is covered. The bevel should be visible under the skin			
32. Releases the taut skin and holds the syringe stable with non-dominant hand. **Does not aspirate**			
33. Slowly injects the solution. A pale wheal, about 6-10mm (1/4 inch) in diameter should appear over the needle bevel			
34. Removes the needle			
35. Engages the needle safety device or places uncapped syringe and needle directly in the sharps container			
36. Gently blots any blood with 2x2. Does not rub or cover with an adhesive bandage			
37. With a pen, draws a 1 inch circle around the bleb/wheal			
38. Places bed in low position			
39. Makes sure side rails are up on bed			
40. Makes patient comfortable			

Procedure Steps	Yes	No	Comments
41. Washes hands			
42. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administration of Intramuscular Injections

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Selects the appropriate syringe and needle, considering volume and type of medication and patient's muscle mass			
a. Usual syringe 1 – 3ml			
b. Usual needle is 21-25 gauge, 1 – 3 inch length for adults			
7. Attains medication from medication cart/computer			
8. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
10. Washes hands upon entering patient's room			
11. Identifies patient by two methods			
12. Provides for privacy			
13. Explains procedure			
14. Teaches patient about the medication			
15. Asks patient about allergies			
16. Takes cap off needle. Holds cap in hand or places cap on clean surface away from opening			
17. Cleans top of vial with alcohol wipe			
18. Draws up air in syringe for the same amount of prescribed medication			

Procedure Steps	Yes	No	Comments
19. Injects air into vial			
20. Inverts vial and draws up medication into syringe			
21. Removes needle from vial			
22. Recaps needle with the scope-method (the only time that the needle is recapped)			
23. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
24. Dons procedure gloves			
25. Opens alcohol wipe and 2x2 packages			
26. Selects appropriate site for intramuscular injection (Rotate sites) **Deltoid Site:**			
a. Uses this site for small amounts of medication, immunizations, or when the ventrogluteal or vastus lateralis site are contraindicated			
b. Completely exposes patient's upper arm, removing the garment if necessary			
c. Locates the lower edge of the acromion process and goes 2 – 3 fingerbreadths down			
d. Draws an imaginary line out from the axillary crease. The resulting inverted triangle is the deltoid site			
e. Al alternative approach is to place four fingerbreadths across the deltoid muscle with the top finger on the acromion process			
27. **Rectus Femoris:** Divides the top of the thigh from the groin to the knee into thirds and identifies the middle third. Visualizes a rectangle in the middle of the anterior surface of the thigh. This location of the injection site			
28. **Vastus Lateralis:** a. Instructs patient to assume a supine or sitting position			
b. Locates the greater trochanter and the lateral femoral condyle			
c. Places hands on patient's thigh with one hand against the greater trochanter and the edge of the other hand against the lateral femoral condyle			

Procedure Steps	Yes	No	Comments
d. Visualizes a rectangle between the hands across the anterolateral thigh. The index fingers of the hands form the smaller ends of the rectangle. The long sides of the rectangle are formed by (a) drawing an imaginary line down the center of the anterior thigh and (b) drawing another line along the side of the leg, halfway between the bed and the front of the thigh. This box marks the middle third of the anterolateral thigh, which is the injection site			
29. **Ventrogluteal Site:** a. Instructs patient to assume a side-lying position, if possible			
b. Locates the greater trochanter, anterior superior iliac spine, and the iliac crest			
c. Places the palm of the hand on the greater trochanter, index finger on the anterior superior iliac spine, and the middle finger pointing toward the iliac crest (uses the right hand on patient's left hip; uses the left hand on the patient's right hip)			
d. The middle of the triangle between the middle and index fingers is the injection site			
30. **Dorsogluteal Site:** a. Divide the buttocks into four imaginary quadrants			
b. Palpate the posterior iliac spine and the greater trochanter			
c. Draw an imaginary diagonal line between the two marks			
d. Injection site is superiorly and laterally to the midpoint of the diagonal line			
e. Keep in mind, this site is less preferred because of the possibility of improperly identifying the site; which can cause damage to the sciatic nerve thereby causing paralysis			
31. Palpates the landmarks and the muscle mass to ensure correct location and muscle adequacy			
32. Cleans injection site with alcohol wipe			
33. Allows alcohol to dry			
34. With the nondominant hand, holds the skin taut between the thumb and index finger **Alternative Method (Z-Track Method):** With the lateral aspect of the nondominant hand, displaces the skin away from injection site about 2.5 – 3.5cm (1 – 1.5 inches)			
35. Holding the syringe between thumb and index finger of the dominant hand like a pencil or dart, inserts needle at a 90^0			

Procedure Steps	Yes	No	Comments
36. Stabilizes the syringe with the fingers of the nondominant hand			
37. Aspirates by pulling back slightly on the plunger for 5 – 10 seconds. If a blood return is obtained, removes the needle, discards and prepares the medication			
38. If there is no blood return with aspiration, using the thumb of the dominant hand, presses the plunger slowly injecting the medication (5 – 10 seconds/ml)			
39. Removes needle smoothly along the line of insertion. Does not recap needle			
40. **For Z-Track Injection Method:** Waits for 10 seconds, then removes the needle smoothly along the line of the insertion; then immediately releases the skin			
41. Engages the needle safety device or places uncapped syringe directly in the sharps container			
42. Applies 2x2 over injection site by blotting and applying light pressure along with applying an adhesive bandage as needed			
43. Disposes of sharps safely			
44. Reassesses for therapeutic and side effects			
45. Places bed in low position			
46. Makes sure side rails are up on bed			
47. Makes patient comfortable			
48. Washes hands			
49. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Locating Intramuscular Injection Sites

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
Before, during, and after the procedure, follows "Principles-Based Checklist to Use with All Procedures," including: Identifies the patient according to agency policy; attends appropriately to standard precautions, hand hygiene, safety, privacy, and body mechanics, and documentation.			
1. Palpates the landmarks and the muscle mass to ensure correct location and muscle adequacy.			
Deltoid Site:			
1. Uses this site for small amounts of medication, immunizations, or when the ventrogluteal or vastus lateralis site are contraindicated.			
2. Completely exposes patient's upper arm, removing the garment if necessary.			
3. Locates the lower edge of the acromion process and goes 2 – 3 fingerbreadths down.			
4. Draws an imaginary line out from the axillary crease. The resulting inverted triangle is the deltoid site.			
5. An alternative approach is to place four fingerbreadths across the deltoid muscle with the top finger on the acromion process.			
Rectus Femoris:			
(Not a site of choice)			
1. Divides the top of the thigh from groin to the kneed into thirds and identifies the middle third. Visualizes a rectangle in the middle of the anterior surface of the thigh. This is location of the injection site.			
Vastus Lateralis:			
1. Instructs patient to assume a supine or sitting position.			
2. Locates the grater trochanter and the lateral femoral condyle.			
3. Places hands on patient's thigh with one hand against the greater trochanter and the edge of the other hand against the lateral femoral condyle.			

Procedure Steps	Yes	No	Comments
4. Visualizes a rectangle between the hands across the anterolateral thigh. The index fingers of the hands form the smaller ends of the rectangle. The long sides of the rectangle are formed by (a) drawing an imaginary line down the center of the anterior thigh and (b) drawing another line along the side of the leg, halfway between the bed and the front of the thigh. This box marks the middle third of the anterolateral thigh, which is the injection site.			
Ventrogluteal Site:			
1. Instructs patient to assume a side-lying position, if possible.			
2. Locates the greater trochanter, anterior superior iliac spine, and the iliac crest.			
3. Places the palm of the hand on the greater trochanter, index finger on the anterior superior iliac spine, and the middle finger pointing toward the iliac crest. (Uses the right hand on patient's left hip; uses the left hand on patient's right hip.)			
4. The middle of the triangle between the middle and index fingers is the injection site.			

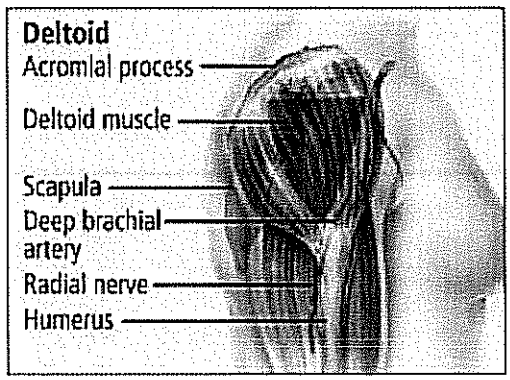
Recommendation: Pass_____ Needs more practice _____

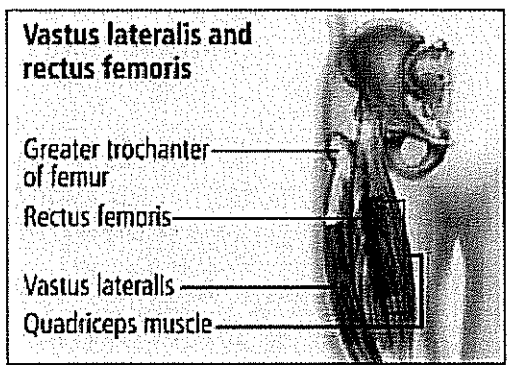
Student:_____ Date:_____

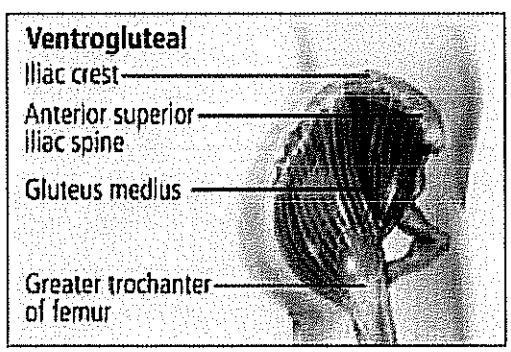
Instructor:_____ Date:_____

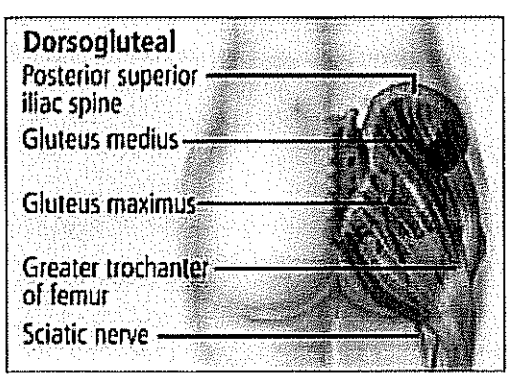
Illustrations of Intramuscular Injection (IM) Sites

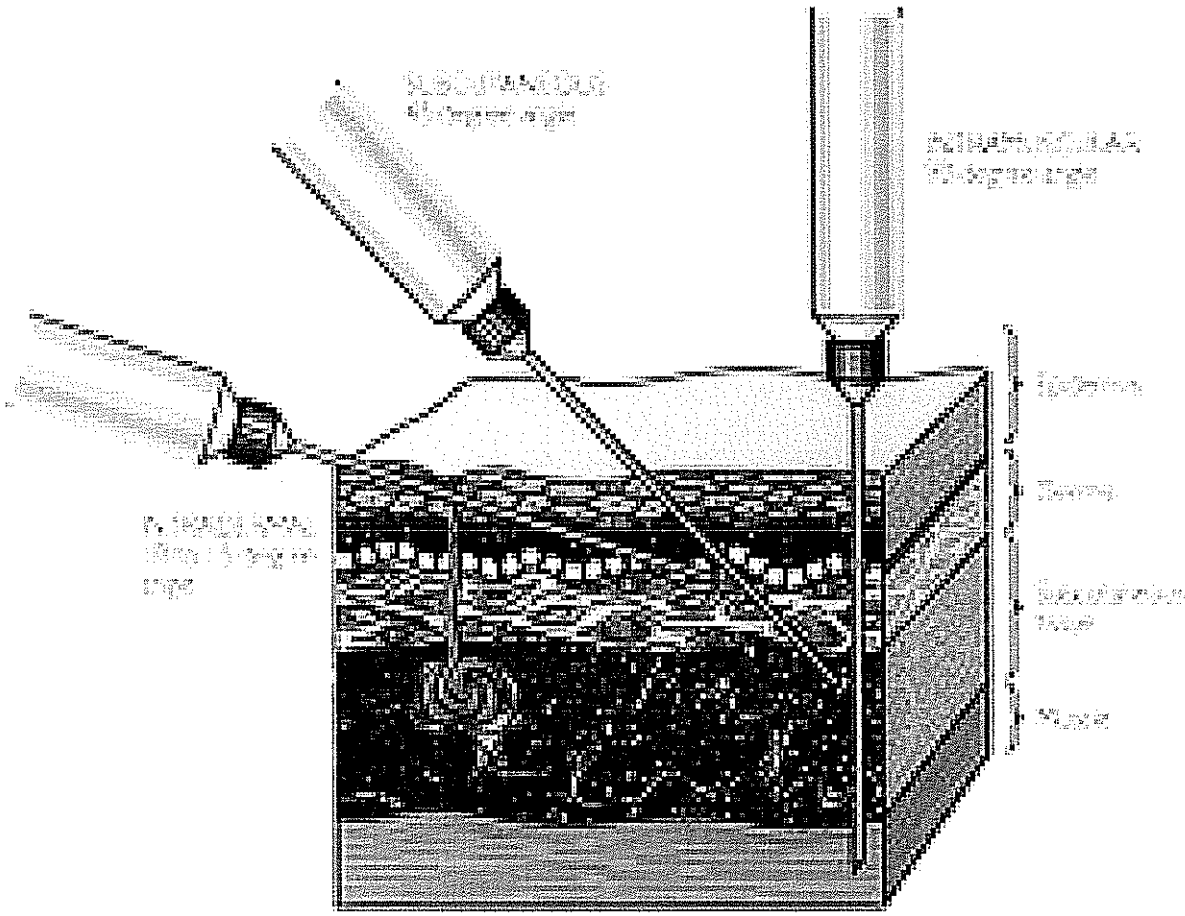
IM injections can be administered into the muscles shown below. In these illustrations, specific injection sites are shaded.











Injection Angles for Subcutaneous, Intramuscular, and Intradermal injections.

Ophthalmic, Otic, Vaginal, & Rectal Drug Administration

Skill of the Week Objectives & Activities
• Utilize the rights of drug administration for optic, otic, vaginal, & rectal medications • List the advantages and disadvantages of optic, otic, vaginal & rectal medications • Identify contraindications for rectal administration.

Ophthalmic Drugs
Typically given for diagnostic and therapeutic purposes such as dilating the pupil, staining the cornea, anesthetizing the eye, lubricating, treating eye disorders like infections or glaucoma, and protecting the vision of neonates. Most common forms are drops or ointments.

Key points
- Make sure eye is free of discharge
- Never use the same eye medication for more than one pt.
- Many elderly have difficulty holding bottle steady
- Never touch the bottle tip to the eye or any other surface

Patient teaching for ophthalmic drugs
1. Instruct patient regarding the purpose of the drops or ointment, adverse side effects to watch for and when to notify the doctor.
2. Stress importance of proper hand washing before and after using eye medication.
3. Teach patient to make sure they have the right medication, the correct # of drops, and the correct eye.
4. Instruct patient that eye medication best given at room temperature.
5. If administering more than one eye medication best to wait at least 5 minutes between administrations.
6. Stress the importance of never placing any medication in the eyes unless the label reads for ophthalmic use or for use in eyes.
7. Provide written instructions.

Otic Drugs
- Treat inflammation and infection
- Soften ear wax
- Produce local anesthesia
- Aid in foreign body removal

Key points
- Never insert anything into the ear so far that you can't see the tip
- Pull pinna down & back for children and up & outward for adults
- Have drug at room temp to avoid vertigo, dizziness, nausea

Patient teaching for otic drugs
1. Tell patient to never to insert any object into the ear.
2. Review importance of hand washing.
3. Review with patient how many drops and into which ear.
4. Review purpose of medication, adverse side effects to look for and when to notify doctor.
5. Teach patient not to use medication if it looks discolored or contains sediment and to call doctor or pharmacist.
6. Provide written instructions.

Vaginal Medication Uses

- Inflammation
- Infections
- Discomfort
- Contraceptive use

Forms of Vaginal Medications

Creams, Gels, Ointments	Inserted with a tubular applicator, gloves, & water soluble lubricant
Foams	Placed on a diaphragm & inserted
Douches	Requires an irrigation bag
Suppositories	Inserted with a gloved hand & water soluble lubricant

Client Education

- Post application:
  - Explain to client that she may experience some drainage & may need to use a pad or liner
  - Caution not to use tampons as they may absorb the medication thereby reducing the effectiveness

Rectal Medication Uses

- Treat local conditions: Pain, inflammation, itching
- May also be used in the treatment of: Fever, Nausea, Constipation

Forms of Rectal Medications

Enema	Water, container, gloves & water soluble lubricant
Suppository	Water soluble lubricant, gloves & tissue
Ointment	Water soluble lubricant, gloves, & gauze pad

Contraindications for Rectal Suppositories

- In cardiac clients may stimulate the vagus nerve causing a vagal response & cardiac dysrhythmias

May cause trauma in clients following rectal surgery

Procedure Checklist
Administering Vaginal Medications

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Attains medication from medication cart/computer			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Calculates dosage accurately (if needed)			
10. Washes hands upon entering patients room			
11. Identifies patient by two methods			
12. Provides for privacy			
13. Explains procedure			
14. Teaches patient about the medication			
15. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
16. Dons gloves			
17. Asks patient to void before procedure			
18. Positions patient in a dorsal recumbent or Sims position			
19. Drapes patient with a bath blanket so that only the perineum is exposed			
20. Prepares medication: a. Removes the wrapper from the suppository and places loosely in wrapper container			

Procedure Steps	Yes	No	Comments
b. Or fills applicator according to the manufacturer's instructions			
21. Uses only a water soluble lubricant			
22. Inspects and cleans around the vaginal orifice; as needed			
23. **Administering a Suppository:** a. After donning procedural gloves, applies a water-soluble lubricant to the rounded end of the suppository and to the gloved index finger on the dominant hand			
b. Separates the labia with the gloved nondominant hand			
c. Inserts the suppository as far as possible along the posterior vaginal wall (about 3 inches; 8cm). If the suppository comes with an applicator, places the suppository in the end of the applicator, inserts the applicator into the vagina, and presses the plunger			
d. Asks patient to remain in a supine position for 5 – 15 minutes. May elevate patient's hips on a pillow			
24. **Applicator Insertion of Creams, Foams or Jelly:** a. Separates the labia with nondominant hand			
b. Inserts the applicator approximately 3 inches into vagina along the posterior vaginal wall			
c. Depresses the plunger, emptying medication into the vagina			
d. Disposes of the applicator or places on a paper towel; if reusable			
e. Asks patient to remain supine for 5 – 15 minutes			
f. Reassesses for therapeutic and side effects			
g. Places bed in lowest position			
h. Assures side rails are up on bed			
i. Places call light in reach			
j. Washes hands			
k. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administering Rectal Suppository

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Attains medication from medication cart/computer			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Calculates dosage accurately (if needed)			
10. Washes hands upon entering patients room			
11. Identifies patient by two methods			
12. Provides for privacy			
13. Explains procedure			
14. Teaches patient about the medication			
15. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
16. Asks if patient needs to defecate prior to the suppository insertion			
17. Assists patient to the Sims position; left side when administering laxatives			
18. Dons gloves			
19. Removes the suppository wrapper and lubricates the smooth end of the suppository and tip of the gloved index finger			
20. Explains that there will be a cool feeling from the lubricant and feeling of pressure during insertion			

Procedure Steps	Yes	No	Comments
21. Uses the nondominant hand to separate the buttocks			
22. Asks patient to take deep breaths in and out through the mouth			
23. Uses the index finger of the dominant hand, to gently insert suppository			
24. Does not force the suppository during insertion			
25. Pushes the suppository past the internal sphincter and along the rectal wall (about 1 – 3 inches) in an adult (1/2 – 1 inch) in an infant			
26. Asks patient to try to retain the suppository if he or she is able. If he or she has difficulty retaining the suppository, after removing finger from the anus, holds the buttocks together for a few seconds			
27. Wipes the anus with tissue or absorbent cloth			
28. Explains to patient the need to remain on a side-lying position for 5 – 10 minutes			
29. Disposes of used materials into a biohazard receptacle and washes hands thoroughly			
30. Leaves the call light and bedpan within reach if suppository is a laxative			
31. Reassesses for therapeutic and side effects			
32. Places bed in lowest position			
33. Assures side rails are up on bed			
34. Places call light in reach			
35. Washes hands			
36. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Inhaled & Nasal Drug Administration

Skill of the Week Objectives & Activities
• Utilize the rights of drug administration for inhaled & nasal medications • List the advantages and disadvantages of inhaled & nasal medications

Respiratory Handheld inhalers with and without spacers

Respiratory inhalants produce fine droplets that are inhaled deep into the respiratory tract. They are absorbed immediately into the lining of the patient's bronchi or alveoli and then to the bloodstream. They produce both local and systemic effects.

Commons Types:

- Bronchodilators – improve airway patency, used to treat bronchospasms, asthma, and allergic reactions.
- Mucolytics – used to liquefy thick bronchial secretions.
- Corticosteriods – anti-inflammatory agents.

Metered Dose Inhaler

- Insert MDI canister into the holder. Remove mouthpiece cover from inhaler & shake inhaler well
- Have client take a deep breath and exhale.
- Instruct the client to position the inhaler in one of two ways (see right).
- Inhale deeply & slowly through mouth while fully depressing medication canister, hold breath for approximately 10 seconds & then exhale through pursed lips.

Using Spacer or Aerochamber

- Insert MDI into end of spacer.
- Have client place aerochamber mouthpiece in mouth & close lips, avoid covering small exhalation slots with lips. Depress MDI prescribed puffs into aerochamber.
- Instruct client to breathe slowly & fully for 3 to 5 seconds, then hold a full breath for 10 seconds, removing MDI and spacer before exhaling.

Using Dry Powder Inhaler

- Remove cover from mouthpiece, turn wheel to right & left until click is heard.
- Have client exhale away from inhaler prior to inhalation, position mouthpiece between the lips & inhale deeply & forcefully through the mouth. Hold breath for 5-10 seconds.

Patient teaching for respiratory inhalers

1. Instruct patient regarding the drug's dose, purpose, adverse side effects and when to notify the doctor.
2. Warn patient against using the inhaler more often than ordered by the doctor because drug can lose its effectiveness.
3. Tell patient to rinse mouth after using the inhaler to prevent oral fungal infection.
4. Teach patient to wait 5 minutes between inhalers if they use both a bronchodilator and corticosteriod inhalers always use the bronchodilator first.
5. Teach patient to wait at least 1 minute between doses of a single inhaled drug.
6. Instruct patient using a corticosteriod inhaler to carry medical information stating this. This patient may need supplemental corticosteriods during severe stress or a severe asthma attack.
7. Provide written instructions.

Nasal Drugs

Drops are usually used to treat a specific nasal area and sprays and aerosols to diffuse the drug through the nasal passages.

Commonly administered nasal drugs:

- Vasoconstrictors – coat and shrink swollen mucous membranes.
- Local anesthetics – promote patient comfort during medical procedures.
- Corticosteriods – reduce inflammation caused by allergies or nasal polyps.

Key points

- Push gently on tip of nose to open nostril completely
- Stay with patient after administering nasal medications (observe for possible respiratory problems

Maxillary and Frontal

- Supine with head tilted toward affected side hanging slightly over bed
- Slight hyperextension
- Ordinary nasal congestion
- Supine position with head tilted toward affected side
- Aim the dropper upward toward the patient's eye, rather than down towards ear.

Patient teaching for nasal drugs

1. Instruct patient regarding the purpose of the drops, spray or aerosol, adverse side effects to watch for and when to notify the doctor.
2. Explain the need for proper positioning when drops are given.
3. Explain the importance that tip of nozzle on sprays placed appropriately – just inside nostril - to ensure proper delivery of drug.
4. Teach patient to breathe through mouth during instillation.
5. Have the patient or significant other perform procedure with supervision and provide written instructions.

   Technique

   - Have client breathe through mouth.
   - Hold dropper 1 cm above nares and instill prescribed number of drops toward midline of ethmoid bone.
   - Have client maintain supine position for 5 minutes.
   - Offer tissue but caution against blowing for several minutes.

Procedure Checklist
Administering Medications Metered-Dose Inhaler Medication

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Attains medication from medication cart/computer			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Calculates dosage accurately (if needed)			
10. Identifies the amount of medication for inhalation remaining in the canister. Based on the start date and instructions for use, a determination can be made about the number of remaining inhalations. Replaces the canister promptly when the canister is nearly empty			
11. Washes hands upon entering patient's room			
12. Identifies patient by two methods			
13. Provides for privacy			
14. Explains procedure			
15. Teaches patient about the medication			
16. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
17. Assists patient to a seated position (if able)			
18. Asks patient to rinse out mouth and to spit the rinse out (not swallow)			

Procedure Steps	Yes	No	Comments
19. Shakes the inhaler. Removes the mouthpiece cap of the inhaler and inserts the mouthpiece into the spacer while holding the canister upright			
20. Removes the cap from the spacer			
21. Asks patient to breath out slowly and completely			
22. Places the spacer mouthpiece into the patient's mouth and have patient seal lips around the mouthpiece. Sharply presses down on the inhaler canister to discharge one puff of medication into the spacer			
23. Asks patient to slowly inhale and then hold breath for as long as possible. Encourages patient to hold breath for 10 seconds if possible			
24. If a second puff is needed, waits at last 1 minute before repeating inhalation steps			
25. If a corticosteroid inhaler is used, assists patient to rinse out mouth with water and spit out the rinse			
26. Cleans the mouthpiece with tissue or moist cloth and replaces the cap. Periodically rinses the spacer, mouthpiece and cap with water			
27. Reassesses for therapeutic and side effects			
28. Places bed in lowest position			
29. Assures side rails are up on bed			
30. Places call light in reach			
31. Washes hands			
32. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administering Nasal Medications

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Attains medication from medication cart/computer			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Calculates dosage accurately (if needed)			
10. Washes hands upon entering patient's room			
11. Identifies patient by two methods			
12. Provides for privacy			
13. Explains procedure			
14. Teaches patient about the medication			
15. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
16. Explains to patient that the medication may have an unusual taste or cause some burning or tingling			
17. Dons gloves			
18. Asks patient to blow nose			
19. Determines head position depending on patient's ability to assume the position: a. Assists patient with positioning either head down and forward or sitting and leaning forward			

Procedure Steps	Yes	No	Comments
b. To medicate ethmoid and sphenoid sinuses, assists patient into the supine position with head over the edge of the bed. Supports the head. Alternatively, places a towel roll behind the shoulders, allowing the head to drop back			
c. To medicate frontal and maxillary sinuses, positions as in step b, but tilts the head toward the affected side			
d. If patient is unable to assume one of those positions, asks patient to tilt head back.			
20. Asks patient to close one nostril and exhale, then inhale deeply through the nose			
21. Administers spray or drops while patient is inhaling through the mouth. Does not touch the dropper to the sides of the nostril			
22. Repeats the same on the other nostril			
23. If nose drops are used, asks patient to stay in the same position for 1 – 5 minutes (following manufacturer's guidelines)			
24. Instructs patient not to blow his nose for several minutes			
25. Reassesses for therapeutic and side effects			
26. Places bed in lowest position			
27. Assures side rails are up on bed			
28. Places call light in reach			
29. Washes hands			
30. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administering Ophthalmic Medications

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Attains medication from medication cart/computer			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Calculates dosage accurately (if needed)			
10. Washes hands upon entering patient's room			
11. Identifies patient by two methods			
12. Provides for privacy			
13. Explains procedure			
14. Teaches patient about the medication			
15. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
16. Assists patient to a high fowler's position with head slightly tilted back			
17. Dons gloves			
18. If needed, cleans the edges of the eyelid from the inner canthus to the outer canthus			
19. **Instilling Eye Drops:** Holding the eyedropper, rests the dominant hand on patient's forehead			

Procedure Steps	Yes	No	Comments
20. With the nondominant hand, pulls the lower lid down to expose the conjunctival sac			
21. Positions eyedropper 1.5 – 2.0 cm (1/2 – ¾ in.) above the patient's eye; does not let the dropper touch the eye. Asks patient to look up; drops the correct number of drops into the conjunctival sac. Does not drop onto cornea			
22. Asks patient to gently close and move eyes			
23. If the medication has a localized effect, presses gently against the same side of the nose to close the lacrimal duct for 1 – 2 minutes			
24. **Administering Eye Ointment:**			
a. Rests the dominant hand, with eye ointment, on patient's forehead			
b. With the dominant hand, pulls the lower lid down to expose the conjunctival sac			
c. Asks patient to look up			
d. Applies a thin strip of ointment (about 1") in conjunctival sac; twists wrists to break off the strip of ointment			
e. Does no let the tube touch the eye			
f. Asks patient to gently close eye for 2 – 3 minutes			
g. Explains that vision will be blurred for a short time			
25. Reassesses for therapeutic and side effects			
26. Places bed in lowest position			
27. Assures side rails are up on bed			
28. Places call light in reach			
29. Washes hands			
30. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administering Otic Medications

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Attains medication from medication cart/computer			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Calculates dosage accurately (if needed)			
10. Washes hands upon entering patient's room			
11. Identifies patient by two methods			
12. Provides for privacy			
13. Explains procedure			
14. Teaches patient about the medication			
15. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
16. Dons gloves			
17. Warms the solution to be instilled (e.g., in hand or in warm, not hot water) and gently shakes the bottle before using the drops			
18. Assists patient to a side-lying position, with the appropriate ear facing up			
19. Cleans the external ear with a cotton-tipped applicator; if needed			
20. Fills the dropper with the correct amount of medication			

Procedure Steps	Yes	No	Comments
21. For infants and young children, asks another caregiver to immobilize the child while administering the medication			
22. Straightens the ear canal: a. For patients older than 3 years, pulls the pinna upward and back			
b. For children younger than 3 years old, pulls the pinna down and back			
23. Instills the correct number of drops along the side of the ear canal			
24. Does not touch the end of the dropper to any part of the ear			
25. Gently tugs on the external ear after drops are instilled			
26. Instructs patient to remain on his or her side for 5 – 10 minutes			
27. Places cotton loosely at the opening of the auditor canal for 15 minutes			
28. Reassesses for therapeutic and side effects			
29. Places bed in lowest position			
30. Assures side rails are up on bed			
31. Places call light in reach			
32. Washes hands			
33. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Gavage/Lavage – NG/GT Medications

Skill of the Week Objectives & Activities
• Identify when tube feedings are used • Explain/demonstrate continuous and bolus/intermittent feedings • Be aware of hazards of NG suctioning & feedings • Check placement of an NG tube that has already been inserted • Correctly administer meds by NG or G tube

Gavage & Decompression

Oral feeding is the best way to receive nutrients; one can receive nutrition in two other ways:

1. Enteral nutrition: through the gastrointestinal system
2. Parenteral nutrition: through blood vessels (peripheral or central)

Gastrointestinal tract is considered to be a clean area rather than a sterile one. The procedures used to place and flush an NG are performed using aseptic (clean) technique unless placed during surgery.

Gavage: Nutritional supplement of high calorie liquid diets through a tube.

- Provided at room temperature to avoid cramping.
- May be bolus (given intermittently) or continuous.
- Started at lower rates/amounts and gradually increased to assess for client tolerance.
    - Daily weights until maximum administration rate reached, then q 3 days.
    - Glucoscan q6h until max rate/amount, then q24h.

NG (nasogastric tube) – from nose to stomach

- Gastric acids decrease risk of infection (aseptic technique)
- Not permanent, usually < 4 wks

NJ – from nose to duodenum or jejunum

PEG (Percutaneoous Endoscopic Gastrostomy tube or G-Tube) – through the abdominal wall into the stomach

NG Purposes

- Decompression – connected to suction to decrease gastric pressure by emptying gastric juices or gas (bowel obstruction or surgery)
- Diagnosis – obtain specimens for lab analysis of acid levels and blood content
- Compression – to apply pressure for hemorrhage
- Lavage – wash gastric contents out or dilute irritants or poisons

Placement (You must check institutional policies for the correct procedure)

1. Auscultation of insufflated air: place diaphragm of stethoscope just below client's xyphoid process, epigastric region. Use syringe to instill 20-30 ml of air and listen for a clear swoosh of air.
2. Visualization of aspirate: use a 60 ml syringe, try to aspirate fluid. If you can't inject 20 ml of air and try again. Observe aspirated fluid for clarity, color, and quantity. Gastric contents tend to be cloudy, green, tan off-white, bloody, or brown. Small bowel contents are generally distinctly yellow to bile colored. Respiratory aspirates are often pale yellow, serous or tan, off white or bloody.
3. Testing pH: Apply pH paper to aspirate. Generally gastric pH is < 4, small bowel >

4, and respiratory is > 5.5.

Ongoing Care

1. Oral care: dry mouth, glycerin swabs, lemon swabs, toothbrush and paste, lubricate lips every 2-4 hours.
2. Nasal care: nares becomes dry, lubricate, moisture
3. Potency of suction: assess lines, connections, disconnect to hear swish of suction, place blue pigtail above the level of the heart and safety pin.
4. Abdominal assessment: assess for hypoactive bowel sounds, abdominal distention, abdominal pain, nausea, or vomiting (s/s of gastric retention)

Complications of Gastric Suction

1. Nasal ulceration: improper taping of NG to nostril
2. Gastric ulceration: Levine connected to continuous suction and not intermittent low suction, blue vent on Salem obstructed.
3. Electrolyte imbalance: due to aspirated fluid being removed contains many electrolytes and not being replaced, hypokalemia may result.

Complications of Feedings (Gavage)

1. Aspiration: improper placement, not evaluated for placement, not checked for residual, head of bed placed < 30-40 degrees
2. Potential for clogged tube: not flushed after medications, feedings, or every 4 hours if not connected to automatic tube feeding with flushing.
3. Electrolyte imbalance: due to high osmolarity concentration from solution causing diarrhea or GI infection from not using aseptic technique

Procedure Checklist
Administering Feedings through Gastric and Enteral Tubes

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order to determine the type of feeding, rate of infusion, and frequency of feedings			
2. Check the medical record to determine that tube placement has been confirmed by radiography before first feeding (or follow facilities' policy)			
3. Washes hands			
4. Obtains feedings and supplies			
5. Checks the expiration date of the feeding formula			
6. Shakes the feeding formula to mix well			
7. Warms the formula to room temperature for intermittent feedings; for continuous feedings, keep formula cool but not cold			
8. Prepares equipment for administration: **For an Open System with Feeding Bag:** a. Fills a disposable tube feeding (TF) bag with a 4 – 6 hour supply of formula; primes tubing			
b. Labels the TF bag with date, time, formula type and rate			
c. Hangs the TF bag on an IV pole			
9. **For an Open System with Syringe:** a. Prepares the syringe by removing the plunger			
b. Pours TF formula into syringe			
10. **For a Closed System with Prefilled Bottle with Drip Chamber:** a. Attaches the administration set to prefilled bottle and primes tubing			
b. Hangs the prefilled bottle on an IV pole			
For all types of feedings			
11. Washes hands upon entering patient room			
12. Identifies patient by two methods			
13. Provides for privacy			
14. Explains procedure			
15. Elevates the head of the bed at least 30^0 to 45^0			
16. Places a linen saver pad or towel under the connection end of the TF tube			
17. Dons procedure gloves			

Procedure Steps	Yes	No	Comments
18. Attaches syringe to connection end of the feeding tube to check tube placement a. Aspirating stomach contents and measuring pH			
b. Asking patient to speak			
c. Measuring the external length of the tubing			
d. For nasogastric tubes, but not for gastrostomy or jejunostomy tubes, can additionally confirm by injecting air into the tube and auscultating for "whoosh"			
19. For subsequent feedings, aspirate and measure the gastric residual (except for jejunostomy tubes) a. Connects the syringe to the proximal end of the feeding tube. Draws back slowly to aspirate			
b. Measures the volume of aspirated contents using a syringe (If volume is .60ml, uses graduated container, reinstills aspirate			
20. Flushes the feeding tube with 30ml of water			
Beginning the Feedings:			
21. **If using an infusion pump:** a. Hang feeding and prime tubing (unless already done on previous step). Threads the administration tubing through the infusion pump according to the manufacturer's instructions			
b. Clamps or pinches of the end of the feeding tubes			
c. Traces the tubing from the bag back to the patient			
d. If a connector is needed, attaches it to the open end of the feeding tube and connects to the distal end of the administration tubing. If no connector is needed, attaches the distal end of the administration tubing to the proximal (open) end of the feeding tube			
e. Turns on the infusion pump; sets the correct infusion rate and volume to be infused			
f. Unclamps the tube; begins infusion			
22. **If Using an Open System and Syringe:** a. Clamps or pinches off the end of the feeding tube			
b. Attaches the syringe to the proximal (open) end of the feeding tube			
c. Fills the syringe with the prescribed amount of formula			
d. Releases the tube clamp or pinch and elevates the syringe. Does not elevate syringe .18/ inches above the tube insertion site			

Procedure Steps	Yes	No	Comments
e. Allows feedings to flow slowly (if too fast, lowers the syringe)			
f. When the syringe is nearly empty, clamps tube or holds it about the level of the stomach; refills the syringe; unclamps and continues feedings until done			
23. **Using a Closed-System with a Pre-filled bottle with a drip chamber (no infusion pump):** a. If connector is needed, attaches to the proximal (open) end of the feeding tube and connects to administration tubing. If no connector is needed, attaches the distal end of the administration tube to the proximal (open) end of the feeding tube. Traces tubing from the bag back to patient			
24. Begins the infusion: Opens the roller clamp on the administration tubing and regulates the flow to the prescribed rate			
End Feedings:			
25. When feeding is infused, proceeds as follows: a. Turns off the pump, pinches the end of the feeding tube, and flushes with the prescribed amount of water			
b. **Open System Syringe:** Disconnects the syringe from the feeding tube, flushes the tube with approximately 50ml of water			
c. **Closed System with Prefilled Bottle with Drip Chamber:** Turns off the pump or turns the roller clamp off. Disconnects the feeding tube from the administration tubing. Flushes the feeding tube with prescribed amount of water			
d. **Continuous Feeding:** Flushes the tube with the prescribed amount of water (typically 50 – 100ml) every 4 – 6 hours			
26. Caps the proximal end of the feeding tube			
27. Keeps the head of the bed elevated at least 30^0 to 45^0 for 1 hours after TF is infused			
28. Provides frequent oral hygiene and gargling			
29. Washes hands			
30. **Procedure Variation for Gastrostomy Tubes and Gastric Buttons:** Cleans insertion site daily with soap and water. A small, precut, gauze dressing may be applied to the site			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Procedure Checklist
Administering Feedings Through an Enteral Tubes

Check (√) Yes or No

Procedure Steps	Yes	No	Comments
1. Check MD order – Checks the medication order against the Medication Administration Record (MAR); patient name, patient birthdate, medication, dose, route, time & allergies			
2. Follows agency policy for medication administration, including the time frame for medication administration (most agencies allow medications to be given 30 minutes before or 30 minutes after the time indicated in the MAR)			
3. Knows drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, nursing implications			
4. Determines if medication dosage is appropriate for patient's age and weight			
5. Identifies any special considerations for medication preparation and administration			
6. Attains medication from medication cart/computer			
7. ***First Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
8. ***Second Check:*** Checks medication against MAR (medication, dose, time, route and expiration date)			
9. Calculates dosage accurately (if needed)			
10. Crushes medication in medication package (Making sure medication can be crushed prior to crushing)			
11. Washes hands upon entering patient's room			
12. Identifies patient by two methods			
13. Provides for privacy			
14. Explains procedure			
15. ***Third Check:*** At bedside, verifies medication, expiration date, dose, route, time and presence of drug allergies			
16. Opens medication and places in medication cup without touching medication (If liquids, shake medication and pour into cup, at eye level, from the side of the container away from the label)			
17. Mixes medication with approximately 20ml of water			
18. If several medications are given, mixes all medication in same medication cup; unless otherwise contraindicated			
19. Performs any assessments that are related to the medication to be given, such as checking the pulse and blood pressure			

Procedure Steps	Yes	No	Comments
20. Places patient in a high-Fowler's position if possible			
21. Checks nasogastric tube for placement by aspirating stomach contents or measuring the pH of the aspirate, if possible. Other, less accurate methods are injecting air into the feeding tube and auscultating or asking patient to speak			
22. Checks for residual volume (making sure all residual volume is placed back into the tube)			
23. Flushes the tube, uses the correct type of size syringe			
24. To flush the tube, removes the bulb or plunger from the syringe, attaches barrel to the tube and pours in 30ml of water			
25. Instills medication by using the barrel of the syringe as a funnel and pouring in the medication			
26. Flushes the medication through the tube by instilling an additional 30ml of water			
27. Has patient maintain a sitting position (if able) for at least 30 minutes after medication administration			
28. Reassesses for therapeutic and side effects			
29. Teaches patient about the medication (if able)			
30. Washes hands			
31. Documents the medication given in the patients record			

Recommendation: Pass_____ Needs more practice _____

Student:_____ Date:_____

Instructor:_____ Date:_____

Merced College

REGN 24

Acute Medical/Surgical and Nursing of the Childbearing Family

Spring 2014

Dan Smith, RN, MSN, FNP

Kitty Cazares, RN, MSN

Merced College
REGN 24-Nursing in Health & Illness II
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"If you have a verified physical, medical, psychological, or learning disability or perhaps you feel you may have one of these disabilities which impact your ability to carry out assigned course work, please contact the Disabled Student Services (DSS) office. DSS staff will review your needs and determine what accommodations are necessary and appropriate. All information and documentation is confidential. DSS is located in the Lesher Student Services Bldg. Room 234, phone 384-6155. In Los Banos, DSS is located in Building A, phone 381-6423."

Section A

Introductory Materials

Merced College
Course Outline

1. **Course Number and Title:** REGN 24, Acute Medical/Surgical and Nursing of the Childbearing Family

2. **Units:** 10 Hours: Lecture 5; Lab 15

3. **Prerequisite:** Completion of REGN 15, REGN 18
   Advisory: none

4. **Catalog Description:**
   REGN-24 provides for the acquisition and application of nursing theory, communication, collaboration, and critical thinking skills necessary for safe, patient-centered nursing care to a developmentally and culturally diverse patient population experiencing various common medical/surgical interventions and to the childbearing family. Incorporates best practices, professional standards, and legal and ethical responsibilities of the professional nurse as applied in various healthcare settings. Includes acquisition of nursing skills required in acute care and childbearing family settings. Application of knowledge and skills occurs in the nursing skills laboratory and clinical settings.

   Registered Nursing 24 Course Outcomes:
   1. Apply medical/surgical and childbearing family nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture.
   2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the childbearing family and patients requiring medical/surgical interventions.
   3. Demonstrate critical thinking/clinical reasoning when caring for the childbearing family and patients requiring medical/surgical interventions.
   4. Implement basic leadership concepts for the purpose of providing and improving care for the childbearing family and patients requiring medical/surgical interventions.
   5. Use information technology to document care for the childbearing family and patients requiring medical/surgical interventions.
   6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the childbearing family and patients requiring medical/surgical interventions.

5. **Required Texts and Supplies:**
   Medical-Surgical Nursing: Patient-Centered Collaborative Care; Ignatavicius, D., 7th, Saunders
   Maternity Nursing w/Study Guide; Lowdermilk & Perry, 8th, Mosby
   Wong's Essentials of Pediatric Nursing; Hockenberry, 9th, Mosby
   ATI Resources

6. Entrance Skills:

Prerequisite Skills: Before entering the course the student should be able to:

REGN 15 and REGN 18: Complete Universal, Conceptual, and Clinical objectives identified in course outlines.

7. Course Outcomes and Competencies:

1. Apply medical/surgical and childbearing family nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture.

- Apply medical/surgical and childbearing family nursing concepts to plan compassionate, patient-centered, evidence-based care taking individual differences into consideration.
- Conduct, at a basic level, a comprehensive and focused physical, behavioral, psychological, spiritual assessment of medical/surgical patients and childbearing families, eliciting patient values, experiences, and expressed needs.
- Plan holistic, patient-centered care that reflects psychosocial integrity, physiological integrity, and health promotion and maintenance of medical/surgical patients and childbearing families within a variety of healthcare systems.
- Demonstrate at a basic level, the application of psychomotor skills for the efficient, safe, and compassionate delivery of patient care.
- Deliver care within expected timeframe.
- Monitor at a basic level patient outcomes, including interpretation of assessment data and appropriate follow-up, to evaluate the effectiveness of nursing interventions.
- Describe the clinical microsystem of the medical-surgical and maternal-newborn units.
- Identify quality measures when evaluating effects of medical-surgical and childbearing family nursing interventions appropriate to the care environment.
- Describe factors that create a culture of caring for the patient and the patient's support network.
- Communicate effectively with the patient and the patient's support network.
- Communicate effectively when reporting care provided and evaluation data including appropriate handoff reports.
- Provide at a basic level appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and level of health literacy.
- Evaluate effectiveness of patient teaching.

2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the childbearing family and patients requiring medical/surgical interventions

- Use effective communication techniques that produce positive professional working relations in the medical-surgical environment.
- Interact with members of the healthcare team to plan patient care and evaluate progress toward patient outcomes for the patient undergoing medical/surgical procedures and those of the childbearing family.
- Explain the nurse's role in decision making related to patient care in the medical/surgical and maternal-newborn environments.
- Identify examples of conflict resolution and describes possible solutions.

- Identify own role as a member of the interdisciplinary healthcare team working with medical/surgical patients and childbearing families.
- Describe ways in which team functioning impacts safety and quality improvement for the medical/surgical patient and childbearing families.

3. Demonstrate critical thinking/clinical reasoning when caring for the childbearing family and patients requiring medical/surgical interventions.
   - Use critical thinking/clinical reasoning when planning patient care and working in the medical-surgical and maternal-newborn environments.
   - Demonstrate tolerance for ambiguity and unpredictability and its effect on care of the medical-surgical patient and childbearing families.
   - Interpret and correctly implement physician and interprofessional orders for the medical-surgical patient and childbearing families.
   - Anticipate risks and predict and manage potential complications that commonly occur in the medical-surgical patient and childbearing families.
   - Use the nursing process to make decisions about care for the medical-surgical patient and childbearing families.

4. Implement basic leadership concepts for the purpose of providing and improving care for the childbearing family and patients requiring medical/surgical interventions.
   - Begin to use the delegation process in the medical-surgical and maternal-newborn settings.
   - Compare and contrasts the differences in the provision of patient care among various medical-surgical patients and childbearing families.
   - Describe the effect of the nursing leadership on a medical-surgical and maternal-newborn unit.
   - Describe the quality improvement processes on a medical-surgical and maternal-newborn unit used to effectively implement patient safety initiatives and monitor performance measures.
   - Apply the National Patient Safety Goals to patients on a medical-surgical and maternal-newborn unit and identify any areas in need of improvement.

5. Use information technology to document care for the childbearing family and patients requiring medical/surgical interventions.
   - Maintain organizational and client confidentiality.
   - Explain how the clinical information system is used on the medical-surgical and maternal-newborn unit for safe nursing practice.
   - Give examples of the role of information technology in improving patient care outcomes and creating a safe care environment on the medical-surgical and maternal-newborn unit.

6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the childbearing family and patients requiring medical/surgical interventions.
   - Apply rules and regulations that authorize and define professional nursing practice on the medical-surgical and maternal-newborn unit.
   - Demonstrate professional standards of moral, ethical, and legal conduct when providing care for the medical-surgical patient and childbearing families.
   - Assume accountability for own behaviors, including a recognition for when to ask for assistance.
   - Practice within the parameters of individual knowledge and experience.

Program Student Learning Outcomes

Faculty believe in the importance of incorporating professional standards, guidelines, and competencies as the basis for the nursing curriculum. The program must reflect current nursing practice. To this end, a rigorous and thorough examination of the current literature on nursing practice and nursing education was conducted. These findings guided the development of the program student learning outcomes. Additionally, faculty examined the current healthcare environment in the Merced area. The program student learning outcomes, along with their related competencies, reflect the expected behaviors of the graduates of Merced's Nursing Program. Therefore, these program student learning outcomes are used to organize the curriculum, and guide all activities related to the teaching/learning process, including delivery of instruction and evaluation of student progress. The six student program learning outcomes are:

1. Provide quality, safe, patient-centered nursing care through evidence-based practice.
2. Participate in collaborative relationships with members of the interdisciplinary team to provide and improve patient care.
3. Engage in critical thinking skills and strategies and clinical reasoning necessary to provide quality patient care.
4. Provide leadership in a variety of healthcare settings for diverse patient populations.
5. Use information technology to communicate, manage knowledge, mitigate error, and support decision-making.
6. Function as a competent nurse assimilating all professional, ethical, and legal principles.

The documentation from which these program student learning outcomes flow is presented in the next section.

The Program Student Learning Outcomes align with Institutional Student Learning Outcomes as follows:

1. Provide quality, safe, patient-centered nursing care through evidence-based practice. **Merced College outcome related to cognition: Assess the impact of science and technology on the world. Patient-centered relates to Merced College's outcome related to Global & Community Consciousness: Distinguish and understand diverse cultures.**
2. Participate in collaborative relationships with members of the interdisciplinary team to provide and improve patient care. **Merced College outcome related to communication such as: Read and analyze written communication appropriate to the subject and Comprehend, analyze, and utilize aural and visual communication in its various modes.**
3. Engage in critical thinking skills and strategies and clinical reasoning necessary to provide quality patient care. **Merced College outcome related to Use Critical thinking skills to analyze, synthesize, and evaluate ideas and information.**
4. Provide leadership in a variety of healthcare settings for diverse patient populations. **Merced College outcome related to Personal development and life-long learning: Demonstrate self-management, maturity, and growth through practices that promote physical, mental, and emotional well-being, such as: Analyze and apply interpersonal skills.**
5. Use information technology to communicate, manage knowledge, mitigate error, and support decision-making. **Merced College outcome related to communication such as: Comprehend, analyze, and utilize aural and visual communication in its various modes.**
6. Function as a competent nurse assimilating all professional, ethical, and legal principles. **Merced College outcome related to Personal development and life-long learning:**

Demonstrate self-management, maturity, and growth through practices that promote physical, mental, and emotional well-being, such as: Demonstrate an understanding of life-long learning (professional principle) and Evaluate and adhere to professional and ethical standards.

Sequencing of Courses

The program is designed to culminate in these student learning outcomes. Therefore, each course is leveled based on these outcomes as well as populations of patients. The sequencing of courses reflects higher cognitive levels, a different patient population, and/or more complexity in patient care provided in a variety of healthcare settings. Patricia Benner's Model of Novice to Expert is used in the development of the professional nurse. Courses build to assist students with their journey to advanced beginner by graduation, prepared to become competent nurses as they experience their first two years of practice (Benner, Tanner, & Chesla, 2009).

Documentation for Development of Program Student Learning Outcomes

Current trends in nursing and health care as well as traditional standards and values of nursing practice influenced the choice of these six program student learning outcomes. The following is an explanation of the specific current trends and traditional standards and values used to develop the program student learning outcomes.

1. Provide quality, safe, patient-centered nursing care through evidence-based practice.

This outcome focuses on the many aspects of the nurse/patient relationship and integrates the work of the QSEN group derived from the IOM studies (Finkelman & Kenner, 2009). Safety is a major concept and is based on QSEN.org documentation as well as the NCSBN's *Nursing Pathways for Patient Safety* (2010). The importance of patient-centered care is addressed by the Institute of Medicine (2010) stating that many systems are designed to meet the needs of providers. "True patient- and family-centered care will focus on the whole patient, putting the patient, family, and care team together as a system" (p. 16). This outcome also relates to two of NLN's Competencies for ADN graduates (2010): "Advocate for patients and families in ways that promote their self-determination, integrity, and ongoing growth as human beings" (p. 33), and "Implement one's role as a nurse in ways that reflect.....a nurse committed to evidence-based practice, caring, and advocacy, and safe, quality care for diverse patients within a family and community context (p. 35). This outcome also embraces the major categories of content presented in the NCLEX-RN® test plan. The ANA's (2010 *Nursing: Scope and Standards of Practice* are applied when planning quality, patient-centered nursing care.

Major concepts for this learning outcome include:

- The nursing process (assessment, diagnosis, goals/outcome criteria, interventions, and evaluation)
- Patient teaching
- Patient-centered care
- Evidence-based practice
- Quality measures
- Caring
- Safety
- NCLEX-RN® categories and their subcategories:
    a. Safe and effective care environment
    b. Health promotion and maintenance
    c. Psychosocial integrity
    d. Physiological integrity

2. Participate in collaborative relationships with members of the interdisciplinary team to provide and improve patient care.

The importance of collaboration is emphasized in the work of the QSEN group derived from the IOM studies (Finkelman & Kenner, 2009) with the competencies of Teamwork and Collaboration. The QSEN and IOM competencies of Quality Improvement and Patient-Centered Care also relate to this outcome. This outcome incorporates NLN's 2010 definition of teamwork: "to function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision making to achieve quality care" (p. 69).

The silo approach to care in which each professional works in parallel is no longer acceptable in the current healthcare environment. Health professionals must "cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable" (IOM, 2003, p. 4). Additionally, the Institute of Medicine (2010) notes that 60 to 70% of adverse events happening to patients in the acute care setting can be traced to problems with communication. Some of those problems stem from disruptive behavior by both nurses and physicians.

This program student learning outcome addresses the nurse's role in working with other healthcare professionals to plan and implement care and quality improvement measures. The importance of the broader context of a systems approach to care rather than the narrower nurse/patient relationship as the primary focus of the work environment is imperative for meeting the quality improvement competency for this outcome (Day & Smith, 2007).

Major concepts for this learning outcome include:

- Patient-centered care
- Teamwork/collaboration
- Quality improvement
- Levels of the work environment:
    - The larger healthcare system
    - Clinical microsystems
    - Nurse/patient relationship

3. Engage in critical thinking skills and strategies and clinical reasoning necessary to provide quality patient care.

Critical thinking is a broad term that encompasses all the thought processes that relate to clinical decision making and clinical reasoning. It is part of the term NLN (2010) defines as nursing judgment which encompasses three processes: critical thinking, clinical judgment, and integration of best evidence into practice (p. 67). The National Council of State Boards of Nursing (NCSBN) identified critical thinking as the number two attribute for entry level RNs (NCSBN, 2006). Critical thinking is evidenced not only by the student's use of the nursing process, but also when interfacing with the clinical microsystem and the larger healthcare system to deliver quality, safe, patient-centered care. This outcome also relates to two of NLN's Competencies for ADN graduates (2010): "Make judgments in practice, substantiated with evidence, that integrate nursing science in the provision of safe, quality care and promote the health of patients within a family and community context" (p. 34) and "Examine the evidence that underlies clinical nursing practice to challenge the status quo, question underlying assumptions, and offer new insights to improve the quality of care for patients, families, and communities" (p. 36).

Major concepts for this learning outcome include:

- Critical thinking
- Clinical decision making
- Clinical judgment
- Integration of best evidence
- Nursing process

4. Provide leadership in a variety of healthcare settings for diverse patient populations.

This outcome focuses on the core component of Leadership. Leadership is comprehensive and includes managing care, delegating to others, integrating and coordinating care, investigating and sharing best practice guidelines, and serving as a leader in many capacities within the healthcare environment. Another major component under leadership derives from the Quality and Safety Education in Nursing (QSEN) (2007) competency, Quality Improvement. Quality improvement refers to the use of data to monitor the outcomes of care processes and the use of improvement methods to design and test changes to continuously improve the quality and safety of healthcare systems (Smith, Cronenwett, & Sherwood, 2007). This outcome also relates to two of NLN's Competencies for ADN graduates (2010): "Advocate for patients and families in ways that promote their self-determination, integrity, and ongoing growth as human beings" (p. 33), and "Implement one's role as a nurse in ways that reflect integrity, responsibility, ethical practices and evolving identity.....for diverse patients within a family and community context" (p. 35).

Major concepts for this learning outcome include:

- Management of care
- Delegation
- Leadership
- Quality improvement
- Human flourishing

5. Use information technology to communicate, manage knowledge, mitigate error, and support decision-making.

Traditionally, communication referred to engaging in verbal and written exchange of information. More recently it also includes using information and communication technologies. Knowledge and use of information systems and nursing informatics in health care mandates that students learn about new technologies. This program student learning outcome is a specific competency recommended by QSEN. Knowledge of informatics is also recommended by the NLN in their 2008 position statement *Preparing the Next Generation of Nurses to Practice in a Technology-Rich Environment: An Informatics Agenda*. In this position paper the NLN called for nursing schools to incorporate informatics into the curriculum.

Major concepts for this learning outcome include:

- Information systems
- Nursing informatics
- Information technology

6. Function as a competent nurse assimilating all professional, ethical, and legal principles.

The general term professionalism is used to include all professional, ethical, and legal principles to guide the practice of the registered nurse. The foundation for this program student learning outcome flows from two American Nurses Association documents, *Nursing: Scope and Standards of Practice* and *The ANA Code of Ethics* as well as the *California Board of Registered Nursing's Nurse Practice Act*. This outcome also relates to one of NLN's Competencies for ADN graduates (2010): "Implement one's role as a nurse in ways that reflect integrity, responsibility, ethical practices, and an evolving identity as a nurse committed to evidence-based practice, caring, advocacy, and safe, quality care for diverse patients within a family and community context" (p. 35). Personal and professional development is part of this competency which includes lifelong learning.

Major concepts for this learning outcome include:

- Professionalism
- Ethical behavior
- Legal principles
- Standards of practice
- Personal and professional development

Registered Nursing Program

Time Guidelines for Clinical Lab Skills

Skill	Time
Bed Making	15 Min
Hand Washing	5 Min
Body Mechanics (Position/turn)	15 Min
Bed Bath	15-20 Min
Vital Signs	10 Min
Enema	15 Min
Restraint/Binder	10 Min
Adv. Body Mechanics (Transfer/amb/rom)	15 Min
Ng Insertion	15 Min
Sterile Gloving	5 Min
Dressing Change	15 Min
Catheter Insertion	20 Min
Oral Medication	10 Min
Specimens	10 Min
Subq Injection	15 Min
Im Injection	15 Min
Assessment	15 Min
Blood Sugar Testing	20 Min
Discontinue IV	15 Min
Suture/staple Removal	15 Min
Bandages	15 Min
Heat/cold	10 Min
Oral/nasal Suction	10 Min
Meds (Otic/ophthalmic/topical)	10 Min

Merced College

REGN 24 - Nursing in Health and Illness II
Second Semester

Spring 2014 - Grading Criteria

Instructors:

Kitty Cazares RN, MSN
Room: AHC - 102
Telephone: 384-6386
Office Hours: TBA

Dan Smith RN, MSN, FNP
Room AHC - 101
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Theory and Clinical Objectives

As outlined in Syllabus

Grading Criteria

1. **Theory Component**

Exams (5)	75
Final	20
ATI	5

2. **Clinical Component**

Clinical	Pass/Fail

You must have a minimum course average of 75% to pass this course.

It is the instructor's right to make changes in the course schedule and learning activities as needed.

ATI Grading

To assist students in preparation for the proctored assessment, assigned readings from the ATI review module are provided. It is recommended that the student completes the application exercises and practice assessments, and create a focused review to address their areas needing improvement to be awarded points.

Five percent of the course grade will be calculated (maximum of 5 points) as follows: preparing for the exam (2 points), and achieving various proficiency levels: Level 3 (3 points); Level 2 (2 points); Level 1 (1 point).

Preparation for the proctored assessment is essential for student success. The items below are to provide students with tools to achieve success. In order to earn two points, the following needs to be completed, prior to taking the Proctored ATI Exam.

1. Attain 95% on the practice assessments Forms A & B. Practice assessments may only be taken once every seventy two (72) hours. Time begins upon completion of a practice assessment. The two points will be calculated as follows: completion of practice Form A (1 point), completion of practice Form B (1 point), and not completing practice Forms A or B (0 points).

**Approved Remediation

1. Students scoring below Level 1 are encouraged to contact their faculty member, by email or in person prior to beginning remediation.

2. The remediation plan is to create and complete a Focused Review on topics missed. The score received on the ATI proctored assessment will determine the required time in focused review. If you are unsure of how to create a focused review, go to the ATI website (www.atitesting.com), log-in and the instructions are located under Orientation Materials > How to Access My Results and Remediation > Page 5.

Section B

Theory Objectives
Kitty Cazares

Merced College
REGN 25 - Nursing Skills Simulation II
Theory Schedule

Month	Date	Topical Outline
January	13	Pre and Post-op Care
	15	Infectious Diseases – Adult
	20	**HOLIDAY**
	22	Infectious Diseases – Child
	27	Hypertension
	29	**EXAM #1**
February	3	Introduction to Maternity Nursing
	5	Reproduction Concerns & Health Assessments
	10	Genetics & Fetal Development
	12	Anatomy & Physiology of Pregnancy
	17	HOLIDAY
	19	Nursing Care During Pregnancy / Maternal & Fetal Nutrition
	24	**EXAM #2**
	26	Labor & Birth Processes
March	3	Nursing Care During Labor, including Managing Discomfort and Fetal Assessment
	5	Assessment of High Risk Pregnancy
	10	Labor & Birth At Risk
	12	Postpartum Complications
	17	**Exam #3**
	19	Maternal Physiological Changes
	24	Postpartum Nursing & Family Transition
	26	Adaptations of the Newborn
	31	Assessment of the Newborn
April	2	The New At Risk
	7	**EXAM #4**
	9	**ATI EXAM**
	14	Anemias
	16	GI Alterations
	21-25	**Spring Break**
	28	GU Alterations
	30	Client with Dyspnea
May	5	**EXAM #5**
	7	Client with CVA
	12	Client with Chest Pain
	14	Diabetes/Care of Immobilized Patient
	19 - 22	**Final Exam Week**

Care of the Perioperative Patient

Purpose:

This unit addresses care of diverse patients undergoing surgical intervention. Differentiation will be made between adult patients and pediatric patients undergoing general surgery. Extremely important to the care of the surgical patient is patient teaching. Teaching is a major factor in preventing postoperative complications. Experiences in the nursing skills laboratory include care of drains and sutures; staple removal, and sterile surgical setup.

Learning Objectives and Course Outcomes

Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Apply surgical nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the surgical patient.
3. Demonstrate critical thinking/clinical reasoning when caring for the surgical patient.
4. Implement basic leadership concepts for the purpose of providing and improving care for the surgical patient.
5. Use information technology to document care for the surgical patient.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the surgical patient.

Major Topics

1. The perioperative experience
2. Nursing care of the surgical patient
3. Pain control

Nursing Skills Laboratory

1. Sterile technique
2. Surgical scrub and sterile surgical setup
3. Care of drains and suture; staple removal
4. IV pain medications: IVP and PCA usage

Required Reading

Ignatavicius & Workman, Chapters 5, 16, 17, 18
Wilkinson & Van Leuven, Vol. 1, Chapter 37
Wilkinson & Van Leuven, Vol. 2, Chapter 37

Introduction to Care of Patients with Infectious Diseases

Purpose:
The unit discusses another common ailment, that of infectious diseases. In children, most infectious diseases are acute illnesses. With immunizations many of the devastating effects of infectious agents are controlled. However, acute infections are still a threat for both children and adults. Experiences in the nursing skills laboratory focus on intravenous infusions, a common intervention for patients hospitalized with infections. Starting an IV and adding medications to a solution are covered.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Apply nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture for the patient with an infectious illness.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the patient with an infectious illness.
3. Demonstrate critical thinking/clinical reasoning when caring for the surgical patient.
4. Implement basic leadership concepts for the purpose of providing and improving care for the patient with an infectious illness.
5. Use information technology to document care for the patient with an infectious illness.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the patient with an infectious illness.

Major Topics
1. Infection control
2. Health promotion and illness prevention
3. Nursing care of the patient with an infectious illness

Nursing Skill Laboratory
1. Transmission-based precautions
2. Donning and removing personal protective equipment (PPE)

Required Reading
Hockenberry & Wilson, pages 423-432.
Ignatavicius & Workman, Chapter 19, 25, 76

Infectious Diseases - Child

Name	Organism	Source	Treatment	Other	Prevention
Measles Rubeola	Virus	resp blood urine	none supportive	rash Koplik spots	MMR SQ live virus
Mumps Parotitis	Paromyxo-virus	resp fomites	none supportive	Affects parotid gland orchitis	MMR SQ live virus
German measles rubella	Rubella virus	resp stool urine blood	immunoglobulin for pregnant women	3 day rash tetragenic to fetus	MMR SQ live virus
Diphtheria	Coryne-bacterium dephtheriae	mucous membranes skin lesions	equine antitoxin; dip, toxoid for contacts	airway obstruction damage to nerve, heart, kidneys	DPT IM
Whooping Cough Pertussis	Bordetella pertussis bacteria	resp	antimicrobials Pertussis immune globulin	high pitched whooping sound	DPT IM
Tetanus	Clostridium tetani bacillus	soil, dust, water, animal mouths and feces	Human tetanus immune globulin (antitoxin)	muscle stiffness---> tetanic seizures	IM

Name	Organism	Source	Treatment	Other	Prevention
Chicken Pox Varicella	varicella zoster virus	resp skin lesions	acyclovir (oral) antipyretics coll baths, careful hygiene	Herpes zoster virus of shingles rash	varivax SQ live virus
Polio	Enterovirus	oral feces	no treatment	motor neurons	oral SQ
Hepatitis B	virus	transfusion injection	immune globulin vaccine		HbV IM
Rotavirus	virus	GI		diarrhea	
Tuberculosis	Mycobacterium				PPD (diagnostic)
Meningitis	H. Influenza type b				Hib IM

Care of Patients with Common Conditions of the Cardiovascular System

Purpose:

The unit covers common alterations of the cardiovascular system. Cardiac disease is a major cause of death in this country so the nurse must be very mindful of complaints of chest pain or detection of hypertension during a physical examination. Hypertension is a common cause of both myocardial infarction and stroke. The common conditions covered in this unit include chest pain, dyspnea, hypertension, and stroke.

Learning Objectives and Course Outcomes

Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Apply nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture for the patient with chest pain, dyspnea, hypertension, and stroke.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the patient with chest pain, dyspnea, hypertension, and stroke.
3. Demonstrate critical thinking/clinical reasoning when caring for the patient with chest pain, dyspnea, hypertension, and stroke.
4. Implement basic leadership concepts for the purpose of providing and improving care for the patient with chest pain, dyspnea, hypertension, and stroke.
5. Use information technology to document care for the patient with chest pain, dyspnea, hypertension, and stroke.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the patient with chest pain, dyspnea, hypertension, and stroke.

Major Topics

1. Cardiovascular conditions: chest pain, hypertension, stroke
2. Dyspnea
3. Nursing care of the patient with chest pain, dyspnea, hypertension, and stroke.

Required Reading

Ignatavicius & Workman, Chapter 38, and pages 775-785.

Weekly Objectives	Reading Assignment
Anemias	
1. Compare and select the appropriate lab values for the specific anemias.	**Ignatavicius, Workman**
2. Contrast and compare the typical signs and symptoms of the following disorders:	Chapter 41
a. Maturation and production of blood cell problems: • megaloblastic (pernicious anemia) • iron deficiency anemia • aplastic anemia	Chapter 42
b. Clotting deficiency: • DIC	
c. Excessive destruction of RBC's: • Acquired hemolytic anemia	
3. Analyze diagnostic tests, medical treatment, and nursing care for the above mentioned conditions and the related nursing interventions.	
4. Examine counseling issues related to genetics, family planning, loss/grief, over protection and health issues such as AIDS risk, insurance etc.	

Weekly Objectives

Care of the Adult Client with Dyspnea

1.	Analyze the key respiratory physiologic principles applicable to this unit.	**Ignatavicius, Workman**
2.	Analyze the major signs and symptoms of a client with respiratory distress and utilize these in assessment.	Chapter 29
3.	Differentiate the various diagnostic tests used for a client with dyspnea. Also be to teach the client about test preparation and interpretation of abnormal findings.	Chapter 30 Relevant material
4.	Assess and select specific care measures for a client for bronchoscopy and thoracentesis procedures.	
5.	For pulmonary tuberculosis and coccidiomycosis compare and contrast the following: a. transmission and risk factors b. pathophysiology and clinical manifestations c. diagnostic evaluation and medical management d. nursing implications including nursing diagnoses and plan of care for a client with dyspnea.	
6.	Analyze the principles of basic ABG's.	

Care of Patients with Common Alterations in Gastrointestinal Function

Purpose:

The unit covers common alterations in gastrointestinal function. Gastrointestinal conditions are common and often times treated with over-the-counter medications. During the health history the nurse is alert to gastrointestinal conditions when taking the nutrition, elimination, and medication history. This data provide clues to issues the patient may have with acute or chronic GI conditions. Experiences in the nursing laboratory include nasogastric tube insertion, maintaining, n1onitoring, and discontinuing.

Learning Objectives and Course Outcomes

Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Apply nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture for the patient with common alterations in the gastrointestinal system.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the patient with common alterations in the gastrointestinal system.
3. Demonstrate critical thinking/clinical reasoning when caring for the patient with common alterations in the gastrointestinal system.
4. Implement basic leadership concepts for the purpose of providing and improving care for the patient with common alterations in the gastrointestinal system.
5. Use information technology to document care for the patient with a common alterations in the gastrointestinal system.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the patient with common alterations in the gastrointestinal system.

Major Topics

1. Common alterations in the gastrointestinal system.
2. Nursing care of the patient with common alterations in the gastrointestinal system.

Nursing Skills Laboratory

Assessment of the gastrointestinal system
Nasogastric tubes – types
Nasogastric tube insertion, maintaining, monitoring, and discontinuing
Docun1entation related to nasogastric tubes

Required Reading

Ignatavicius & Workman, Chapters 55, 57, 58 (Relevant material in Chapters 59-63)

Care of Patients with Common Alterations in Urinary Function

Purpose:
The unit covers common alterations in urinary function. One of the most frequently occurring conditions is urinary tract infection, a problem that occurs more frequently in women than men. Other problems, such as urinary calculi, commonly occur in both men and women. Experiences in the nursing laboratory include insertion, care of, and removal of urinary catheters and care of urinary diversions.

Learning Objectives and Course Outcomes
Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Apply nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture for the patient with common alterations in urinary function.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the patient with common alterations in urinary function.
3. Demonstrate critical thinking/clinical reasoning when caring for the patient with common alterations in urinary function.
4. Implement basic leadership concepts for the purpose of providing and improving care for the patient with common alterations in urinary function.
5. Use information technology to document care for the patient with a common alterations in urinary function.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the patient with common alterations in urinary function.

Major Topics
1. Common alterations in urinary function.
2. Nursing care of the patient with common alterations in urinary function.

Nursing Skills Laboratory
Assessment of the urinary system
Insertion and removal of indwelling urinary catheter
Insertion of straight catheter
Urinary diversion

Required Reading
Ignatavicius & Workman, Chapters 68, 69, and 70

Care of the Patient with Diabetes Mellitus

Purpose:

This unit addresses an increasingly common condition in both adults and children. This condition is so pervasive that all patients should be routinely assessed for this condition. Covered in this unit are the common manifestations, complications, treatment options, patient teaching, and nursing care.

Learning Objectives and Course Outcomes

Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Apply nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture for the patient with diabetes mellitus.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the patient with diabetes mellitus.
3. Demonstrate critical thinking/clinical reasoning when caring for the surgical patient.
4. Implement basic leadership concepts for the purpose of providing and improving care for the patient with diabetes mellitus.
5. Use information technology to document care for the patient with diabetes mellitus.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the patient with diabetes mellitus.

Major Topics

1. The pathology of diabetes mellitus
2. Health pro1notion and illness prevention
3. Nursing care of the patient with diabetes mellitus

Required Reading

241-242. Ignatavicius & Workman, Chapter 67

Care of Elderly Patients

Purpose:

The fastest growing segment of the population are those 65 years and older. The unit covers common changes with aging and how the nurse can adapt to these changes. The nurse must be able to differentiate between normal changes with aging and manifestations which may indicate pathologies. Early detection and treatment can assist the elderly to adapt and enjoy a quality life. The unit concludes with end of life care.

Learning Objectives and Course Outcomes

Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Apply nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture for the elderly patient.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the elderly patient.
3. Demonstrate critical thinking/clinical reasoning when caring for the elderly patient.
4. Implement basic leadership concepts for the purpose of providing and improving care for the elderly patient.
5. Use information technology to document care for the elderly patient.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the elderly patient.

Major Topics

1. Normal changes with aging
2. Manifestations that might indicate pathology
3. Rehabilitation concepts
4. End of life issues and care

Nursing Skills Laboratory

Focused assessment of the elderly

Required Reading

Ignatavicius & Workman, Chapters 3, 8, and 9

Weekly Objectives
Care of the Client with Cerebrovascular Disorders

1. Analyze the major risk factors for developing cerebrovascular disorders. 2. Differentiate the pathophysiology and clinical manifestations of transient ischemic attack, complete stroke, and subarachnoid hemorrhage (SAH). 3. Differentiate the signs and symptoms of persons with right and left hemipheric stroke. 4. Inventory the major medications and surgical procedures that may be used to treat cerebrovascular disorders. 5. Relate principles of nursing management to the care of a patient in the acute stage of stroke. 6. Plan for principles of nursing management to the care of the stroke patient in the rehabilitative stage. 7. Differentiate the traditional and neurodevelopmental (Bobath) approaches in the care and retraining of stroke patients. 8. Distinguish essential elements for family teaching and preparation for home care of the stroke patient.	Ignatavicius Chapter 47 pgs. 1004-1020

Introduction to Care of Patients with Alterations in Musculoskeletal or Articular Function

Purpose:

The unit covers conditions interfering with muscularskeletal or articular functioning. Many of these conditions are treated with surgical intervention and/or traction. Both adults and children are addressed. Experiences in the nursing skills laboratory focus on traction, using crutches, canes, and walkers.

Learning Objectives and Course Outcomes

Specific student learning objectives appear at the beginning of each chapter. These will be used as the focus of the content. The specific content is then related to the following course outcomes:

1. Apply nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture for the patient with an alteration in musculoskeletal or articular function.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when caring for the patient with an alteration in musculoskeletal or articular function.
3. Demonstrate critical thinking/clinical reasoning when caring for the patient with an alteration in musculoskeletal or articular function..
4. Implement basic leadership concepts for the purpose of providing and improving care for the patient with an alteration in musculoskeletal or articular function.
5. Use information technology to document care for the patient with an alteration in musculoskeletal or articular function.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the patient with an alteration in musculoskeletal or articular function.

Major Topics

1. Common alterations of musculoskeletal or articular function
2. Nursing care of the patient with an alteration in musculoskeletal or articular function

Nursing Skills Laboratory

Assessment of the musculoskeletal system
Traction
Using crutches, canes, and walkers

Required Reading

Ignatavicius & Workman, Chapters 52 and 53

Weekly Objectives

Care of the Adult Client with Coronary Chest Pain

1. Differentiate the various characteristics of pain and relate how to use them while gathering data in assessment of a patient with chest pain.	**Ignatavicius, Workman**
2. Distinguish among the major types of chest pain.	Chap. 40 Relevant material
3. Analyze risk factors, pathophysiology , chest pain descriptors and diagnostic screening for both MI and angina.	Chap. 35 Relevant material
4. Prepare the client with chest pain both physically and with teaching for diagnostic tests. Also be able to interpret the tests.	
5. Compare and contrast the pathophysiology, stages in development, medical management and development of complications for both a MI and angina.	**ACLS Provider Manual** Recommended resource
6. Assess and intervene with nursing management activities to relieve client symptoms of chest pain, in addition to assisting with the relief of anxiety related to the pain and fear of possible death.	

Section C

Theory Objectives
Dan Smith

Month	Date	Lowdermilk Units	Topical Title	Reading
February	3	1 & 2	**Introduction to Maternity Nursing**	Lowdermilk: Chapters 1 & 2
	5	1 & 2	**Reproduction Concerns & Health Assessments**	Lowdermilk: Chapters 3 & 4 ATI: Chapters 1 & 2
	10	1 & 2	**Genetics & Fetal Development**	Lowdermilk: Chapters 3 & 4 ATI: Chapter 6
	12	1 & 2	**Anatomy & Physiology of Pregnancy**	Lowdermilk: Chapter 6 ATI: Chapter 3
	17		**HOLIDAY**	
	19	1 & 2	**Nursing Care During Pregnancy / Maternal & Fetal Nutrition**	Lowdermilk: Chapters 7 & 8 ATI: Chapters 4 & 5
	24		**EXAM #2**	
	26	3 & 6	**Labor & Birth Processes**	Lowdermilk: Chapters 9 ATI: Chapter 11
March	3	3 & 6	**Nursing Care During Labor , including Managing Discomfort and Fetal Assessment**	Lowdermilk: Chapters 10, 11, 12 ATI: Chapters 12, 13
	5	3 & 6	**Assessment of High Risk Pregnancy**	Lowdermilk: Chapter 19 ATI: Chapters 7, 8, 9, 10
	10	3 & 6	**Labor & Birth At Risk**	Lowdermilk: Chapters 22 ATI: Chapter 16
	12	3 & 6	**Postpartum Complications**	Lowdermilk: Chapter 23 ATI: Chapters 20, 21
	17		**EXAM #3**	

Month	Date	Lowdermilk Units	Topical Title	Reading
March	19	4 & 5	**Maternal Physiological Changes**	Lowdermilk: Chapter 13 ATI: Chapter 17
	24	4 & 5	**Postpartum Nursing & Family Transition**	Lowdermilk: Chapter 14 & 15 ATI: Chapter 18, 19
	26	4 & 5	**Adaptations of the Newborn**	Lowdermilk: Chapter 16 ATI: Chapter 23
	31	4 & 5	**Assessment of the Newborn**	Lowdermilk: Chapter 17 ATI: Chapter 23
April	2	6	**The Newborn At Risk**	Lowdermilk: Chapter 24 ATI: Chapter 27
	7		**EXAM #4**	
	9		**ATI EXAM**	

Care of the Childbearing Family:
Pregnancy

Purpose:
This section is the first of a series on the childbearing family. It presents the pregnant patient. Pregnancy is a normal condition. Occasionally the pregnant patient may experience complications. Prenatal care is directed at keeping the patient and baby healthy and the prevention of problems. If problems do occur, early detection and treatment provide the best changes for positive outcome. The nursing skills laboratory learning experience focuses on assessment of the pregnant patient.

Learning Objectives and Course Outcomes
Specific student learning objects appear at the beginning of each chapter. **These will be used as the focus of the content.** The specific content is then related to the following course outcomes:

1. Apply childbearing family nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when care for the childbearing family.
3. Demonstrate critical thinking/clinical reasoning when caring for the childbearing family.
4. Implement basic leadership concepts for the purpose of providing and improving care for the childbearing family.
5. Use information technology to document care for the childbearing family.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the childbearing family.

Major Topics
1. The pregnant patient & reproductive concerns
2. Culturally competent care
3. The nurse as a patient advocate for the childbearing family
4. Nursing care of the family during pregnancy
5. Anatomy and physiology of pregnancy
6. Fetal development

Nursing Skills Laboratory
1. Taking a health history of the pregnant patient
2. Physical assessment of the pregnant patient

Required Reading
Dillon: Chapter 14
Lowdermilk, Perry: Chapters 1, 7, and 8
Lowdermilk, Perry, *Study Guide*: Chapters 1, 7 and 8

Weekly Objectives

Introduction to Maternity And Reproductive Health

1. Define the key terms listed. 2. Distinguish contemporary issues in maternity nursing. 3. Compare social concerns in maternity care. 4. Construct a schedule for women's health promotion and screening. 5. Distinguish how assessment varies with culture, age, physical handicaps. 6. Construct steps for patient teaching of breast self-exam for early detection of cancer. 7. Differentiate between the internal, external and accessory structures of both the male and female reproductive systems. 8. Compare the function of both male and female reproductive systems. 9. Analyze the menstrual cycle in relation to hormonal, ovarian, and endometrial response. 10. Examine the four phases of the sexual response cycle.	**Lowdermilk** 1, 2, 3, 4 Review Study Guides for Lowdermilk **ATI** Chapters 1, 2

Weekly Objectives

Genetics and Fetal Development
Anatomy and Physiology of Pregnancy

1. Define the key terms listed. 2. Analyze health assessment of the pregnant woman and fetus. 3. Propose a schedule for care during a normal pregnancy. 4. Examine ethical dimensions of genetic screening. 5. Examine physiological and maternal adaptations to pregnancy that occur on a system level. 6. Evaluate the various diagnostic techniques and implications of findings.	**Lowdermilk** Chapters 5 and 6 **ATI:** Chapters 3, 6

Weekly Objectives

Nursing Care During Pregnancy
Maternal and Fetal Nutrition

1. Discuss the physical, psychosocial, and behavior changes as the mother and family adapt to the pregnancy. 2. Identify nursing assessments, interventions and methods of evaluation in providing care during pregnancy. 3. Discuss the benefits of prenatal care. 4. Identify barriers to prenatal care. 5. Examine the role of nutritional supplements during pregnancy. 6. Examine the nurse's role in prenatal and perinatal education. 7. Compare cultural food patterns and possible dietary problems for various ethnic groups.	**Lowdermilk** Chapters 7 and 8 **ATI:** Chapters 4 and 5

Care of the Childbearing Family:
Labor & Delivery and Postpartum

Purpose:
This section addresses the nursing care of the patient in labor and delivery, then in the postpartum period. This is a crucial period for both the mother and infant, both physiologically and emotionally. Bonding among the mother, father, and baby occurs at this time and it is part of the nurse's assessment. The postpartum period is also a time of heavy emphasis on family teaching. The nursing skills laboratory learning experiences focuses on assessment of the postpartum patient and potential complications.

Learning Objectives and Course Outcomes
Specific student learning objects appear at the beginning of each chapter. **These will be used as the focus of the content.** The specific content is then related to the following course outcomes:

1. Apply childbearing family nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when care for the childbearing family.
3. Demonstrate critical thinking/clinical reasoning when caring for the childbearing family.
4. Implement basic leadership concepts for the purpose of providing and improving care for the childbearing family.
5. Use information technology to document care for the childbearing family.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the childbearing family.

Major Topics
1. The laboring patient
2. The baby during the labor and birth process
3. Labor and Birth Risks
4. Care of the family during the immediate postpartum period

Nursing Skills Laboratory
1. Assessment of the patient during labor and birth
2. Assessment during the postpartum period

Required Reading
Lowdermilk, Perry: Chapters 9, 10, 11, 12, 19, 22, 23
Lowdermilk, Perry, *Study Guide*: Chapters 9, 10, 11, 12, 19, 22, 23

Weekly Objectives

Nursing Care During Labor and Delivery
Managing Discomfort and Fetal Assessment

1.	Define key terms.	**Lowdermilk**
2.	Analyze factors affecting labor, including anatomical structure.	Chapters 9, 10, 11, 12
3.	Assess the maternal and fetal adaptations to labor.	
4.	Distinguish factors involved in the assessment of a woman in labor.	**ATI:**
5.	Analyze the processes of labor.	Chapters 11, 12, 13
6.	Compare techniques, strategies and methods for managing pain during childbirth.	
7.	Propose nursing diagnoses and develop a plan of care for a woman throughout the four stages of labor.	
8.	Assess and evaluate maternal and fetal changes during labor.	
9.	Compare beliefs/practices of selected cultures about labor and birth.	
10.	Compare the role of the nurse and support persons during the four stages of labor.	
11.	Evaluate interventions for possible complications and pain relief.	

Weekly Objectives

Assessing High Risk Pregnancy Labor and Birth

1.	Examine risk factors identified through patient history, examination of diagnostic procedures.	**Lowdermilk** Chapter 19, 20, 21
2.	Describe the pathophysiology of preeclampsia and eclampsia.	**ATI:**
3.	Describe HELLP Syndrome and appropriate nursing actions.	Chapters 7, 8, 9, 10, 16
4.	Compare and contrast Placenta Previa and Abruptio Placentae related to nursing interventions, recognitions of signs and symptoms as well as potential complications to maternal and fetal well being.	
5.	Analyze and differentiate between the signs and symptoms, as well as the treatment plan for miscarriages, ectopic pregnancies and hydatidiform mole.	
6.	Propose nursing interventions for the treatment of hyperemesis gravidarum.	
7.	Differentiate the types of Diabetes Mellitus and their respective risk factors in pregnancy.	
8.	Examine maternal and fetal risk or complications associated with diabetes in pregnancy.	
9.	Analyze care management for the pregnant woman with pregestational or gestational diabetes.	

Weekly Objectives

Postpartum Care and Complications in the Postpartum Period

1. Identify and differentiate the anatomic and physiologic changes that occur during the postpartum period. 2. Compare components of a systematic postpartum assessment and list expected values for vital signs. 3. Identify signs of complications in the postpartum woman. 4. Analyze the nurse's role in postpartum teaching and follow-up care.	**Lowdermilk** Chapter 23 **ATI:** Chapters 20, 21, 22

Care of the Newborn

Purpose:
This section continues to address postpartum care as well as the nursing care of the newborn. Within the first 24 hours the newborn goes through remarkable changes in the transition to the extrauterine life. The nurse is always on alert to distinguish normal from abnormal changes. Assessment is crucial during this time with both the mother and newborn.

Learning Objectives and Course Outcomes
Specific student learning objects appear at the beginning of each chapter. **These will be used as the focus of the content.** The specific content is then related to the following course outcomes:

1. Apply childbearing family nursing concepts to plan patient-centered, evidence-based care taking into consideration individual differences, developmental level, and culture.
2. Identify the collaborative role of the nurse when working with the interdisciplinary team when care for the childbearing family.
3. Demonstrate critical thinking/clinical reasoning when caring for the childbearing family.
4. Implement basic leadership concepts for the purpose of providing and improving care for the childbearing family.
5. Use information technology to document care for the childbearing family.
6. Identify ways in which professional standards of legal and ethical conduct apply to safe, quality, patient-centered care for the childbearing family.

Major Topics
1. Care of the newborn
2. Care of the family during the postpartum period
3. Postpartum complications
4. The newborn at risk

Nursing Skills Laboratory
1. Newborn care
2. Bathing the newborn
3. Newborn assessment

Required Reading
Dillon, Chapter 15
Lowdermilk, Perry: Chapters 13–17, and 24
Lowdermilk, Perry, *Study Guide*: Chapters 13–17, and 24

Weekly Objectives

Postpartum Maternal Physiological Changes and Family Transition

1. Describe the anatomic and physiologic changes that occur during the postpartum period. 2. Explain the influence of cultural beliefs on postpartum care and transition of the newborn into the family. 3. Discuss nursing management and interventions for women during the postpartum period. 4. Recognize signs of complications in the postpartum woman. 5 Describe how the nurse can facilitate parent-infant adjustments and bonding. 6. Examine the effects of the following on parental response: parental age, social support, culture, socioeconomic conditions.	**Lowdermilk** Chapters 13, 14, 15 **ATI:** Chapters 17, 18, 19

Weekly Objectives

Newborn Care and Nursing Care of the Newborn

1. Define the key terms listed. 2. Distinguish physical and behavioral characteristics of the newborn. 3. Select the essential features for a newborn assessment. 4. Assess reflexes of a newborn. 5. Examine the method and purpose of APGAR scoring. 6. Propose safety steps for maintenance of temperature, airway, and oxygen supply. 7. Select key points for parent teaching if the newborn must have phototherapy. 8. Examine the purpose and methods of circumcision, post procedure care, and parent teaching. 9. Analyze procedures for heel stick, collection of urine specimen, and restraining the newborn. 10. Plan home care of a newborn. 11. Select fluid and nutrient needs of the newborn. 12. Compare nutritional value of breast milk with infant formula. 13. Evaluate differences in infant response, breast care, diet and fluids as the parents are taught about infant feeding choices.	**Lowdermilk** Chapters 16, 17, 18 **ATI:** Chapters 23

APGAR Score			
	0	1	2
Heart Rate	Absent	Below 100	Over 100
Respiratory Rate	Absent	Slow, Weak, Cry	Good Cry
Muscle Tone	Flaccid	Slight Flex	Well Flexed
Reflex Irritability	No Response	Grimace	Cry
Color	Blue, Pale	Body Pink Extremities Blue	All Pink

Complications of the Newborn

1. Define the key terms. 2. Assess and evacuate complications associated with pre and post term infants 3. Examine the effects substance abuse during pregnancy has on the new born. 4. Distinguish and compare various neonatal infections. 5. Analyze care management for infants with congenital abnormalities. 6. Develop a teaching plan to explain collaboration care of at risk infants.	**Lowdermilk** Chapter 24 **ATI:** Chapter 27

Section D

Clinical Information

Scavenger Hunt
Mercy Medical Center Merced

Student Name:_____Unit of Orientation:_____Date:_____

Directions:

I. The following information may be collected alone or with one or two other students.

II. Questions 1-15 are to be completed in writing and placed in your folder on the first Thursday of clinical - use handout to write responses.

III. Be **brief in written** responses.

A. Be able to locate areas as outlined on map

B. For the Unit you are assigned:

1. Where are the Nursing Policy/ Procedure Manuals kept?
2. How do you call a CODE BLUE?
3. How do you report a fire?
4. Locate the Fire escape routes from the area and describe where they are.
5. What are the room numbers for the Unit?
6. Where are the Med Carts kept?
7. Identify the Omnicell System? Give some examples of its use.
8. Locate the supply areas on each floor.
9. Find the location of the reflux protective masks you would need for CPR.
10. Where is the Crash Cart kept?
11. How are Lab reports received?
12. Where is the Census Board located?
13. Where is the Family Waiting Room? How often do families visit and what is the procedure for contacting staff?
14. When/how is the quality control check done on the One Touch?
15. What is the procedure for replacing a patient identification band? What colors are used with identification bands and why?

Make a checkmark and date it (after the section), as you complete Questions 16 -18

16. Find an empty patient room:
    Check how the wall suction works,
    How the O_2 is turned on and off,
    Location of Code button in room and bathroom.

17. Also in a patient room:

    Sharps boxes
    Sinks
    Bedside bags
    How beds and side rails work,
    Call lights and TV are located and function,
    Method for maintaining patient privacy for an exam,
    Where contaminated dressings etc. are disposed.
    Waste paper baskets,
    Where charge sticker cards are located,
    Gloves,

18. Be able to describe the use of the following forms:

    Admission Assessment Form
    Patient Care Plan
    MAR
    Nursing Discharge Summary
    Transfusion Record
    Surgical Check List
    Clothing List
    Acuity Documentation
    Approved Standard Abbreviation List
    Intake and Output
    Drs Order Form
    MD Progress Record
    Patient Progress Record
    Graphics Record
    Surgical Permit

Section E

Outmigration Information

Outmigration Clinical Instructions
(General)

REGN 24 CLINICAL practice moves away from acute care for some of your clinical rotations. We expect these weeks will be beneficial experiences that add to your knowledge base. These instructions should help smooth the transition.

1. Your clinical obligation is 15 hours for each of these rotations. Some time will also be at the designated acute care facility. If for some reason the usual hours of the outpatient facility is not being observed (e.g. low census, unexpected meeting etc.) call the instructor to talk over the situation before you leave the facility.

2. **Review and bring to the designated outpatient facility the clinical objectives, guidelines etc. for each specific rotation**. If you do not have the appropriate paper work, it must be completed before you start your assignment and you will be counted as tardy or partial absence form clinical.

3. Lunch breaks are according to the facility policy - usually an hour.

4. Professional appearance is expected. Wear your uniform except for the OR assignment. **For ALL sites, Name tags must be clearly visible at all times**.

5. You are professionally accountable and expected to be present and on time for each assignment. It is UNACCEPTABLE to be absent or tardy without contacting the instructor ASAP. **Do not rely on other students to relay a message**.

6. The Outmigration Instructor is available by beeper at all times on Tuesdays while you are in the assigned clinical area. An instructor will be available to assist you with immunizations in the pediatric clinics.

7. When the instructor makes clinical rounds, you are expected to make yourself and your designated paperwork available.

8. Medication administration, invasive or sterile procedures, are NOT to be done without instructor.

Pediatric Clinic Guidelines

Note: You must have these Guidelines, Completed Pediatric Clinic Med Sheet, and Clinic Peds packet (from class) physically with you in the Clinic at the time of rotation. Also bring you Pediatric and Drug textbooks with you.

The student will actively participate in the following:

1. Clinical assignments

a. With assistance of staff prepare pediatric patients for admission procedures to the facility within the guidelines and time frame of the facility.
b. Measure height/length, weight, and head circumference if indicated.
c. Complete vital sign assessment.
d. Assist physician/nurse practitioner with pediatric exams.
e. Participate in teaching child and caretaker as appropriate.
f. Observe/assist with hemoglobin finger stick testing.
g. Perform immunizations with assistance of instructor or clinic designee.
h. Assist with discharge procedures including any follow-up teaching.
i. Complete charting as appropriate with supervision of clinic staff.

2. Written Pediatric Folder Requirements

Weekly:

a. Medication Sheet - Immunization medications and others specified.
b. From the clients available select one from the pediatric groupings - infant, toddler, pre-school, or school age. Using Wong's Essentials of Pediatric Nursing compare the child you selected with expected normal growth and development patterns. Document your findings on the Growth and Development Patterns Sheet.
c. Self Evaluation
d. Tracking Sheet
e. Summary of your experience - limit one page