NURSING SKILLS LABORATORY

NURSING 301

OHLONE COLLEGE

SKILLS LAB
INTRODUCTION

This portion of the syllabus is a comprehensive guide for Nursing Skills that are practiced and critiqued by an instructor as satisfactory before student performance in the clinical setting. Each skill is arranged in order of its introduction in the first course, Nursing 301.

Advanced preparation is required prior to the introduction of the skill. Please refer to the course calendar for the skills assignment so you will be prepared in advance.

The Skills Contract located in the front of this syllabus lists the individual skills as they are presented. When the student completes a satisfactory demonstration of a skill, the Skills Lab Instructor will date and sign the contract. The contract must be signed by the Clinical Instructor when the skill has been performed satisfactorily in the clinical setting.

GENERAL DIRECTIONS FOR SKILLS LAB

1. The student is responsible for all required readings and viewing the skills CD's **before** practice in the skills lab.

2. Activities may be practiced alone, with a partner, or in a group.

3. All Skills Lab activities must be completed in the Skills Lab and contract signed before the student will be allowed to perform the skill in clinical.

4. Contracts must be taken to all Skills Lab sessions.

5. Read each class assignment carefully, and note specific items you need.

6. Wear clothing **appropriate** for skill being practiced.

7. Wear a **watch with a second hand** to all Skills Labs.

8. A **stethoscope and a penlight** are required. Bring to lab when appropriate.

9. Skills Labs are designed to augment the theory material to prepare students for clinical assignments. Therefore all lab sessions are mandatory.

10. Additional open labs may be available for practice.

N301-Fall 09

	SKILLS CONTRACT	SKILLS LAB		CLINICAL	
		Date	Initial	Date	Initial
Lab #1	Handwashing				
	Applying Mask				
	Applying and Removing Gloves				
	Applying and Removing Gown				
	Double Bagging (demo)				
	Standard Precautions Test				
	Making the Unoccupied Bed				
	Making a Surgical Bed				
	Making the Occupied Bed				
Lab #2	Admitting a Patient				
	Discharging a Patient				
	Documentation				
	Abbreviation Test				
Lab #3	Body Mechanics				
	Moving Patient to Side of Bed				
	Turning to Lateral Position				
	Turning to Prone Position (demo)				
	Moving the Patient Up in Bed				
	Moving the Patient Using a Lift Sheet				
	Logrolling				
	Dangling				
	Ambulating with One or Two Assistants				
	Ambulating with a Cane				
	Ambulating with a Walker				
	Simple Transfer to a Wheelchair				
	Hemiplegic Transfer to a Wheelchair				
	Stretcher Transfer				
	Helpless Patient Transfer				
	Using the Hoyer Lift or Bed Scale (demo)				
	Applying Wrist and Posey Restraints				
Lab #4	Collection of Throat Culture				
	Collection of Midstream Urine Specimen				
	Obtaining an Occult Blood (Guaiac) Stool Specimen				
	Collecting a Sputum Specimen				

Lab #4	Turn, Cough, Deep Breathe				
	Incentive Spirometer				
Lab #5	Bed Bath: Complete				
	Monitoring Skin Condition				
	Pulse Sites				
	Mouth Care for the Conscious Patient				
	Care of Dentures				
	Assisting the Patient on a Bedpan				
	Foley Care				

N 301

SKILLS CONTRACT		SKILLS LAB			CLINICAL
Lab #5	Changing Gown for Patient with IV				
Con't	Applying and Removing Antiembolic Stockings				
	Assessing IV site for complications				
Lab #6	Assisting the Adult to Eat				
	Measuring of Fluid Intake and Output				
Lab # 7	Nursing Care Plans—Clinical Application part I				
Lab #8	Oral Temperature				
	Axillary Temperature				
	Rectal Temperature				
	Electronic Thermometer				
	Radial Pulse				
	Apical Pulse				
	Respirations				
	Blood Pressure				
	Pain Assessment				
	Use of Pulse Oximetry				
	Measurement and Recording T.P.R., B.P.				
Lab #9	Nursing Care Plans-Clinical Application part II				
Lab #10	**Math Exam,** Range of motion Assessing Casted Extremity				
Lab #11	Heart and Lung Assessment				
Lab #12	Neurological Assessment				
Lab #13	Abdominal Assessment				
	Integumentary Assessment				
Lab #14	Quick Head to Toe and Elder Assessment				

NOTE: All skills checkoffs must be complete by end of N 301. Clinical checkoffs are completed as clinical opportunity arises. Thus, all N 301 clinical checks may not be completed by end of course. Vital signs must be checked off in clinical by the end of N301 as well as pertinent assessments.

OHLONE COLLEGE
NURSING SKILLS LAB
STUDENT RESPONSIBILITIES

1. Each student is required to provide their own supplies.
2. When practicing skills, students are to remove shoes when on the beds.
3. Linens are to be neatly arranged in the linen cabinet and/or on linen cart.
4. Tables and chairs are to be kept clean and neatly in place.
5. Beds are to be left made and neat.
6. Follow the procedure for checking out a book and/or a piece of equipment.
7. Students may be able to store their Nursing Skills Lab kit. Be sure to label the kit clearly with your name.

Every health care institution has a list of approved abbreviations. To be safe, be familiar with this list.

Abbreviations and symbols commonly used by Health Practitioners

Activities:

Amb ambulatory
BRP bathroom privileges
CBR complete bedrest
OOB out of bed
PWB partial weight bearing
ROM range of motion
TDWB touch down weight bearing
up ab lib up as desired

Assessment:

abd abdomen
BP blood pressure
bx biopsy
C Celsius (centigrade)
cc chief complaint
CDI clean, dry, intact
CNS Central Nervous System
c/o complains of
CTA clear to auscultation
CVP central venous pressure
DBP diastolic blood pressure
DOE dyspnea on exertion
Dx diagnosis
ECF extracellular fluid
F Fahrenheit
GI gastrointestional
GU genitourinary
GYN gynecological
h/o history of
H & P history and physical exam
HPI history of present illness
HR heart rate
Ht height
Hx history
Imp impressions
I & O intake and output
ICP intracranial pressure
L, lf. left
LLL left lower lobe
LLQ left lower quadrant
LMP last menstrual period
LOC level of consciousness
LUL left upper lobe
LUOQ left upper outer quadrant
MAE moves all extremities
NAD no apparent distress
NKA no known allergies
NKDA no known drug allergies

Assessment (continued):

N/V nausea and vomiting
Neg negative
P pulse
PE physical exam
PERRLA pupils equally round react to light and accommodate
PMH past medical history
RLL right lower lobe
RML right middle lobe
R/O rule out
RUL right upper lobe
RUOQ right upper outer quadrant
R respirations
RR respiratory rate
RRR regular rate and rhythm
Rx treatment
SBP systolic blood pressure
SOB shortness of breath
S/P status post
Sx symptom
T temperature
TLC total lung capacity
TPR temperature, pulse, respirations
VC vital capacity
VS vital signs
WNL within normal limits
wt weight

Symbols:

> greater than
< less than
↑ increase
↓ decrease
2° secondary to
= equal to
@ at
♀ female
♂ male

Diagnostic Studies:

ABG arterial blood gases
BE barium enema
CBC complete blood count
CO2 carbon dioxide
C&S culture and sensitivity
CPK creatine phosphokinase
CT computed tomography
CXR chest x-ray
diff differential blood count
ECG (EKG) electrocardiogram
ECT electroconvulsive therapy
ESR erythrocyte sedimentation rate
FSBS finger stick blood sugar
GTT glucose tolerance test

HAV	hepatitis A virus
Hb	hemoglobin
HBAg	hepatitis B antigen
HBV	hepatitis B virus
Hct., HCT	hematocrit
Hgb	hemoglobin
Ig	immunoglobulin
KUB	kidney, ureters and bladder (radiograph)
LP	lumbar puncture
lytes	electrolytes
MRI	magnetic resonance imaging
pH	hydrogen ion concentration
PKU	phenylketonuria
PT	prothrombin time
PTT	partial thromboplastin time
RBC	red blood cells
Rh+	positive Rh factor
Rh-	negative Rh factor
SMAC	chemistry panel
Sp. Gr.	specific gravity
SR	sedimentation rate
TG	triglyceride
TIBC	total iron binding capacity
UA	urinalysis
UGI	upper GI
WBC	white blood cells

Diseases and Conditions:

AKA	above knee amputation
AIDS	acquired immunodeficiency syndrome
ASCVD	arteriosclerotic cardiovascular disease
ASHD	arteriosclerotic heart disease
BKA	below knee amputation
BPH	benign prostatic hypertrophy
CABG	coronary artery bypass graft
CA	cancer
CAD	coronary artery disease
CHF	congestive heart failure
COPD	chronic obstructive pulmonary disease
CVA	cerebral vascular accident
DIC	disseminated intravascular coagulation
DM	diabetes mellitus
DJD	degenerative joint disease
EBV	Epstein-Barr virus
ESRD	end stage renal disease
FTT	failure to thrive
FUO	fever unknown origin
Fx	fracture
HF	heart failure
HIV	human immunodeficiency virus
HTN	hypertension
HSV	herpes simplex virus
IDDM	insulin dependent diabetes mellitus
MG	myasthenia gravis
MI	myocardial infarction
MS	multiple sclerosis
NIDDM	non-insulin dependent diabetes mellitus
ORIF	open reduction, internal fixation
OA	osteoarthritis
PE	pulmonary embolism
PID	pelvic inflammatory disease
PMS	premenstrual syndrome
PND	paroxysmal nocturnal dyspnea
PVD	peripheral vascular disease
RDS	respiratory distress syndrome
RA	rheumatoid arthritis
RHD	rheumatoid heart disease
SIDS	sudden infant death syndrome
STD	sexually transmitted disease
T & A	tonsillectomy and adenoidectomy
TAH	total abdominal hysterectomy
TB	tuberculosis
THR	total hip replacement
TKR	total knee replacement
TURP	transurethral resection of prostate
TIA	transient ischemic attack
VD	venereal disease
VSD	ventricular septal defect

Common Pharmacy:

a	before
a.c.	before meals
AM	morning
amp	ampule
b.i.d.	twice a day
c	with
cap	capsule
cm	centimeter
g, gm, Gm	gram
gr	grain
gtts	drops
HHN	hand held nebulizer
hr	hour
IM	intramuscular
inj	injection
IV	intravenous
IVP	intravenous push
kg	kilogram
L	liter
liq	liquid
mcg	microgram
mg	milligram
ml	milliliter
OTC	over the counter
Oz	ounce
p.c.	after meals
PM	afternoon, evening
p.o.	by mouth
p.r.	by rectum
p. vag	by vagina
p.r.n.	as needed
q, Q	every
q2hr	every 2 hours
q4hr	every 4 hours
q12hr	every 12 hours
q.i.d.	four times a day
SL	sublingually
ss	one-half
susp	suspension

t.i.d. three times a day
tinct tincture

Miscellaneous:

@ at
ADA American Diabetic Association
ADLs activities of daily living
AMA against medical advice
BM bowel movement
BMR basal metabolic rate
BSC bedside commode
CPR cardiopulmonary resuscitation
CHO carbohydrate
D5W 5% dextrose in water
DNR do not resuscitate
Dsg dressing
dx diagnosis
HOB head of bed
I & O intake and output
ICU intensive care unit
IPPB intermittent positive pressure breathing
IS incentive spirometer
NC nasal cannula
NG nasogastric
NPO nothing by mouth
NS normal saline
O2 oxygen
OT occupational therapy
PCA patient controlled analgesia
PD postural drainage
PM postmortem
postop postoperative
preop preoperative
prep preparation
PT physical therapy
RDA recommended daily allowance
Rx treatment
SCD sequential compression device
SICU surgical intensive care unit
S/P status post
STAT immediately
TF tube feeding
T/L teaching learning
TKO to keep open
TO telephone order
TPN total parenteral nutrition
Tx treatment
VO verbal order
VS vital signs
WA while awake
X times

Abbreviations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has determined the use of certain abbreviations, acronyms and symbols have been an issue in patient safety. They have developed a "Do not use" list. This list is as follows with recommended verbiage.

Do not use list:

1. **U = Write "unit"**
2. **IU = Write "international unit"**
3. **Q.D. = Write "daily"**
4. **Q.O.D. =Write "every other day"**
5. **Trailing zero (X.0 mg)=Never write a zero by itself after a decimal write (X mg)**
6. **Always write a zero before a decimal point (0.X mg)**
7. **MS=Write "morphine sulfate"**
8. **MSO4= Write "morphine sulfate"**
9. **MgSO4= Write "magnesium sulfate"**

In addition, to the above list, the following items should also be considered when health care institutions are expanding the "Do not use" list.

Suggested Do not use items:

1. **ug=Write "mcg"**
2. **H.S. Write "half–strength"**
3. **q.H.S.=Write "at bedtime"**
4. **T.I.W.= Write "3 times weekly"**
5. **S.C.=Write "subcutaneously"**
6. **S.Q.=Write "Sub-Q" or subQ"**
7. **D/C=Write "discharge"**
8. **D/C=Write "discontinue" when referring to a medication**
9. **c.c.=Write "ml"**
10. **A.S.=Write "left ear"**
11. **A.D.=Write "right ear"**
12. **A.U.= Write "both ears"**

OHLONE COLLEGE NURSING
MATH CONTRACT

1. Safe administration of medication is a requirement in nursing. Accurate calculation of dosage and/or rate of administration are essential to safety.

2. The nursing math exam must be successfully passed prior to administration of medications as it pertains to specific course content. To maintain consistency within the pre-nursing and nursing program, the student must pass the math exam at an 80% level of accuracy. The student will demonstrate knowledge of the mathematical process by correcting errors to a 100% level of accuracy based on the below listed criteria:
   a. If the math exam is completed at 90 to 99%, the student will correct the missed math problems.
   b. If the math exam is completed at an 80 to 89% level of accuracy, then the student must successfully answer a comparable number of math questions to the number originally missed.
   c. If the math exam is completed at 79% or lower, then student must re-take a complete comparable math exam at the 80 % accuracy level. The student will demonstrate accuracy by correcting errors to a 100% level of accuracy.

3. The math exam must be successfully passed prior to passing medications as it pertains to specific course content. The math exam is considered part of your clinical objectives. Clinical objectives regarding the safe administration of medications cannot be met without successfully passing the math exam.

4. A student has only two (2) opportunities to pass the nursing math exam.

GRADING SCALE

90% to 100%	correct missed problems to 100%
80% to 89%	retest comparable number of problems to pass at 100% level of accuracy
Below 80%	must retake entire math test and pass at 80% level, and demonstrate accuracy by correcting errors to a 100% level of accuracy.

REMEDIATION

Each student has two (2) opportunities to pass each specific nursing course content math exam. If the student is unable to pass after the first attempt, THE STUDENT MUST MAKE ARRANGEMENTS FOR A MATH TUTOR AND/OR PRACTICE TIME IN THE MATH LAB. A final testing opportunity will be given to the student prior to medication administration as it pertains to specific course content. If the math exam is not passed according to the identified criteria, the student will not pass the course.

Calculators may be used.

I have read the above and understand the grading policy.
I understand each specific nursing course math exam must be successfully passed.

Signed: _____

Dated: _____

Hand in one copy to your clinical instructor during the first week of class. One copy is for your file.

Revised: 3/2000

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Revised: 3/2000

Math Review for Nursing 301

Common Conversions

grain (gr) 1 = 60 mg
gr ½ = 30 mg
gr ¼ = 15 mg
gr 2 = 120 mg
gr 15 = 1000 mg (or 1 gram)

1 liter (L) = 1000 milliliter (ml)
1 ounce (oz) = 30 ml
1 tablespoon (T) = 15 ml
1 teaspoon (t) = 5 ml

1kilogram (kg) = 1000 grams
1 gram = 1000 mg
1 milligram (mg) = 1000 microgram (mcg)

When converting from large to small, move the decimal to the right.
When converting from small to large, move the decimal to the left.

Example:
7 mg = 7000 mcg
160 mg = 0.16 grams

N301 PRACTICE MATH TEST

CONVERT: SHOW ALL WORK.

1. gr 1/6 = _____ mg

2. 1.5 mg = _____ mcg

3. 35 g = _____ mg

4. 1 T = _____ ml

5. 1.5 L = _____ ml

6. 0.5 g = _____ mg

7. 3 oz = _____ ml

EXPRESS IN DECIMAL FORM:

8. two and a half milligrams _____

9. one half of a kilogram _____

10. one quarter of a gram _____

OVERRIDERS

Because each student in the clinical setting must be expected to perform according to basic standards for safe nursing practice, there are certain overriding areas of concern that must be considered. These overriders describe behaviors that are expected and will be monitored by your instructors whenever you are being critiqued or "checked-out" on a procedure in skills lab and clinically.

Read these overriders carefully:

INTERPERSONAL COMMUNICATION: verbal and nonverbal patient-focused communication

1. Introduces self and purpose of interaction.
2. Explains procedure and patient's role.
3. Provides privacy.
4. Maintains therapeutic communication.
5. Determines patient's comfort by asking at least one question

SAFETY: Protects the patient's physical and emotional well being

1. Identifies patient.
2. Verifies physician's order.
3. Maintains a safe environment.
4. Evaluates patient's response to procedure.
5. Observes principles of body mechanics for the nurse as well as the patient.
6. Observes the "6 Rights" when administering medications.

ASEPSIS: prevents the introduction and/or transfer of organisms

1. Washes hands before and after patient contact or procedure.
2. Prevents self-contamination by wearing gloves when handling body fluids and using good isolation technique when applicable.
3. Prevents patient contamination.
4. Protects clean areas from contamination.
5. Maintains sterile field where required.

These overriders will be introduced and reinforced in many different ways. In N 301, therapeutic communication is taught and the importance of patient confidentiality is stressed. Medical asepsis is introduced in the very beginning skills lab class to protect the patient as well as the student and others working with the patient. Surgical asepsis is introduced in N 302 and reinforced throughout the courses which follow.

Providing for the physical and emotional safety of the patient, as well as the physical safety of the student, is introduced in the beginning of skills lab classes to stress the importance of prevention of accidents by the use of side rails, bed positions, correct patient identification, body mechanics, restraints, etc.

Many of these overriders will be recognized as critical requirements and/or clinical objectives in evaluating the student progress in the clinical setting.

SKILLS LAB #1

Skills Lab #1

DIRECTIONS:

1. Read Elkin, Perry & Potter, Nursing Interventions and Clinical Skills(4th edition)

   Chapter 4, Medical Aseptic Technique

   Skill 4.1 Handwashing & Disinfection
   Skill 4.1 Using Disposable Clean Gloves
   Skill 4.2 Caring for Clients under Isolation Precautions

   Chapter 3, Promoting a Safe Environment

   Skill 3.1 Safety Equipment and fall Prevention

2. View on your Basic Video Skills (CD's)
   - Basic Infection Control

3. Read in Potter and Perry: Fundamentals of Nursing – Chapter 34 (pp 642-645)

Skills:

Handwashing
Applying Mask
Applying and Removing Gloves
Applying and Removing Gown
Double Bagging
Standard Precautions Test

Bring from Nursing Skills Kit: isolation gown, mask, gloves (if your kit has not arrived as yet, don't worry, we will provide the equipment and then you will replace what you utilized from your kit)

Administer: Standard Precautions Test (not graded). Place in student file.

DEMONSTRATION ONLY

CHECKLIST: Double Bagging

1. Observes overriders

2. Closes the half- to three-fourths-full contaminated bag inside the isolation room.

3. Sets up a new bag for continued use inside the room.

4. Has someone outside the room hold a clean bag with the top of the bag cuffed over her hands.

5. Places the contaminated bag into the clean bag being held by another person. Is careful not to contaminate the outside of the clean bag.

6. Closes the clean bag and marks it "Isolation."

7. Double-bags all items used for the care of a patient in isolation and marks "Isolation" to protect the environment.

8. Disposes of isolation room equipment using appropriate guidelines.

OHLONE COLLEGE

MEMORANDUM ON STANDARD PRECAUTIONS AND INFECTION CONTROL

Infection Control Precautions – Recommendations for Prevention of Viral or Other Blood-Borne Pathogens Transmitted in Health Care Settings, September 23, 1987.

Medical history and examination cannot reliably identify all patients infected with viral or other blood-borne pathogens. Therefore, blood and body-fluid precautions should be consistently used for all patients. This approach is recommended by the Ohlone Nursing faculty; Center for Disease Control (CDC), and the California Association of Hospitals and Health Systems(CAHHS).

1. Wash hands with soap before and after caring for each patient.

2. Wear gloves when handling blood, blood products, mucous membranes and body fluids (urine, fees, saliva, wound drainage). Remove the gloves, discard after their use and wash your hands.

3. Wear gowns when there is the potential for contaminating your clothing with the patient's blood or body fluid. Contaminated gowns are to be discarded per hospital policy.

4. Disposable articles contaminated with blood, blood products, wound drainage or body secretions/excretions should be disposed of per hospital policy.

5. Wear a mask if you are likely to be splashed with blood, (for example: during bronchoscopy, intubation, mouth care, tracheal suctioning).

6. Do not recap used needles and syringes if you can immediately dispose of them in containers provided. When there is a delay in disposing, lay the cap on the table and slide the syringe into it without touching it with your fingers.

7. For your convenience, it is recommended that you carry a set of gloves in your uniform at all times.

8. For your added protection, documented evidence of Rubella, Rubeola, Mumps and Hepatitis B immunity is a one-time requirement due upon admission to the program.

Skills Lab #1

DIRECTIONS:

1. Read Elkin, Perry & Potter, Nursing Interventions and Clinical Skills,

   Chapter 7, Promoting Hygiene.

   Skill 7.5 Bedmaking

2. View on your Basic Video Skills (CD's)
   - Bedmaking

Skills:

Making the unoccupied bed
Making a surgical bed
Making the occupied bed

SKILLS LAB #2

ADMITTING AND DISCHARGING THE PATIENT

Bring your chart packet

DIRECTIONS:

1. Read Potter and Perry, pp. 394-398, 400-401.
2. View on your Basic Video Skills (CD)
   - Measurements: review ht/wt which is in the vital signs section.

EQUIPMENT: Tell us what you think is needed

CHECKLIST: Admitting the Patient

__ 1. Observes overriders.

__ 2. Introduce patient to staff and to roommate if present.

__ 3. Explain hospital routines for that unit.

__ 4. Orient to bedside and bathroom equipment.

__ 5. Instruct patient to change into hospital gown.

__ 6. Obtain patient's height, weight, and vital signs.

__ 7. Obtain patient's health history, and complete nursing assessment.

__ 8. Notify physician of patient's admission and review physician's orders for priority of implementation.

__ 9. Document patient admission and initial assessment on admitting nurse's note form.

__ 10. Identify nursing diagnoses and develop nursing care plan.

CHECKLIST: Discharging the Patient (discharge summary form for nursing, medication list)

__ 1. Observes overriders.

__ 2. Review details of discharge with patient and significant other.

__ 3. Review instructions and answer questions about medications, physical care or activity, and supplies.

__ 4. Check all areas of patient room to insure that all belongings are packed and offer assistance as needed.

__ 5. Instruct significant other to take belongings to vehicle, and where to park for patient's entry into vehicle.

__ 6. Encourage patient to express feelings and impressions concerning the experience of the hospital.

__ 7. Follow agency procedure for patient discharge.

__ 8. Document patient's discharge on required forms.

Admission and Discharge Scenarios

I. Admission
   A. Mrs. Sanchez is a 58-year-old Hispanic who still works parttime as a supervisor of a small factory. She is married and has two grown children who live outside the home. She was diagnosed two weeks ago with breast cancer and is being admitted for a lumpectomy and lymph node dissection later today. She has been NPO since midnight and is very anxious over the upcoming surgery. She has no known allergies and has mild hypertension and slight obesity.
   B. Mr. Lopeca is a 45-year-old Caucasian male who is being admitted for a cardiac catheterization because he had a heart attack last week. He is very obese and loves to eat red meat and gravy. He is a computer programmer and works long hours. He is single but lives with his mother.
   C. Mrs. Chen is 65-year-old Asian female who is being admitted for a hysterectomy because of dysfunctional uterine bleeding. She is married and her youngest daughter is living with them. She is a housewife but helps out her husband with his bookkeeping for his business. She also is the childcare provider for her daughter's two-year-old. She has a history of CHF and takes Lasix and Digoxin daily.

II. Discharge
   A. Mr. Antenucci is a 44-year-old Italian male who is being discharged after a bout with diverticulitis. He is overweight and loves to eat peanuts and drink a few beers each night. He really doesn't want to change his eating habits.
   B. Mrs. Jones is a 78-year-old widow who is being discharged after a mild CVA. She is some residual weakness on her left side and will have her daughter to help her when she goes home. She currently takes anti-hypertensives.
   C. Molly Simpson is 33-year-old female who is being discharged after an ectopic pregnancy. She is single and did not want to become pregnant. Her boyfriend has not been able to provide her with support during the hospitalization. She has no other medical problems.

Skills Lab #2

DIRECTIONS:

1. Read Elkin, Perry & Potter, Nursing Interventions and Clinical Skills,

   Chapter 1, Professional Nursing Practice

   Skill 1.1 Documenting Nurses' Progress Notes
   Skill 1.2 Giving a Change-of-Shift Report

2. Complete Medical Terminology Worksheet.

3. Complete Data Collection worksheet using the appropriate information found in the data collection exercise in this section.

4. Read in Potter and Perry, Fundamentals of Nursing – Chapter 26

   Skills:
   Data Collection
   Documentation

   Bring charting forms with you to each skills lab if any have been distributed by your clinical faculty.

Information found on Nursing Kardexes (form and terminology varies by hospital). Some Hospitals use a hard copy that is kept in a binder at the desk Some hospitals have you print this form off of the computer. Many hospitals are transitioning entirely to the electronic medical record where this information is located.

1. Kardex forms vary in style from one hospital to another, but the basic information included is the same.

   Name, Age, Physician, Marital Status, Sex, Admitting Date, Procedures Scheduled, Room Number, Diagnosis, Surgery, Date of Surgery, Code Status, Religion, Intravenous Therapy, Family Support

   Labs, Diagnostic Studies Treatments, Diet, Hygiene, and Activity Status, Vital Signs, Allergies, if any Discharge Plan Intake & Output, Elimination needs

2. The Kardex is recorded in pencil if it is kept in a binder at the nurses' station. In this way, erasures can be made for any information which is likely to change and the card kept current and neat.

3. Allergies, Isolation and Code Status are recorded in red ink.

4. Complete the Data Collection Worksheet, using information listed in the Data Collection exercise.

NURSING 301

PATIENT REPORT

The following information needs to be communicated during report to ensure safe care for each patient.

1. Room number
2. Patient's name
3. Age
4. Physician's Name
5. Diagnosis
6. Observations made: (include time of occurrence) i.e., pain, pain relief, mobility, toleration of procedures, I & O, CMST, integument assessment
7. Change in patient condition
8. Vital signs (if changed)

Other information to be included in report as you progress through the program is listed below.

1. I.V.s
2. Nursing assessments
3. New medical orders, including meds and treatments
4. Lab work, diagnostic tests
5. Teaching, referrals, discharge planning

Note: Different hospitals and floors may have a specific emphasis or order in which to give report. This information will be provided by your instructor at the beginning of each clinical rotation.

SBAR (situation, background, assessment and recommendation) has become a standard method for communicating changes in patient condition to the physician. This method helps provide focus and save time with the intent of being able to intervene effectively in a more timely manner. Many hospitals also incorporate this method into change of shift report.

MEDICAL TERMINOLOGY WORKSHEET

1. phlebotomy _____
2. thrombophlebitis _____
3. pyrexia _____
4. hyperemesis _____
5. nephrosclerosis _____
6. bradypnea _____
7. exocrine _____
8. osteoma _____
9. tachycardia _____
10. hematuria _____
11. arthrotomy _____
12. cystocele _____
13 supraclavicular _____
14. gastrectomy _____
15. lobectomy _____
16. anuria _____
17. paraplegia _____
18. cardiomegaly _____
19. cystitis _____
20. rhinitis _____
21. hysterectomy _____
22. cholecystectomy _____
23. cholelithiasis _____
24. hemiplegia _____
25. arthrotomy _____
26. gastrostomy _____
27. appendectomy _____
28. rhinoplasty _____

OHLONE COLLEGE
NURSING 301

DATA COLLECTION EXERCISE

Mrs. Betty Heath is a 61-year-old female, married, who was admitted to the hospital for gastritis and upper gastrointestinal bleeding. She is also an insulin dependent diabetic. She speaks English, is American born, 2nd generation, of German, Spanish descendants. She works part-time as a Word Processor for PG &E. Her husband is employed by NUMI Motors and has Blue Cross insurance. Mrs. Heath is allergic to Penicillin and Sulfa.

She came to the hospital with the following problems:

Periodic vomiting (3-4 x a day) with evidence of bright red blood in the emesis.

Mild to moderate dehydration

Stomach pain, moderately severe

Dark, tarry-like stools (2^+ a day)

Feeling of heartburn and some referred pain in the chest

Moderate weakness on exertion and occasional shortness of breath

Loss of appetite

Her admission vital signs were: Temperature 99.4, Pulse 92, Respirations 24, Blood Pressure 110/70.

This is her second hospital day.

Physician orders include the following:

02 @ 2L NC

IV D51/2NS @ 125ml/hr

NPO for now

I&O
BRP ć assist
VS q2hrs x 24hrs then q4hrs
FSBS q12
Call for BS < 60 > 200
Daily CBC, blood sugar
Stool OB x 3
CXR

Use the appropriate information above to fill out a Data Collection Worksheet which follows.

DATA COLLECTION WORKSHEET

PT. Initials _____Age _____ Rm. # _____ Dr./s _____ Adm. Date _____ Dates of Care _____

Current Med. Dx _____ Surgical Procedure & Date: _____

Social Hx: Language, Ethnicity, Supports, Job, Economics:

Allergies: _____ Diet: _____

Pertinent Health/Illness/Surgical or O.B. Hx:

Significance of Dx/Hospitalization on ADLs/Future:

Time	Medical Treatment Plan (Activity Status, IVs, Treatments)
Time	Current T/L Needs
Time	Possible D/C Needs

SKILLS LAB #3

Skills Lab #3

1. Read Elkin, Perry & Potter, Nursing Interventions and Clinical Skills.

   Chapter 6, Promoting Activity and Mobility

   Skill 6.1 Assisting with Moving and Positioning Clients in Bed
   Skill 6.2 Using Safe and Effective Transfer Techniques
   Skill 6.2 Minimizing Orthostatic Hypotension
   Skill 6.3 Assisting with Ambulation
   Skill 6.4 Teaching Use of Cane and Walker

   Chapter 3, Promoting a Safe Environment

   Skill 3.1 Safety Equipment and Fall Prevention
   Skill 3.2 Designing a Restraint-Free Environment
   Skill 3.3 Applying Physical Restraints

2. View on your Basic Video Skills (CD)
   - Using Restraint Alternatives
   - Applying Restraints

3. View on your Basic Video Skills (CD)
   - Safe Patient Handling

Skills:

Body mechanics
Moving patient to side of bed
Turning to lateral and prone positions
Moving the patient up in bed
Moving the patient using a life sheet
Logrolling
Dangling
Ambulating with one or two assistants
Ambulating with a cane and walker
Simple transfer to a wheelchair
Hemiplegic transfer to a wheelchair
Stretcher transfer
Helpless patient transfer
Using the Hoyer lift or bedscale
Applying wrist and posey vest restraints – review your facility form for charting restraints.

DEMONSTRATION ONLY

TRANSFERRING A HELPLESS PATIENT TO A CHAIR WITHOUT A MECHANICAL LIFTER

Often you will be called upon to get a helpless patient out of bed and into a chair. It is possible to lift some patients with the assistance of one or more workers when a mechanical lifter is not available for the transfer. Avoid the method of lifting or swinging the patient, from the bed to a wheelchair placed parallel to the side of the bed. Although this method is frequently used, many workers are injured by twisting and bending their backs, and lifting while off- balance

You will need another person to assist you to transfer the helpless patient from the bed to a wheelchair. In the skill laboratory, practice the procedure until you feel at ease with it, and confident of your ability to perform with an actual patient.

1. Position the wheelchair and set the brakes.	Place the chair at right angles to the bed and about the level of the patient's hips. Put the bed in a low position--or even with the seat of the wheelchair.
2. Position and prepare the patient.	Move him to the proximal side of the bed. Dress him in his robe and slippers, if appropriate, and bring him to an upright sitting position.
3. With assistance, transfer the patient into the wheelchair.	With one worker on each side of the patient, place one arm around his shoulders and one under his hips. Some patients may be able to sit erect and put their arms around the workers' necks and help support their weight, but weaker patients cannot do this. On signal, the workers slide the patient back into the seat of the wheelchair. One worker then releases the brakes and moves the chair slowly away from the bed. The other worker supports the patient's feet, and lowers them onto the foot pedals.

SKILLS LAB #4

Skills Lab #4

DIRECTIONS:

1. Read Elkin, Perry & Potter, Nursing Interventions and Clinical Skills,

   Chapter 13, Laboratory Tests.

   Skill 13.1 Urine Specimen Collection—Midstream, Sterile Urinary Catheter
   Skill 13.2 Testing for Gastrointestinal Alterations (Stool Specimen, Hemoccult test, gastroocult test).
   Procedural Guideline 13.6 (p.334) Collecting a Sputum Specimen by Expectoration
   Skill 13.5 Collecting Specimens from the Nose and Throat
   Skill 13.7 Obtaining Wound Cultures

2. View your Intermediate Video Skills (CD)
   - Specimen Collection (all skills except blood glucose)

Skills:

Collection of Midstream Urine Specimen
Obtaining an Occult Blood (Guiac) Stool Specimen
Turn Cough, and Deep Breath
Incentive Spirometer
Empty Foley Catheter Bag

DEEP BREATHING AND COUGHING EXERCISES

INSPIRATION DEVICES

View prior to skills lab. Content not covered in skills lab.

DIRECTIONS:

1. Read Potter & Perry, Fundamentals of Nursing, pps. 1381-1383

CHECKLIST: Instructing Patients to Deep Breathe and Cough.

__ 1. Observes overriders.

__ 2. Places patient in a sitting position to initiate coughing.

__ 3. Demonstrates the deep breathing steps.

__ 4. Places hands palm down around the sides of patient's lower ribs.

__ 5. Tells patient to breathe in slowly through nose until chest is expanded and abdominal muscles rise visibly.

__ 6. Watches for contraction of intercostal muscles and diaphragm.

__ 7. Instructs patient to inhale deeply and to cough, using abdominal and other respiratory muscles.

__ 8. Supports any abdominal incision with the hands on either side of the patient's incision or pillow over incision.

__ 9. Encourages patient to cough frequently. Explains why coughing would be beneficial.

CHECKLIST: Instructing Patient to use a Spirometer.

View prior to skills lab. Content not covered in skills lab.

__ 1. Observes overriders.

__ 2. Places patient's mouthpiece on spirometer.

__ 3. Instructs patient to inhale through mouthpiece.

__ 4. Instructs patient to hold breath for 2 1/2 to 3 seconds. Repeats procedure according to physician's orders.

__ 5. Following breathing exercises, removes mouthpiece, cleans with warm water, and stores in bedside unit.

SKILLS LAB #5

Skills Lab # 5
Directions:

1. Read Elkin, Perry & Potter, Nursing Interventions and Clinical Skills, Chapter 7, Promoting Hygiene.

   Skill 7.1 Complete Bath
   Skill 7.2 Oral Care

   Chapter 9, Assisting with Elimination
   Skill 9.2 Providing a Bedpan and Urinal
   Skill 9.4 Catheter Care

   Chapter 12, Health Assessment
   Skill 12.4 Emphasis on pulse sites and peripheral vascular assessement.

2. View your Basic Video Skills (CD)
   - Bathing
   - Elimination Assistance (all except giving an enema)
   - Personal Hygiene/Grooming

3. Read Perry & Potter, Fundamentals of Nursing, Chapter 33, pp 566-574, ch 41, pp. 1012, 1021, ch 45, p. 1139, figure 45-6, Skill 45-3, pp. 1162-1163, ch. 47, pp. 1247-1250.

7. Bring from home: bath towel, washcloth, toothpaste, toothbrush, mouthwash, deodorant, body lotion, bathing suit (or sports bra and shorts).

Skills:

Bed bath: complete
Monitoring skin condition
Peri care; foley care
Assessing CMST
Pulse sites
Mouth care for the conscious patient
Care of dentures
Assisting the patient on a bedpan
Changing gown for patient with IV
Applying and removing antiembolic stockings
Assessing IV site for complications (erythema, edema, pain, leakage)

INTEGUMENT ASSESSMENT

DIRECTIONS:

CHECKLIST (Critical Elements): Monitoring Skin Condition

__ 1. Observes overriders

__ 2. Removes linens and gown if necessary. Covers patient with bath blanket.

__ 3. Compares color of patient's skin with normal range of color within the individual's race.

__ 4. Places the back of fingers or hand on patient's skin to check temperature.

__ 5. Correlates abnormalities in skin color with changes in skin temperature.

__ 6. Observes for areas of excessive dryness, moisture, wrinkling, flaking, and general texture of skin.

__ 7. Gently picks up a small section of the skin with thumb and finger. Observes for ease of movement and speed of return to original position to check for skin turgor.

__ 8. Presses finger firmly against patient's skin for several seconds (especially ankle area). After removing finger, observes for lasting impression or indication.

__ 9. Notes the patient's response to heat, cold, gentle touch, and pressure.

__ 10. Observes the amount of oil, moisture, and dirt on the skin surface.

__ 11. Notes presence of strong body odors.

__ 12. Uses a disposable blunt-end probe such as a comb to detect small moving white lice.

__ 13. Observes for areas of broken skin (lesions) or ulcers. Checks if lesions were present over entire body or if they are localizes to a specific area.

__ 14. Checks for skin discolorations e.g., ecchymosis, petechiae, purpura, erythema, and altered pigmentation.

DOCUMENTATION: Check skin assessment, especially abnormalities.
Write short paragraph using assessment guideline on next page.

TERMS:					
	purpura	ecchymosis	hematoma	cyanosis	blanching
	macule	papule	nodule	edema	tumor
	wheal	vesicle	bula	pustule	crusted lesion
	erosion	petechiae	paronychia	pallor	jaundice
	vitiligo				

INTEGUMENT ASSESSMENT TERMS

PURPURA	Hemorrhage into tissues, particularly under the skin and mucus membranes, producing large patchy ecchymosed areas
MACULAE	Small pigmented area or spot that appears different from the surrounding tissue
WHEAL	An individual lesion of urticaria (hives)
EROSION	The wearing away or gradual destruction of a surface
ECCHYMOSIS	Bruise
PAPULA	Small superficial elevation of the skin
VESICLE	Small fluid-filled bladder or blister, such as a small, thin-walled raised skin lesion
PETECHIAE	Tiny purple or red spots appearing on the skin as a result of tiny hemorrhages within the dermal or submucosal layers. Pinpoint to pinhead size, flush with the skin
HEMATOMA	Collection of extravasated blood trapped in the tissues of the skin or in an organ, resulting from trauma or incomplete hemostasis after surgery
NODULE	Small node, small nodelike structure
BULLA	Thin-walled blister of the skin or mucous membranes greater than 1 cm in diameter containing clear, serous fluid (compare to vesicle)
PARONYCHIA	An infection of the fold of skin at the margin of a nail
CYANOSIS	Bluish discoloration of the skin/mucous membranes d/t excess deO_2 Hbg in the blood
EDEMA	Accumulation of fluid in interstitial spaces, swelling
PUSTULE	Small circumscribed elevation of the skin containing pus that is usually purulent
PALLOR	Paleness, absence of color in the skin
BLANCHING	To become pale by digital pressure (test for circulation in fingers or toes)
TUMOR/NEOPLASM	Swelling or enlargement occurring in inflammatory conditions.
CRUSTED	Solidified, hard outer layer formed by the drying of a body exudite, common in dermatological conditions such as eczema, impetigo, seborrhea and favus (fungal infection of the scalp, skin, or nails, more common in children. Rare in North America)
JAUNDICE	Yellow discoloration of the skin, mucous membranes, and sclerae of the eyes caused by greater than normal amounts of bilirubin in the blood
VITILIGO	Benign acquired skin disease, of unknown etiology, consisting of irregular patches of skin w/ no pigment w/ hyperpigmented borders.

SKIN, HAIR, NAILS

FUNCTIONS:

A. Temperature regulation
B. Protection
C. Secretion of sebum
D. Sensation
E. Aids in Vitamin D production

ASSESSMENT:

A. Skin:
    1. Coloration: pigment, cyanosis, pallor, jaundice, flush
    2. Vascularity: evidence of bruising, bleeding, petechiae, purpura
    3. Moisture: dry, perspiration, oiliness
    4. Temperature: use back of hand to assess): warm, hot, cool
    5. Texture: thin, friable, rough, smooth, leathery, flaky
    6. Mobility/Turgor: lift fold of skin; see how easily it falls back into place; elastic, tented, thickness, edema
    7. Lesions: characteristics, type, grouping, distribution, including scars, ulcers, calluses, rashes.
    8. Body hair distribution: generalized, patchy, alopecia
    9. Surgical Incision

B. Nails
    1. Color nails and nail beds
    2. Smoothness
    3. Thickness
    4. Clubbing
    5. Lesions (Note: ridges, paronychia - inflammation of skin around nail, other abnormalities)

C. Hair and Scalp
    1. Texture: luster and thickness
    2. Absence, excess, loss, itching, patchy, or generalized
    3. Distribution
    4. Scalp (Note: examine for itching, dandruff, lesions, scars, tenderness, lice, and nits.

CHECKLIST: CMST—NEUROVASCULAR ASSESSMENT: The assessment of circulation (perfusion, pulse, color), sensation, movement, and temperature in extremities. Assess both hands and feet.

__ 1. Observes overriders

__ 2. Compares the involved extremity to the uninvolved extremity by all of the following:

a. Palpates for presence or absence of pulses

b. Assesses perfusion of extremity by

1) Checking capillary refill

2) Noting color

3) Noting temperature

4) Note edema

c. Elicits patient's response to tactile stimuli applied to the distal portion of the extremities

d. Asks patient to move extremities

OR

e. Observes for movement of the extremities for a child or non-communicating adult

f. Elicits patient’s response to pain

CHECKLIST Changing Gown for Patient with an IV. (if non-snap gown)

__ 1. Observes overriders

__ 2. Checks Patient Care Plan for infusion drip rate, type of solution, and any special considerations.

__ 3. Unties back of gown and removes gown from unaffected arm.

__ 4. Places clean gown over patient's chest and abdomen.

__ 5. Supports arm with IV and slips old gown down arm to IV tubing.

__ 6. Removes IV bottle from hook and slips the sleeve over the bottle, keeping bottle above patient's arm.

__ 7. Passes bottle through new gown's sleeve.

__ 8. Returns bottle to IV stand and guides remaining sleeve of gown up the patient's arm to the shoulder.

__ 9. Ties gown at the back.

__ 10. Checks IV infusion rate and IV tubing to determine that solution is flowing unimpeded into patient's vein.

MEASURING AND APPLYING ANTIEMBOLIC STOCKINGS

DIRECTIONS:

Read Potter & Perry, Fundamentals of Nursing, Chapter 47 (pp 1247-50).

EQUIPMENT: Measuring tape, elastic stockings (A.E., TEDS)

CHECKLIST: Measuring, Applying, Removing Antiembolic Stocking

__ 1. Observes overriders.

__ 2. Assists patient to lying position in bed.

__ 3. Measures stockings and compares to size chart:
Knee Length
Measures circumference of calf at widest point
Measures length from heel to popliteal space
Thigh Length
Measures circumference of calf
Measures circumference of thigh at widest point
Measures length from heel to gluteal fold.

__ 4. Turns stocking almost completely inside out.

__ 5. Slips the foot portion of stocking over toes, foot and heel.

__ 6. Pulls stocking up over foot and up the leg evenly to full length.

__ 7. Makes sure there are no wrinkles, creases or twists.

__ 8. Repeats for other leg.

__ 9. Removes by holding the top of stocking with both hands and pulls down off foot.

__ 10. Repeats for other leg.

NOTE: A.E. hose are removed for 30 minutes per shift. This is usually done at bath time on day shift.

SKILLS LAB #6

Skills Lab #6
Bring pertinent charting form if distributed by clinical faculty.

DIRECTIONS:

1. Read Elkin, Perry & Potter, Nursing Interventions and Clinical Skills,

   Chapter 8, Promoting Nutrition

   Skill 8.1 Feeding Dependent Clients
   Skill 8.2 Aspiration Precautions
   Read Box 44-10, p 1111 of Potter/Perry, Fundamentals of Nursing

   Chapter 9, Assisting with Elimination, pp. 200-205, 210-213

   Skill 9.1 Monitoring Intake and Output
   Skill 9.3 Applying an External Catheter

2. View your Basic Video Skills (CD)
   - Nutrition and Fluids
   - Applying a condom catheter (only) in Elimination Assistance CD

3. **Complete I & O Study Guide and Case Study prior to class (p210-211) –**
   Read Potter and Perry, Fundamentals of Nursing – Chapter 41 (pp 969-971; 978-984).

4. Practice measuring amounts of fluids in a variety of containers in skills lab.

EQUIPMENT: Variety of containers, measuring containers.

Skills:
Assisting the adult to eat
Measurement of Fluid Intake and Output

I & O STUDY GUIDE

1. What is the normal daily fluid intake and daily fluid output in a typical 24 hour pattern?

2. Differentiate between sensible and insensible water loss.

3. List the fluids measured when calculating input and output.

4. List at least four common sources of error in I & O measurement.

5. Identify some nursing implications when caring for patients with a MD-prescribed fluid restriction.

6. What additional assessments can the nurse make to assess a patient's fluid balance?

CASE STUDY

Kathy McAllister knew she was in trouble. Recently she underwent major surgery, an ileostomy. It had been rough adjusting to the stoma and its care but she was learning to deal with it. Now something else was wrong. The nurse had removed the indwelling catheter that had been inserted at the time of surgery. Kathy was delighted that it was gone, but now she couldn't void. She had urinated a few drops an hour ago and was surprised at how much it had hurt. "The burning sensation is terrible," she told the nurse. "Why am I having this pain?" Monica Stuart, Kathy's nurse, responded, "Client's sometimes experience discomfort after a retention catheter has been removed."

Monica reviewed Kathy's intake and output for the last 24 hours. She noted that during the night she drank one glass of water, and received 600 cc of IV fluid (D5.45 NS). This morning Kathy had one glass of milk and two cups of coffee at breakfast and a cup of soup and two glasses of ice tea at lunch. Between 7 a.m. and 3 p.m. she also drank three glasses of water between meals and received the last 400 cc of IV fluid. This evening Kathy drank two cups of tea, three glasses of water, and one-half glass of pear juice. Monica was concerned because Kathy had taken in adequate amounts of fluid during the last 24 hours. She noted that Kathy's output on night shift had been 350 cc; during the day shift her output had been 420 cc. However, Kathy voided only 50 cc since the retention catheter had been removed at 3:00 p.m. Monica checked Kathy's abdomen and noted that the suprapubic area was firm and distended. "I want you to try and urinate," she told Kathy, "I'll help you."

1. Complete the 24-hour intake and output worksheet using the data supplied in the case study.

2. Discuss how I & O might be recorded differently if the patient is ordered to be on strict I & O VS the patient who is simply be monitored by the nurse.

Commonly Used Fluid Containers and Their Volumes

water glass	200 ml
juice glass	120 ml
tea/coffee cup	180 ml
soup bowl	
adult	180 ml
child	100 ml
teapot	240 ml
creamer	
large	90 ml
small	30 ml
water pitcher	1000 ml
jello, custard dish	100 ml
ice cream dish	120 ml
paper cup	
large	200 ml
small	120 ml

SKILLS LAB #7

Nursing Care Planning: Clinical Application Part I

Bring Nursing Diagnosis Book

SKILLS LAB #8

Skills Lab # 8

1. Elkin, Potter and Perry, Nursing Interventions and Clinical Skills
   Chapter 11, Vital Signs (Bring watch with second hand).
   (Blood pressure tutorial site: www.abdn.ac.uk/medical/bhs/tutorial/q25.htm)
   Skill 11.1 Assessing Temperature, Pulse, Respirations, and Blood Pressure
   Skill 11.2 Measuring Oxygen Saturation with Pulse Oximetry

2. View Basic Video Skills (CD)
   - Vital Signs (everything except height and weight)

3. Elkin, Potter and Perry, Nursing Interventions and Clinical Skills
   Chapter 10 Pain Management
   - Skill 10.1 Nonpharmacological Pain Management

Skills:

Oral, Axillary, & Rectal Temperature
Radial and Apical Pulse
Respirations
Blood Pressure
Measurement of Pulse Oximetry
Pain Assessment
Measurement and Recording of Vital Signs

VITAL SIGNS:
MEASUREMENT AND RECORDING T.P.R., B.P.

DIRECTIONS:

1. Read Potter & Perry, Fundamentals of Nursing, Chapter 31
2. Complete graphic sheets.

EQUIPMENT: As listed with individual vital sign assessments

CHECKLIST: (Critical Elements): Vital Signs: Measurement and Recording of Temperature, Pulse Respiration, and Blood Pressure.

_____ 1. Observes overriders.

_____ 2. Places instrument in correct location.

_____ 3. Reads instrument within range of

_____ a. +/– 0.2 for temperature

_____ b. +/– 6 for blood pressure

_____ c. +/– 4 for apical pulse (+/– 10 beats/minute for apical pulse for child under one year) (count one full minute)

_____ 4. Counts without an instrument within range of

_____ a. +/– 2 for respiration

_____ b. +/– 4 for radial pulse

_____ 5. Reports significant changes in vital signs within 15 minutes (as related to patient's trend).

_____ 6. Records vital signs on patients graphic accurately.

SKILLS LAB #9

Nursing Care Planning Clinical Application Part II

Bring nursing diagnosis book

SKILLS LAB # 10

Skills Lab #10

DIRECTIONS:

1. Read Elkin, Perry & Potter, Nursing Interventions and Clinical Skills,

   Chapter 6, Promoting Range of Motion
   Skill 6.2 (p. 124-127) Promoting Activity and Mobility
   Chapter 26, Care of the Client In Traction
   Skill 26.3 (582-588) Care of Client with a Cast

2. View your Basic Video Skills (CD)
   - In Safe Patient Handling- Assisting with Range of Motion Exercises

3. Read Potter and Perry, Fundamentals of Nursing – pp 1232-1236, Table 47-2.

Skills:

Range of Motion
Assessing a casted extremity

Math Exam

CHECKLIST: Assessing a Casted Extremity

__ 1. Observes overriders.

__ 2. Encourages the patient to notify nurse if he feels any unusual sensations or changes in sensations in the casted extremity.

__ 3. Checks the patient's fingers or toes to make sure they are pink in color.

__ 4. Checks the patient's fingers or toes to make sure they are warm.

__ 5. Asks what the patient feels when toes are touched.

__ 6. Assesses for capillary refill by applying pressure to one of the patients toe nails or fingernails.

_ 7. Asks the patient to move the fingers or toes that are effected by the cast.

__ 8. Asks the patient to identify the exact location of any pain. Assesses for adequate blood supply or nerve paralysis.

__ 9. Checks for any drainage from a wound under the cast. Notes the color and amount of drainage. Marks the circumference of the stain on the cast as a gauge for any increase in the amount of drainage.

Skills Labs #11-14
Heart and Lung Assessment
Neurological Assessment
Abdominal Assessment
Integumentary Assessment
Quick Head to Toe and Elder Assessment

Before Each Lab:

Complete appropriate readings in Elkin, Potter and Perry, and Jarvis, Physical Examination and Health Assessment.

Review any CD or video preparation if available. Additionally, review your Skills Performance Checklists from Elkin or any assessment guidelines distributed by your faculty to help you prepare for checkoffs in the skills lab.

Finally review the related NCP system assessment (mode) sheet.

CLINICAL SECTION

NURSING 301

OHLONE COLLEGE

Guidelines for Clinical Preparation - N 301

A. Data Collection Worksheet

Think of it as your copy of the nursing kardex (or Patient Worklist for those at Washington Hospital). All nursing activities for the patient that appear on the kardex should be transposed onto this form. You can fill this out at the facility as you look up the information. You now have all nursing activities on one page in your possession.

The categories of Current T/L needs and Possible D/C needs will become easier to fill in as you progress through the program and develop your own data base. Challenge yourself to put 1-2 entries in each of these categories, even if it feels like a guess. These ideas will come out of your reading regarding your patient's medical condition and treatment regime.

B. Documentation

Obtain information from the nursing notes regarding your patients hygiene needs, activity abilities, bathroom needs, skin assessment, CMST, appetite and 24 hour I/O. This data will be recorded under the Wednesday column on the N301 Worksheet. You will complete the data, more completely, for each day of care.

D. Chart Review for Patient Preparation

1. History and physical (H & P) of current hospitalization. The physician's H & P is, your key to the medical diagnosis. Write down all of information provided regarding your patient's symptoms (both subjective and objective). Try and review progress notes as well.

2. Front Sheet – has information on support systems, living arrangements, religion, insurance, employment.

3. Graphic Sheet - to see 24 hour trend of VS, stools and I & O balance.

E. Additional Patient Prep on Wednesday afternoon/evening

1. Review kardex in patient notebook Transpose info onto data collection worksheet.

2. Introduce self to patient—make sure they agree to a student caring for them.

3. Check in with RN caring for patient if you have any questions about what you found from chart review.

F. Home Preparation

1. Use relevant information from your patient's chart, your Medical Surgical Nursing Text, your pathophysiology text, your Geriatric nursing text and your Cultural Health Assessment text to assist you in responding to the questions below:

2. What brought your patient to the hospital? What was his admitting diagnosis? What causes that diagnosis, ie., pneumonia? What if any risk factors did your patient have for this diagnosis? What are the typical signs and symptoms (clinical manifestations) for this diagnosis? What signs and symptoms did your patient present with on admission? Identify the **normal changes of aging** that may have increased your patient's risk for this diagnosis. (ie, pneumonia) as they apply. From your reading identify two related laboratory findings that assist the physician with validating the patient's medical diagnosis. Were these labs ordered for your patient? What is the usual medical treatment for this diagnosis and the usual nursing care?

   Note: If your patient has undergone a surgical procedure briefly explain the procedure and the usual nursing care after surgery.

3. **Begin** a care plan that when complete, will contain **three nursing diagnoses**. The nursing diagnoses need to contain a related to aspect. Include expected outcomes and a **minimum** of three nursing interventions for each nursing diagnosis. Be sure to include interventions that you have learned to do in the skills labs including your assessments. Follow guidelines discussed in NCP skills lab workshop.

4. What cultural characteristics do you need to consider in caring for your patient? What preferences do you anticipate in terms of eye contact, touch, attitudes/response to pain, dietary restrictions, and beliefs concerning health and illness?

*Some faculty may prefer that you use the tables on the following two pages for your pathophysiology and cultural characteristics.

G. Day of Care

Within first hour of arrival on hospital floor, obtain report from RN assigned to your patient. Are there any changes in the medical orders from your chart review from the previous day? How was your patient's night? Any changes in status from previous day?

* = kardex refers to the system of communicating nursing care indicated in the chart.

Pathophysiology

Student Name:
Date:
Patient's Initials:
Diagnosis:

Normal changes of aging that may have increased risk for dx:

Definition of medical diagnosis	
Risk factors/Etiology	**Patient's risk factors/Etiology of patient's disease**
Pathophysiology (brief description of changes that occur in involved system/s).	
Clinical Manifestations (Typical signs and symptoms expected).	**Signs and Symptoms Manifested by Patient**
Diagnostic Studies (Lab tests, X-rays, Scans, etc) to confirm diagnosis	**Diagnostic tests done on patient AND results**
Treatments	**Patient's treatments**

Cultural Characteristics (may include religion aspects)

Preferences:	Anticipated (book)	Actual (patient)
Eye contact		
Touch		
Attitudes/Response to Pain		
Diet		
Health and Illness Beliefs		

FAQ's on Clinical Paperwork – N301

What comprises a care plan?
Nursing diagnosis statement using NANDA terminology, goal statement regarding an achievable goal during your time of care, nursing interventions especially those that the student has learned to do, evaluation of care plan. If goal is NOT met, state changes to the care plan needed to achieve goal or whether the goal was realistic. Perhaps a new goal should be written.

How many nursing diagnoses are required?
Three nursing diagnoses statements, two goals that are measurable and realistic for EACH nursing diagnosis statement, a **minimum** of three nursing interventions for EACH nursing diagnosis statement, each goal is evaluated.

When is the evaluation column completed?
Set up the evaluation column of the NCP with the **goal criteria** ahead of time when you are writing your care plan, so that you can just circle or check whether goals have been achieved. Ask your instructor for assistance with this.

What do I do for clinical preparation?
Complete entire Data Collection Sheet, answer questions on patient's admitting symptoms, medical diagnosis, pathophysiology, normal changes of aging and selected laboratory values as detailed in F2 on the previous page. **Begin** your Nursing Care Plan. Complete **at least one** diagnosis with related goals and interventions. Have two additional diagnoses in mind based on your research. Complete Wednesday column on N301 Worksheet.

When is this preparation due?
Preparation paperwork is to be completed by the beginning of clinical on Thursday.

Do I do anything additional on the paperwork after Thursday morning?
Yes, complete the Thursday and Friday columns on the N301 Worksheet based on your patient care and assessments, on a daily basis. Update medical and orders as needed. **Complete** the remaining two nursing diagnoses with related goals and interventions on Thursday evening.

After completing the above, when do I turn it in?
At completion of clinical week – ie noon on Friday.

When I do the exercise and rest careplan, is there any different paperwork?
The only aspect of the paperwork that will change is that the exercise and assessment sheet will need to be completed and 2 of the nursing diagnosis statements are derived from nursing diagnoses in this category of the Roy Adaptation Model. **When I do the psychosocial careplan is there any different paperwork?**
As above, complete the psychosocial assessment sheet and 1 of the nursing diagnoses will be from the psychosocial category of the Roy Adaptation Model.

DATA COLLECTION/WORKSHEET

PT. Initials _____Age _____ Rm. # _____ Dr./s _____ Adm. Date _____ Dates of Care _____

Current Med. Dx _____ Surgical Procedure & Date: _____

Social Hx: Language, Ethnicity, Supports, Job, Economics:

Allergies: _____ Diet: _____

Pertinent Health/Illness/Surgical or O.B. Hx:

Significance of Dx/Hospitalization on ADLs/Future:

Time	Medical Treatment Plan (Activity Status, IVs, Treatments)
Time	Current T/L Needs
Time	Possible D/C Needs

Student Name: _____

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N301 WORKSHEET

WEDNESDAY(information from chart review)	THURSDAY	FRIDAY
VITAL SIGNS: Baseline:	8 a.m.T P R B/P Pain sat 11 a.m.T P R B/P Pain sat	8 a.m.T P R B/P Pain sat 11 a.m.T P R B/P Pain sat
HYGIENE: Nursing Care Provided: Ability of Patient to Assist		
ACTIVITY: Doctor's Order: How Patient Tolerated:		
DIET: Doctor's Order: Percent eaten	Breakfast Lunch	Breakfast Lunch
I & O I & O order 24 hour total :	Intake Output	Intake Output
INTEGUMENT ASSESSMENT: Document assessment using guidelines presented in skills lab.	Skin: Hair/scalp: Nails	Skin: Hair/scalp: Nails
CMST ASSESSMENT: (Circulation, movement, sensation, and temperature) Document assessment using guidelines presented in skills lab.		

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