GRAYSON COLLEGE
ASSOCIATE DEGREE
NURSING PROGRAM

NURSING 1

RNSG 1119

Fall 2020

Course Information: ***RNSG 1119, Introduction to Professional Nursing for Integrated Programs, Spring 2020***

Professor Contact Information

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Course Description

(0-3-0-48-1) Study of the concepts and principles necessary to perform basic nursing skills for care of diverse patients across the life span; demonstrate competence in the performance of nursing procedures. Content includes knowledge, judgment, skills, and professional values within a legal/ethical framework.

Course Pre-requisites, Co-requisites, and/or Other Restrictions

Pre-requisites: BIOL 2301/2101 or 2401 & 2302/2102 or 2402; MATH 1314 or MATH 1342.

Co-requisites: RNSG 1423 must be taken concurrently with RNSG 1119 and RNSG 1360.

Restrictions: A grade of "C" (74.5) or better is required to progress onto Nursing 2 courses.

Course Placement**:** First semester of the nursing program. Acceptance to the nursing program required.

End of Program Student Learning Outcomes

Member of the profession

1.1 Demonstrate professional attitudes and behaviors.
1.2 Demonstrate personal accountability and growth.
1.3 Advocate on behalf of patients, families, self, and the profession.

Provider of patient-centered care

2.1 Use clinical decision-making skills to provide safe, effective care for patients and families.
2.2 Develop, implement, and evaluate teaching plans to meet the needs of patients and families.
2.3 Integrate a caring approach in the provision of care for diverse patients and families.
2.4 Perform skills safely and correctly in the provision of patient care.
2.5 Manage resources in the provision of safe, effective care for patients and families.

Patient safety advocate

3.1 Implement measures to promote a safe environment for patients, self, and others
3.2 Formulate goals and outcomes to reduce risk using evidence-based guidelines.

Member of the health care team

4.1 Initiate and facilitate communication to meet the needs of patients and families.
4.2 Collaborate with patients, families, and health care team members to promote quality care.
4.3 Function as a member of the interdisciplinary team.

Course Outcomes

- Integrate theoretical concepts related to fundamental skills of nursing
- Demonstrate correct procedures for fundamental nursing skills
- Apply principles of physical examination and demonstrate correct examination techniques
- Demonstrate correct medication administration procedures
- Identify therapeutic equipment and appropriate use
- Demonstrate correct procedures for obtaining vital signs and other examination measurements
- Integrate concepts of clinical decision making
- Apply evidence-based practices
- Demonstrate adherence to established safety standards

SCANS Skills: When taken concurrently with RNSG 1423 and RNSG 1360, the following skills will be achieved:

Workplace Competencies

1. Resources: Identifies, organizes, plans, and allocates resources
   Students in RNSG 1119 have to be able to manage the care of one client and organize their time in the clinical setting to complete the objectives of the clinical assignment. Students assign themselves to a group of 3-4 students to practice skills in the laboratory. Peer evaluation is used as a learning strategy.
2. Interpersonal: Works with others
   Students in RNSG 1119 must learn to work in groups for the achievement of goals. This learning is also reflected in the student's ability to work with the healthcare team.
3. Information: Acquires and uses information
   Students in RNSG 1119 must learn to access all available information sources in order to collect data including the Internet, patient record, physician record and peer reviewed nursing journals. They must be able to evaluate what information is pertinent to solve patient problems and deliver appropriate nursing care. Students must learn to use the information for communicating therapeutically to clients and documenting on client records and clinical assignments.
4. Systems: Understands complex inter-relationships
   Students in RNSG 1119 must be able to demonstrate that they understand the operations of various healthcare delivery systems, especially nursing services. Students must become familiar with managed care, a system of health care that provides a generalized structure and focus when managing the use, cost, quality and effectiveness of health care services.
5. Technology: Works with a variety of technologies
   Students in RNSG 1119 are introduced to a variety of technology in the healthcare system. They must learn to use information technology for information handling. Students must analyze, store, retrieve and/or manage data and information needed by nurses in providing care to individual clients.

Foundations Skills

1. Basic Skills: Reading, Writing, Math, Listening and Speaking
   Students in RNSG 1119 are required to complete nursing care plans and physical assessments. Students must also demonstrate mastery with dosage calculations by completing an exam with 90% accuracy.
2. Thinking Skills: Creative thinking, problem solving, visualizing relationships, reasoning and learning
   Students in RNSG 1119 are required to demonstrate reflective and critical thinking by being inquisitive, honest in facing personal biases, and prudent in making judgments. The students must develop a value system of right and wrong that helps the student with affective behavioral skills.
3. Personal Qualities: Responsibility, Sociability, self-management, integrity and honesty
   Students in RNSG 1119 must learn to actively participate in the process of gaining knowledge. They must transition from the passive to active learner role. They must come to class prepared to engage with the content while interacting with faculty and fellow students in planned learning activities.

Methods of Instruction

1. Lecture/discussion
2. Group Process – Role Play
3. Simulated client situations
4. Study Groups
5. Audio-Visual Materials
6. Computer programs

7. Required Textbooks
8. Instructor – Student Conferences
9. Lab Skill Practice and demonstration

Methods of Evaluation

Successful completion of RNSG 1119 is based upon the following criteria:

1. Achieve 90% on a pharmacological math test (3 attempts within specified time frame -see RNSG 1423 calendar).

2. Satisfactory return demonstration of the following designated skills:
    a. Hygiene Care, Bedmaking and Proper Body Mechanics
    b. Proper Positioning of clients
    c. Draining urine from urinary bag and obtaining specimens
    d. Discontinuation of urinary catheter and IV catheter
    e. Basic Dressing Change
3. Satisfactory check-off of the following critical skills: (two attempts only)
    f. Handwashing
    g. Vital Signs
    h. Physical Assessment
    i. Non-parenteral Medication Administration
    j. Parenteral Injection Medication Administration

Skills Lab Evaluation

All skills demonstrations (checkoffs), study module / practice sessions and assignments must be satisfactorily completed within the designated time frame. A passing lab grade includes successful demonstration of skills. Students in all nursing courses are allowed two (2) attempts at successful skill check-off demonstration. Each check-off must be completed within thirty (30) minutes. Students will be given an option for a five-minute warning. Students who are unsuccessful on the first check-off attempt must wait until at least the following day to perform the second attempt. The second check-off will be observed and evaluated by a different instructor**.** Inability to successfully pass skills check-off demonstration within the allowed number of attempts will result in the student failing the course, and the student will not be eligible to participate in clinical experiences and will need to withdraw from the clinical course. A student who fails an ADN skills lab will be considered for re-entry based on priority ranking, faculty and Admission, Retention, & Graduation committee recommendations, and available space. (Refer to readmission policy.)

Course Grade Policy

1. RNSG 1119 is a pass/fail course.

Course & Instructor Policies

Skills Lab Attendance

Regular attendance is mandatory for accomplishment of the ADN program's goals and objectives. The ADN program adheres to the *Grayson College Student Handbook* attendance policy. Should tardiness or absences occur which do not allow for full evaluation of student performance (quality and consistency) faculty will be unable to assign a passing grade.

1. Students are required to attend all lab classes on time, bring lab supplies and daily paperwork, and remain in lab for the full class period.
2. Students are expected to arrive on time for scheduled skills labs. Being tardy for a lab will be considered as a lab absence. Tardy is not being present at the time the instructor begins class.
3. Students who must be absent from a lab are required to make arrangements prior to the assigned lab with the designated lab instructor.
4. Students who miss a scheduled lab class will be required to complete assigned work, and submit documentation of the completed work by a designated date. The student who does not submit this documentation by the designated date will be penalized as designated in the lab syllabus.

Please refer to your ADN Student Handbook for additional information/policies on attendance.

Student Conduct & Discipline

Refer to Grayson Nursing Student Handbook for policies and procedure.

Grayson College campus-wide student policies may be found on our Current Student Page on our website: http://grayson.edu/current-students/index.html

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Academic Integrity

Refer to the Grayson Nursing Student Handbook for policies and procedure.

The faculty expects from its students a high level of responsibility and academic honesty. Because the value of an academic degree depends upon the absolute integrity of the work done by the student for that degree, it is imperative that a student demonstrate a high standard of individual honor in his or her scholastic work.

Scholastic dishonesty includes but is not limited to cheating, plagiarism, collusion, and the submission for credit of any work or materials that are attributable in whole or in part to another person, taking an examination for another person, any act designed to give unfair advantage to a student or the attempt to commit such acts. Plagiarism, especially from the web, from portions of papers for other classes, and from any other source is unacceptable and will be dealt with under the college's policy on plagiarism (see GC Student Handbook for details). Grayson College subscribes to turnitin.com, which allows faculty to search the web and identify plagiarized material.

Plagiarism is a form of scholastic dishonesty involving the theft of or fraudulent representation of someone else's ideas or words as the student's original work. Plagiarism can be intentional/deliberate or unintentional/accidental. Unintentional/Accidental plagiarism may include minor instances where an attempt to acknowledge the source exists but is incorrect or insufficient. Deliberate/Intentional plagiarism violates a student's academic integrity and exists in the following forms:

- Turning in someone else's work as the student's own (such as buying a paper and submitting it, exchanging papers or collaborating on a paper with someone else without permission, or paying someone else to write or translate a paper)
- Recycling in whole or in part previously submitted or published work or concurrently submitting the same written work where the expectation for current original work exists, including agreeing to write or sell one's own work to someone else
- Quoting or copy/pasting phrases of three words or more from someone else without citation, • Paraphrasing ideas without citation or paraphrasing incompletely, with or without correct citation, where the material too closely matches the wording or structure of the original

- Submitting an assignment with a majority of quoted or paraphrased material from other sources
- Copying images or media and inserting them into a presentation or video without citation,
- Using copyrighted soundtracks or video and inserting them into a presentation or video without citation
- Giving incorrect or nonexistent source information or inventing source information
- Performing a copyrighted piece of music in a public setting without permission
- Composing music based heavily on someone else's musical composition.

Student Responsibility

You have already made the decision to go to college; now the follow-up decisions on whether to commit to doing the work could very well determine whether you end up working at a good paying job in a field you enjoy or working at minimum wage for the rest of your life. Education involves a partnership that requires both students and instructors to do their parts. By entering into this partnership, you have a responsibility to show up for class, do the assignments and reading, be engaged and pay attention in class, follow directions, and put your best effort into it. You will get out of your experience here exactly what you put into it – nothing more and nothing less.

Disability Services

The ADN faculty recognizes that, in specific circumstances, students in the ADN program may require modifications. This policy is consistent with the Rules & Regulations Relation to Professional Nursing Education, Licensure & Practice, Texas Board of Nursing, and with the Americans with Disabilities Act (ADA). Please refer to Grayson College's policy regarding student accommodations, the Grayson College Student Handbook, or refer to the website: www.grayson.edu for more information.

In case of inclement weather, emergency closings, or other unforeseen disruptions to scheduled classes, student must log onto their Canvas accounts for directions on where or how to continue their coursework. The schedule is subject to change with fair notice and will be made through Announcements in the Canvas accounts.

TITLE IX

GC policy prohibits discrimination on the basis of age, ancestry, color, disability, gender identity, genetic information, national origin, race, religion, retaliation, serious medical condition, sex, sexual orientation, spousal affiliation and protected veterans' status.

Furthermore, Title IX prohibits sex discrimination to include sexual misconduct: sexual violence (sexual assault, rape), sexual harassment and retaliation.

For more information on Title IX, please contact:

- Dr. Molly M. Harris, Title IX Coordinator (903)463-8714
- Ms. Logan Maxwell, Title IX Deputy Coordinator - South Campus (903) 415-2646
- Mr. Mike McBrayer, Title IX Deputy Coordinator - Main Campus (903) 463-8753
- Website: http://www.grayson.edu/campus-life/campus-police/title-ix-policies.html
- GC Police Department: (903) 463-8777- Main Campus) (903-415-2501 - South Campus)

- GC Counseling Center: (903) 463-8730
  For Any On-campus Emergencies: 911

****Grayson College is not responsible for illness/injury that occurs during the normal course of classroom/lab/clinical experiences.**

****These descriptions and timelines are subject to change at the discretion of the Professor(s).**

** Grayson College campus-wide student policies may be found at the following URL on the College website: https://www.grayson.edu/currentstudents/Academic%20Resources/index.html

Required Textbooks

Required Textbooks for RNSG 1119 Fall 2020

You will either buy them from the Grayson Bookstore (if you are using financial aid), or you will buy them from Wolters Kluwer directly to save money. If you buy from the bookstore, Wolters Kluwer has a form to fill out and they will refund the difference in what you had to pay the bookstore vs. the savings from buying directly from the publisher.
All products are digital (the program will include a copy of a digital version on your textbook.)
You will have the option of buying a paper copy of your textbook directly through Wolters Kluwer for 50.00 dollars each.
The website to go to is: https://lippincottdirect.lww.com/NursingEducation-GraysonCollege-Fall2020

Coursepoint + Product	ISBN #	Subscription Length	Retail Price	
Ricci & Kyle Maternity and Pediatrics Coursepoint+	978-1-975131-41-8	24 months	$311.67	
Taylor Fundamentals Coursepoint+	978-1-975123-90-1	24 months	$345.00	
Brunner Med Surg Coursepoint+	978-1-975124-46-5	24 months	$300.00	

Bookstore ISBNs for the Coursepoint+ products:
Lippincott CoursePoint+ Enhanced for Brunner & Suddarth's Textbook of Medical-Surgical Nursing: **9781975124465**

Lippincott CoursePoint+ Enhanced for Ricci, Kyle & Carman's Maternity and Pediatric Nursing: **9781975131494**

Lippincott CoursePoint+ Enhanced for Taylor's Fundamentals of Nursing: **9781975124151**

Online Assignments

Assignments from online resources must be completed by designated date for successful course completion.

Math Application Objectives

Students are responsible for objectives listed under their current semester level in addition to all previous semester(s).

Level I

1. Interpret & properly express metric and household notations.
2. Convert from one unit to another within the same system of measurement.
3. Convert units of measure from one system of measurement to another system of measurement (metric and household).
4. Interpret drug labels and calculate prescribed dosages.
5. Interpret drug prescriptions and standard abbreviations.
6. Calculate the number of tablets, capsules or volume of liquid for prescribed oral dosages.
7. Calculate the amount of a drug to be administered per pound or kilogram of body weight.

Level II

8. Calculate the volume of a liquid for injection administration.
9. When given specific diluents information for drug reconstitution, calculate the volume to be administered.
10. Select the appropriate syringe for a calculated volume for parenteral administration.
11. Express a calculated answer by selecting the correct calibrated line on a syringe.
12. Calculate the rate of direct IV infusions.
13. Recognize the calibration or drop factor of IV administration sets.
14. Calculate the flow rate in drops per minute, and/or ml/hr. of a prescribed amount of intravenous fluid.

Level III & IV

15. From a given label and/or hypothetical situation, select the information needed to calculate the medication dosage.
16. Recognize the reasonable amount of drug to be administered.
17. Appropriately label a multi-use vial following reconstitution.
18. From a ml/hr. setting, calculate the units/hr. delivered. (Ex: heparin, pitocin)
19. For a given dosage/time order (ex: mg/min) calculate the flow rate in ml/hr. or gtts./min.
20. Convert IV's with additive medications to mg/hr. or mg/min. to check for therapeutic dosage ranges.
21. Demonstrate accurate titration of medications based on a nomogram or other given parameters.
22. For a given IV dosage ordered by weight per minute (mcg/kg/min), calculate the correct flow rate in ml/hr or gtts/min.
23. For a given IV delivery rate (ml/hr), calculate the equivalent mg/hr, units/hr; or units/mg) dosage

Pharmacologic Math: Medication Dosage Calculation

Instructions for rounding will be included on all nursing exams that contain pharmacologic math questions. The instructions will be specific to the medication dose being calculated.

These general rules must be used for correct dosage calculation and documentation:
(These rules will not be included in exam rounding instructions: memorize these rules!!)

- Do not use trailing zeros after a decimal point.
  Example: X mg. (correct)
  X.0 mg. (incorrect)

- Do use a leading zero prior to a decimal point.
  Example: 0.X mg. (correct)
  .X mg. (incorrect)

- Do not round until the very last step in the calculation.

Other helpful guidelines:

Tablets
Tablets are most frequently administered whole or cut in half. Occasionally, tablets may be cut in quarters. Follow standard rounding rules to determine the most accurate dose.

Oral liquids
Round according to the measuring device being used

3 mL syringe
Calibrated in tenths of a mL, so doses should be rounded to the nearest one decimal point.

Use for doses greater than 1 mL.
Examples: 1.25 mL = 1.3 mL
2.67 mL = 2.7 mL

Tuberculin syringe
Calibrated in hundredths of a mL, so doses should be rounded to the nearest two decimal points.

Use for doses less than 1 mL.
Examples: 0.536 mL = 0.54 mL
0.695 mL = 0.7 mL

Intravenous fluids
May be administered in drops/minute or mL/hour
When calculating drops/minute: round to the nearest whole number
When calculating mL/hour: round according to the capability of the infusion pump (may be to a decimal point).

LAB MAKE-UP PERMIT

Student: _____ has my permission to make up the _____(Skill) Lab. This lab must be completed by _____(Date).

_____

Signature of Lab Instructor

I understand that it is my responsibility to make an appointment with another lab instructor and attend the required lab.

_____

Signature of Student

This student attended my lab session and has successfully completed the required skill.

Comments:

_____

Signature of Make-Up Lab Instructor

Grayson College
Associate Degree Nursing
Health Science Lab

Lab Orientation (8/26/2020)
(revised 08/14)

Please do not eat in any part of the lab, keep lids on drinks, and leave at tables.

Lab Hours: Monday through Friday, 7am-5pm

Please notify lab personnel of any problems with computers or other lab equipment.

*ALWAYS SIGN IN on the sign in sheet in Practice Room if it is **NOT** your scheduled lab time.* Your use of the Lab for practicing skills, or studying is important to your instructors. Signing in on the log allows your instructor to know you have been using the lab.

1. Lab is open for practice, see calendar in hall for the computers and skills lab, practice room is always open 7-3.
2. Use of the computers for Internet research and other studies is available in the computer lab, **printing is not available.**
3. Please leave computers on, do not add or remove any programs on computers.
4. Please leave manikins in the same way, you as an individual would like to be left.
   Example: covered up, pulled up in bed, bedside table within reach. (If you have extra supplies you are planning to throw away, please place them on the large cabinet in lab.
5. You may use pencils **only** around manikins. No pens to bedside.
6. Please ask for an IV arm if you are practicing IV insertion, do not use mannequins for this skill. Also, if you are needing the Chester chest, we have several of these.
7. There is **bleach** in the IV fluids hanging at the bedside, so be careful not to get on your clothes.
8. Please do not use any betadine products on the mannequins, use the simulated swab-sticks when practicing. Also, do not use the lubricant that comes in your kits, use the lubricant located in lab for practicing skills.
9. During your simulation clinical, you will see a short video that will give you more details about the use of the simulators and equipment.
10. Please allow the drain bag for the IV fluids to hang on the back of the bed, do not place on bed.

Grayson College
Associate Degree Nursing
RNSG 1119

Lab 1: Overview, Lab Kit, Handwashing Checkoff, Transfers (8/26 & 8/27/2020)

Objectives

1. Discuss essential resources for success in the nursing program.
2. Demonstrate the procedure for proper hand washing.
3. Demonstrate safe techniques when transferring, repositioning, and lifting patients.

Content	**Learning Activities:**
Discuss Lab syllabus Go over lab kit supplies Handwashing check off Body Mechanics/Repositioning	Go over Lab Syllabus Go over lab kit content **Preparation: Read & view PRIOR to lab!** **Hinkle & Cheever:** Read: p. 2129-2130 & Chart 71.1: Hand hygiene methods **Taylor, Lynn, & Bartlett:** Read: p. 603-604 p. 1151-1158 **Assignment in the Point:** Watch & Learn: Performing Hand Hygiene **Bring to lab:** Lab Syllabus & printed copy of Handwashing check off sheet Body Mechanics-Activity Utilizing Safe Lifting Practices, Moving Client up in Bed, Transferring Client Between Bed and Chair Sensory: Assign sensory worksheets for next lab Supplies to bring: syllabus & hand-washing check off form

Students bring electronic device and/or printed syllabus and printed copy of HW check off sheet.

Lab kits to be delivered to students in during lab time.

Activity: Body Mechanics

1. Demonstrate proper body mechanics when lifting a patient in bed and when transferring a patient from the bed to a chair. Use a gait belt.
2. In pairs, practice lifting a patient in bed and transferring a patient from the bed to the chair using proper body mechanics. _____ Evaluator's Initials
3. In pair with another pair of students, practice logrolling a client in bed. _____ Evaluator's Initials
4. In pair with another pair of students, practice repositioning a client in bed and placing a bedpan under each other while lying in bed. _____ Evaluator's Initials for repositioning _____Initial for bedpan

Grayson College
Associate Degree Nursing
RNSG 1119
Skill Performance Checklist: Hand Hygiene

Student _____ _____ Date_____

Time started _____Time ended _____Five-minute warning_____
*Critical Items must be performed correctly for successful completion

		S	U	Comments
	1. Inspect surfaces of hands for breaks or cuts and heavy soiling.			
	2. Push wristwatch and clothing sleeves above wrists.			
	3. Remove rings during washing.			
	4. Stand in front of sink, keeping hands and clothing away from sink surface.			
	5. Turn on water and regulate to a warm temperature.			
	6. Avoid splashing water onto clothing.			
	7. Wet hands and wrists thoroughly under running water. Keep hands and forearms lower than elbows during washing.			
	8. Apply a small amount of soap and lather thoroughly.			
*	9. Wash hands using plenty of lather for at least 10-15 seconds. Interlace fingers and rub palms and back of hands with circular motion at least 5 times each keeping fingers down.			
*	10. Clean fingernails with additional soap or orangewood stick.			
*	11. Rinse hands and wrists thoroughly, keeping hands down and elbows up.			
*	12. Dry hands thoroughly from fingers to wrists and forearms with paper towel.			
	13. Discard paper towel in proper receptacle.			
*	14. Turn off water faucet, using clean dry paper towel. Avoid touching handle with hands.			

Date	**Faculty Signature**

Revised 8/15/2020

Nursing Lab Kit Supplies

Health Tote Black
3 GC PATCHES
1 EA Stethoscope
1 EA Blood Pressure Cuff
1 EA Pocket Nurse® Disp. Penlight with Pupil Gauge
2 PR -7.5 Glove Surgeon Nitrile Sterile Powder Free Size 7.5
1 EA Face Mask with Earloop
1 EA Isolation Gown
1 EA Surgical Paper Tape 1INx10YD
2 EA Pocket Nurse® Swabstick Simulated w/Distilled Water
1 EA Combine Pad Sterile
1 EA Transparent Dressing Tegaderm 4x4 3/4IN
1 EA Surgical Gauze Sponge Sterile 4x4IN
1 EA ORMD Central Line Dressing Tray with Chloraprep
2 EA Transparent Dressing Tegaderm 2 3/8x2 3/4IN
1 EA Closed Insert Foley Tray 16FR Sterile
1 EA Saf-T Wing® Blood Collection Set 21Gx3/4IN
1 EA Vacutainer holder
3 EA Safety IV Catheter 22Gx1IN PROTECTIV®
3 EA IV Catheter Teflon Wingless 22G x 1"
1 EA Demo B-Patch
1EA ORMD IV Start Kit Custom with Chloraprep
2 EA Secondary IV Set Duo Vent 37IN Clearlink
1 EA Micro Extension Set 8IN Clearlink
1 EA Continu-Flo Solution Set 112IN Clearlink
1 EA Multi Sample Needle 21Gx1IN Green
2 EA Hypodermic Needle-Pro® Insulin 1mL 28Gx.5IN
2 EA SafetyGlide Needle 22Gx1.5IN
2 EA SafetyGlide Needle 25Gx5/8IN
1 EA SafetyGlide Needle 21Gx1IN
1 EA FILTER Needle
1 EA SafetyGlide TB Syringe w/Needle 1mL 27Gx.5IN
3 EA Syringe Only Luer Lock 3mL
5 EA Syringe Only Luer Lock 10mL
1 EA Demo Dose® Sodim Chlorid .9PCT 9mg mL 30 mL
1 EA Demo Dose® .9PCT Sodim Chlorid 500mL
2 EA Demo Dose® .9PCT Sodim Chlorid 50mL
1 EA Demo Dose® Ampule Clear 2mL
1 EA Demo Dose® Regulr Insuln 100 Units mL 10mL
1 EA Demo Dose® NPH Insuln 100 Units mL 10 mL
1 EA Whistle Open Suction Catheter Kit with Solution 14FR
1 EA Tracheostomy Care Trays Argyle
1 EA Tracheostomy Tube Holder with Velcro
1 EA Demo Dose® Inject-Ed Pad

Grayson College
Associate Degree Nursing
RNSG 1119

Lab 2: Hygiene and Bedside Care (9/2 & 9/3/2020)

Objectives

1. Demonstrate the correct procedure for making an unoccupied and occupied bed.
2. Demonstrate safe techniques when transferring, repositioning, and lifting patients.

Content	**Learning Activities:**
Sensory Worksheets Hygiene Care Pericare Bed making Unoccupied Occupied Bedpan placement Body Mechanics/Repositioning	**Preparation: Read & view PRIOR to lab!** **Read:** **Taylor, Lynn, & Bartlett:** Ch. 31 p. 984-1040 **Skills checklists:** p. 1018: Skill 31-1 1022: Skill 31-2 1026: Skill 31-3 1029: Skill 31-4 1032: Skill 31-5 **Assignments in The Point:** Watch & Learn: Making an Occupied bed Watch & Learn: Providing a Bed Bath Providing Oral Care for the Dependent Patient Nursing Skills: Hygiene Perform bed bath on mannequin Peri-care station Making the Occupied Bed Making the Unoccupied Bed Assisting the Client to Use Bedpan Review Body Mechanics-Activity Utilizing Safe Lifting Practices, Moving Client up in Bed Supplies to bring: completed sensory work sheets & lab 2 work sheet.

Skills Competency Worksheet
Lab 2: Bedside Care

This competency skills worksheet is designed to ensure competence in performing hygiene care, making occupied/unoccupied beds, and placing bedpans for clients in the health care setting. Please turn in required paperwork before leaving lab.

Activity One: Hygiene & Oral Care

Each student will perform a bed bath on the mannequin and make an occupied bed.

Evaluator's Initials: _____Completed bath _____Made bed _____ Oral Care

List two reasons why a bath is therapeutic to the client.

1.

2.

Activity Two: Peri care

Each student will perform peri-care on both models, male and female.

☐ Female ☐ Male _____ Initials of Evaluator/Student

Sensory Review Worksheets- Due Lab 2

(Note: Please complete **prior** to next lab)

Match the following terms related to sensations.

_____auditory	a. enables a person to be aware of position and movement of body parts
_____tactile	b. taste
_____olfactory	c. hearing
_____gustatory	d. smell
_____kinesthetic	e. recognition of an object's size, shape and texture
_____stereognosis	f. touch

1. Sensory overload generally occurs when a person is unable to process or manage the amount of intensity of sensory stimuli. What are the three factors that contribute to sensory overload?

a._____

b._____

c. _____

2. Clinical signs of sensory deprivation include:

a._____

b._____

c._____

d._____

e._____

f._____

g._____

h. _____

3. Which client is at greatest risk for experiencing sensory overload?

a. A forty-year-old client in isolation with no family.
b. A 28-year-old quadriplegic client in a private room.
c. A 16-year-old listening to loud music

d. An 80-year-old client admitted for emergency surgery

4. Which statement indicates the client needs a sensory aid in the home?

a. "I tripped over the throw rug again,"
b. "I can't hear the doorbell."
c. "My eyesight is good if I wear my glasses."
d. "I can hear the TV if I turn it up high."

5. A hospitalized client is disoriented and believes she is in a train station. Which response from the nurse is the most appropriate?

a. "You wouldn't be getting a bath at the train station."
b. "Let's finish your bath before the train arrives."
c. "Don't you know where you are?"
d. "It may seem like a train station sometimes, but this is Valley Hospital."

6. A client with impaired vision is admitted to the hospital. Which interventions are most appropriate to meet the client's needs? **Select all that apply.**

a. Identify yourself by name.
b. Decrease background noise before speaking.
c. Stay in the client's field of vision.
d. Explain the sounds in the environment
e. Keep your voice at the same level throughout the conversation.

7. A client is at risk for sensory deprivation. Which clinical signs would the nurse observe? **Select all that apply.**

a. anxiety
b. reduced attention span
c. irritability
d. drowsiness
e. depression

8. The nurse is assessing for sensory function. Match the assessment tool to the specific sense it will be testing.

a. identifying taste_____
b. Stereognosis_____
c. Snellen chart_____
d. Identifying aromas_____
e. Tuning fork_____

1. Visual
2. Hearing
3. Tactile
4. Olfactory
5. Gustatory

9. An 85-year-old client has impaired hearing. When creating the care plan, which intervention would have the highest priority?

a. Obtaining an amplified telephone
b. Teaching the importance of changing his position
c. Providing reading material with large print
d. Checking expiration dates on food packages

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Lab 3: Vital Signs (9/9 & 9/10/2020)

Objectives

1. Demonstrate the steps used in assessing body temperature, apical & peripheral pulses, respirations, blood pressure, oxygen saturation
2. Demonstrate accurate recording of vital signs.

Content	Learning Activities
Vital Signs Temperature Pulse Respiration Blood Pressure Respirations Orthostatic VS-BP & pulse Height/Weight Peripheral Pulses Apical-Radial Deficit Common terms and abbreviations wksht	**Preparation: Read & view PRIOR to lab!** **Read:** Taylor Fundamentals of Nursing: Ch. 25: pg 642-690 Ricci: Ch. 16: pg. 559 Table 18.7 pg 626 **Activities in The Point:** Taylor: Ch. 14- Vital Sign Assessment Picmonic Ch. 25 Practice and Learn Case Study Ch. 25 Fever Picmonic Ch. 25 Watch and Learn Video on Assessing Apical Pulse Ch. 25 Watch and Learn Video on Measuring Oral Temp., radial pulse, respiratory rate, and blood pressure

Students need to bring watch with second hand, BP cuff, stethoscope, and skills performance checklist for handwashing and vital signs.

Skills Competency Worksheet

Lab 3: Vital Signs

1. **A client has been admitted with a lung infection. His vital signs indicate hypertension, tachycardia, and eupnea. Which set of vital signs support this data?**
   a. BP 150/105, pulse 123, Respirations 12
   b. BP 90/40, Pulse 110, Respirations 28
   c. BP 85/50, Pulse 50, Respirations 40
   d. BP 115/84, Pulse 100, Respirations 30

2. **Vital Sign Assessments at Grayson College Health Clinic:**
   a. Assess the blood pressure, pulse and respirations of 2 student clients and 2 GC clinic clients**.**
   b. Obtain a temperature, oxygen saturation and orthostatic vital signs reading of only **1** student client.
   Record your findings in the chart below.

	Student A	**Student B**	**Clinic A**	**Clinic B**
Blood Pressure Lying				
Sitting				
Standing				
Apical Pulse				
Respirations				
Temperature				
O2 Saturation				

3. **Select one student client to assess height and weight.**
   Ht_____ Wt_____
4. **Choose a partner and locate all peripheral pulse sites (except femoral). Check off sites below as you locate each. NOTE: you do not have to count the pulse at each of these sites, just locate them.**

	Left located	**Right located**
Radial		
Brachial		
Carotid		
Popliteal		
Dorsalis Pedis		

5. **Choose a partner and obtain an apical-radial pulse deficit on a third student.**
   Apical _____ Radial _____ Pulse Deficit _____

6. **Start learning your "Common Nursing Terms & Abbreviations" worksheet**

Common Nursing Terms & Abbreviations

Symbols		**Assessment**	
$\overline{c}$	with	A&O x 4	alert and oriented x 4
$\overline{s}$	without	BBS	bilateral breath sounds

a̅	before	B/P, BP	blood pressure
p̅	after	BS present	bowel sounds present
Ø	nothing, not, none	CTA	clear to auscultation
i̅i̅, i̅i̅i̅	2,3 of something	dx	diagnosis
2°	secondary	H/A	headache
Δ	change	HOH	hard of hearing
q	every	hx	history
Activities		TPR	temp, pulse & resp
ac	before meals	KVO	keep vein open
ad lib	as desired	LBM	last bowel movement
ADL	activities of daily living	NKA	no known allergies
am	before noon	NKDA	no known drug allergies
AMB	ambulatory	N/V/D	nausea, vomiting, diarrhea
BID	twice a day	OTC	over the counter
BRP	bathroom privileges	PERRLA	pupils equal, round, reactive to light & accommodation
CBR	complete bed rest	R/O	rule out
MAE	moves all extremities	rx	prescription
OOB	out of bed	SL	saline lock
pc	after meals	SOA	shortness of air
pm	after noon	s/s, S&S	signs/symptoms
ROM	range of motion	tx	treatment
TID	three times a day	unk	unknown
WC	wheelchair		
Measurements		**Miscellaneous**	
g or gm	gram	AMA	against medical advice
kg	kilogram	ASAP	as soon as possible
L	liter	DNR	do not resuscitate
lb	pound	HOB	head of bed
mcg	microgram	hs	hour of sleep
mEq	millequivalent	I & O	intake and output
mg	milligram	OT	occupational therapy
mL	milliliter	PT	physical therapy
oz	ounce	STAT	immediately
tsp	teaspoon	S/P	status post
Tbsp	tablespoon	VS	vital signs
Labs		**Medications**	
ABGs	arterial blood gases	ID	intradermal
BE	barium enema	IM	intramuscular
BUN	blood urea nitrogen	IV	intravenous
CAT	computederized axial tomagraphy	NG	nasogastric
CBC	complete blood count	NPO	nothing by mouth

C&S, C/S	culture & sensitivity	NS	normal saline
CXR	chest x-ray	PO	by mouth
ECG/EKG	electrocardiogram	PR	per rectal
FBS	Fasting blood sugar	PRN	as needed
FSBS	Fingerstick blood sugar	Subcut	subcutaneous
Hgb	hemoglobin	SR	sustained release
Hct	hematocrit	supp	suppository
KUB	kidneys, ureters, bladder	susp	suspension
MRI	magnetic resonance imaging	tab	tablet
PT	Prothrombin time	sl	sublingual
RBC	red blood cells	hs	hour of sleep
UA	urinalysis		
WBC	white blood cells		
Clinical s			
CA	cancer		
CAD	coronary artery disease		
CHF	congestive heart failure		
COPD	chronic obstructive pulmonary disease		
CVA	cerebrovascular accident		
DM	diabetes mellitus		
HTN	hypertension		
MI	myocardial infarction (heart attack)		
UTI	urinary tract infection		
URI	upper respiratory infection		

ERROR-PRONED ABBREVIATIONS	
<	less than
≤	less than or equal to
>	greater than
≥	greater than or equal to
<	less than
@	at

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Lab 4: Skill Performance Checklist: Vital Signs

Student _____ _____ Date_____

Time started _____Time ended _____Five-minute warning_____
*Critical Items must be performed correctly for successful completion

	Preparation:	**S**	**U**	**Comments**
*	1. Verify order.			
*	2. Gather supplies and equipment.			
*	3. Perform hand hygiene.			
*	4. Introduce self to patient.			
*	5. Identify patient with 2 patient identifiers.			
*	6. Explain procedure to patient.			
*	7. Provide privacy.			

	Procedure for obtaining **blood pressure:**	**S**	**U**	**Comments**
	1. Remove all clothing from area where BP is to be taken.			
*	2. Assuming use of the upper arm, locate the brachial pulse.			
*	3. Apply BP cuff 1-2 inches above antecubital space. Place the balloon of the cuff over the brachial pulse site.			
*	4. Locate the radial pulse.			
	5. Inflate cuff until the radial pulse is no longer palpable and note the number.			
*	6. Deflate the cuff and add 30 to the number from Step 3.			
	7. Wait 2 minutes before proceeding with the BP (take other vital signs or visit with the client).			
	8. Return to BP. Insert earpieces of stethoscope into ears and place the diaphragm side of the amplifier over the brachial pulse site.			
	9. Inflate the cuff to the number calculated in Step 6.			
*	10. Slowly deflate the cuff by 2-3 mm/Hg per second and listen for the first sound (Systolic number) and continue listening until the last sound is heard (Diastolic number).			
	11. Remove the cuff and ensure client comfort.			

	Procedure for obtaining **pulse:**	**S**	**U**	**Comments**
*	1. Place tips of first two or middle three fingers of hand over groove, along thumb side of client's inner wrist to palpate pulse. Obtain a 30 second radial pulse measurement and multiply by 2.			

	Procedure for obtaining **respirations:**	**S**	**U**	**Comments**
	1. Assist client into a comfortable position, preferably sitting or lying with chest visible.			
*	2. Place client's arm in a relaxed position across the abdomen or lower chest, or place nurse's hand directly over client's lower abdomen.			

*	3. Using second hand on watch, count rate for 30 seconds and multiply by 2. Be sure to observe for rhythm and depth.			

	Upon completion of skill:	**S**	**U**	**Comments**
*	1. Leave client in comfortable safe position, bed in lowest position, with call light within reach.			
*	2. Hand hygiene before leaving room.			
*	3. Document the procedure, including patient response.			

Date	**Faculty Signature**

Revised 8/15/2020

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Lab 5: Therapeutic Nursing Skills (9/23 & 9/24/2020)

Objectives

1. Calculate the intake and output for specific examples.
2. Demonstrate the correct procedure for discontinuing a urinary catheter and IV.
3. Identify specimen collections.
4. Demonstrate the correct procedure for applying and removing PPE.
5. Recognize a variety of hospital diets.
6. Identify different types of therapeutic equipment.
7. Discuss the purpose of the different types of therapeutic equipment.
8. Demonstrate the correct procedure for performing a basic dressing change.
9. Accurately assess wounds using length X width X depth for measurements and is able to follow prescriptions for cleaning and dressing changes of wounds
10. Demonstrate the correct assessment of patient in restraints

Content	Learning Activities
Intake and Output Nursing 1 Skills D/C Foley and IV Empty Foley Catheter bag Specimen Collection Isolation Procedures Applying & removing PPE Therapeutic Diets Therapeutic Equipment Basic wound care Safety- Restraints-GC Policy	**Preparation: Read & view PRIOR to lab!** **Read:** **Taylor, Lynn, & Bartlett:** Review CH. 26 p. 1553-1627 Urinary Elimination Removing an Indwelling Urine Catheter: p. 1371 Emptying the Urine Drainage Collection Bag: p. 1351 Circulatory support Applying Compression Devices: p. 963 Isolation Procedures Applying & Removing PPE: p. 624-628 Oxygen and Ventilation Administering Oxygen (NC & mask): p. 1532-1538 Using an Incentive Spirometer: p. 1504 Basic Wound Care Providing basic dressing change: p. 1074 Diagnostic Testing Occult Diagnostic Test on a Stool Specimen: p. 1428 Collecting a Specimen for Culture: Urine: p. 1351-1354 Collecting a Specimen for Culture: Wound: p. 1079, 1112-1116 **Hinkle & Cheever:** p. 251-281 Circulatory Support Applying Antiembolism Stockings: p. 872 Diagnostic Testing Collecting a Specimen for Culture: Sputum: p. 503

Students need to bring lab kits for PPE & wound care

I & O Calculations

Benny Long **Elizabeth Riley**

Julie Bells **Andrew Knight**

Susan Chan

Skills Competency Worksheet
Lab 5: Therapeutic Nursing Skills

This competency skills worksheet is designed to ensure competence in calculating intake and output, performing nursing 1 skills, collecting various specimen, understanding special diets, as well as identifying therapeutic equipment and understanding its purpose. All activities must be completed and receive signed verification by the evaluator: student or instructor.

Activity One: Assessing & Recording Intake and Output

You are caring for 5 clients in a med/surg floor. It is the end of your 12-hour shift and you must calculate input & output for each client. Using assessment skills for your patient, calculate the I&O for the 5 GC clients that have I&O set up. Record the data on the table below:

Client	Total Intake	Total Output	Balance
Benny Long			
Andrew Knight			
Julie Bells			
Elizabeth Riley			
Susan Chan			

I & O Question: At 0700 the client received 2 Tbsp. of potassium chloride elixir with 4 ounces of water via a nasogastric tube. At 0930 the client voided 500 mL, and at 1400 had one incontinent stool. The client had a continuous infusion of IV fluids at 100 mL/hr that was discontinued at 1300. At 1430 the Jackson Pratt (JP) drain with 45 mL was emptied.

What was the total intake for the 7a-3p shift in milliliters? _____mL
What was the total output for the 7a-3p shift in milliliters? _____mL
What was the balance? _____mL (State in terms of positive or negative)

Activity Two: Nursing 1 Skills

A. Using the graduated cylinder, empty 50mL out of the urinary drainage bag.
_____ Initials of Evaluator/Student
B. Practice the proper technique for obtaining a urine specimen from a Foley catheter.
_____ Initials of Evaluator/Student
C. Practice the removal of a Foley catheter.
_____ Initials of Evaluator/Student
D. Practice the proper technique for discontinuing a peripheral IV.
_____ Initials of Evaluator/Student

Activity Three: Specimen Collection

Identify various specimen collection containers and discuss the proper collection technique for each.

A. Sputum Collection Cup

B. Hemoccult Card (Guiac)

C. Sterile Specimen Cup

D. Stool Collection Container

E. Clean Specimen Cup

F. 24 hour urine collections container

G. Culture swab

Activity Four: Isolation Patient

Using the personal protective equipment, please prepare to take care of a patient in the designated isolation. Once the student has finished applying the required PPE, have the instructor verify and initial.

_____ Initials of Evaluator/Student

After the instructor has verified the correct PPE, please remove it in order and receive verification from the instructor for completion of this activity. _____ Initials of Evaluator/Student

Activity Five: Wound Care

Choose one of the mannequin patients that has a wound. Remove the old dressing and perform a basic, dry dressing change.

_____ Initials of Evaluator/Student

Activity Six: Therapeutic Diets

Choose one type of special diet and prepare for the patient an appropriate meal using the plastic foods. Once, the meal is prepared, have the instructor verify and initial for completion of this activity.

_____ Initials of Evaluator/Student

Therapeutic Diets Information Sheet

Clear liquid - Broth, bouillon, coffee, tea, carbonated beverages, clear fruit juices, gelatin, and popsicles.

Full liquid – Ice cream, yogurt drinks, milk, custards, vegetable juice, refined cooked cereals, pureed vegetables and all fruit juices.

Dysphagia- stages, thickened liquids; pureed – scrambled eggs, pureed meats, vegetables and fruits; mashed potatoes and gravy.

Mechanical soft - ground or finely diced meats, flaked fish, cottage cheese, rice, potatoes, pancakes, light breads, cooked vegetables, cooked or canned fruits, bananas, soups peanut butter.

Soft / low residue – low-fiber is easily digested foods such as pastas, casseroles, moist tender meats, canned cooked fruits and vegetables; desserts, cakes and cookies without nuts or coconut.

High fiber - fresh uncooked fruits, steamed vegetables, bran, oatmeal, and dried fruits.

Low sodium -4g(no added salt), 2g, 1g, or 500mg sodium diets; vary from no added salt to severe sodium restriction (500mg sodium diet) that requires selective food purchases.

Low cholesterol -300 mg/day cholesterol, in keeping with American Heart Association guidelines for serum lipid reduction.

Protein –Under 6 mo. – 2.2g/kg, adolescents 1g/kg, adult 0.8g/kg, pregnant additional 30g, lactating additional 20g.

Diabetic –nutrition recommendations by the American Diabetes Association.

Gluten Free –Eliminates wheat, oats, rye, barley.

Activity Seven: Restraints

Appropriately release restraints on a client and have instructor evaluate actions.
_____ Initials of **Instructor**

What assessment would the nurse perform while a patient is in restraints?

Activity Eight: Glucometer Practice

Appropriately demonstrate use of the glucometer. _____ Initials of Evaluator/Student

Activity Nine: Therapeutic Equipment

Complete the activity setup by answering the therapeutic equipment questions in accordance to what is seen in the activity.

Therapeutic Equipment
Oxygenation Station
1a. What is this?
1b. What are indications for use of this device?
1c. What is the maximum amount of liters per minute for this device? _____lpm
2a. What is this device?
3a. What is this device?
4a. What is this device?
5a. What is this device?
6a. What does the nurse set the oxygen flow rate for this mask? _____lpm
7a. What is this used for?
7b. Where would the nurse apply this device?
8a. What are 3 different locations where this device can be applied for an accurate reading?
8b. What reading would need nursing intervention?
9a. How would the nurse abbreviate the name of this equipment?
9b. How would the nurse instruct the patient to use this piece of equipment?

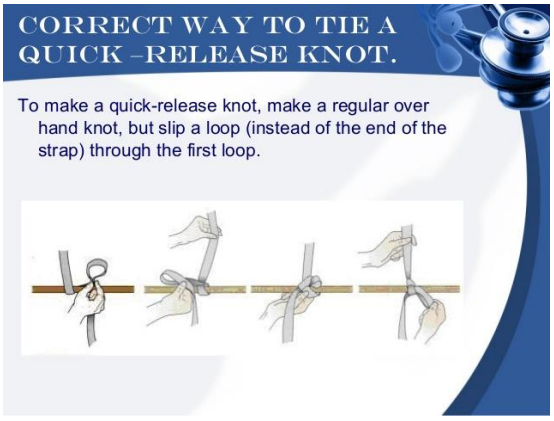
10a. What is an example of when this piece of equipment might be utilized?
11a. What is this device used for?
12a. What are 3 important teaching aspects for a patient who wears oxygen at home?
Intravenous Station
13a. What is the primary purpose of this equipment?
14a. How can the nurse implement look, check, connect with this device?
15a. What is the name of this IV solution?
16a. What does the nurse assess for at the SL lock insertion site?
17a. Can N1 students discontinue IVs?
Urinary & Bowel Station
18a. What is this used for?
18b. How often do you provide catheter care?
19a. What positioning is most important for this device?
19b. What does the nurse need to remember about this tubing?
20a. When do you empty this?
20b. How should the stoma appear for the patient?
Post-Surgical Station
21a. When would a patient require this equipment?
21b. How often would the nurse empty this device?
23a. How would the nurse empty this device?
24a. What is this device?
24b. What is the purpose of this device?
Cardiac Station
25a. What is the purpose of this device?

25b. How many leads are on this device?
25c. How often do you replace electrode pads?
26a. What are risk factors for this device?
27a. How is this name of this device abbreviated?
27b. How does this device work?
27c. What specific assessment should the nurse perform before applying this device?
Gastric Station
28a. Where is this device inserted?
28b. Where is the end placement of this tube?
28c. What is this device used for?
28d. What type of diet is ordered for a patient with this device present?
29a. What are two levels of suction this device can be set at?
30a. Why would this device be indicated for a patient?
30b. In what position should the patient's bed remain when the receiving feedings?
31a. What is this device?
Glucometer Station
32a. What type of patient would require this?
32b. What is a normal reading for this device?
33a. What does the end of the glucometer strip look like that is inserted into the glucometer?
33b. How much blood is necessary for the strip to read?

Grayson College Nursing Program

The use of Restraints and how it relates to the Grayson Student in the clinical setting

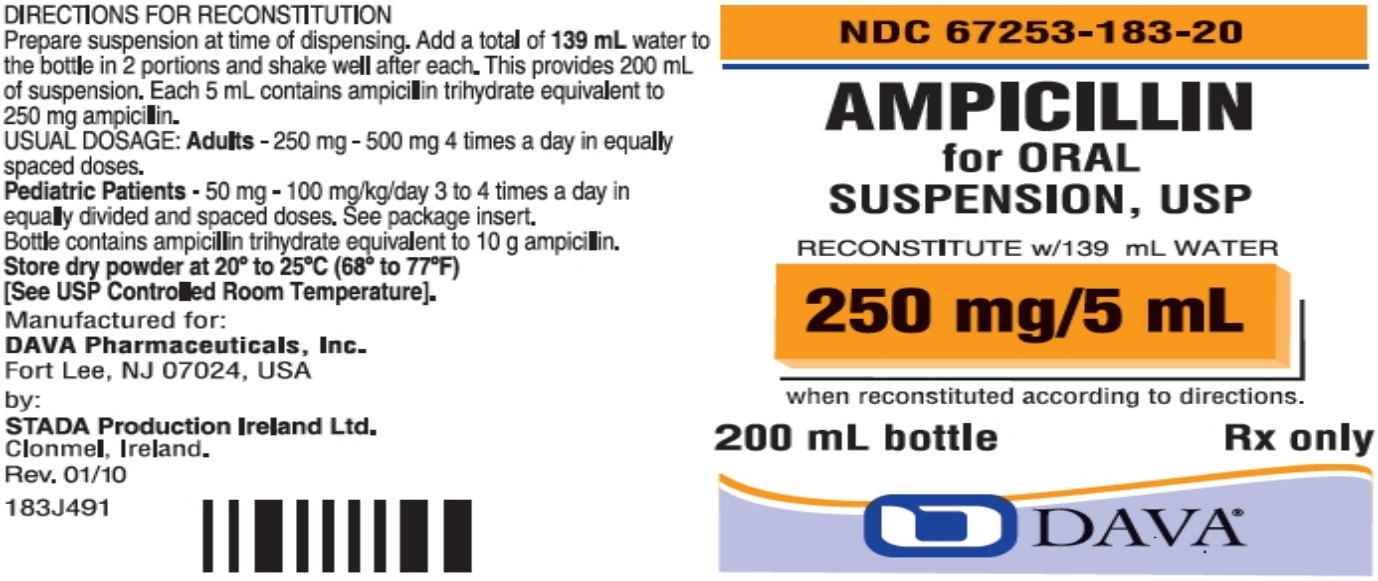
- Students **will not** initiate, manipulate, or discontinue any form of restraint without direct supervision from the instructor or an RN that is involved in the care of the patient.
- Physical restraint is any intervention or device that prevents mobility or free movement including wrist, ankle, or waist devices; the tightly tucking of a sheet, or the use of all side rails to prevent a patient from getting out of bed.
- Federal guidelines regulate the use of restraints, but each medical facility will have specific policies that must be followed.
- It is the responsibility of the student, faculty, and nurse to know the general and specific policies related to the use of restraints before interacting with a patient in restraints.
- Students **may** assess patients in restraints and include in the assessment findings related to proper use and application of the restraint, as well as any complications.
- Assessment will include patient's medical condition, mental status, behavior, number and type of restraints, extremity range of motion, vitals, skin condition and care, frequency and time that food, fluid, and toileting is offered, safety, and education provided to client and family.
- Restraining a patient is a high risk intervention and should be implemented as a last resort. The safety of the patient is a **critically important** priority.
- The three categories of restraint are physical, chemical, and seclusion
- Restraints place the patient in greater risk for injury and the potential for respiratory restriction, circulatory problems, or other mechanical injuries.
- Any issues, concerns, or questions about a patient in restraints encountered by the student must be immediately reported to the clinical instructor and/or the primary care nurse.



- Wrist restraints must be secured in an manner that allows adequate circulation and tied in a quick release knot to the bedframe. This allows restraints to be rapidly released in an emergency. Restraints are never secured to anything that can move independantly from the patient in the bed, such as the bedrail, a table, or any object not directly connected to the bed frame.

Math Problems
Lab 5

HCP Order: Ibuprofen 600 mg po twice a day
How many mL will you give per dose?_____
How many tablespoons will you give daily?_____



When reconstituted with _____mL of sterile water you have a dosage of _____mg per _____mL or ____tsp.

Ordered: Ampicillin 750 mg po every 8 hours
How many mL will you give per dose?_____ How many mL will you give daily?_____

Intake & Output
Lab 5

Regular Diet

The nurse receives report @ 0700 on a 2 day post-op patient who is on a regular diet. The patient's IV is saline locked and urinary catheter has been discontinued. The patient will be going home after the JP drain is removed and the HCP writes discharge orders.

Please calculate the fluid balance for this patient prior to discharge.

Breakfast	Lunch
1 Tbsp of yogurt 1 piece of toast 1 bowl of cereal with 3oz of milk 2 ½ cup of orange juice	4 oz chicken breast 1 cup of mashed potatoes ½ cup of green beans 1 cup of tea

Took 0900 meds with 25 mLof water and drank 75mL when taking 1300 meds.

Urinal was emptied at 0915 with 220 mL, 1145 with 100 mL, and 1315 with 320 mL. JP bulb was discontinued with 15 mL of serosanguineous drainage.

1 lg BM was reported by patient.

Intake	Output

Fluid Balance=

Soft Diet

A patient who has difficulty swallowing was placed on a soft diet.

Please calculate the fluid balance from 1500-2300.

Dinner	Snack
1 cup of pureed chicken 3 oz of mashed potatoes 2 Tbsp of squash ¼ cup of tea ½ cup of pudding	2 Tbsp of yogurt 8 oz can of diet coke

Took 2100 meds with 75 mL of water.

Voided 150mL in urinal @ 1645, 420mL voided at 1930, and 55mL voided at 2230.
Patient had 1 large, loose bowel movement @ 1740.

Intake	Output

Fluid Balance=

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Lab 6: Physical Assessment (9/30 & 10/01/2020)

Objectives

1. Perform a shift assessment using head to toe technique.
2. Recognize the need for a focused assessment based on patient presentation findings.
3. Practice documentation of health assessment.

Content	Learning Activities
Health Assessment Physical Assessment	**Preparation: Read & view PRIOR to lab!** **Read:** Taylor Fundamentals of Nursing: Ch 14 pg. 334-358 Ch. 26 pg. 691-706 **Activities in The Point:** Taylor-Ch. 26- Watch and Learn: 10 Minute Head to Toe Assessment

Students need to bring: watch with second hand, BP cuff, stethoscope, and pen light, Doppler, amplified stethoscope.

Skills Competency Worksheet

Lab 6: Physical Assessment

This competency skills worksheet is designed to ensure competence in performing physical assessments. Please turn in required paperwork before leaving lab.

Activity One: Focused Assessment

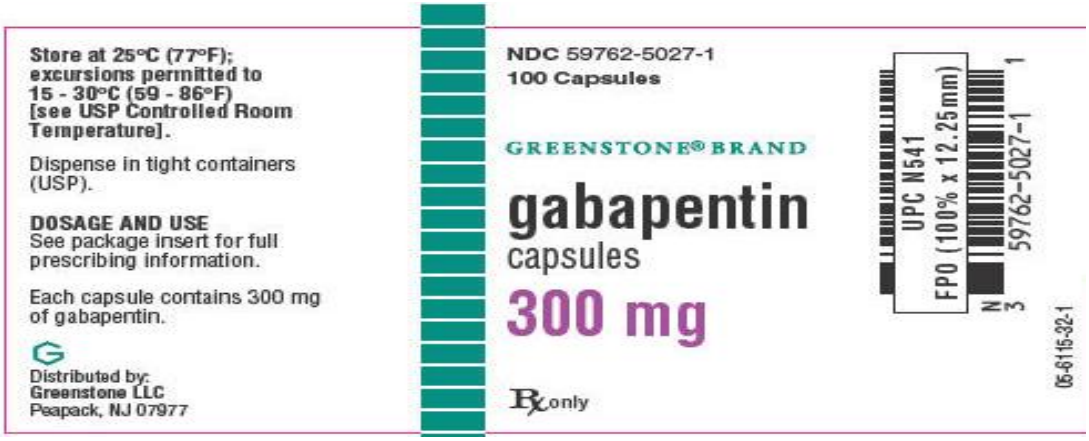
The instructor will divide the students into pairs. Each pair will be assigned a bed. Working in pairs, each student will perform a shift assessment, on the mannequin. Fill out the shift assessment form with the patient findings. **You will turn in your assessment form as well as this skill competency worksheet prior to leaving lab.**

Activity Two: Assessment sounds

Listen to the variation in sounds for the different systems set up on the mannequins.

☐ Lungs ☐ Heart ☐ Bowel _____ Initials of Evaluator/Student

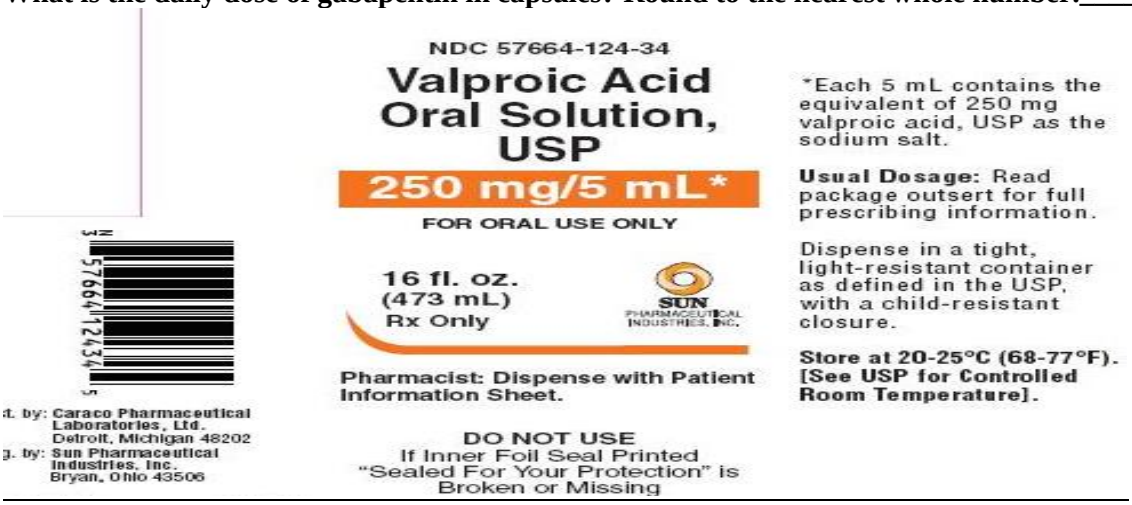
Math Problems
Lab 6



HCP Order: gabapentin 600mg PO TID
Supply: See label
How many capsule(s) will be administered per dose? Round to the nearest whole number._____

What is the daily dose of gabapentin in mg? Round to the nearest whole number._____

What is the daily dose of gabapentin in capsules? Round to the nearest whole number._____



HCP Order: valproic acid 30 mg/kg daily in three divided doses
Supply: See label
The client weighs 88 lbs.
How many mg will you give per dose? Round to the nearest whole number._____

How many mg will you give daily? Round to the nearest whole number._____

How many mL will you give per dose? Round to the nearest whole number._____

How many mL will you give daily? Round to the nearest whole number.____

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Lab 7: Skill Performance Checklist: Physical Assessment

Student _____ _____ Date_____

Time started _____Time ended _____Five-minute warning_____
*Critical Items must be performed correctly for successful completion

	Preparation:	**S**	**U**	**Comments**
*	1. Verify order.			
*	2. Gather supplies and equipment.			
*	3. Perform hand hygiene.			
*	4. Introduce self to patient.			
*	5. Identify patient with 2 patient identifiers.			
*	6. Explain procedure to patient.			
*	7. Provide privacy.			

		S	**U**	**Comments**
*	**1. Initial Assessment/ General Survey** Signs of distress; behavior; affect Look-check-connect - is everything attached, patent & working properly? State of health (nutrition/hygiene)			
*	**2. Student identifies and performs focused assessment, then completes shift assessment.**			
*	**3. Communication/Relationship to patient** Present professionally Body Mechanics ID-name, dob, allergies Appropriate explanation of actions Provide modesty/privacy Chief concern			
*	**4. Vital Signs** Blood pressure ___/___ Pulse____ Resp Rate____ O2 sat ____ Temp _____ Pain? ___ Location? ____ Frequency? ____ Descriptors? _____			
*	**5. HEENT-Neurological** Alert & oriented x 4 (person, place, time, situation) Verbalization clear & understandable All extremities equal strength- No parenthesis or numbness Hearing deficit/external ears Vision/PERRLA/eyes Nose/mouth			
*	**6. Integumentary** Skin warm, dry, intact, skin color within patient's norm; turgor Surgical site and/or dressing Lesions, rashes, redness, breakdown IV site: Asymptomatic(redness, warmth, edema)			
*	**7. Cardiovascular** Apical rate & describe rhythm			

	Mucosa membranes-color, moisture Auscultate 4 cardiac sites & identify S1/S2 No peripheral edema No calf tenderness No JVD Capillary refill < 3 seconds/ nailbeds Peripheral pulses (Radial x 2; Pedal x 2)			
*	**8. Respiratory** Inspect thorax- rhythm, symmetrical expansion Accessory muscle use Auscultate & describe breath sounds x 5 lobes (anterior & posterior) Cough-productive or non-productive			
*	**9. Gastrointestinal** Abdominal shape/contour N/V/diarrhea Auscultate bowel sounds x 4 quads & describe (hyper, normo, hypo) If eating: tolerates diet No pain with palpation Bruits/ pulsations Continent of stool/last BM			
*	**10. Genitourinary** Able to empty bladder completely without pain Continent of urine/last void Assess urine color/odor Hematuria			
*	**11. Musculoskeletal** Absence of joint swelling and tenderness ROM Extremities are symmetrical & in alignment Ambulate with steady gait At Risk for Falls? Grip strength Level of needed assistance w/ ADLs			

	Upon completion of skill:	**S**	**U**	**Comments**
*	1. Leave patient in comfortable safe position, bed in lowest position, with call light within reach.			
*	2. Hand hygiene before leaving room.			
*	3. Document the procedure, including patient response.			

Date	**Faculty Signature**

Rev 8/15/2020

Grayson College
Associate Degree Nursing
RNSG 1119

Lab 8: Medication Administration: Part 1 (10/14 & 10/15/2020)

Objectives

1. Review the principles & steps in medication administration.
2. Demonstrate correct technique in non-parenteral medication administration.
3. Practice non-parenteral medication administration.
4. Demonstrate correct technique in recording non-parenteral medication administration.

Content	Learning Activities
Medication administration Procedure Non-parenteral meds Practice utilizing Nursing Drug Handbook Demonstrate: Patches/ointment Pop pills from board Pills into cup Pouring liquid Pill cutter/crusher Inhalers/spacers Discuss reputable websites for Rx look up: MEDLINE PLUS Mayo.org	**Preparation: Read & view PRIOR to lab!** **Read:** **Taylor, Lynn, & Bartlett:** p. 831-845 p. 857-880 through Skill 29-1 p. 573 Box 23-3 p. 873-879: Skill 29-1: Administering oral medications **Assignments in The Point:** Watch & Learn: Three Checks & Rights of Medication Administration Watch & Learn: Preparing Unit Dose Packaged Medications Watch & Learn: Administering Oral Medications Watch & Learn: Administering Eye Drops Watch & Learn: Administering Ear Drops **Hinkle & Cheever:** p. 1889, Chart 63-4

Students need to bring: Saunders Nursing Drug Handbook

Skills Competency Worksheet
Lab 6: Medication Administration Part 1

This competency skills worksheet is designed to prepare students for performing proper non-parenteral medication administration skills in the health care setting. All activities must be completed and receive signed verification by the evaluator: student or instructor.

Activity One: Verify Medication Administration Record to HCP orders.

Activity Two: Instructor demonstrates oral medication administration for Sally Gunter. Make sure you look up meds and do three checks.

Activity Three: Work in partners to practice medication administration. Each student will pretend to be Sally Gunter while his/her partner administers medications to him/her.

Activity Four: In partners, utilize pyxis to remove medications for Rhonda Williams and/or Anthony Johnson. Each student will perform 3 checks and administer at the bedside for designated patient, while other partner observes and evaluates you with non-parenteral medication skills performance check-off sheet.

Activity Five: Question of the Day

The client demonstrates facial grimacing when moving and just refused his PRN pain medication because it makes him "feel fuzzy." What is the appropriate nursing intervention?

a. Insist the client take the pain medication to get better.
b. Chart pain assessment score and client refusal of medication.
c. Discuss reasons for refusal and call HCP for new orders.
d. Disregard charting since the client did not take any medication.

Activity Six:

Each student will discuss with a partner and document how to instill the following:
Student will do the following on each of these instillations: Check MAR, prepare, hand hygiene, explain procedure, put on gloves

A. Eye drops:

B. Eye ointment:

C. Nasal drops:

D. Ear drops:

E. Vaginal medication instillations:

F. Rectal suppositories:

G. Metered dose or dry powder inhalers:

Medication Administration and Error Prevention Worksheets

Directions: Please complete worksheets prior to coming to lab. Circle T for True or F for False on each statement below.

1. In some facilities, medication orders can be written by Nurse Practitioners or Physician Assistants. T or F
2. PRN medication orders must include the reason for use of the drug. T or F
3. MAR stands for Medication Administration Report. T or F
4. If a patient has no armband but knows his name, you can go ahead and give medications. T or F
5. Medications are sometimes confused because the names or the packaging are very similar. T or F
6. If you have extra time, you can assist your colleagues by preparing the medications they will be giving. T or F
7. Critical thinking is an important aspect of preventing medication errors. T or F
8. Many common abbreviations are being eliminated from the approved list as it is too easy to confuse them with another abbreviation or misread them. T or F
9. STAT and ASAP both mean "immediately." T or F
10. Each hospital has standardized time guidelines for medication ordered as "daily" or a specific number of doses per day. T or F
11. QID (four times a day) and "every 6 hours" mean the same thing. T or F
12. If a medication is held, the time it should have been given must be written on the MAR and circled. T or F

13. If reasons for holding a medication are delineated in the order, you do not need to chart them. T or F

14. NPO refers to food, not to oral medications. T or F

15. A patient with an NG tube to low suction can still take oral medications. T or F

16. The nurse needs to look up any drug with which she is unfamiliar prior to administration. T or F

17. Pain levels must be charted with each dose of analgesic. T or F

Answer the following questions:

1. What methods can be used to verify patient identity?
2. What are the various sources a nurse can use to verify dosages and drug compatibilities?
3. Why does interrupting the nurse when preparing medications make it more likely that errors will occur?

Mr. Fredericks, 68, is recovering from a recent surgical procedure. When the nurse goes in to give Mr. Fredericks his morning medications, he looks at them carefully and tells her that he only gets three medications, not four. The nurse brings the MAR and shows him that all four medications are listed. The medication in question was added last evening. Mr. Fredericks names the three medications he takes, pointing each of them out, and insists that he does not get the fourth medication.

What is the appropriate action for the nurse to take?

a. Explain to Mr. Fredericks that this is a new order from his HCP and encourage him to take the medication.

b. Hold the medication until the order can be verified as correct.

c. Hold the medication and note that Mr. Fredericks refused it.

d. Call the family and see if they can get Mr. Fredericks to cooperate.

M.A.R. VERIFIED
BY: _____

Medication Administration Record
Grayson College Hospital
6101 Grayson Dr. Denison, TX

Name: **Sally Gunter** **(for demonstration)**
Allergies: **PCN**
Diagnosis:
Physician: **Dr. Doolittle**
Comments:

Room:
PCU:
Admit Date: **10/14/2020**
Sex: F Age:
DOB: **5-8-41**

Visit ID
MR ID: **0013579**
Hgt. 66”
Wgt. 224 lbs
CrCl:

Administration Period			Shift 1	Shift 2
Medication	Start	Stop	07:01 – 1900	1901 – 07:00
potassium chloride oral liquid 40 meq PO three times a day	**10/14**	**10/24**	**0900** **1300** **1700**	
cephalexin 250 mg PO every 6 hours	**10/14**	**10/24**	**1200** **1800**	**2400** **0600**
amlodipine 5 mg PO twice a day	**10/14**	**10/24**	**0900**	**2100**
omeprazole 20 mg PO daily	**10/14**	**10/24**	**0900**	

Key to Unadministered Doses	Site Codes			Initials	Print Name
C – Condition of Patient H – Admin at Home N – Not on Unit R - Refused DO – Doctor’s Orders ER – Admin in ER	R - Right	L – Left	G - Gluteal		
	T – Thigh	AB – Abdomen	M- Mid		
	H – Love Handles	V – Ventral	D- Dorsal		
	LW – Lower	UP – Upper			

M.A.R. VERIFIED
BY: _____

Medication Administration Record
Grayson College Hospital
6101 Grayson Dr. Denison, TX

PRN

Name: **Sally Gunter** **(for demonstration)**
Allergies: **PCN**
Diagnosis:
Physician: **Dr. Doolittle**
Comments:

Room:
PCU:
Admit Date: **10/14/2020**
Sex: F Age:
DOB: **5-8-41**

Visit ID
MR ID: **0013579**
Hgt. 66”
Wgt. 224lbs
CrCl:

Administration Period			Shift 1	Shift 2
Medication	Start	Stop	07:01 – 19:00	19:01 – 07:00
clonidine Hcl 0.1 mg tablet PO every 6 hours PRN diastolic > 90	**10/14**	**10/24**		

Key to Unadministered Doses	Site Codes			Initials	Print Name
C – Condition of Patient H – Admin at Home N – Not on Unit R - Refused DO – Doctor’s Orders ER – Admin in ER	R - Right	L – Left	G - Gluteal		
	T – Thigh	AB – Abdomen	M- Mid		
	H – Love Handles	V – Ventral	D- Dorsal		
	LW – Lower	UP – Upper			

Grayson College Hospital **HCP Prescription Sheet**

DOB 5-8-41 Patient Sticker **Sally Gunter** **0013579**	**Date and Time: 10/14/2020 0552**
	Admit to private room
	Allergy: PCN
Unit Clerk Signature For demonstration	1) potassium chloride liquid 40meq PO three times a day
	2) cephalexin 250 mg PO every 6 hours
Date / Time **10/14/2020** 0612	3) amlodipine 5 mg PO twice a day
	4) omeprazole 20mg PO daily
Nurse Signature *S. NurseRN* Verbal Telephone Order Read Back	*Dr. Doolittle*

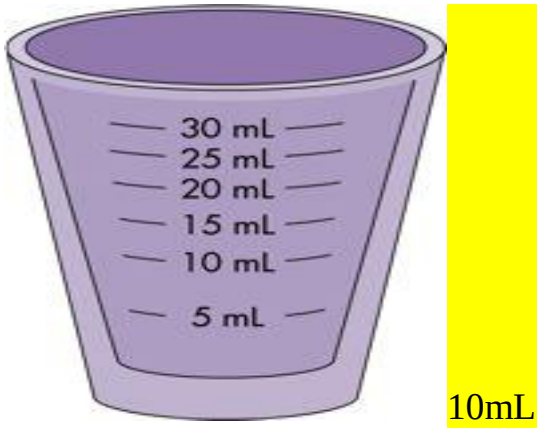
DOB 5-8-41 Patient Sticker **Sally Gunter** **0013579**	**Date and Time: 10/14/2020 0600**
	1) CMP QAM.
	2) clonidine Hcl 0.1mg tablet PO every 6 hours PRN diastolic bp > 90
Unit Clerk Signature	3) CBC QAM.
Date / Time **10/14/2020** 0615	
Nurse Signature *S. NurseRN* Verbal Telephone Order Read Back	*Dr. Doolittle*

DOB 5-8-41 Patient Sticker **Sally Gunter** **0013579**	**Date and Time**
Unit Clerk Signature	
Date / Time	
Nurse Signature	

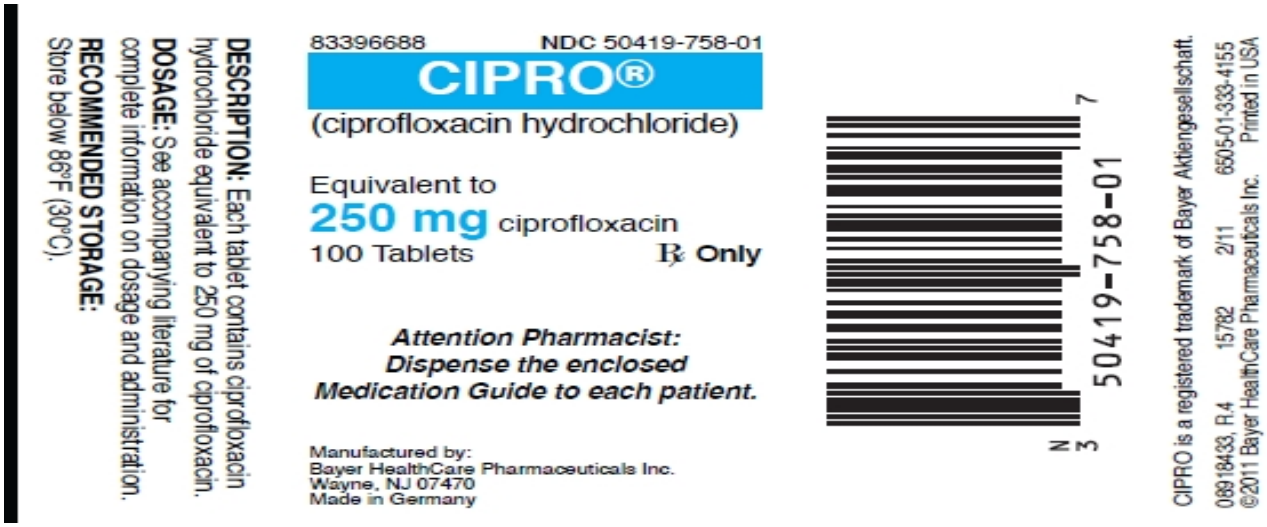
Date	Time	Nurses Notes
		For demonstration.

ID# 0013579
DOB 5-8-41
Gunter, Sally

Math Problems
Lab 8



HCP Order: Amoxil 250mg.
Supply: Amoxil 125mg/5mL oral suspension
Indicate on the medicine cup how much medication will be administered.



Answer the following questions using the above label and your Saunders Drug Handbook.

What is the generic name of this medication?_____

What is the brand name of this medication?_____

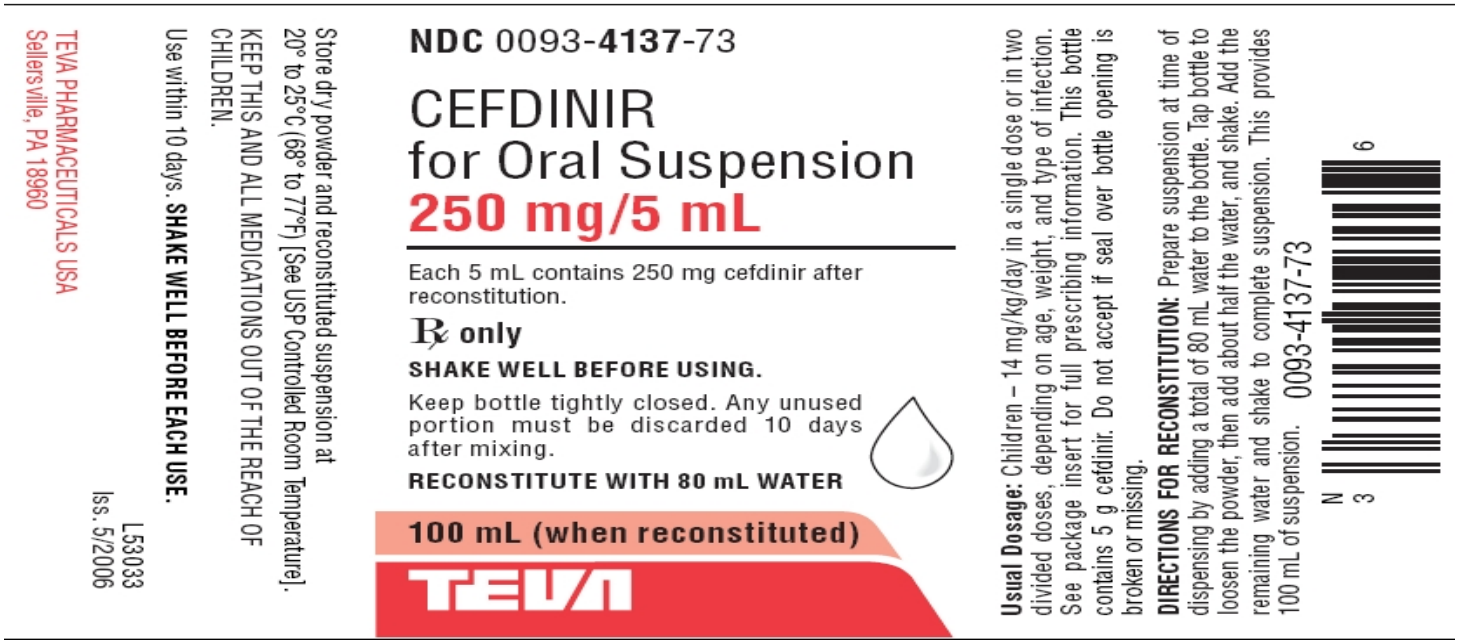
Who is the manufacturer?_____

What is the drug used for?_____

What is the usual adult dosage regimen?____

Math Problems

Lab 8



Reconstitute with _____mL of sterile water. Once reconstituted, the dosage will be ___mg per 1 mL or every 5mL will contain _____mg of Cefdinir.

HCP Order: Lisinopril 5 mg po daily
Supply: See Label
What is the daily dosage?_____mg
How many tablets are needed for a single dose? _____tablets

Grayson College
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RNSG 1119
Lab 9: Skill Performance Checklist: PO Medication Administration

Student _____ _____ Date_____
Time started _____Time ended _____Five-minute warning_____
*Critical Items must be performed correctly for successful completion

		S	U	Comments
*	1. Compare HCP order sheet with MAR. Verbalize the six rights. Know start/stop dates. Check for allergies.			
*	2. Perform hand hygiene and gather equipment.			
*	3. Remove medications from drawer/medication dispenser. One at a time: Read name of medication from MAR. Check label FIRST time when taking medication from drawer/med dispenser. Calculate dose if necessary.			
*	4. Prepare medication for transport to patient's room. a. Check label a SECOND time as the medication is being prepared. b. Unit dose meds: LEAVE in individual container. c. Bottled tablets or capsules: pour into bottle cap and transfer to cup. d. Liquids: place cap upside down on counter and pour medication at eye level.			
*	5. Check label of medication a THIRD time. a. Unit dose labels: as medication is being opened at the bedside. b. Non-unit dose labels: as medication container is returned to drawer.			
*	6. Take medication AND MAR to bedside.			
*	7. Introduce self to patient and provide privacy.			
*	8. Identify patient: a. Compare armband with MAR (a DIRECT COMPARISON). b. Use a 2nd form of ID – birth date or hospital number. c. Check patient allergies.			
*	9. Explain medications and procedure as necessary.			
*	10. Give Medication with liquid as needed.			
*	11. Stay with client until assured that medication has been swallowed.			
*	12. Chart procedure on appropriate documentation form.			

	Upon completion of skill:	**S**	**U**	**Comments**
*	1. Leave patient in comfortable safe position, bed in lowest position, with call light within reach.			
*	2. Hand hygiene before leaving room.			
*	3. Document the procedure, including patient response.			

Date	**Faculty Signature**

Revised 8/15/2020

Grayson College
Associate Degree Nursing
RNSG 1119

Lab 10: Medication Administration Part 2: Parenteral Injections (10/28 & 10/29/2020)

Objectives

1. Review principles in administration parenteral injections.
2. Identify landmarks for subcutaneous, intramuscular & intradermal injection sites.
3. Demonstrate the correct technique in administering a subcutaneous, intradermal & intramuscular injections.

Content	Learning Activities
Parenteral medication administration Principles Techniques Landmarks Administration Intradermal, subcutaneous, IM, Z-track Withdrawal from vial and ampule Mixing medications	**Preparation: Read & view PRIOR to lab!** **Read:** **Taylor, Lynn, & Bartlett:** p. 837-856, 880-900 **Assignments in The Point:** Concepts in Action: Intramuscular injection Practice & Learn: Administering a Subcutaneous Injection Watch & Learn: Administering a Subcutaneous Injection Watch & Learn: Administering an Intramuscular injection

Parenteral Injections Table (fill in prior to coming to lab)

	Intradermal Injection	Subcutaneous Injection	Intramuscular Injection
Tissue depth **ADULT** **PEDIATRIC**			
Common medications **ADULTS** **PEDIATRIC**			
Site locations **ADULT** **PEDIATRIC**			
Volume of medication **ADULT** **PEDIATRIC**			
Syringe size **ADULT** **PEDIATRIC**			
Needle size **ADULT** **PEDIATRIC**			
Angle of insertion **ADULT** **PEDIATRIC**			

Skills Competency Worksheet
Lab 10: Parenteral Injections

This competency skills worksheet is designed to prepare students for performing proper parenteral medication administration skills in the health care setting. All activities must be completed and receive signed verification by the evaluator: student or instructor.

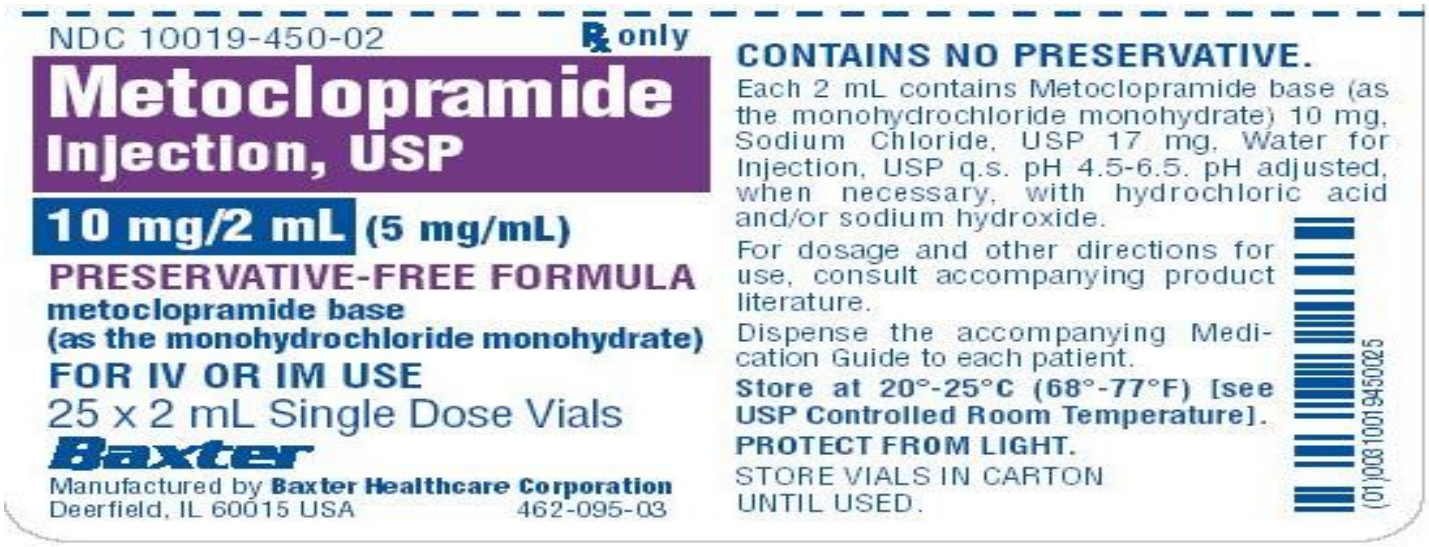
Initial the following skills after practicing with your supplies.

- Review principles for intradermal, subcutaneous, and intramuscular injections. (Use clinical injection handout) _____
- Review needle size, volume and angle _____
- Proper handling of equipment _____
- Drawing med from ampule _____
- Drawing med from vial _____
- Practice injecting with demo dose:

  ID _____ Subcutaneous _____ IM _____
- Review and practice landmarks on mannequins/partner _____
- Review mixing insulins:

	Gauge	Length	Angle	Site
1. 6 month old 1 mL IM injection				
2. 25 year old 0.5 mL IM injection				
3. 80 year old 0.5 mL subQ injection				
4. Heparin subQ injection				
5. 54 year old 3 mL IM injection				
6. TB testing				

Math Problems
Lab 10


NDC 10019-450-02 ℞ only

Metoclopramide Injection, USP

10 mg/2 mL (5 mg/mL)

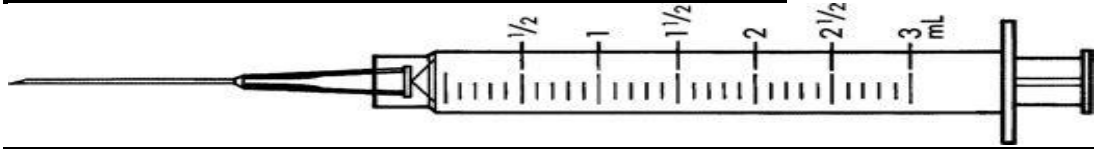
PRESERVATIVE-FREE FORMULA
metoclopramide base
(as the monohydrochloride monohydrate)
FOR IV OR IM USE
25 x 2 mL Single Dose Vials

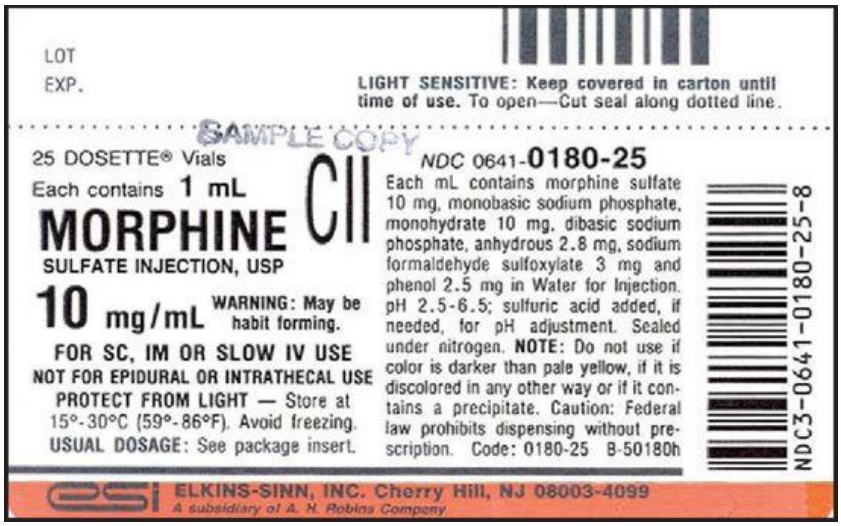
Baxter
Manufactured by **Baxter Healthcare Corporation**
Deerfield, IL 60015 USA 462-095-03

CONTAINS NO PRESERVATIVE.
Each 2 mL contains Metoclopramide base (as the monohydrochloride monohydrate) 10 mg, Sodium Chloride, USP 17 mg, Water for Injection, USP q.s. pH 4.5-6.5. pH adjusted, when necessary, with hydrochloric acid and/or sodium hydroxide.
For dosage and other directions for use, consult accompanying product literature.
Dispense the accompanying Medication Guide to each patient.
Store at 20°-25°C (68°-77°F) [see USP Controlled Room Temperature].
PROTECT FROM LIGHT.
STORE VIALS IN CARTON UNTIL USED.

(01)00301001945002 5

HCP Orders: Metoclopramide 15mg IM q12 hrs
How many milliliters per dose will be administered?
Indicate the correct amount of medication on the syringe.




LOT
EXP.

LIGHT SENSITIVE: Keep covered in carton until time of use. To open—Cut seal along dotted line.

SAMPLE COPY

25 DOSETTE® Vials
Each contains **1 mL**

MORPHINE CII
SULFATE INJECTION, USP

10 mg/mL WARNING: May be habit forming.

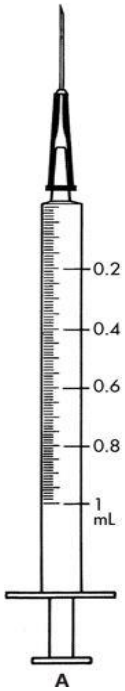
FOR SC, IM OR SLOW IV USE
NOT FOR EPIDURAL OR INTRATHECAL USE
PROTECT FROM LIGHT — Store at 15°-30°C (59°-86°F). Avoid freezing.
USUAL DOSAGE: See package insert.

NDC 0641-**0180-25**

Each mL contains morphine sulfate 10 mg, monobasic sodium phosphate, monohydrate 10 mg, dibasic sodium phosphate, anhydrous 2.8 mg, sodium formaldehyde sulfoxylate 3 mg and phenol 2.5 mg in Water for Injection. pH 2.5-6.5; sulfuric acid added, if needed, for pH adjustment. Sealed under nitrogen. **NOTE:** Do not use if color is darker than pale yellow, if it is discolored in any other way or if it contains a precipitate. Caution: Federal law prohibits dispensing without prescription. Code: 0180-25 B-50180h

NDC3-0641-0180-25-8

ESI ELKINS-SINN, INC. Cherry Hill, NJ 08003-4099
A subsidiary of A. H. Robins Company



A

HCP Orders: Morphine sulfate 8 mg IM stat.
How many milliliters will be administered?
(Round to the nearest tenth)
Indicate the correct amount of medication on the syringe.

Math Problems
Lab 10


NDC 0641-0928-25

Promethazine HCl Injection, USP

25 mg/mL ℞ only

FOR DEEP INTRAMUSCULAR OR INTRAVENOUS USE

25 x 1 mL Vials

Baxter

Manufactured by
Baxter Healthcare Corporation
Deerfield, IL 60015 USA

462-229-01

Each mL contains promethazine hydrochloride 25 mg, edetate disodium 0.1 mg, calcium chloride 0.04 mg, sodium metabisulfite 0.25 mg and phenol 5 mg in Water for Injection. pH 4.0-5.5; buffered with acetic acid-sodium acetate.

Usual Dosage: See package insert.

PROTECT FROM LIGHT: Keep covered in carton until time of use.

Store at 20°-25°C (68°-77°F) [see USP Controlled Room Temperature].

(01)00306410928256

HCP Order: Promethazine 12.5 mg IM q 12 hrs prn for nausea

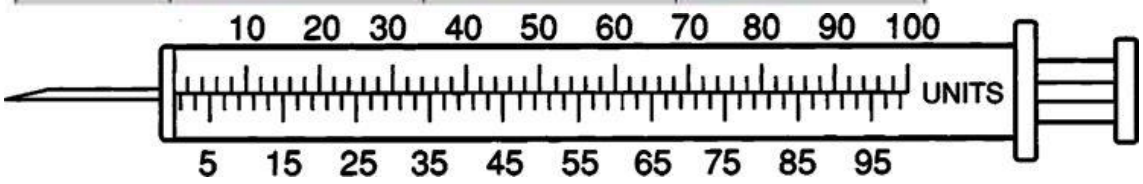
How many mL will you give per dose?_____
Where will you administer the injection? _____

Insulin Sliding Scale

Blood Sugar (mg/dl)	Low Dose Scale	Moderate Dose Scale	High Dose Scale
<70	Initiate Hypoglycemia Protocol	Initiate Hypoglycemia Protocol	Initiate Hypoglycemia Protocol
70-130	0 units	0 units	0 units
131-180	2 units	4 units	8 units
181-240	4 units	8 units	12 units
241-300	6 units	10 units	16 units
301-350	8 units	12 units	20 units
351-400	10 units	16 units	24 units
>400	12 units and call MD	20 units and call MD	28 units and call MD

A client has orders for the moderate dose sliding scale of insulin. Client has a blood glucose level of 354. How many units of insulin will you give?_____

Indicate the correct amount of insulin on the syringe.



Intake & Output
Lab 10

Full Liquid Diet

<table>
<tr><td colspan="2">A post-op patient has progressed to a full liquid diet after tolerating clear liquids yesterday. Her IV has been decreased to ½ NS @ 80mL/hr and her foley catheter will be removed today during the day shift.

As a nurse assuming this patient's care, please calculate the fluid balance from 0700-1500.</td></tr>
<tr><td><u>Breakfast</u>
¼ cup of orange juice
½ cup of jello
½ cup of oatmeal
¾ cup of decaffeinated coffee</td><td><u>Lunch</u>
¾ cup of tomato soup
4 oz of tea
3 tsp of chocolate pudding</td></tr>
<tr><td colspan="2">Took 0900 & 1300 meds with 45 mL of water each time.</td></tr>
<tr><td colspan="2">Urinary catheter bag was emptied and removed @ 1130 with 1020mL of clear, yellow urine. Patient voided 335mL in a nun's hat @1410.
Patient had 1 small bowel movement @ 1245</td></tr>
<tr><td>Intake</td><td>Output</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">Fluid Balance=</td></tr>
</table>

Grayson College
Associate Degree Nursing
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Lab 11: Skill Performance Checklist: Parenteral Injections

Student _____ Date_____

Time started _____ Time ended _____ Five-minute warning_____
*Critical Items must be performed correctly for successful completion

This is a correct technique demonstration. Please refer to Skill Performance Checklist: Medication Administration while giving injections in the clinical setting.

	Landmarks	**S**	**U**	**Comments**
*	1. Name the six rights.			
*	2. Assess for allergies.			
*	3. Identify the landmarks for the following: a. ID b. SQ c. IM			

	Drawing Up Medications	**S**	**U**	**Comments**
	1. Determine whether the size of the muscle is appropriate for the volume of medication.			
	2. Organize the equipment needed for prescribed injections.			
	3. Perform hand hygiene.			
*	4. Correctly prepare the prescribed IM injection from the vial.			
*	5. Correctly prepare the prescribed ID injection from the vial.			
*	6. Correctly prepare the prescribed SQ injection from the vial.			

	Intramuscular, Subcutaneous, and Intradermal Injections	**S**	**U**	**Comments**
	1. Apply gloves.			
	2. Clean the **IM** site with an antiseptic swab. Use a circular motion starting at the center and moving outward about 2 inches.			
	3. Discard the swab and allow the skin to dry prior to the injection.			
*	4. Prepare the IM injection syringe by removing the needle cover and discard without contaminating the needle.			
*	5. Inject medication at a rate of 10 sec/mL.			
*	6. Remove the needle after 10 seconds and activate the needle safety device or discard uncapped needle.			
	7. Apply gentle pressure with gauze. Place a band-aid before leaving room, if site is bleeding.			
	8. Clean the **ID** site with an antiseptic swab. Use a circular motion starting at the center and moving outward about 2 inches.			
	9. Discard the swab and allow the skin to dry prior to the injection.			
*	10. Prepare the ID injection syringe by removing the needle cover and discard without contaminating the needle.			
*	11. Pull the skin taut and inject the needle at a 5-15 degree angle.			
*	12. Inject the medication slowly, producing a small wheal/bleb.			

*	13. Remove needle quickly and activate the needle safety device or discard uncapped needle.			
	14. Place gauze or band-aid before leaving room, if site is bleeding.			
	15. Clean the **SQ** site with an antiseptic swab. Use a circular motion starting at the center and moving outward about 2 inches.			
	16. Discard the swab and allow the skin to dry prior to the injection.			
*	17. Prepare the SQ injection syringe by removing the needle cover and discard without contaminating the needle.			
*	18. Pinch/Spread the skin (approp. per site) and inject the needle at a 45 deg or 90 deg angle (approp. per site).			
*	19. Inject medication at a rate of 10 sec/mL.			
*	20. Remove needle after 5 seconds and activate the needle safety device or discard uncapped needle.			
	21. Apply gentle pressure with gauze. Place a band-aid if site is bleeding.			
	22. Remove gloves.			

	Upon completion of skill:	**S**	**U**	**Comments**
*	1.Leave patient in comfortable safe position, bed in lowest position, with call light within reach.			
*	2.Hand hygiene before leaving room.			
*	3.Document the procedure, including patient response.			

Date	**Faculty Signature**

Revised 8/15/2020

Grayson College
Associate Degree Nursing
RNSG 1119

Lab 12: Practice Medication Scenarios, Sensory Alterations, Safety

Objectives

1. Participate in patient scenario to recognize common safety hazards.
2. Actively participates in role playing and simulation scenarios.
3. Discuss common sensory changes that normally occur with aging.
4. Participate in activity utilizing different barriers to sensory function
5. Contributes to the debriefing process using a positive approach.
6. Actively participates in reflective games that reviews nursing 1 content.

Content	Learning Activities
Medication Scenarios Safety Activity Sensory Activity	

Students need to bring: Saunders Nursing Drug Handbook, stethoscope

Skills Competency Worksheet
Lab 12: Practice Medication Scenarios

This skills competency worksheet is designed to assist students in practicing medication administration skills, performing clinical decision making in simulation scenarios, identifying safety concerns, and understanding sensory changes that occur with aging adults. All activities must be completed and receive signed verification by the evaluator: student or instructor.

Activity One: Medication Administration Scenarios

Med Admin Scenario- Case 1: Andrew Knight

What actions will the nurse implement?

_____
_____
_____
_____
_____
_____
_____
_____

Med Admin Scenario- Case 2: Elizabeth Garcia-Riley

What actions will the nurse implement?

_____
_____
_____
_____
_____
_____
_____
_____

Med Admin Scenario- Case 3: Susan Chan

What actions will the nurse implement?

Med Admin Scenario- Case 4: Julie Bells

What actions will the nurse implement?

Med Admin Scenario- Case 5: Isaiah Morris

What actions will the nurse implement?

Med Admin Scenario- Case 6: Benny Long

What actions will the nurse implement?

_____
_____
_____
_____
_____
_____
_____
_____

Activity Two: Patient Safety Scenario:

A school-age male was admitted to the hospital for nausea and vomiting yesterday. He is feeling much better at this time after receiving IV fluids and anti-emetics for his nausea. He can get up to ambulate with minimal assistance, but due to his dehydration status he is at risk for falls. His urinary catheter had small amounts of concentrated urine in it yesterday, but the amount is slowly increasing and the urine is becoming clear yellow. This patient's room is filled with "little errors" that can affect patient safety. Please assess these errors and write them below.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____

13) _____

14) _____

15) _____

16) _____

17) _____

18) _____

Activity Three: Aging Activity: Sensory Deprivation in Older Client

Each of you will "experience" the aging process. Put an elbow brace on one arm and the knee brace on the opposing leg. Put eyeglasses on and ear plugs in both ears to demonstrate decreased visual acuity and hearing. Don gloves to simulate a decreased sense of touch. Add a tablespoon of birdseed to your shoes. After becoming "elderly" do the following activities.

Read from newspaper
Take medications out of container
Put on sock
Thread a needle
Button a shirt
Count out 27 cents and 44 cents
Feed another student (apple sauce)

Write a brief description of how it feels to be "elderly." Documents thoughts and emotions in space provided below.

_____

_____

_____

_____

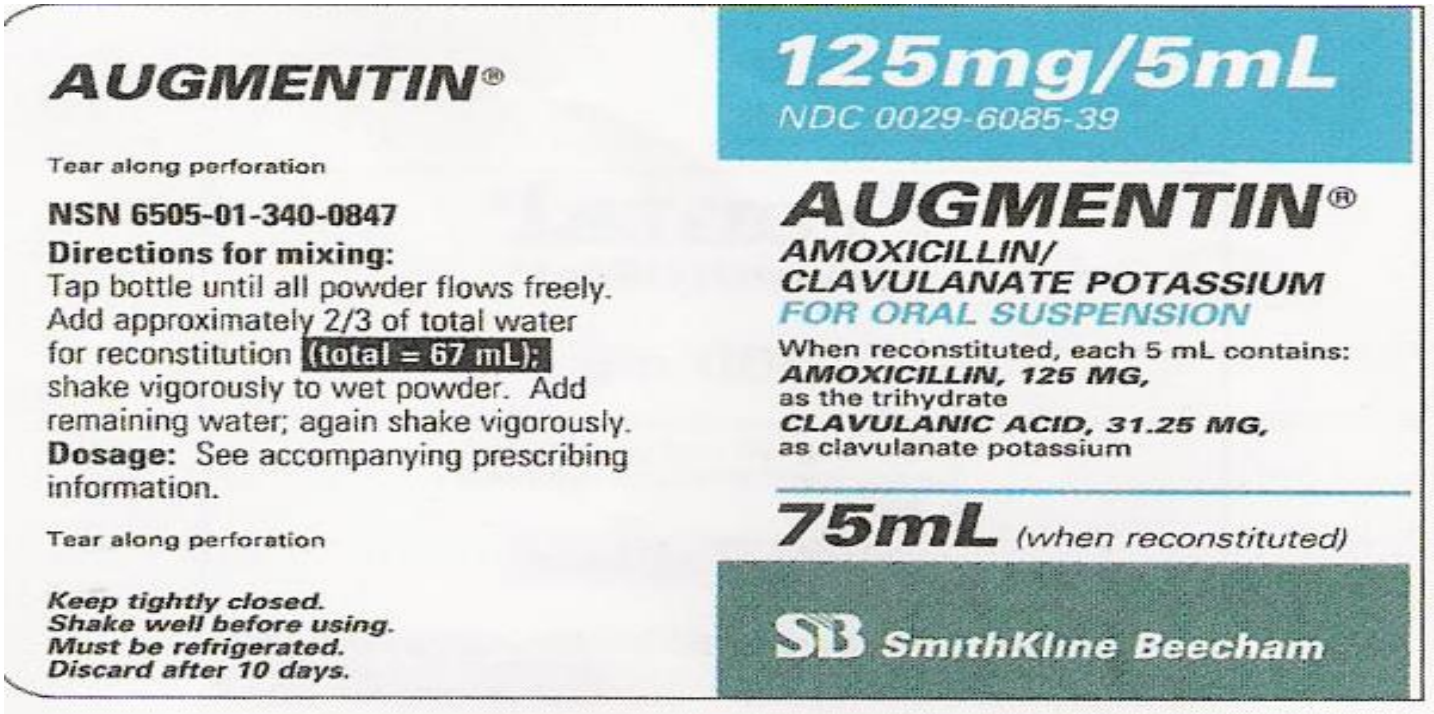
_____

_____

_____

_____

Math Problem
Lab 12



HCP Order: amoxicillin clavulanate/potassium 40 mg/kg daily into two divided doses
Supply: See label

The client weighs 77 lbs.
How many mg will you give per dose? Round to the nearest whole number._____

How many mg will you give daily?___

How many mL will you give per dose? Round to the nearest whole number._____

How many mL will you give daily?___

Intake & Output
Lab 12

Clear Liquid Diet

A post-op patient is on a clear liquid diet. The IV of NS is running at 100mL/hr. A urinary catheter draining amber, colored urine is present, as well as a JP drain from the abdominal incision. **Please calculate the fluid balance for this patient 1500-2300.**	
Dinner ½ cup of water 3 oz of cranberry juice 8 oz of chicken broth ¾ cup of gelatin	
Took 1900 meds with 1 oz of water	
Patient got nauseated after dinner. Her emesis basin had 130 mL of greenish-brown liquid in it. Urinary catheter bag was emptied at 1815 with 720mL in bag and at 2210 with 625 mL in bag. JP bulb was emptied at 1645 with 75 mL of sanguineous drainage and later at 2215 with 65 mL of drainage. Patient had 1 small bowel movement @ 1245.	
Intake	**Output**
Fluid Balance=	

NPO Diet

A patient with a small bowel obstruction is NPO. The IV of NS is running at 125 mL/hr. A urinary catheter draining amber, colored urine is present, as well as an NG tube draining brownish, green contents. **Please calculate the fluid balance from 1500-2300.**	
1700 meds were administered via NG tube with 1 ½ oz of water to flush.	
Suction canister on the wall contains 320 mL of contents at 1500 and 940mL at end of shift. Foley catheter bag was emptied at 1815 with 260 mL in bag and at 2210 with 175 mL in bag.	
Intake	**Output**
Fluid Balance=	

Lab 11:

Activity 2: Patient Safety

Scenario:

A school-age male was admitted to the hospital for nausea and vomiting yesterday. He is feeling much better at this time after receiving IV fluids and anti-emetics for his nausea. He can get up to ambulate with minimal assistance, but due to his dehydration status he is at risk for falls. His foley had small amounts of concentrated urine in it yesterday, but the amount is slowly increasing and the urine is becoming clear yellow.

This patient's room is filled with "little errors" that can affect patient safety. Please assess these errors and write them below.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____
13) _____
14) _____
15) _____ _____
16) _____
17) _____
18) _____
19) _____
20) _____

Activity 3: Sensory Alteration

Rules of Engagement for Sensory Deprivation Lab

1. Have students feed each other several spoonfuls of apple sauce. Student feeding and student receiving should be seated (more like it will be in an actual situation). (Or, the student being fed could be lying down) Spoons, even used for just getting applesauce out of container, should be discarded immediately after use.
2. Have student assist the “aging client” to the bathroom. (No need to go beyond assisting to the door).
3. Have student read newspaper and answer questions about the article.
4. Please be sure students put birdseed in shoes over a trash can. Students should take birdseed out of shoes over a trash can as well.
5. Change will be in a small coin purse. Students may not pour out change on over bed table and count it out.
6. Pills will be in a small pill bottle.
7. Each student should have some sort of immobilizer over a joint.
8. Ear plugs to be discarded in trash can before leaving lab.

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Lab 13: Interactive games

Objectives

1. Actively participate in games that review Nursing 1 content.
2. Clinical judgement activities.

Content	Learning Activities
Interactive Nursing 1 activities	Per N1 instructor.

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Lab 10: Simulation- Standardized Pediatric Assessments

Objectives

1. Demonstrate understanding of pediatric assessment and how it varies from assessment of an adult patient.
2. Demonstrate performance of a thorough pediatric assessment based on patient's age of development.
3. Contributes to the debriefing process using a positive approach to evaluate performance and areas that need improvement.

Content	**Learning Activities**
Pediatric Assessment	Review: Powerpoint with Pediatric Lifespan Considerations

Students need to bring:

Watch with second hand
BP cuff
Stethoscope
Pen light
Pencil/paper
Clipboard
WEAR SCRUBS and name tag

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Standardized Pediatric Patient Assessments

Student Name _____

Age 3-5 years

Patient's age _____ Erickson's Developmental Stage _____

Ht: _____inches Wt: _____kg

Heartrate: _____bpm ☐ Regular ☐ Irregular

Respirations: _____breaths/minute

Lungs: _____

Bowel sounds: _____

Comments: _____
_____
_____
_____
_____

Student Nurse Signature:_____

Age 6-12 years

Patient's age _____ Erickson's Developmental Stage:_____

Current Medications:

_____
_____
_____
_____
_____

Past Medical History:

_____
_____
_____

Ht: _____inches Wt: _____kg

Heartrate: _____bpm ☐ Regular ☐ Irregular

Respirations: _____breaths/minute

Temp: _____ * Celsius ☐ Temporal ☐ Oral ☐ Tympanic ☐ Axillary

LOC: ☐ Alert ☐ Oriented x _____ ☐ Other:_____

Lungs: _____

Bowel sounds: _____

Radial Pulses:

R____ L_____

Pedal Pulses:

R_____ L_____

Pain

Comments: _____
_____
_____
_____
_____

Student Nurse Signature:_____

SHIFT ASSESSMENT

Ages 13-15 years or 15-17 years

Student Name: _____ **Date:** _____

DOB: _____ Sex: ☐ Male ☐ Female Erickson's Developmental Stage:_____

Wt: _____ **Ht:** _____

_____

Informant: ☐ Patient ☐ Other _____

Allergies and Reactions: _____

Temp: _____degree C* _____degree F* ☐ Temporal ☐ Oral ☐ Axillary ☐ Rectal ☐ Tympanic	**Pulse:** _____ bpm ☐ Reg ☐ Irreg	**SpO_2** _____% ☐ RA ☐ O_2 at __ l/min ☐ NC ☐ Mask	**Respiration:** _____breaths/min	**BP:** _____ ☐ Lying ☐ Sitting ☐ Standing	**Pain** _____/10 Location: _____ Descriptors: _____ _____

Current Medications:

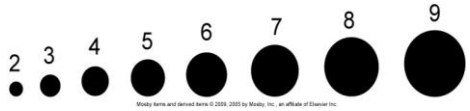
_____

_____

Past Medical History:_____

_____

_____

Safety	Fall Risk	☐ Low ☐ High ☐ Bed alarm in use Comments_____
	Safety Needs	☐ Call light in reach/ pt able to use ☐ Bed low/brake on # of siderails up: ____ ☐ Seizure precautions ☐ Allergy band on ☐ ID band on ☐ Safety check complete
Activity	Activity	☐ Bedrest ☐ HOB @ ____ degrees ☐ BRP ☐ Self ☐ Assist ☐ Total
	Hygiene	☐ Bath: ☐ Complete ☐ Partial ☐ Shower ☐ Oral Care ☐ Pericare ☐ Hair care ☐ Backrub ☐ Other : ____
	Drains	☐ None ☐ Other ____ ☐ Drainage: Amt-_____ Color-_____
Integumentary	Skin Integrity	☐ Intact ☐ Turgor ☐ Ulcer ☐ Skin tear Location: _____ Description: _____
	Open wound/ Surgical Incision	☐ None Location: _____ Size: _____ Description: _____ ☐ Drainage Color: _____ Amount: ____ ☐ Drsg- CDI ☐ Drsg changed Other: _____
	Other	☐ Air Mattress ☐ Specialty bed ☐ Other: _____
Neurological	Mentation LOC	Oriented: ☐ Person ☐ Place ☐ Time ☐ Situation/Event ☐ Disoriented LOC: ☐ Alert ☐ Sedated ☐ Restless ☐ Confused ☐ Sleepy/arousable ☐ Lethargic ☐ Unresponsive ☐ Responds only to pain ☐ Agitated ☐ Hallucinations Speech: ☐ Clear ☐ Slurred ☐ Aphasic ☐ Dysphasia ☐ Non-verbal
	Pupils	Pupils: Right: Size: ____ ☐ PERRLA Left: Size: ____ ☐ PERRLA 
	Grips	Right: ☐ Strong ☐ Weak ☐ Flaccid Left: ☐ Strong ☐ Weak ☐ Flaccid

Respiratory	Respirations	☐ No distress ☐ Dyspnea ☐ Shallow ☐ Labored ☐ Orthopnea ☐ Nasal Flaring
	Breath Sounds	☐ Clear _____ ☐ Wheezes ☐ Crackles ☐ Rhonchi ☐ Diminished Other: _____
	Thorax	☐ Symmetrical expansion ☐ Retractions
	Cough/ Sputum	☐ Absent ☐ Non-productive ☐ Productive Color: _____ Consistency: ☐ Thick ☐ Thin
	Respiratory Rx	☐ None ☐ IS ☐ TCDB ____ ☐ Neb/MDI ☐ Chest tube ☐ Drainage _____ ☐ Oxygen therapy @ ____lpm per ☐ NC ☐ Mask ☐ BiPap/CPAP Oximetry: ☐ None ☐ intermittent ☐ continuous
Cardiovascular	Edema	☐ None ☐ Non-pitting ☐ Pitting ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ Location: _____
	Heart Sounds	☐ Regular ☐ Irregular ☐ S1 ☐ S2 ☐ Telemetry
	Capillary Refill	UEs x 2: ☐ Brisk, < 3 sec ☐ Sluggish, >3 sec | LEs x 2: ☐ Brisk, < 3 sec ☐ Sluggish, >3 sec
	Periph Pulses	UEs x 2: ☐ Present ☐ Equal Strength: _____ | LEs x 2: ☐ Present ☐ Equal Strength: _____
	Skin Temp	☐ Warm ☐ Cool ☐ Dry ☐ Clammy ☐ Moist ☐ Diaphoretic
	Skin Color	☐ Pink/Natural ☐ Flushed ☐ Pale ☐ Jaundiced ☐ Mottled ☐ Cyanotic
Gastrointestinal	Diet	☐ NPO ☐ Reg ☐ CL ☐ ADA ☐ Cardiac ☐ Other _____ ☐ Swallowing Precautions
	Appetite	☐ Good ☐ Fair ☐ Poor ☐ Nausea ☐ Emesis Amt: _____ Color: _____
	Abdomen	☐ Soft ☐ Firm ☐ Hard ☐ Distended ☐ Guarded ☐ Girth _____
	Bowel Sounds	☐ Present ☐ Hyperactive ☐ Hypoactive ☐ Absent ☐ Flatus ☐ Other _____
	Stool	☐ Incontinent ☐ Formed ☐ Soft ☐ Liquid ☐ Constipation ☐ Other _____ LBM ____
GU	Urine	☐ Continent ☐ Incontinent Color: _____ Characteristics: _____ ☐ Dysuria ☐ Nocturia
	Discharge	☐ Foley cath ☐ Straight cath: ____ ☐ None ☐ Menses: ____
Musculoskeletal	Muscle Strength	

R. Upper Extremity	L. Upper Extremity	R. Lower Extremity	L. Lower Extremity
Strong ☐	Strong ☐	Strong ☐	Strong ☐
Moderate ☐	Moderate ☐	Moderate ☐	Moderate ☐
Weak ☐	Weak ☐	Weak ☐	Weak ☐
Paralysis ☐	Paralysis ☐	Paralysis ☐	Paralysis ☐

Current Mobility: ☐ amb unassisted ☐ amb assisted ☐ up in chair ☐ not amb
☐ Active ROM ☐ Passive ROM
☐ Tingling ☐ Numbness ☐ Contracture ☐ Amputation ☐ Inflammation

Sensory	Eyes	☐ No correction ☐ Correction ☐ Glasses ☐ Contacts ☐ Other _____
	Ears	☐ No deficit ☐ HOH ☐ Hearing Aids: ☐ R ☐ L
	Lips/Mouth	☐ Discoloration ☐ Moist Membranes ☐ Dry Membranes ☐ Lesions ☐ Other _____

Comments: _____ _____ _____ _____ _____	
Nurse Signature:	Date/Time of assessment: