TABLE OF CONTENTS
ADN 11AL - Introduction to Nursing Laboratory

Table of Contents .......................................................... i
Course Information for ADN 11AL ................................... iv
Course Outline 11AL ....................................................... v
Conceptual Framework .................................................... vi
Course Requirements for ADN 11AL ................................. vii
Learning Outcomes for ADN 11AL ................................... viii
Challenge Option ........................................................... ix
Skills Assessment ........................................................... xiii
Attendance ....................................................................... xiv

CAMPUS LABORATORIES

Introduction to Skills Lab .................................................. 20.0
Facility Orientation .......................................................... 20.1

Helping Relationships/Group Dynamics ............................... 21.0
  Developing Helping Relationships ................................... 21.1
  Oath of Confidentiality ................................................... 21.2
  Honesty Policy ............................................................... 21.3
  Simulation Agreement .................................................... 21.4

Hand Hygiene ................................................................. 23.0

Patient Rights .................................................................. 24.0

Vital Signs, Behavioral Objectives ....................................... 25.0
  Skill Lab: Vital Signs ...................................................... 25.2
  Skill Assessment: Vital Signs ........................................... 25.4

Aseptic technique ............................................................. 26.0

Skill Lab: Transmission Precautions ................................... 27.0
  Skill Assessment: Transmission Precautions ..................... 27.3

Skill Lab: Opening Sterile Packages ................................... 28.0
  Skill Assessment: Opening Sterile Packages ...................... 28.1

Skill Lab: Open Gloving ................................................... 29.0
  Skill Assessment: Open Gloving ....................................... 29.1
Skill Lab: Transferring, Pivot Transfer ................................................................. 30.0
Skill Worksheet: Pivot Transfer ....................................................................... 30.2

Skill Lab: Transfer by Mechanical Lift .......................................................... 31.0
Skill Worksheet: Transfer by Mechanical Lift ................................................. 31.2

Skill Lab: Restraints ...................................................................................... 32.0
OBRA Regulations Regarding Restraints ....................................................... 32.1

Skill Lab: Tube Feedings .............................................................................. 33.0
Skill Assessment: Nasogastric Tube Feeding .................................................. 33.2

Skill Lab: Bedmaking .................................................................................... 34.0

Skill Lab: Positioning .................................................................................... 35.0
Skill Assessment: Positioning ........................................................................ 35.2

Skill Lab: Lift/Turn Sheet ............................................................................. 36.0

Skill Lab: Range of Motion (ROM) ................................................................. 37.0
Skill Assessment: Passive Range of Motion ................................................... 37.2

Skill Lab: Assisting with Elimination ............................................................. 38.0
Part A-Bedpan and Urinal Use ....................................................................... 38.0
Part B-Condom Cath Application .................................................................. 38.1
Part C-Adult Incontinence Pads .................................................................... 38.1
Part D-Enemas .............................................................................................. 38.2

Skill Lab: Bathing, including Draping ............................................................. 39.0

Skill Lab: Back Rub ...................................................................................... 40.0

Skill Lab: Oral Hygiene ................................................................................ 41.0

Skill Lab: Feeding the Dependent Patient ....................................................... 42.0

Skill Lab: Dressing Change ......................................................................... 43.0
General Information For Clinical

Skill Lab: 4 ½ Hour Day and Documentation .......................................................44.0
Skill Lab: “Head to Toe” Baseline Assessment ....................................................45.0
Skill Lab: Simulated Hospital Lab........................................................................46.0
Older Adult Assessment.........................................................................................47.0
Nursing Care Plan..................................................................................................48.0
Assessment Guide..................................................................................................49.0
Hunt and Find ........................................................................................................50.0

EVALUATIONS
Clinical Evaluation for ADN 11AL........................................................................51.0
Clinical lab:  9 hours per week

Required Texts:
1. LBCC Staff, ADN 11A Syllabus Current semester edition on line
3. eDose, Meti
6. LBCC Staff, Student Handbook for Associate Degree Nursing Program on line

Supplementary Learning Materials:
1. Articles, videos and other media assigned in the Learning Center/Library

Requirements of the Course:
Clinical Lab/discussion  Laboratory experiences
Clinical self evaluations
Video and other media

Student Clinical Evaluation:
See Criteria for Satisfactory Clinical Performance in syllabus

Student Course Grade:
The theory and lab portion of this course must be taken concurrently and both theory and lab must be passed in order for the student to proceed in the program. The student will receive the same letter grade for theory and for lab unless he/she is less than satisfactory clinically in which case the policy in the Student Handbook for marginal or unsatisfactory clinical ratings will be followed.

Teachers - Office hours posted on the door of each office
Lead: Debi Beitler RN, MSN, FNP Office I 938-4182
Co-Lead: Joanne Armenia RN, MSN, ANP-C Office I 938-4908

Agencies for Clinical Experiences:
Long Beach Veterans Affairs Medical Center Nursing Home Units
LONG BEACH CITY COLLEGE
Associate Degree Nursing Program
ADN 11AL - Introduction to Nursing Laboratory

COURSE OUTLINE

Activities include on-campus laboratory practice and application of the course content to the clinical settings, namely long term care facility settings and well senior client settings.

COURSE CONTENT
1. An introduction to the program and course
   A. Course requirements
   B. Program Policies
2. Application of the nursing process and nursing care plan
   A. Assessment
   B. Nursing Diagnosis
   C. Planning
   D. Interventions
   E. Evaluation
3. Application of concepts of interpersonal relationships
4. Apply organization and management skills by timely completion of clients' assignments.
   A. Able to transfer theory to the clinical setting
   B. Able to complete documentation
5. Sterile/ Aseptic Technique
   A. Aseptic Dressing
   B. Open Sterile Packages
   C. Sterile Gloving
6. Basic bedside activities of daily living skills
   A. bathing
   B. bed making
   C. positioning
   D. ROM
   E. Feeding
7. Vital Signs
   A. Temperature
   B. Blood Pressure
   C. Respirations
   D. Heart Rate
   E. Pain Level
Long Beach Community College District  
LONG BEACH CITY COLLEGE  
Associate Degree Nursing Program  

ADN 11AL – Introduction to Nursing  
Conceptual Framework: Orem’s Self Care Model

<table>
<thead>
<tr>
<th>SELF CARE MODEL</th>
<th>THEORY IMPLEMENTATION</th>
<th>CLINICAL IMPLEMENTATION</th>
</tr>
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<tbody>
<tr>
<td>The Universal Self Care Requisites (USCR) are common to all persons regardless of health status. Developmental Self Care Requisites are needs associated with development throughout the life cycle.</td>
<td>The Universal Self Care Requisites serve as an outline for learning. Students learn how to use the nursing process at the beginning level to meet the USCRs.</td>
<td>All of the basic nursing skills are taught in on campus labs. Student attention is directed to the necessity of having a repertoire of nursing skills to assist patients to meet the Universal Self Care Requisites. After demonstration of satisfactory performance on campus, students give care to stable, adult patients under direct supervision. Students develop a nursing care plan based on beginning assessment, diagnosis, goals, interventions and evaluation.</td>
</tr>
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</table>
During this course each student will:

1. Come to lab on time, prepared to meet the assigned behavioral objectives for the day.

2. Complete all assigned readings, media, and written work prior to lab.

3. Follow guidelines in the ADN Student Handbook regarding hygiene, dress, and behavior on campus and in clinical agencies.

4. Consult a member of the teaching team when a problem is encountered regarding clinical application and/or application of program policies.

5. Achieve a Satisfactory or Marginal rating on the Evaluation of Student Performance - Campus Laboratory Practice in order to progress from the on-campus portion of the course to the clinical agency portion.

6. Achieve a Satisfactory or Marginal clinical rating in the course, according to the Student Clinical Evaluation Process, in order to continue in the program.

7. Achieve a minimum of 75% in theory testing on completion of the course in order to continue in the program.


9. Assume responsibility for the behavioral objectives and handouts missed due to absence from lab.

10. Assume responsibility for providing documentation of compliance with all elements of the *Standards of Alliance for Clinical Affiliations*, Orange County/ Long Beach Consortium for Nursing.

11. Demonstrate at all times, behavior consistent with the College Policy on Academic Honesty.
ADN 11AL Learning Outcomes

Upon satisfactory completion of the course, the student will be able to demonstrate the following learning outcomes:

**Professional Role**
- Demonstrate accountability for nursing on assigned patient

**Communication**
- Apply the principles of effective oral communication with colleagues and clinical staff

**Orem’s Self Care Theory as it relates to the Nursing Process**
- Apply the principles of Orem’s Self Care Theory
- Implement the nursing process in the care of a stable patient with multiple self-care requisites
- Apply the concepts of developmental self-care requisites to the geriatric patient in a stable environment

**Critical Thinking**
- Discuss the concepts of developmental self-care requisites to the geriatric patient in a stable environment

**Safety**
- Demonstrate safe and effective performance of nursing practice.

**Teaching and Learning**
- Prepare proper documentation.

**Collaborative Management of Care**
- Discuss patient status with selected members of the multidisciplinary team to perform safe patient care on a stable geriatric patient.
POLICY STATEMENT
Challenge Option for Advanced Placement

1. The challenge option for each course consists of two parts:
   - 1<sup>st</sup>: challenge of the theory course
   - 2<sup>nd</sup>: Challenge of the laboratory course

2. An announcement regarding the challenge options will be made at the beginning of every course on the first day of class.

3. The student must have evidence on file in the college and program cumulative folder of formal instruction in this course content.

4. Formal instruction and direct patient care experience (in the content of the course being challenged) must have taken place within the three years previous to the challenge request.

5. If the student satisfactorily passed the clinical exam the grade earned for the course or portion of the course will be the grade achieved on the theory course.

6. The student must utilize both the conceptual framework and the nursing process in the laboratory challenge portion of this option.

7. For details refer to the LBCC Catalog “Nursing Programs and Courses: Policies for Transfer Credit, Advanced Placement and Credit by Examination for the Associate Degree.”
LONG BEACH CITY COLLEGE  
Associate Degree Nursing Program  
ADN 11A Introduction to Nursing

CHALLENGE OPTION

Specific to ADN 11AL

Challenge of ADN 11AL

1. The student submits the department “Application for Challenge by Examination for ADN 11AL” and the college application for challenge by examination.

2. After successfully passing the written examination, a thirty minute appointment must be made with the teaching team to finalize arrangements for the clinical portion of the advanced placement examination.
   A. Clinical Exam - hospital portion
      1. The following areas must be satisfactorily completed:
         a. Vital signs, baseline assessment and care plan must be completed within 60 minutes.
         b. Personal cleanliness of patient, including bath, oral hygiene, and cath care.
         c. Comfort and safety needs; including decubitus care, back care, and bed making.
      2. Two of the following 4 skills must be completed. The skills to be tested will be selected by the instructor.
         a. Tube feeding
         b. ROM
         c. Positioning
         d. Aseptic Technique
   3. In addition to the successful completion of the written and clinical examination the student must attend labs and classes covering the following topics:
      A. Nursing Process: Assessment
      B. Nursing Process: Diagnosis.
      C. Nursing Process: Planning and determining outcomes
      D. Nursing Process: Interventions
      E. Nursing Process: Evaluation

4. The Math Submodule must be passed by the same deadline as all other students.

Clinical

Clinical assessment will be individualized to evaluate the clinical competency of the student. The student is advised to attend clinical orientation day. The student and instructor will plan a specified number of days on a medical-surgical nursing unit of not less two clinical days. During this time, the student is to demonstrate competencies expected of a student who would be at the end of the ADN 11AL course.
Grade for ADN 11AL

If successful, the grade earned for ADN 11AL will be the same that is earned in
the challenge of ADN 11A.

Completion of the Challenge Option for both ADN 11A and ADN 11AL

All the components of the challenge are to be completed by the end of the third
week.
SKILLS ASSESSMENT EXPECTATIONS

The philosophy of the Associate Degree Nursing Program faculty includes the concept that students should be held accountable for all skills learned previously in the nursing program. The following statement is published in the ADN 11AL course study guide:

SKILLS ASSESSMENT STATEMENT

The critical elements for specific skills are listed on Campus Lab and Skill Assessment Sheets. All of the parts of the skill MUST be performed in order that the skill is evaluated as having been done satisfactorily. Skill Assessment sheets are kept on file to validate that the student has successfully completed the skill. Skill competency may be tested at any time throughout the program in scheduled campus labs. Students are expected to meet the critical elements of any skill after testing, and any time in the hospital lab.

See also 4.9.2 Skills Testing in the Student Handbook.

Previously learned skills are listed in the Clinical Behavioral Objectives in this syllabus. The student is responsible for being prepared to perform these skills in the clinical area under supervision, with minimal on-the-spot review or teaching.

_The student must follow appropriate standard precautions for each skill learned._

If self-assessment by the student demonstrates that he/she is not able to safely perform previously learned skills, the following are suggested resources.

1. Review media in the learning center
2. Review appropriate syllabus pages to see that all critical elements are being met
3. Make an appointment with the Skills Adjunct Lab teacher
4. Practice in the skills lab with a peer who is proficient in the skill
5. Make an appointment with your clinical instructor for help
6. Review the hospital procedure manual

If the student is unable to perform a previously learned skill with 100% accuracy in the clinical area during this course, the student will receive an overall clinical marginal until remediation is achieved and clinical practice of skills is satisfactory.
ADN 11AL

Introduction to Nursing Lab

CAMPUS
LABORATORIES
CAMPUS LAB: Introduction to Skills Lab

BEHAVIORAL OBJECTIVE

1. Discuss use of the Skills Lab.
2. Discuss skill testing during this course.
3. Explain the rationale for wearing a name pin to all clinical labs.
4. Describe appropriate behavior and student responsibilities when using the Skills Lab.
5. Discuss appropriate attire for campus labs.
6. Discuss the equipment needed for clinical practice.
CAMPUS LAB FACILITY ORIENTATION

BEHAVIORAL OBJECTIVES:

1. Become oriented to the physical facility and the personnel of the School of Health and Science: Location and use of:
   
   Bulletin board for Nursing Student Association (NSA) publicity and announcements
   
   Bulleting board box for posting grades
   
   Learning Center: Phone 938-4299. Marie Monaus, Instructional Assistant
   
   Practice labs, including demonstration of hi-low beds
   
   Program Director/ Department Head

   Supervised lab practice room “Skills Lab” C200

2. Discuss how to arrange for appointments and/or practice sessions with: Instructor, Learning Center, Skills Lab, etc.

3. Discuss student responsibilities and appropriate behaviors regarding building, equipment, and supplies.

4. Discuss proper attire for campus labs. See Associate Degree Nursing Student Handbook.

5. Discuss, in class, the equipment needed for clinical practice: stethoscope; BP cuff; bandage scissors, and a watch that displays second (digital or sweep second hand).
LEARNING OBJECTIVES:

1. Compare the similarities and contrast the differences between a professional and a social relationship. Identify the elements of professional communication.

2. Identify methods and give examples of the techniques for developing a helping relationship. Give personal examples of each.

4. Define the helping relationship and briefly describe the four phases:
   a. pre-interaction
   b. orientation
   c. working
   d. termination

5. Describe the characteristics of an effective student nurse study group formed to improve coping skills and grades.


ASSIGNMENTS:

1. Potter and Perry
2. Complete "Developing Helping Relationship" form in syllabus.
3. Read and sign each statement on the Signature Sheet (p 21.2 of syllabus).
4. Read and sign the Honesty Policy (p 21.3 of syllabus).
Directions: Read the descriptions "Caring and Methods of Effective Communication" in your text. These methods do not require special training. Describe a real or related situation with a friend and give an example of how you used each technique.

1. Listening actively

2. Conveying acceptance

3. Asking related questions

4. Paraphrasing

5. Clarifying

6. Focusing

7. Stating observations

8. Offering information

9. Maintaining silence

10. Assertiveness

11. Summarizing

21.1
Academic Honesty Policy

The ADN faculty have the responsibility of assigning grades that accurately reflect the knowledge and skill of the individual student. Academic dishonesty interferes with this process and weakens the strength of the nursing program. Maintaining academic honesty is a shared responsibility of faculty, students, and classified staff. The consequences of cheating are severe and may include expulsion from the college according to Long Beach City College policy.

Faculty Responsibilities:
Faculty are to maintain an atmosphere that does not provide the opportunity for cheating, plagiarism, and dishonesty. All incidents of suspected dishonesty are to be brought to the teaching team for a decision on the course of action.

Faculty are to meet with any student suspected of dishonesty and administer disciplinary action as outlined:

• In cases of suspected cheating, plagiarism, or dishonest conduct that can not be proven or that may be the result of a lack of understanding on the student’s part, an oral reprimand may be given.
• Written test: In the case of cheating on any written test, a grade of zero will be given, a progress note will be written, and the student will be referred to the Office of the Vice President of Student Affairs for further disciplinary action. A file will be maintained in that office on the student. Any further infractions may result in dismissal from the college.
• Skills testing: In cases of cheating during skill testing, the student will fail the skill and receive a written progress note.
• Dishonesty in the clinical setting will be handled on an individual basis depending on the seriousness of the event. For example, the falsifying of hospital records may lead to immediate dismissal from the nursing program.
• Any infraction involving academic honesty will be discussed with the teaching team and the program director.
• Any repeat offense or evidence of premeditation will result in the assignment of an E for the course and follow-up disciplinary action will be taken as outlined in the College Catalog.
• Any student knowingly or intentionally assisting another student to cheat will be disciplined in the same manner as outlined above.
• Incidents of dishonesty will be communicated to the next team via wrap-up minutes.
• Incidents will be reported to the Student Affairs Committee in order to maintain communication regarding students with dishonest behavior throughout their time with the ADN program.

Student Responsibilities:

• Students are to conduct themselves in an honest manner at all times.
• Students are to refuse to assist any student to cheat and are to report any knowledge of cheating by other students to the instructor or program director.

The Student Affairs Committee will be informed of all violations of the academic honesty policy.
If the student disagrees with the disciplinary action (taken, the student may meet with the Program Director to discuss the issue. The Program Director may bring the issue to the Student Affairs Committee. If dissatisfied with the outcome, the student may follow19the college grievance policy as outlined in the College Catalog.

I acknowledge reading and accepting the above (standards).

Student Name_____________________________________
Signature______________________________________________
Date____________________________

21.2
OATH OF CONFIDENTIALITY

As a condition of performing clinical assignments required in the ADN/RN Program I agree not to divulge any information obtained in the course of such activities to unauthorized persons and not to publish or otherwise make public any information regarding persons who have or are receiving services in such a way that the person is identifiable. I recognize that unauthorized release of confidential information may make me subject to a civil action under the provisions of the California Welfare and Institutions Code. I further recognize that unauthorized release of confidential information may make me subject to a criminal action, civil action, or both under provisions of Part 2 of Title 42 of the Code of Federal Regulations.

Signature _________________________________________     Date _________________

MEDICAL EXPENSE AND PERSONAL LOSS STATEMENT

As a student in the ADN/RN Program of Long Beach City College, I understand that I must assume responsibility for my own medical expenses. Neither the college nor the hospitals/clinical settings are responsible for emergency care rendered. If I choose to pay the LBCC optional health fee, I understand that the health care coverage included in this fee will become effective after all other primary health insurance coverage has been utilized and deductibles have been met. Further, I realize that neither the college nor the clinical agencies are responsible for any personal losses, i.e., uniform, purses, wallets, etc., that I may suffer while assigned to the clinical agencies.

Signature ___________________________________   Date _______________________

MALPRACTICE INSURANCE STATEMENT

As a condition of assignment in clinical agencies, I agree to maintain registered nursing student professional liability coverage with at least minimum limits while enrolled in the program.

Signature _________________________________     Date ______________________

STUDENT HANDBOOK

I have obtained a copy of the ADN Student Handbook and understand that I must comply with both the student policies and the standards of ethical and legal behavior described in this handbook.

Signature _________________________________     Date ______________________

21.3
Simulation Agreement

As a nursing student at Long Beach City College I will participate in clinical laboratory/hospital simulations. I understand that the content of these simulations is to be kept confidential to maintain the integrity of the learning experience for me and my fellow students. I also understand that in working side by side with my fellow students, I will be witnessing their performance. It would be unethical for me to share information with person outside the laboratory/hospital.

I acknowledge that I fully understand that the unauthorized release, inappropriate exchange, or mishandling of confidential information is prohibited, and serious consequences may occur if I violate this agreement. I will exemplify the Long Beach City College Department of Nursing values of integrity, human dignity and confidentiality.

I understand that for learning purposes I may be photographed/recorded during simulations. Further consent will be obtained for any other use; i.e. brochures.

Name: __________________________
Signature: ______________________
Date: __________________________
SKILL LAB: Hand Hygiene

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION

1. Assessment
   a. Describe situations when hand washing should be performed
   b. Discuss the role of hand washing in carrying out Standard Precautions
   c. If hands and not visibly soiled, describe the process to decontaminate the hands.
   d. Compare and contrast Cleaning, Disinfection, and Sterilization.

2. Planning
   a. Discuss the purpose of hand washing
   b. Assess adequacy of supplies and equipment: liquid soap, antiseptic hand rub, warm running water, and paper towels or air dryer.

3. Implementation
   a. Adjust water flow before beginning hand washing procedure.
   b. Position hands so water flows downward at all times (hands lower than elbows).
   c. Prevent water from splashing on clothes and surrounding environment.
   d. Create lather with application of soap.
   e. Use friction to all surfaces of fingers and hands for 15 seconds.
   f. Rinse hands to remove lather.
   g. Dry all surfaces of hands and fingers.
   h. Turn off water flow without contaminating self.

4. Evaluation - discuss expected outcomes of good hand washing techniques

CRITICAL ELEMENTS:
All ultraviolet sensitive material, (“pathogens”) applied to the hands prior to hand washing is removed.

TEACHER RESPONSIBILITIES:
1. Demonstrate hand washing techniques.
2. Provide environment and equipment for practice using ultraviolet light.

STUDENT RESPONSIBILITIES:
1. Come to lab prepared to:
   a. Discuss critical elements and behavioral objectives.
   b. Practice skills as demonstrated.
2. View video, first 5 minutes of "Medical Asepsis".

HOW SKILL WILL BE LEARNED:
1. Reading assignment: Potter and Perry: p. 655-659
2. Repeated practice

HOW SKILL WILL BE TESTED:
This skill will be observed in the clinical area.

23.0
Behavior Objectives:

1. Discuss the correlation between resident rights and OBRA regulations.

2. Identify the specific resident rights that are protected by federal and state law.

3. Discuss the importance of the individual resident’s right to be informed both orally and in writing.

4. Describe when the right to be informed should occur.

5. List at least five specific issues that involve the right to be informed.

6. Describe what the right to self-determination or the right to make decisions concerns.

7. Identify appropriate personnel responses if a resident refuses to eat or take prescribed medications.

8. Describe how the right to association and communication can be implemented.

9. Discuss circumstances when the right to privacy must be protected.

10. Discuss how the right to keep personal property must be balanced with the right of other residents.

11. Identify methods that may help to resolve conflicts that can occur between residents regarding personal property.

12. Identify personnel’s responsibilities to insure the resident’s right to freedom from abuse and restraint.

13. Explain health care personnel’s responsibility in reporting actual or strongly suspected cases of elder abuse.

14. Discuss the legitimate circumstances when physical restraints can be applied.

15. List the areas of personal care that an individual resident should receive to insure quality of care and dignity.
16. Identify those professional health related services, which must be provided in long term care facilities under OBRA regulation.

17. Identify facility environment requirements mandated by OBRA.

18. Discuss documentation and care planning requirements mandated by OBRA.

ASSIGNMENT: Video – Resident Rights: The Art of Caring, Medcom Trainex film
BEHAVIORAL OBJECTIVES:

1. Prior to class, review briefly Biology notes regarding the following physiology content:
   a. body temperature regulation
   b. heart rate regulation
   c. control of respirations
   d. arterial blood pressure

2. Define the following terms:
   - bradycardia
   - tachycardia
   - rhythm
   - dysrhythmia
   - apnea
   - tachypnea/bradypnea
   - dyspnea/eupnea
   - orthopnea
   - Cheyne-Stokes respirations

3. Identify and describe the basic components of the nursing skill, Vital Signs (T-P-R-BP, pain scale).

4. Body Temperature:
   a. State normal body temperature, both average and range, for the oral, rectal, axillary and tympanic routes.
   b. Briefly describe the various types of thermometers: glass mercury, electronic probe (such as IVAC), disposable chemical strip, and tympanic infrared thermometer.
   c. Identify the advantages and disadvantages of each type of thermometer.
   d. List 5 factors that may cause an individual's body temperature to differ from the normal range.
   e. Briefly describe 4 conditions that contraindicate taking either an oral and/or rectal temperature.
   f. Identify and discuss the clinical manifestations of a fever.

5. Pulse:
   a. State normal pulse rate, both average and range, for a healthy, resting adult.
   b. Identify and list sites ordinarily used to assess pulse rates, giving rationales for the sites most frequently used.
   c. Define and describe the characteristics of a pulse, specific to rhythm and strength.
   d. Discuss factors which may cause the pulse rate to vary.
   e. List and discuss several reasons for assessing the apical pulse rate.
   f. Identify anatomical landmarks used to locate the apical pulse.

6. Respirations:
   a. State the average and normal range of respiratory rates for resting adults.
   b. Identify and describe five characteristics of respiration that are routinely assessed: rate, depth, rhythm, quality, and noise.
   c. State need and rationale for counting the respiratory rate without making the client aware of the procedure.
   d. Discuss factors which may cause the respiratory rate to vary.
7. Blood Pressure:
   a. State the normal blood pressure range for resting adults.
   b. Describe and discuss the procedure for measuring BP and equipment needed.
   c. Identify the importance of appropriate cuff size when measuring BP.
   d. Identify and distinguish between the beginning, muffling, and disappearance of sounds when measuring BP.
   e. Describe four physiologic factors that may cause the blood pressure to vary.
   f. Identify and list several reasons why a BP might not be measured on a particular arm.

8. Pain:
   a. State the normal pain intensity range for resting adults.
   b. Identify and describe the four characteristics of pain that are routinely assessed:
      - Localization
      - Intensity
      - Quality
      - Behavioral manifestations
   c. Describe the correct method of using the 0 – 10 (numerical) pain scale

9. Identify and briefly describe the importance of applying the nursing process as needed whenever obtaining vital signs of a client.

<table>
<thead>
<tr>
<th>Normal Values for Vital Signs in a Resting Adult</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Temperature, oral</td>
</tr>
<tr>
<td>Pulse</td>
</tr>
<tr>
<td>Respiration</td>
</tr>
<tr>
<td>Blood Pressure</td>
</tr>
<tr>
<td>Pain</td>
</tr>
</tbody>
</table>

ASSIGNMENTS:
Potter and Perry Chapter 32
Recommended: Castillo pp 3-20
ATI Fundamentals for nursing pp 232-254
SKILL LAB: Vital Signs

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION

1. Assessment
   a. Determines appropriate route, method, time and frequency when performing vital signs in the clinical setting.
   b. Assess for presence of factors which may alter vital sign readings.

2. Planning
   a. Identify/obtain appropriate equipment needed to monitor vital signs.
   b. Maintain medical asepsis concepts throughout skill.

3. Implementation
   a. Obtain baseline values for T-P-R-BP
   b. See assigned pages in nursing fundamentals text book for actual procedure for monitoring vital signs.

4. Evaluation - Identify vital sign values as within normal range/baseline or deviating from the expected outcome.

CRITICAL ELEMENTS:

TEMPERATURE:
  1. Prepare and place the instrument at the correct location for oral and tympanic reading.
  2. Read and record: +/- 0.2 degrees for temperature
  3. Maintain medical asepsis

RADIAL PULSE:
  1. Place fingers at the correct location.
  2. Count pulse for minimum of 30 seconds if pulse is regular.
  3. Report pulse rate +/- 4 beats per minute.

APICAL PULSE:
  1. Place stethoscope at the correct location.
  2. Count pulse for one full minute.
  3. Report pulse rate +/- 2 beats per minute.

RESPIRATIONS:
  1. Count without cueing patient.
  2. Count respirations for a minimum of 30 seconds.
  3. Report respiratory rate +/- 2 breaths per minute.
BLOOD PRESSURE:
1. Apply cuff correctly.
2. Uses the two step BP method correctly.

PAIN:
1. Assess pain intensity
2. Assess location of pain
3. Assess quality of pain (electrical, aching, cramping, shooting, sharp, pressure, stabbing)
4. Assess behavioral manifestations of pain
   a. Vocal - moaning, whimpering, whining, crying or pain words
   b. Facial - Frowning, grimacing
   c. Body Movements - guarding, restless, thrashing, withdrawing

STUDENT RESPONSIBILITIES:
1. Read assigned pages in nursing fundamentals text book.
2. Come to lab prepared to discuss the BO’s for vital signs.
3. Bring stethoscope (and own BP cuff if you have one) to lab to practice.
4. Practice in the lab until proficient with meeting the critical elements prior to testing.
5. Ask for instructor assistance as needed.

TEACHER RESPONSIBILITIES:
1. Demonstrate oral temperature, respirations, and blood pressure techniques.
2. Demonstrate a method to be used when assessing vital signs (temperature, pulse, respiration, and blood pressure) at the client's bedside.
3. Clarify questions related to the mastery of the skills of assessing vital signs.
4. Provide equipment in the lab to practice.

HOW THIS SKILL WILL BE LEARNED:
1. In lab, the student will practice the techniques of measuring oral body temperature, radial/apical pulse, respiration, and blood pressure.
2. Practice independently until all critical elements can be met.
3. Practices with sphygmomanometer to increase/improve skills of assessing blood pressures.
4. Read Potter and Perry Chapter 32

HOW THIS SKILL WILL BE TESTED:
Students will demonstrate vital signs skill to instructor with 100% accuracy according to critical elements on scheduled lab day.
**SKILL ASSESSMENT: Vital Signs**

**Student (print) __________________________________**
**Student (sign) __________________________________**
**Evaluator(s) __________________________________**

<table>
<thead>
<tr>
<th>CRITICAL ELEMENTS</th>
<th>Record Results</th>
<th>Pass</th>
<th>Fail</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>TEMPERATURE:</strong></td>
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<tr>
<td>1. Prepare and place instrument at correct location</td>
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<td>2. Read the temperature +/− 0.2 degrees</td>
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<tr>
<td>3. Maintain medical asepsis</td>
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<tr>
<td><strong>RADIAL PULSE:</strong></td>
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<tr>
<td>1. Place fingers at the correct location</td>
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<tr>
<td>2. Count pulse for a minimum of 30 seconds if pulse is regular.</td>
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<tr>
<td>3. Report pulse rate +/− 4 beats per minute.</td>
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<tr>
<td><strong>APICAL PULSE:</strong></td>
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<tr>
<td>1. Place stethoscope at the correct location.</td>
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<td>2. Count pulse for one full minute .</td>
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<tr>
<td>3 Report pulse rate +/− 2 beats per minute.</td>
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<tr>
<td><strong>RESPIRATIONS:</strong></td>
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<tr>
<td>1. Count without cueing patient</td>
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<tr>
<td>2. Count respirations for a minimum of 30 seconds.</td>
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<td>3. Report respiratory rate +/− 2 breaths per minute</td>
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<td><strong>BLOOD PRESSURE</strong></td>
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<tr>
<td>1. Apply cuff correctly</td>
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<tr>
<td>2. Use the two step BP method correctly</td>
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<td>3. Report BP reading +/− 4 mm mercury.</td>
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**RETEST:_________________________**
**Evaluator_______________________**
**Date___________________________**
CAMPUS LAB: Aseptic Technique

BEHAVIORAL OBJECTIVES:

1. Define and memorize the following terms:
   - Healthcare acquired infection
   - Disinfectant
   - Contamination
   - Antiseptic
   - Sterilization

2. Discuss and give examples of the chain of infection.

3. Define medical asepsis and describe common methods of medical aseptic technique.

4. Define surgical asepsis and describe common methods of surgical aseptic technique.

5. List and memorize the principles of surgical aseptic technique.

6. Identify five examples of the utilization of surgical aseptic technique at the bedside in health care agencies.

7. Discuss the components of a "sterile conscience", including the following:
   - Identify what is sterile
   - Identify what is not sterile
   - Identify how to keep the two apart
   - Identify how to remedy contamination

8. Compare and contrast medical asepsis and surgical asepsis, listing examples and rationales.

9. Identify and discuss the importance of applying principles and critical thinking whenever using medical or surgical aseptic technique in the clinical setting.

ASSIGNMENTS:

1. Potter and Perry p 654-664
2. Videotape in Learning Center: “Safer Medical Devices and Bloodborne Pathogens-OSHA’s Revised Standards, Envision, Inc. (this is shown in class)
3. Partnering to Heal http://www.hhs.gov/ash/initiatives/hai/training/
SKILL LAB OVERVIEW: TRANSMISSION PRECAUTIONS

BEHAVIORAL OBJECTIVES

1. Describe diseases that require Transmission-Based Precautions in addition to Standard Precautions.
   a. Airborne Precautions
   b. Droplet Precautions
   c. Contact Precautions

2. Clinical Decision Making
   a. Discuss how a nursing student determines what type of precautions are needed for his/her assigned patient on the nursing unit.
   b. Describe how the responsible registered nurse determines whether or not a patient needs to have transmission precautions.

3. Planning
   a. Describe engineering controls and equipment needed to implement airborne precautions, droplet precautions, and contact precautions.
   b. For each of the transmission-based precautions, describe how the following equipment/procedure is handled: oral medication, IM or IV medication; VS (watch, thermometer, BP cuff, and stethoscope); recreational equipment; transportation of patient.
   c. State how to transport a patient in each of the transmission-based precautions.

4. Procedure for Barrier Precautions:
   a. Check barrier supplies outside the room. If possible, visually check supplies already in the room. Gather any needed supplies before entering the room.
   b. Wash hands with soap and water before entering the room.
   c. Prepare to enter the room:
      d. Don clean gown.
      e. Don clean mask.
      f. Apply clean utility gloves.
      g. Enter the room to provide care. Do not leave the room in personal protective equipment.
   h. Prepare to leave the room:
      i. Untie gown at waist.
      j. Remove gloves “glove to glove” and discard.
      k. Remove mask and discard without touching moist part of mask. OR
      l. Untie gown at neck and remove gown so that hands are not contaminated.
      m. Wash hands thoroughly with soap and water, preferably outside the barrier room.
5. Goals for barrier precautions:
   n. Protect self from contamination from patient respiratory secretions and/or shed pathogens.
   o. Protect environment outside the room from contamination with pathogens.
   p. Follow health agency policy in implementing barrier precautions.

CRITICAL ELEMENTS
   1. Protect self from contamination from patient respiratory secretions and/or shed pathogens.
   2. Protect environment outside the room from contamination with pathogens.
   3. Follow health agency policy in implementing barrier precautions.

PROCEDURAL ELEMENTS
   1. Wash hands with soap and water prior to applying protective apparel.
   2. Don clean mask.
   3. Don clean gown, fully protecting clothing.
   4. Don clean gloves.
   5. Verbally describe method of taking vital signs and giving other personal care.
   6. Untie gown at waist.
   7. Remove and dispose of gloves.
   8. Remove and dispose of mask (or untie gown at neck).
   9. Untie gown at neck (or remove mask).
  10. Remove and dispose of gown without contaminating own clothing.
  11. Wash hands with soap and water.
  12. Complete all procedural elements within 10 minutes.

TEACHER RESPONSIBILITIES
   1. Clarify any questions related to barrier precautions.
   2. In lab, demonstrate the procedure for donning strict barrier gear to meet critical elements.
   3. Provide equipment for practice as needed by students.

STUDENT RESPONSIBILITIES
   1. Come prepared to discuss objectives and implement critical elements for strict barrier procedure.
   2. Practice in lab with personal protective equipment.
   3. Practice independently or with requested teacher assistance in preparation for use of procedure in clinical practice.
   4. Discussion and clarification of critical and procedural elements.
   5. In lab, observe and practice procedure for donning barrier gear (personal protective equipment) to meet critical elements.
REQUIRED READING


Articles:


HOW THIS SKILL WILL BE TESTED

Campus lab, meeting critical elements with 100% accuracy.
SKILL ASSESSMENT: TRANSMISSION PRECAUTIONS

Student Name: ___________________________ Date: __________
Evaluator: ______________________________

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<th>CRITICAL ELEMENTS</th>
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<th>COMMENTS</th>
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<tbody>
<tr>
<td>Protects self from contamination from patient, respiratory secretions and/or pathogens</td>
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<tr>
<td>Protects environment outside the room from contamination with pathogens.</td>
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<tr>
<td>Follows health agency policy in implementing barrier precautions</td>
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<td>Complete all elements within 10 minutes.</td>
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RETEST: ___________________________
SKILL LAB: Opening Sterile Packages

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. Review principles of surgical asepsis as they relate to the opening of sterile packages.
   b. Identify and describe indicators of sterility for commercially packaged sterile supplies.
   c. State rationale for dating/labeling sterile packages indicating sterility.

2. Planning
   a. Identify and describe the physical needs of a working area when opening sterile packages: include in this discussion the height of work, area, confining vs. open area, using a flat/dry surface, and presence of air currents.

3. Implementation
   a. Check package for tears, holes, moisture, date, indicators of sterility.
   b. Place package on clean, dry surface free of air currents, above waist level.
   c. Center package on table.
   d. Open flap away from you first.
   e. Open flaps side to side next.
   f. Open flap toward you last.
   g. Do not touch inside of package.
   h. Do not reach over sterile field.

4. Evaluation - discuss the expected outcome of proper opening of a sterile package

CRITICAL ELEMENTS:

1. Identifies verbally indicators of package sterility.
2. Places package on clean, dry surface, above the waist level
3. Opens package(s) without contaminating the contents.
4. If contamination occurs, recognizes it and remedies it.

STUDENT RESPONSIBILITIES:

1. Come to class prepared to discuss behavioral objectives and identify critical elements.
2. Practice as directed in lab.
3. Practice independently following campus lab.

TEACHER RESPONSIBILITIES:

1. Demonstrate correct procedure to meet critical elements.
2. Provide equipment for practice.

HOW THIS SKILL WILL BE LEARNED:

1. Campus lab demonstration.
2. Independent practice.
3. Prior to lab read Potter and Perry 670-671

HOW THIS SKILL WILL BE TESTED:

1. On campus lab, meeting critical elements to 100% accuracy.
Long Beach Community College District  
LONG BEACH CITY COLLEGE  
Associate Degree Nursing Program

SKILL ASSESSMENT: Opening Sterile Packages

Name (print) ________________________________________________
Date______________________________________________________
Name (sign) ________________________________________________
Evaluator ____________________________________________________

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<tr>
<td>1. Identifies verbally indicators of package sterility.</td>
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<tr>
<td>2. Places package on clean, dry surface, above waist level.</td>
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<td>3. Opens package without contaminating contents.</td>
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<td>4. If contamination occurs, recognizes it and remedies it.</td>
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RETEST:

Date______________________________________________________
Evaluator______________________________________________
SKILL LAB: Open Gloving

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. Describe situations when sterile gloves must be worn.
   b. Discuss uses of utility gloves vs. sterile gloves.
   c. Identify areas of the glove wrapper which must remain sterile.
   d. Identify areas of the gloves which may be touched with the bare hand and areas which must remain sterile.
   e. Describe ways and means of determining that the inside of a package of gloves is sterile.

2. Planning
   a. Identify situations/skills during which sterile gloves must be worn.
   b. Identify situations/skills where sterile gloves are optional or contraindicated.

3. Implementation
   a. Open outer wrapper to allow for removal of inner wrapper and gloves.
   b. Open inner wrapper without contaminating gloves.
   c. Pick up and put on first and second glove without contamination of gloves or inside of wrapper.
   d. Adjust fingers inside gloves without contamination.
   e. Keep gloved hands above waist and in sight.
   f. Remove gloves without contaminating hands with outer glove surface.

4. Evaluation - discuss the expected outcome of proper use of open gloving technique.

CRITICAL ELEMENTS:
   1. Apply sterile gloves without contamination of gloves.
   2. Remove sterile gloves without contamination of self/environment.
   3. Perform skill within one minute.

STUDENT RESPONSIBILITIES:
   1. Come to lab prepared to:
      a. Identify critical elements
      b. Practice application and removal of gloves
      c. Identify sterile and non-sterile surfaces of gloves
   2. Practice as directed in lab
   3. Practice independently following campus lab

TEACHER RESPONSIBILITIES:
   1. Demonstrate correct application and removal of sterile gloves.
   2. Provide equipment for student practice.
HOW THIS SKILL WILL BE LEARNED:
1. Campus lab demonstration.
2. Repeat practice.
3. Read Perry and Potter p 681-682

HOW THIS SKILL WILL BE TESTED:
   On campus assessment of critical elements with 100% accuracy
SKILL ASSESSMENT: Open Gloving

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<tr>
<th>CRITICAL ELEMENTS</th>
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<tbody>
<tr>
<td>1. Apply sterile gloves without contamination.</td>
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<tr>
<td>2. Apply gloves within one minute.</td>
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<tr>
<td>3. Remove gloves without contamination of self/environment</td>
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RETEST: Date ___________ Evaluator ____________________________

Comments:
SKILL LAB: Pivot Transfer

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION

1. Assessment
   a. Identify basic principles of good body mechanics and give at least five examples of the utilization of the Principles of Body Mechanics when performing patient care.
   b. Describe the implications of the Principles of Body Mechanics for nurses.
   c. Identify and describe the use of a back support and a gait belt.

2. Planning
   a. Identify safety guidelines for transferring patients, i.e., wheelchairs, gurneys, etc.)

3. Implementation
   a. Identify the patient's strong side
   b. Position and lock chair so it is nearest the patient's strong side
   c. Raise the bed if appropriate.
   d. Explain the procedure to the patient.
   e. Move the patient to the side of the bed if necessary
   f. Lower the bed so the patient's feet touch the floor*
   g. Cross the patient's legs and swing the patient to sitting position
   h. Immediately support the patient to prevent falling out of bed and allow needed time to adjust to position change.
   i. Instruct patient to pivot on his/her strong leg into chair safely
   j. Support knee(s) and feet during transfer
   k. Guide client during pivot into chair
   *Can be done after “h” if desired

4. Evaluation - discuss expected outcomes of proper transfer.

CRITICAL ELEMENTS:

1. Maintain appropriate body mechanics for self and patient.
   Body Alignment: Nurse
   a. Keep back straight
   b. Bend knees before lifting
   c. Position feet in a wide stance


STUDENT RESPONSIBILITIES:

1. Read assignment prior to lab and be prepared to discuss critical elements and behavioral objectives.
2. Come to lab dressed to allow transfer with desired modesty.
3. Practice transferring each other under teacher supervision.
4. Practice transferring independently as needed to meet critical elements.

30.0
TEACHER RESPONSIBILITIES:

1. Clarify and discuss critical elements and behavioral objectives.
2. Demonstrate safe method of pivot transfer.
3. Supervise students during return demonstration.

HOW THIS SKILL WILL BE LEARNED:

1. Observe teacher demonstration of detailed methods of transferring patients to meet critical elements
2. Practice transferring techniques under teacher supervision to meet critical elements

HOW THIS SKILL WILL BE TESTED:

1. There will be no formal testing by the teachers.
2. Each student is to pivot transfer at least one other student from bed to chair or wheelchair and back, following Critical Elements. Signature on the form of the student who observed and assisted the lead nurse attests to lead student's successful completion of Critical Elements.
SKILL ASSESSMENT: Pivot Transfer

Student Name (print)_____________________________  Date ____________________

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<tr>
<th>CRITICAL ELEMENTS</th>
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Signatures certify that these activities were carried out safely.

Student_______________________________ (student who performed transfer)

Evaluator____________________________ (student who observed procedure and assisted lead student)

Patient______________________________ (student who was transferred)

Date_____________________________
SKILL LAB: Transferring with Mechanical Lift

BEHAVIORAL OBJECTIVES – NURSING PROCESS APPLICATION:

1. Assessment
   a. Describe situations when a mechanical lifter should be used.
   b. Identify various mechanical devices used to move clients.

2. Planning
   a. Identify the clients who require a mechanical lift.
   b. List the safety factors which must be observed at all times when using a mechanical lift.

3. Implementation
   a. Position the mesh sheet in the appropriate place.
   b. Fasten the lift hooks to the metal loops on the mesh.
   c. Use mechanical lift to move client from bed to wheelchair and back again.
   d. Involve two nurses at bedside at all times during movement of patient.
   e. One nurse has hands on client at all times during movement of client.

4. Evaluation – discuss expected outcomes of proper mechanical lift transfer

CRITICAL ELEMENTS:
1. Maintain appropriate body mechanics for self and “client”.
2. Perform all safety precautions, including two nurses to perform lift.
4. Safely move “client” into wheelchair in a sitting position using mechanical lift.
5. Safely transfers “client” from wheelchair to bed using mechanical lift.

STUDENT RESPONSIBILITIES:
1. Attend lab demonstration.
2. Practice use of mechanical lift with classmates to meet Critical Elements.

TEACHER RESPONSIBILITIES:
1. Demonstrate safe use of mechanical lift and supervise students during return demonstration.
2. Provide equipment needed for transfer by mechanical lift.
3. Be available during lab time to assist as needed.

HOW THIS SKILL WILL BE LEARNED:
   Page 1261-1274.
1. Observe on campus demonstration by teacher to meet critical elements.
2. Several students will return demonstration of mechanical lift under supervision.
3. Students will practice use of mechanical lift during practice lab time.
4. Students to seek teacher assistance as needed.
HOW THIS SKILL WILL BE TESTED:
1. There will be no formal testing by the teachers.
2. Each student is to transfer at least one other student from bed to wheelchair and back, following Critical Elements. Signature on the form attests to student's successful completion of Critical Elements.
SKILL WORKSHEET: TRANSFER BY MECHANICAL LIFT

Name(print)___________________________________________________ Date_______

Directions: To be completed by student who observed the procedure

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<tbody>
<tr>
<td>1. Maintain appropriate body mechanics for self and “client”</td>
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<tr>
<td>2. Perform all safety precautions, including two nurses to perform lift.</td>
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<td>3. Place wheelchair in optimum position and lock wheels.</td>
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<tr>
<td>4. Safely move “client” into wheelchair in a sitting position using mechanical lift.</td>
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<tr>
<td>5. Safely transfer “client” from wheelchair to bed using mechanical lift.</td>
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Signatures certify that these activities were carried out safely.

Student____________________________________ (student who performed lift)

Evaluator__________________________________ (student who observed procedure and assisted lead student)

Patient__________________________ (student who was lifted)

Date_______________________________
SKILL LAB: Restraints

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION

1. Assessment
   a. Describe client health deviations or prescribed medical therapy where restraints are needed.
   b. Describe legal implications of applying restraints.
   c. Identify five (5) types of restraints.
   d. Describe the frequency and type of assessments routinely used for clients who require wrist restraints or vest restraints.

2. Planning
   a. State rationale for selection of the appropriate type of restraint for each health deviation or medical therapy listed above.
   b. State rationale for discontinuing use of restraints.
   c. Discuss several devices that serve as alternatives to restraints.

3. Implementation
   a. Describe a procedure for safe application of soft wrist restraints.
   b. Describe a procedure for safe application of a vest restraint.
   c. Describe a seat-belt type of restraint for use with clients in wheelchairs.

4. Evaluation - discuss expected outcomes of properly applied restraints.

CRITICAL ELEMENTS: discuss expected outcomes of properly applied restraints.

1. Maintain position of extremity without extreme flexion or extension.
2. Pad extremity and secure knots so as to not impede circulation.
3. Secure restraints to bed frame or chair frame out of reach of client.
4. Remove and exercise restrained joint every 4 hours.

STUDENT RESPONSIBILITIES:

1. Read assigned pages in nursing fundamentals text book and be prepared to identify and discuss behavioral objectives and critical elements in lab.
2. Seek assistance of instructor with questions related to the application of restraints.

TEACHER RESPONSIBILITIES:

1. Demonstrate safe application of several types of restraints.
2. Supervise students’ practice of application of restraints in the lab.

HOW SKILL WILL BE LEARNED:

1. Reading assignment: Potter and Perry: p. 829-840
2. Observe campus lab demonstration
3. Practice with a peer until critical elements can be met.

HOW SKILL WILL BE TESTED:

1. During lab, supervised demonstration.
2. Testing will be on an actual patient in the hospital setting, meeting critical elements with 100% accuracy.
OBRA & RESTRAINTS
(OBRA = Omnibus Reconciliation Act)

1. *What does OBRA say in regard to the use of restraints?*

The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.

2. *What is a physical restraint?*

Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

3. *How are DISCIPLINE and CONVENIENCE defined?*

**DISCIPLINE** is any action taken by the facility for the purpose of punishing or penalizing residents.

**CONVENIENCE** is any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident’s best interest.

4. *What are some examples of physical restraints?*

Leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars, bedrails, or chairs that prevent rising. Such practices as tucking in a sheet so tightly that a bed bound resident cannot move or placing a wheelchair-bound resident so close to a wall that the wall prevents rising are also considered as physical restraints.

5. *What are some examples of alternatives to restraints?*

When coupled with appropriate exercise, therapeutic interventions such as pillows, pads and removable lap trays. Attention to individual, mental, physical and psychosocial needs, meaningful activity, aggressive nursing rehabilitation or restorative programs and environmental changes are also less restrictive methods of meeting resident needs. (Note: Environmental changes include seating changes.)
6. **Under what circumstances can physical restraints be used?**

If the restraint is used to enable the resident to attain or maintain his or her highest practicable level of functioning, a facility must have evidence of consultation with appropriate health professionals, such as occupational or physical therapists. This consultation should consider the use of less restrictive therapeutic intervention prior to using restraints.

7. **What procedures must be followed before and while a resident is restrained?**

A resident must be comprehensively assessed by an appropriate health professional to determine the resident’s specific medical symptoms. If a resident is restrained, the assessment must show the presence of a specific medical symptom that would require restraints, those symptoms that are being treated, and how the use of restraints will help the resident reach his or her highest level of physical and psychosocial well-being. Before using restraints, the least restrictive therapeutic intervention must be considered. The least restrictive therapeutic intervention is one that provides the resident the maximum amount of freedom of movement.

8. **Does the resident have the right to refuse?**

The resident, or resident’s surrogate or representative, has the right to participate in care planning and has the right to accept or refuse restraints.

9. **What information does a resident require in order to make an informed decision regarding restraint use?**

The facility should explain potential negative outcomes of restraint use. These might include incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.

10. **Can restraints be used in the event of an emergency?**

If the resident needs emergency care, restraints may be used for brief periods to allow medical treatment unless the facility has noticed that the resident has previously made a valid refusal of the treatment in question.

_This material was abstracted from the State Operations Manual, Provider Certification, “Guidance to surveyors for Long Term Care Facilities,” published April 1992 by the Health Care Financing Administration._
SKILL LAB: Tube Feeding

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION

1. Assessment
   a. Identify client health deviations and medical treatment regimens associated with enteral feedings.
   b. Describe the appearance and location of a gastric tube (GT) and a nasogastric tube (NGT) on the patient's body.
   c. Identify bedside equipment needed with intermittent (bolus) feedings and for continuous feedings.
   d. Briefly identify commonly used tube feeding formulas and food. Describe a typical treatment order for such feedings.
   e. Describe assessments to determine adequacy of fluid intake.
   f. Identify fecal elimination problems associated with tube feedings.

2. Planning
   a. Identify the expected outcomes of tube feedings.
      I. Identify the risk factors associated with tube feedings, and the nursing interventions designed to prevent complications.
      II. Differential between the nursing interventions required when administering any fluids through a GT as opposed to those required when administering fluids through a NGT.

3. Implementation
   a. Discuss medical asepsis and Standard Precautions as they apply to enteral feedings.
   b. Position patient with head of bed up to at least 45 degrees.
   c. For N/G tube, perform two checks for proper placement of the tube: aspiration of gastric contents and auscultation of air.
   d. For G- tube and NG tube, aspirate stomach for residual and if more than 50 ml, do not proceed with the feeding.
   e. Administer feeding by bolus or drip, as ordered.
   f. Adjust drip rate or speed as appropriate.
   g. Document procedure

CRITICAL ELEMENTS:
1. Protects self and others from contamination during administration of tube feeding.
2. Position patient with HOB up at least 45 degrees.
3. Perform two checks for placement of tube.
4. Verbalize amount aspirated and state rationale for proceeding or discontinuing feeding.
5. Use equipment appropriately to prevent air from entering the stomach during feeding.

STUDENT RESPONSIBILITIES:
1. Come to lab prepared to discuss behavioral objectives and critical elements for nasogastric tube feeding, textbook pages read, skill lab and assessment sheet read.
2. Perform steps as directed by instructor in supervised lab.
3. Practice independently or with requested teacher assistance in preparation for assessment of nasogastric tube feeding.
TEACHER RESPONSIBILITIES:
1. Exhibit different kinds of gastrointestinal tubes and compare and contrast them.
2. Demonstrate each step and observe return demonstration of tube feeding.
3. Provide equipment for practice as needed by students.

HOW THIS SKILL WILL BE LEARNED:
1. Read Potter and Perry p 1111-1112
2. Observe teacher demonstration of skill.
3. Practice skill in lab.

HOW THIS SKILL WILL BE TESTED:

On scheduled campus lab, perform skill according to critical elements with 100% accuracy.
SKILL ASSESSMENT: NASOGASTRIC TUBE FEEDING

Student (print) ______________________________________
Student (sign) ______________________________________
Evaluator ____________________________________________

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<th>Critical ELEMENTS</th>
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RETEST:

Date: ____________________________________________

Evaluator: ________________________________________

33.2
SKILL LAB: Bedmaking

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. Determine when a bed needs to have the linen changed.
   b. Identify when you would make an occupied vs. an unoccupied bed.
   c. Differentiate between an open and closed bed.
   d. Identify/list supplies needed to make the bed.

2. Planning
   a. Describe the principles of medical asepsis needing to be followed in the care of linens
   b. Determine the nurse's responsibility for care of the unit.

3. Implementation
   a. Remove bedspread and loosen sheets.
   b. Roll client to far side of bed and lower the near side rail.
   c. Tuck soiled bottom and pad under client.
   d. Place fitted bottom sheet on bed securing one side.
   e. Place pad on bed.
   f. Roll client onto clean sheets keeping draped at all times and put side rail up.
   g. Go to opposite side of bed and lower side rail.
   h. Remove soiled sheets and dispose.
   i. Pull clean sheets through and secure tightly.
   j. A sure pad is in place without wrinkles.
   k. Roll client onto back.
   l. Place clean top sheet over soiled sheet.
   m. Have client hold clean sheet while removing soiled one.
   n. Apply bedspread to cover sheet evenly and tuck using mitered corners at bottom.
   o. Replace pillowcase.
   p. Clean up bedside unit.
   q. Maintain medical asepsis and safety throughout procedure.

4. Evaluation - discuss expected outcomes of proper bed making procedure.

CRITICAL ELEMENTS:

1. Bottom sheet free of wrinkles.
2. Pad is in place without wrinkles.
3. Pillow case changed and pillow in place.
4. Maintains client safety.
5. Completes procedure without contamination of self/environment.
6. Performs skill within 10 minutes
STUDENT RESPONSIBILITIES:

1. Come to lab prepared to discuss and implement critical elements for occupied bed making. The textbook pages should have been read.
2. Perform steps as directed by instructor in on-campus lab.
3. View video as needed.
4. Practice independently, or with requested teacher assistance, in preparation for assessment of occupied bed making with 100% accuracy according to critical elements.

TEACHER RESPONSIBILITIES:

1. Answer questions and demonstrate possible problem areas.
2. Provide linen for practice.

HOW THIS SKILL WILL BE LEARNED:

1. In the lab demonstration by instructor.
2. Return demonstration under supervision of instructor.
3. Practice independently until skill acquired
4. View video as needed in Learning Center
5. Read Potter and Perry pp 897-904

HOW SKILL WILL BE TESTED:

1. Direct observation in the clinical setting.
2. Students not proficient in this skill in the hospital will be sent to the skills lab for remediation.
SKILL LAB: Positioning – Modified Side Lying (30° Lateral) and Dorsal Recumbent

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. Describe a systematic method of observation of client for muscle strength and quality of alignment: in bed; moving from lying to sitting; in wheel chair.
   b. Identify variables that will alter the positioning and alignment procedures in the client.

2. Planning
   a. Discuss reasons for proper positioning of the client.
   b. Determine appropriate positioning for the client including:
      1. Dorsal Recumbent (supine)
      2. Modified side lying (30° Lateral) position
      3. Prone
      4. Sim’s
      5. Fowler’s
      6. Semi-Fowler’s
      7. Trendelenberg
   c. Identify and describe criteria for selecting support devices.

3. Implementation
   a. Briefly discuss application of principles of body mechanics of the nurse related to turning and positioning of the client.
   b. Procedure - Modified Side Lying Position (Modified Lateral)
      1. Position the client on his/her side.
      2. Support the head on a pillow so that the cervical and thoracic spine are in straight alignment.
      3. Place pillow, folded lengthwise behind client’s back.
      4. Roll client’s torso back on pillow so that the bulk of body pressure is no longer directly on the trochanter
      5. Position upper arm on back pillow. Upper arm may also be supported on a pillow level with the shoulder. Lower arm is supported by mattress.

35.0
6. Use hand rolls if client has paresis or paralysis of an extremity/extremities.
7. Place a pillow lengthwise under semi flexed upper leg from groin to foot
8. Lower semi flexed leg is supported by mattress.
9. Insure malleolus of lower leg is not in contact with mattress. If it is, place a folded washcloth or small towel above the lower malleolus to raise it slightly off the mattress.
10. Maintain dorsiflexion of the feet by placing pillows and sandbags parallel to the plantar surface of the feet. You can also place high top sneakers or other assistive devices on the feet.
11. Stand at foot of bed and check that there is alignment of the cervical and thoracic vertebrae.
12. If the patient is able to reply, ask, "Are you comfortable"?
13. Make any adjustments so that the client can reply, "Yes".

b. Procedure - Dorsal Recumbent Position (bilateral weakness)
1. Position the client on his/her back.
2. Support the head on a pillow so that the cervical and thoracic spine are in straight alignment.
3. Place pillow under each forearm to relieve pressure on elbow.
4. Place hand roll in each hand as is appropriate.
5. Place trochanter rolls along the outer side of the thigh.
6. Place a pillow under leg and ankle to relieve pressure on heel.
7. Support the feet in dorsiflexion by placing pillows and sandbags parallel to the plantar surface of the feet or use of a foot board.
8. Stand at foot of bed and check that there is alignment of the cervical and thoracic vertebrae.
9. If able to reply, ask the client “Are you comfortable?”
10. Make any adjustments so that the client can reply “Yes”.

4. Evaluation - discuss expected outcomes of proper positioning of the client

CRITICAL ELEMENTS:
Moves and positions patient/client to meet the following criteria.

a. The injured or weak body parts are supported.

b. The head, shoulders and pelvis are supported.

c. Correct body alignment is supported.

d. Position is changed in ways that relieve previous pressure areas.

e. Devices and/or body positions are used to reduce pressure on vulnerable skin surfaces (sacrum, head of trochanter, back of heel, shoulder, ankle) and prevent contractures (arms, hands, hips, legs, feet).

STUDENT RESPONSIBILITIES:
1. Come to lab dressed in clothing that allows full movement of body.
2. Read assigned pages in nursing fundamentals text book and be prepared to discuss procedure and critical elements.
3. Practice with a classmate, seeking teacher supervision as needed.
TEACHER RESPONSIBILITIES:

1. Discuss and clarify behavioral objectives and critical elements.
2. Demonstrate positioning to meet critical elements.
3. Provide equipment for practice.

HOW THIS SKILL WILL BE LEARNED:

1. In lab, demonstration of positioning to meet critical elements.
2. Supervised practice of positioning
3. Read Potter and Perry p 1251-1259
4. Recommended: View video - Positioning to Prevent Complications
5. Recommended: Castillo p 31-32

HOW THIS SKILL WILL BE TESTED:

On campus lab testing with student "client" with 100% accuracy
SKILL ASSESSMENT: POSITIONING

Student(print)__________________________________              Date_____________

Student(sign)__________________________________

Evaluator______________________________________

________________________________________________________________________

CRITICAL ELEMENTS

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Side-Lying Position:
1. Moves or positions client by:
   a. supporting the weak or injured parts of the body
   b. supporting the client's head, shoulders, and pelvis
   c. turning, lifting or moving the client to a different position
   d. using body parts or external devices to maintain correct body alignment
   e. using positioning and/or devices to reduce pressure on vulnerable skin surfaces.

Dorsal Recumbent Position (with leg support):
1. Moves or positions client by:
   a. supporting the weak or injured parts of the body
   b. supporting the client's head, shoulders, and pelvis
   c. turning, lifting or moving the client to a different position
   d. using body parts or external devices to maintain correct body alignment
   e. using positioning and/or devices to reduce pressure on vulnerable skin surfaces.

2. Complete procedure in 10 minutes or less

RETEST:
Evaluator______________________________________ Date:________

35.3
SKILL LAB: Lift/Turn Sheet

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION

1. Assessment
   a. Describe characteristics of clients who needs a "lift sheet".
   b. Discuss practical methods of assessment of above characteristics.

2. Planning
   a. Differentiate between a "draw" sheet and a "lift sheet".
   b. Describe types of sheets to use for lifting.
   c. Discuss placement of "Chux" underpads.

3. Implementation
   Describe procedures to carry out following activities safely.
   a. Turning dependent client to place sheet under hips.
   b. Lifting dependent client up in bed with two or more nurses.
   c. Lifting dependent client to side of bed.

4. Evaluation - Discuss expected outcomes of the use of a lift/turn sheet
   a. Client comfort and safety will be maintained
   b. Clients position will be changed effectively
   c. Nurse safety and comfort will be maintained

CRITICAL ELEMENTS:

1. Nurse maintains good body mechanics throughout.
2. Client is moved safely and comfortably.

HOW THIS SKILL WILL BE LEARNED:

1. In the lab, demonstration followed by return demonstration of appropriate use of a lift sheet.

TEACHER RESPONSIBILITIES:
1. Demonstrate a procedure for safe use of turn or lift sheets.
2. Provide environment and equipment for practice

STUDENT RESPONSIBILITIES:

1. Come to lab prepared to discuss BOs and Critical Elements
2. Practice skills as demonstrated.

TESTING: This skill will be observed in the clinical area.
SKILL LAB: Passive Range of Motion (ROM)

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. Define range of motion (ROM).
   b. Determine client's physical ability to perform exercises.
   c. Ascertain client's present level of joint movement and/or muscle strength.
   d. Identify and discuss the purpose and primary principle of ROM.
   e. Differentiate between active and passive ROM.

2. Planning
   a. Differentiate between the role of the physical therapist and the role of the nurse in performing ROM.
   b. Discuss situations when ROM should be performed.
   c. Discuss use of continuous passive motion machines.

3. Implementation
   Using guidelines for ROM:
   a. Place shoulder and elbow in flexion and extension.
   b. Place shoulder through abduction and adduction with elbow flexed and extended.
   c. Place shoulder through horizontal abduction/adduction.
   d. Rotate shoulder through internal/external rotation.
   e. Rotate elbow in supination and pronation.
   f. Rotate wrist with dorsiflexion/extension, with palmar flexion/extension.
   g. Rotate, extend, and flex fingers.
   h. Flex and extend knee.
   i. Rotate hip inward and outward with the knee flexed.
   j. Place the hip through abduction and adduction.
   k. Place ankle through dorsiflexion and plantar flexion.
   l. Place ankle through eversion and inversion.
   m. Place toes through flexion and extension.

4. Evaluation - discuss the expected outcomes of properly administered range of motion.

CRITICAL ELEMENTS:
1. Perform movements smoothly and rhythmically to point of resistance.
2. Supports weight of the extremity at joints during range of motion.

STUDENT RESPONSIBILITIES:

1. Read assigned pages prior to class.
2. Come to lab dressed in clothing that allows full ROM.
TEACHER RESPONSIBILITIES:

1. Discuss critical elements and answer questions to clarify procedure.
2. Demonstrate PROM to meet critical elements.

HOW THIS SKILL WILL BE LEARNED:

1. Teacher will demonstrate range of motion.
2. Students will return demonstration of each movement.
3. Students will practice critical elements prior to testing.

HOW THIS SKILL WILL BE TESTED:

On campus testing with 100% accuracy of critical elements.
**SKILL ASSESSMENT: PASSIVE ROM**

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RETEST:

Date _____________________________

Evaluator _________________________
SKILL LAB: Assisting with Elimination

Part A - Bedpan and Urinal Use

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION

1. Assessment
   a. Identify and distinguish between the two most common types of bedpans and a urinal.
   b. Describe and discuss the use of both a bedpan and a urinal for a client who:
      - cannot raise buttocks/hips
      - can raise buttocks/hips
      - cannot place a urinal
      - can place a urinal
   c. State importance of determining a client's usual urinary and bowel elimination patterns/habits and subsequent application for individualized care.

2. Planning
   a. Identify equipment necessary for assisting a client with use of a bedpan and/or urinal.
   b. Review Universal Precautions and their use when caring for clients who have toileting self care deficits.

3. Implementation:
   a. Wash hands and put on clean/utility gloves.
   b. Obtain bedpan or urinal.
   c. Provide privacy.
   d. Place absorbent pad under hips, if needed.
   e. Position client for use of bedpan or urinal:
      - elevate HOB, and have client raise hips, or
      - have client roll on side, then roll onto pan, or
      - have client sit in chair/commode at bedside, or
      - place urinal base flat on the bed between the client's thighs, position client's penis/urethral opening over the urinal.
   f. Place call light and toilet tissue within reach.
   g. Assist as needed with wiping
   h. Reposition client for comfort and safety.
   i. Observe and measure for intake and output if needed.
   j. Dispose of elimination waste in toilet
   k. Clean urinal/bedpan as needed and return to proper area.
   l. Remove utility gloves and wash hands.

4. Evaluation - discuss expected outcomes of appropriate use of bedpans and urinals.

CRITICAL ELEMENTS FOR BEDPAN AND URINAL USE:

1. Place bedpan/urinal, using appropriate placement and positioning techniques.
2. Place toilet paper and call light within reach.
3. Remove bedpan as soon as client is finished.
4. Protect self and client from contamination, dispose of waste.
5. Monitor and record amount and characteristics of output.
**Part B - Condom Catheter Application**

**BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:**

1. Assessment  
   a. Identify and describe common types of condom catheters, also known as external catheters.  
   b. Distinguish between the use of a condom catheter and an indwelling catheter.  
   c. Describe observation to be made of the genital area whenever using an external catheter including: signs of irritation, edema, skin breakdown, lesions.  
   d. State two possible advantages and disadvantages for the use of an external catheter.

2. Planning  
   a. List all equipment/supplies needed for the application and care of a condom.  
   b. Review use of Universal Precautions appropriate to application and care of a condom catheter.  
   c. Discuss integration of daily condom catheter care during the bath of assigned clients.

3. Implementation - Read assigned pages in nursing fundamentals text book for actual procedure

4. Evaluation - discuss expected outcomes of external condom catheter application and care.

**CRITICAL ELEMENTS FOR APPLICATION OF CONDOM CATHETER:**

1. Cleanse and dry genital area.  
2. Apply a protective coating to the skin.  
3. Place condom on penis, allowing space between the tip of the penis and tubing.  
4. Attach to drainage bag tubing.

**Part C - Adult Incontinence Pads (briefs)**

**BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION**

1. Assessment  
   a. Describe client assessments that indicate a need for incontinent briefs (brand names: Attends, Depends, etc.).  
   b. Describe potential risks associated with use of incontinent briefs.

2. Planning  
   a. Relate the use of incontinent briefs to the client problems identified via assessment  
   b. With instructor’s assistance in lab, describe various types of commercial and “in-house” equipment for adult incontinence problems.

3. Implementation  
   a. Discuss medical asepsis and Universal Precautions as these principles apply to removal of adult continence pads (briefs).  
   c. Describe a procedure for removal of soiled brief and application of clean pads.

4. Evaluation  
   a. Discuss expected outcomes of provision of assisted elimination with clients who are incontinent of bowel and bladder.
CRITICAL ELEMENTS FOR APPLICATION OF INCONTINENT BRIEFS:
1. Cleanse and dry genital area.
2. Client’s dignity will be maintained.
3. Clean brief will provide for effective control of products of elimination.

**Part D - Enemas**

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION

1. Assessment
   a. Describe client assessments that indicate a need for an enema or for a Harris Flush.
   b. Identify common physician orders for enemas.
   c. Describe methods of assessing client's ability to control/assist with enema administration.
   d. Describe potential risks associated with various enema solutions and methods.

2. Planning
   a. Relate type of enema to the client problems identified via assessment
   b. Discuss timing of enemas in relation to the nurse's shift and other hygiene measures.

3. Implementation
   a. Discuss medical asepsis and Universal Precautions as these principles apply to enemas.
   b. Identify/select equipment needed to administer an enema.
   c. Describe a procedure for cleansing tap water enemas and for a small hypertonic enema (Fleets Phosphosoda Enema).
   d. Describe a procedure for a Harris Flush
   e. Describe modifications of procedure needed for clients too weak to walk to toilet.
   f. Describe modifications of procedure needed for clients who are incontinent of bowel and bladder.
   g. Discuss the methods needed to prevent unpleasant odors in the client's room.

4. Evaluation
   a. Discuss expected outcomes of a cleansing enema.
   b. Discuss expected outcomes of a Harris Flush.
   c. Discuss expected outcomes of provision of assisted elimination with clients who are incontinent of bowel and bladder.

CRITICAL ELEMENTS FOR ENEMAS:
1. Select the correct solution per MD order.
2. Position patient to facilitate flow and provide modesty.
3. Provide for safe and effective administration of enema.
4. Provide for safe and aesthetic disposal of incontinence products.

STUDENT RESPONSIBILITIES FOR ASSISTING WITH ELIMINATION LAB:
1. Read assigned pages in nursing fundamentals text book and be prepared to discuss behavioral objectives and critical elements.
2. Practice in lab with equipment and appropriate demonstration dolls.
3. Give a return demonstration during the same lab, meeting the critical elements.
TEACHER RESPONSIBILITIES:
1. In lab, demonstrate the procedures related to assisting with elimination to meet critical elements.
2. Clarify any questions related to assisting with elimination.
3. Provide equipment in lab so that students may practice use of bed pan, urinals, Fleets enemas, tap water enemas, and Harris Flushes.

HOW THIS SKILL WILL BE LEARNED:
1. Prior to lab read Potter and Perry pp 1165-1171, 1195-1203
2. Discuss and clarify critical elements in lab.
3. In lab, observe teacher demonstration of bedpan and urinal use, application of condom catheter, Fleets enema, tap water enema, and Harris Flush.

HOW THIS SKILL WILL BE TESTED:
When opportunity presents in the clinical facility, the student will administer an enema to a patient meeting critical elements with 100% accuracy.
SKILL LAB: Bathing including Draping

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. Assess client's need for bathing and other personal hygiene activities.
   b. Assess client's abilities, preferences and activity order.

2. Planning
   a. Identify purposes (objectives) of giving a bed bath.
   b. Identify the equipment needed for giving a bed bath.
   c. Discuss perineal care of the client with a catheter.
   d. Discuss the applications of the principles of Medical Asepsis and Universal Precautions in providing personal hygiene for clients.

3. Implementation - see procedure in textbook.

4. Evaluation - discuss expected outcomes of a properly administered bed bath.

CRITICAL ELEMENTS:

1. Provides privacy appropriate to the situation.
2. Prevents chilling by covering parts of body not being washed.
3. Assesses the condition of the skin.
4. Washes skin surfaces client cannot wash.
5. Rinses skin surfaces client cannot rinse.
6. Dries skin surfaces client cannot dry.
7. Applies skin preparation when designated.
8. Changes water at least once during the bath.

TEACHER RESPONSIBILITIES:

1. Answer questions and discuss behavioral objectives and critical elements.
2. Provide equipment for practice as needed, including basin, soap dish, lotion, towels, wash cloth, and bath blanket.
3. Observe students during practice and assist as needed.

STUDENT RESPONSIBILITIES:

1. Watch video #43. Basic Clinical Skills: The Bed Bath prior to class.
2. Come to lab prepared to discuss hygiene behavioral objectives and implement procedure and critical elements for bathing.

HOW THIS SKILL WILL BE LEARNED:

1. Demonstration of draping and bathing.
2. Discussion of bed bath procedure and any questions related to critical elements.
3. Prior to lab, read Potter and Perry p 866-884

HOW THIS SKILL WILL BE TESTED:

Students will be tested in the hospital giving actual patient care. All critical elements must be met with 100% accuracy.
SKILL LAB: Back Rub

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. List some health deviations and ordered medical treatments that are associated with the need for a back rub to prevent problems.
   b. List patient assessments that indicate a need for a back rub.
   c. Identify conditions or factors for which a back rub would be contraindicated.

2. Planning
   a. Discuss the purpose/goals of a back rub/ massage.
   b. Identify/obtain appropriate supplies

3. Implementation
   a. Use skin lotion to lubricate.
   b. Position client and environment following correct body mechanics.
   c. Describe a back rub technique for a patient with:
      - Stage I decubiti (pressure area)
      - No evidence of pressure area
      - Muscle tension (no evidence of pressure area)

4. Evaluation - describe desired outcomes of a back rub when given:
   a. For muscle tension
   b. To increase circulation

CRITICAL ELEMENTS:

1. Use a skin lubricant.
2. Use appropriate massage techniques over intact skin.
3. Does not massage over damaged skin areas.

STUDENT RESPONSIBILITIES:

1. Come to lab prepared to discuss behavioral objectives and implement the critical elements.
2. Complete reading assignment prior to class.
3. Wear appropriate clothing to allow receiving a back rub with desired modesty.

TEACHER RESPONSIBILITIES:

1. Demonstrate back rub
2. Provide equipment necessary for back rub, including lotion.

HOW THIS SKILL WILL BE LEARNED:

1. In the lab demonstration on video
2. Prior to lab read Potter and Perry p868

HOW THIS SKILL WILL BE TESTED:

1. Testing will be on an actual patient in the clinical setting meeting critical elements with 100% accuracy.
BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATIONS:

1. Assessment
   a. Describe information to be obtained from the client or chart to determine previous oral hygiene status and practices. Include condition of teeth, dental appliances and/or dentures.
   b. Describe routine observation of client's present oral hygiene status. Include: presence of lesions or tenderness (stomatitis, sordes), degree of moisture and/or dryness of mouth, cleanliness of teeth and mouth, condition of skin of lips and surrounding area.
   c. Discuss client characteristics that indicate how much assistance the nurse will need to give in providing oral hygiene:
      1. Self care or minimal assist (educative, supportive in Orem's theory)
      2. With assistance (partially compensatory in Orem's theory)
      3. Total care (wholly compensatory in Orem's theory)

2. Planning
   a. Identify and state safety measures to be used whenever cleansing dentures.
   b. Describe application of Standard Precautions to the provision of oral hygiene for clients.
   c. List equipment necessary for providing oral hygiene care for the following situations:
      1. Alert client, minimal or no assistance (educative supportive role of nurse)
      2. Alert client requiring assistance (partially supportive role of nurse)
      3. Unconscious client (wholly compensatory role of nurse)
      4. Client with dentures or other removable dental appliances

3. Implementation see procedure in Potter and Perry.

4. Evaluation - discuss expected outcomes after performing oral hygiene, including description of physical findings of oral cavity.
   a. Oral mucous membrane and lips will remain intact
   b. Teeth will remain in stable condition

CRITICAL ELEMENTS:

1. Employ universal precautions when performing oral hygiene.
2. Maintain client safety, especially in prevention of aspiration in the unconscious client.
3. Assess mouth and lips before and after care.
4. Record description of physical findings of mouth.
5. Safeguard client's dentures from loss or breakage.

STUDENT RESPONSIBILITIES:

1. Come prepared to discuss behavioral objectives and implement critical elements.
2. This skill will be assessed in the hospital on an actual patient.
TEACHER RESPONSIBILITIES:

1. Answer any questions and assist prior to testing as requested.
2. Provide equipment for practice as necessary.

HOW THIS SKILL WILL BE LEARNED:

1. Campus lab demonstration.
2. Read Potter and Perry p884-888
3. View video: first few minutes of Application of Principles of Infection Control: Bath and Personal Hygiene, Health Science Consortium, 18 minutes (#190.4)

HOW SKILL WILL BE TESTED:

1. Actual testing will be in health care agency.
SKILL LAB: Feeding the Dependent Patient

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. Identify situations when clients need to be assisted with eating/drinking
   b. Identify methods of determining client's ability to safely chew and swallow food/liquids.

2. Planning
   a. Identify/obtain special equipment available to aid clients with specific problems.

3. Implementation
   a. Position client in sitting or high Fowler's position.
   b. Offer water to assess swallowing ability.
   c. Feed dependent client, maintaining client dignity.


CRITICAL ELEMENTS:

1. Maintain safety and patency of airway.
2. Maintain client's dignity while feeding.
3. Prepare food for safety.

STUDENT RESPONSIBILITIES:

1. Be prepared to feed dependent patients.
2. Practice as needed to be able to feed patients.

TEACHER RESPONSIBILITIES:

1. Discuss and briefly demonstrate feeding methods to meet critical elements.

HOW THIS SKILL WILL BE LEARNED:

1. Discussion of critical elements and behavioral objectives.
2. Observing teacher demonstration of methods of oral feeding.
3. Return demonstration of critical elements will be on actual patients.
4. Prior to lab, read Perry and Potter 1110-1111

HOW THIS SKILL WILL BE TESTED:

1. Return demonstration, in hospital, meeting above critical elements.
SKILL LAB: Dressing Change

BEHAVIORAL OBJECTIVES - NURSING PROCESS APPLICATION:

1. Assessment
   a. Identify and describe the rationale for and advantages of dressings.
   b. Identify types of dry dressing materials and agents used to clean wounds.
   c. Identify and describe the characteristics of a healing wound specific to size, color, drainage, and/or the presence of granulation tissue.

2. Planning
   a. Discuss the rationale for frequency of dressing changes and the impact on healing specific to dressing materials ordered.
   b. Identify and describe the importance of maintaining a sterile conscience when performing a sterile dressing change.

3. Implementation
   a. Put on clean gloves to remove old dressing.
   b. Remove soiled dressing without contaminating self or wound.
   c. Dispose of soiled dressing into a bag and close bag to contain contamination.
   d. Remove contaminated gloves without contaminating self.
   e. Create and maintain a clean field with dressing materials.
   f. Prepare tape for application by adding date, time and initials.
   g. Prepare prescribed cleansing solution, if ordered.
   h. Prepare prescribed medication, if ordered.
   i. Put on clean gloves without contamination.
   j. If ordered, cleanse wound with cleansing solution.
   k. If prescribed, apply medication as ordered.
   l. If packing, select correct material.
   m. Apply clean dressing.
   n. Secure new dressing in place.
   o. Record an accurate description of current status of the wound and application of new dressing.

4. Evaluation
   a. Identify and describe the expected outcomes for wound care; include in this description wound healing status, client/family education needs, and availability of resources/equipment.
CRITICAL ELEMENTS:

1. Remove and dispose of soiled dressing without contamination.
2. Assess wound and/or surrounding skin.
3. Cleanse wound with designated solution when prescribed.
4. Apply topical preparation when prescribed.
5. Apply dressing correctly.

STUDENT RESPONSIBILITIES:

1. Come to lab prepared to:
   a. Discuss critical elements and behavioral objectives.
   b. Practice skills as demonstrated.
2. Seek assistance as needed.

TEACHER RESPONSIBILITIES:

1. Demonstrate many different dressing changes.
   a. Simple dry dressing
   b. medicated dry dressing
   c. wet to dry dressing
   d. packing a sinus tract
   e. wrapping a limb
   f. wrapping a stump
2. Provide rationale for the select of each type of dressing.
3. Provide time and equipment to practice.
4. Be available for supervised practicing.

HOW THIS SKILL WILL BE LEARNED:

1. Campus lab demonstration of procedure to meet critical elements.
2. Read Potter and Perry 669-671
3. View: Videotape - "Infection Control - an Update for the Health Professional, Medcom. Beginning at about 240 on the tape dressing a wound is discussed.

HOW THIS SKILL WILL BE TESTED:

1. Through direct observation in the clinical setting.
2. Students who have difficulty in the clinical area will be sent to the skills lab for further evaluation.
4 ½ hour Day and Documentation

1) Describe the use of the following pages from the syllabus:
   (a) The “Head to Toe” Baseline Assessment guidelines
   (b) The 11A Nursing Care Pan (NCP)

2) Describe how to complete the nursing diagnosis, and the goals/outcomes portions of the NCP.

3) Describe how to complete the interventions and nursing agency portions of the NCP.

4) Describe principles of setting priorities. Using these principles, determine the order in which you would do the following: make a bed; give a bed bath; give the bedpan; serve breakfast; get the patient into the chair, etc. Give reasons for your order of care.

5) Determine the time required to do each of the items in #1. Prepare a schedule to perform these tasks from 0700 -11:00.

6) List several tasks that are routine for a nurse (e.g., charting, reporting off duty). Fit these into your schedule.

7) Describe the timing and content of the student verbal report off to the co-assigned licensed nurse who has responsibility for the care of the client.
   i) Discuss the purpose of writing your personal “Today’s Learning Objective” on each clinical day’s NCP.

8) Discuss the organization of a 4.5 hour day of patient care:
   (a) VS, baseline assessment, charting of taken vital signs
   (b) Check patient’s Kardex or similar sources of information
   (c) Finalize nursing care plan and turn in to your instructor PRIOR to the beginning of nursing care, except that feeding of breakfast may be done when the tray arrives
   (d) Recheck patient’s status

9) Report off duty to assigned nurse and responsible CNA.

44.0
11) Attend conference on time.
12) Describe the purpose and content of the post-conference
   a) Share feelings and experiences of first day in the hospital
   b) Complete the evaluation of your personal learning objective and nursing care given
   c) Turn in completed NCP to clinical instructor at the time specified by the instructor.

13) Identify the “Self Evaluation for Nursing Students” form and discuss how to
    (1) complete this form daily to maintain a record of achievement.
14) Define and give example of “patient abandonment”.

15) Discuss basic documentation rules including:
   b) Black ink is used for legal chart records
   c) Signature: M. Nurse, NSI, LBCC
   d) Initials: First and last initial used, with no fancy flourishes. The initial alone
      means that an action was completed. Circling the initials means that the activity
      was NOT done.
   e) Errors are corrected by a single line through the wrong entry. Write the
      word error over the entry and write your initials.
   e) Do not scribble over the words, use white out, or attempt to erase.
LAB CONFERENCE: "Head to Toe" Baseline "Assessment

Follow instructor’s directions for carrying out the “baseline assessment” on mannequins in the practice lab before starting your clinical experience. In the real world of clinical experience, try to follow a routine that will include all of the important data.

1. Describe how to perform a “head to toe” assessment of a patient and where to place this information on the NCP.

2. Establish initial communication:
   i) Hand hygiene
   ii) Introduce yourselves
   iii) Provide privacy
   iv) Identify patient
   v) Explain procedure

3. Note need for hair care and/or shaving. Take the temperature with the available instrument (ear or mouth usually), noting condition of oral mucous membranes and teeth/dentures. Note color of face and lips.

4. Take the pulse, note rate and rhythm of the beat. Note the color and feel the temperature of the upper extremities.

5. While still holding wrist for pulse, count respirations. Note the presence of any difficulty breathing, any noises with respirations.

6. Take BP. Note presence of any upper extremity contractures, deformities, or weaknesses. Note presence of IV and take BP on opposite arm.

7. Ask the patient how (s)he eats and drinks, or note the presence of feeding tube - NG or Gastrostomy. If appropriate, have the patient take a drink of water to evaluate swallowing.

8. If alert, ask patient when last BM occurred and whether normal or not.

9. Tell patient you want to listen to the heart, and pull up gown to expose chest and abdomen. While placing stethoscope on chest wall, observe chest and abdomen for presence of lesions or recent surgical scars. Check for perineal odors and presence of a “brief”, condom catheter or Foley catheter.

10. Ask the patient to turn over so you can examine his/her back. Assess the ability of the patient to turn over in bed. Note cleanliness and any breaks in the skin. Look for any lower extremity weakness or contractures. Note condition of skin on heels.
11. If you are not certain that client is fully alert, determine LOC and orientation: If awake, ask "Can you tell me where you are now", "What is today?", "Tell me your name". If alert, ask why in hospital.

12. Estimate ethnicity and developmental level. Ask about occupation, or former occupation. Ask about any spiritual concerns.

13. If there are any clues that the patient has pain, ask him/her what hurts and how much pain is present. Reposition the client and replace the covers. Wash your hands.

14. Look all around the bed and immediate area for any drainage container; note amount and color of urine, suction, etc

15. Look around patient’s area for any safety hazards.

16. Read the Flow sheet and/or Graphic Record to assess general status of vital signs the last few days. Note temperature elevations and any marked changes in respiration, pulse rates and blood pressure. If recorded, find the 24 hour totals of Intake and Output and look at the output last shift (during the night). Note stool record to confirm or refute patient’s recollection. Look for usual amount of food eaten.

17. Read the Daily Activity Record. Note what patient’s ADLs have been over the past few days.

18. When assessment and intervention portions of the LBCC Nursing Care Plan is completed, follow clinical instructor’s directions for completion of the campus lab.
Simulated Hospital Lab

Uniform check: Come to the assigned campus lab room on your clinical day. Read the LBCC uniform policy so that your appearance will comply with the written guidelines. Dress in complete uniform and bring stethoscope, pen, pencil, all appropriate course study guide pages. Mosby’s Nursing Diagnosis Book and A CHANGE OF CLOTHING. You will be allowed time during the morning to change into street clothes. The class will break into clinical groups for discussion of first day activities and information. BE PREPARED.

OVERVIEW OF LAB AND LEARNING OBJECTIVES:

A. Uniform and appearance check:
   1. Validate that your uniform is appropriate or identify changes needed.

B. Follow instructor’s directions for carrying out the “baseline assessment” on mannequins in the lab

C. Complete a head to toe assessment on your mannequin patient.

D. Discuss and clarify information gathered from the baseline assessment exercise.

E. Describe and discuss possible nursing diagnoses and goals for the simulated patient.

F. Describe and discuss nursing interventions appropriate for the simulated patient,

G. Select the agency appropriate for each category of the NCP

H. Fill out a NCP and submit to your clinical instructor as directed.
Long Beach Community College District
LONG BEACH CITY COLLEGE
Associate Degree Nursing Program
ADN11 AL Introduction to Nursing
FORM: ASSESSMENT OF THE OLDER ADULT

Student Name: ______________________________
Facility: ___________________________ Date: ___________________________

### Patient Profile

<table>
<thead>
<tr>
<th>Initials:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex: M/F</td>
<td>Language:</td>
</tr>
<tr>
<td>Race:</td>
<td>Religion:</td>
</tr>
</tbody>
</table>

### Family Profile

<table>
<thead>
<tr>
<th>Spouse: Living/Deceased</th>
<th>No. of living children:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation:</td>
<td>Others in household:</td>
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</table>

### Education, Financial, Occupational Profile

<table>
<thead>
<tr>
<th>Educational Level:</th>
<th>Employment:</th>
</tr>
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<tbody>
<tr>
<td>Length of unemployment/retirement:</td>
<td></td>
</tr>
</tbody>
</table>

### Home Profile

<table>
<thead>
<tr>
<th>Dwelling type: Home/Apt.</th>
<th>Multiple/Single/Detached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own/Rent:</td>
<td>Tel./Utilities:</td>
</tr>
<tr>
<td>Location of bathroom:</td>
<td>Location of bedroom</td>
</tr>
<tr>
<td>Household Responsibilities:</td>
<td>Pets:</td>
</tr>
<tr>
<td>Gen. Living Conditions:</td>
<td>Safety:</td>
</tr>
<tr>
<td>Nearest Neighbor:</td>
<td></td>
</tr>
</tbody>
</table>

47.0
### Health and Social Resources

<table>
<thead>
<tr>
<th>Home Health Nurse:</th>
<th>Meals on Wheels:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO/Clinic:</td>
<td>Other:</td>
</tr>
<tr>
<td>Social/Leisure activities:</td>
<td></td>
</tr>
<tr>
<td>Organization membership:</td>
<td></td>
</tr>
<tr>
<td>Hobbies/Interests:</td>
<td></td>
</tr>
</tbody>
</table>

### Health History

<table>
<thead>
<tr>
<th>Allergies:</th>
<th>Hospitalizations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Health Problems:</td>
<td></td>
</tr>
<tr>
<td>Diabetes:</td>
<td>Hypertension:</td>
</tr>
<tr>
<td>Fractures:</td>
<td>Cancer:</td>
</tr>
<tr>
<td>CVA:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

### Current Health Status

<table>
<thead>
<tr>
<th>Understanding of health problems:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limitations of function or ADL’s:</td>
</tr>
<tr>
<td>Management of limitations:</td>
</tr>
<tr>
<td>Health goals:</td>
</tr>
</tbody>
</table>

47.1
## Physical Assessment

**VS:**

**LOC:**

**Ht:**

**Wt:**

**Speech:**

Memory of past events:

### Oral Health & Nutrition:

<table>
<thead>
<tr>
<th>No. teeth/condition:</th>
<th>Hearing Impairment:</th>
<th>Full Vision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentures Fit</td>
<td>Hearing Aids:</td>
<td>Night Vision:</td>
</tr>
<tr>
<td>Last Dental Visit</td>
<td>Last hearing exam</td>
<td>Color</td>
</tr>
<tr>
<td>discrimination:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chewing problems</td>
<td>Taste:</td>
<td>Reading:</td>
</tr>
<tr>
<td>Swallowing problems</td>
<td>Smell</td>
<td>Eye Glasses:</td>
</tr>
<tr>
<td>Appetite</td>
<td>Touch/Painful Stimuli</td>
<td>Contact Lenses:</td>
</tr>
<tr>
<td>Fluid intake exam:</td>
<td></td>
<td>Date of last eye</td>
</tr>
<tr>
<td>Appetite: problems:</td>
<td></td>
<td>Other eye</td>
</tr>
<tr>
<td>Usual Meal Pattern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Preferences:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet Restrictions:</td>
<td></td>
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</tr>
</tbody>
</table>

47.2
<table>
<thead>
<tr>
<th>Rest/Sleep</th>
<th>Mental/Emotional Status</th>
<th>Attitude /Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual sleep pattern:</td>
<td>Attention Span:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LOC:</td>
<td></td>
</tr>
<tr>
<td>Insomnia:</td>
<td>Behavior:</td>
<td></td>
</tr>
<tr>
<td>Meds/Alcohol to induce sleep:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self Concept:</td>
<td></td>
</tr>
<tr>
<td>Factors affecting sleep:</td>
<td>Stressors:</td>
<td></td>
</tr>
<tr>
<td>Night confusion/Restlessness:</td>
<td>Coping Skills:</td>
<td></td>
</tr>
</tbody>
</table>

**Elimination**

<table>
<thead>
<tr>
<th>Bladder:</th>
<th>Bowel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voiding Pattern:</td>
<td>Usual Pattern:</td>
</tr>
<tr>
<td>Generic/Brand Names:</td>
<td></td>
</tr>
<tr>
<td>Urine Characteristics:</td>
<td>Constipation/Diarrhea:</td>
</tr>
<tr>
<td>Nocturia:</td>
<td>Incontinence:</td>
</tr>
<tr>
<td>Frequency:</td>
<td>Hemorrhoids:</td>
</tr>
<tr>
<td>Enemas:</td>
<td>Incontinence:</td>
</tr>
<tr>
<td>Straining:</td>
<td>Catheter/Ostomy:</td>
</tr>
<tr>
<td>Recent changes in habits:</td>
<td>Suppositories:</td>
</tr>
<tr>
<td>Stools:</td>
<td>Laxatives:</td>
</tr>
</tbody>
</table>

**Skin Condition**

| Intact:                        | Rash:                    |
| Any normal findings:           | Dry:                     |
| Discoloration:                 | Pruritus:                |
|                                | Wounds:                  |
|                                | **47.3**                 |
### Functional Status

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility:</td>
<td>Contractures:</td>
</tr>
<tr>
<td>ADL’s Independent/Assist:</td>
<td>Arthritis:</td>
</tr>
<tr>
<td>ROM U E</td>
<td>ROM LE:</td>
</tr>
<tr>
<td>Dominant Hand:</td>
<td>Drive/Bus/Other:</td>
</tr>
<tr>
<td>Gait:</td>
<td>Paralysis/Weakness:</td>
</tr>
<tr>
<td>Assistive Device(s):</td>
<td>Other Physical Limitations:</td>
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<tr>
<td>Caregiver @ home:</td>
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</table>

### Sexual Profile

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude towards sex:</td>
<td>Sexual concerns:</td>
</tr>
</tbody>
</table>
### Long Beach City College ADN Program

**Nursing Care Plan** for ADN 11 AL-Introduction to Nursing

<table>
<thead>
<tr>
<th>Student_______________</th>
<th>Date_______</th>
<th>Patient’s Initials_______</th>
<th>RM/Bed#_______________</th>
<th>Adm Date_______</th>
<th>Responsible Nurse________________</th>
<th>Coassigned NA__________________</th>
<th>MD_________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Diagnosis_______</td>
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</tbody>
</table>

**Basic Conditioning Factors:**

- Age______
- Sex______
- Religion______
- Occupation______
- Ethnicity______
- Family Role______
- Develop Level______
- Predisposing Factors/Past Medical Hx_____________________________________________

**Code Status_________________**

**Allergies_________________**

---

**Universal Self Care Requisites**

<table>
<thead>
<tr>
<th>Physical Assessment</th>
<th>Self Care Deficits</th>
<th>Goals</th>
<th>Therapeutic Self Care Demands</th>
<th>Nsg Agy</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.N.S. &amp; Psychosocial:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>LOC:</td>
<td></td>
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<tr>
<td>Affect:</td>
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<td></td>
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</tr>
<tr>
<td>Communication:</td>
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<tr>
<td>Deficits:</td>
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<td></td>
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<tr>
<td>Spiritual Concerns:</td>
<td></td>
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</tbody>
</table>

| Cardio-Respiratory: |                   |       |                               |         |
| VS:                 |                    |       |                               |         |
| Pain scale:         |                    |       |                               |         |
| Resp. Pattern:      |                    |       |                               |         |
| SOB:                |                    |       |                               |         |
| Cough:              |                    |       |                               |         |
| Sputum:             |                    |       |                               |         |
| Skin Color:         |                    |       |                               |         |
| O2 Sat:             |                    |       |                               |         |
| O2:                 |                    |       |                               |         |

| GI, Metabolic:      |                   |       |                               |         |
| Intake:             |                    |       |                               |         |
| N/V:                |                    |       |                               |         |
| Abd:                |                    |       |                               |         |
| BM:                 |                    |       |                               |         |
| Tubes/Drains:       |                    |       |                               |         |
| Hygiene:            |                    |       |                               |         |

| GU, Fluid and Electrolyte: | | | Measure intake PO: | |
| Turgor:                   | | | Other: Measure output Urine: | |
| Urine color:              | | | Other: | |
| Tubes/Drains:             | | | | |

| MS, Integument & Comfort: | | | | |
| Body Build:               | | | | |
| Strength:                 | | | | |
| Posture:                  | | | | |
| Deficits:                 | | | | |
| Pain Loc:                 | | | | |
| Pain Character:           | | | | |
| Sleeping:                 | | | | |
| Skin cond:                | | | | |
| Dressing:                 | | | | |

***STAR the PRIORITY PROBLEMS 48.0***
List below any topical medications ordered:

<table>
<thead>
<tr>
<th>Name of Topical Med</th>
<th>Class of Medication</th>
<th>Ordered Dose</th>
<th>Normal Dose Range</th>
<th>Nursing Responsibility</th>
<th>Reason Medication was Prescribed</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Write a note below related to one patient problem. Include your signature and title.

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

Timeline for clinical day

<table>
<thead>
<tr>
<th>0700</th>
<th>0800</th>
<th>0900</th>
<th>1000</th>
<th>1100</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Report to Staff patient status: ________________________________

Present location of patient: __________ Charting Complete: ________________________________

My learning objective for today is:

____________________________________________________________________________________

Self Evaluation of today’s performance:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Interventions completed:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

48.1
Samples of appropriate terms to be used in writing the LBCC Nursing Care Worksheet for ADN 11A:

BASIC CONDITIONING FACTORS:
- **Ethnicity** - any convenient group name, i.e., Caucasian, Latino, American Indian, African American, Asian, etc.
- **Occupation** - general term - laborer, teacher, retired Army, etc. If retired, give former occupation.
- **Family Role** - grandfather, husband, wife, father, mother, head of household, no close family,
- **Developmental Level** - Ego Integrity versus Despair; Generatively versus Self-absorption; Intimacy versus Isolation, etc.
- **Predisposing Factors/Hx** - any condition that would make the patient more vulnerable or susceptible to the onset of the medical diagnosis. Hx - medical conditions the patient has had in the past. Examples: chest pain; recent episode of bleeding, etc.
- **Code Status** - Full Code, DNR, or other agency terms

MENTAL AND PSYCHOSOCIAL ASSESSMENT:
- **LOC** - alert, awake, drowsy, semi-conscious, unconscious
- **Thought content** - appropriate, rambling, inappropriate. If unable to assess, write “Unable” or “aphasic, etc.”
- **General affect** - happy, sad, anxious, hostile, angry, cooperative, non-responsive
- **Communication** - normal speech, slurred speech, no response;
- **Hearing/vision deficit** - normal hard of hearing, wears hearing aid; normal vision, wears glasses, blind, artificial eye, cataracts
- **Spiritual concerns** - record patient's reply to questions regarding concerns patient has regarding their spirit Write "Unknown" if unable to assess

CARDIO-RESPIRATORY ASSESSMENT:
- **V/S** - Write in the Vital signs. Write O (oral), Ax (axillary), R (rectal), T (tympanic) If apical pulse taken describe the rhythm (regular, irregular)
- **Pain Scale** - Use 0-10
- **Respiratory pattern** - normal, labored, noisy
- **Skin color** - pink, pale, cyanotic, gray
- **Cough** - none, occasional frequent, productive, non-productive
- **Sputum** - include the color (clear, white, yellow, pink, cloudy), the consistency (thin, thick, tenacious) and the amount: (small, moderate, large).
- **Oxygen** - via nasal cannula (nc) or mask; at flow rate in liters per minute,
- **Suction at bedside** - if equipment is present at bedside, check

49.0
GI, METABOLIC ASSESSMENT:
- **Intake** - percentage What diet is the patient on?
- **Nausea/vomiting** - no, yes - if so, how often, color, amount
- **Hygiene** - teeth and mm - clean, foul odor, sordes, lips cracked
- **Last BM** - give date from reliable patient or from nursing records. Character of BM - diarrhea, soft, hard. Check appropriate flowsheet for this info.
- **Continent of bowel** - continent, incontinent, incontinence brief. Check appropriately.
- **Drains** - Colostomy, Ileostomy, Fecal bag. Write in if present. Enteral feeding - check if G tube, NG or J tube is present. Under “Amt. taken by 7 AM,” write the number of mls displayed on the enteral pump.

GU, FLUID AND ELECTROLYTE ASSESSMENT:
- **Skin turgor** - normal, delayed, poor
- **Mucous membranes** - moist, sticky, dry
- **Urine color** - straw, yellow, amber, brown, pink, red; clear, cloudy
- **Tubes/Drains** - Urinary cath: If present, write in Foley, suprapubic, External urinary cath - refers to a condom catheter. If present, check.

MUSCULOSKELETAL, SKIN AND COMFORT ASSESSMENT:
- **Body Build** - thin, normal, obese description (example, cachectic)
- **Strength** - If bilaterally write equal. If not, specify difference examples: no response, R side weak, L side weak, paralysis of R/L side, weakness of lower extremities (LE)/ upper extremities (UE).
- **Posture** - write good, Slumps to L/R, indicate posture such as fetal position.
- **Deficits** - R BKA (below knee amputation), contractures of R arm, etc. Use of Assistive devices - cane, quad cane, walker, wheelchair, traction, cast, splints, eggcrate mattress, sheep skin, heel protectors, elbow protectors. Restraints - wrist, ankle, posey, soft, leather
- **Resting quietly, restlessness, agitation** - check appropriately. Other_________ - write in other descriptors of behavior, example: noisy.
- **Pain** - Character: sharp, dull, ache; Behavioral manifestations (facial, verbal, body language); Location: write site
- **Skin** - dry, moist, well lubricated; hair dry, clean, oily; Skin lesions - any decubiti with location and depth (Stage I, II, III), bruises, swelling, laceration, senile atrophic changes
- **Dressings** - location, dry, moist, no drainage, foul odor, type of drainage: serous, serosanguinous, sanguinous

NURSING AGENCY COLUMN
Document the level of nursing care required in each category of care by writing WC (wholly compensatory), PC (partially compensatory), or ES (educative/supportive)
### HUNT & FIND AT VA

Find the following and write down where they are located:

<table>
<thead>
<tr>
<th>Item</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. student assignment board</td>
<td></td>
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<tr>
<td>2. crash cart</td>
<td></td>
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<tr>
<td>3. fire alarms &amp; extinguishers</td>
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<tr>
<td>4. staff assignment board</td>
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<td>5. patient therapy board</td>
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<tr>
<td>6. patient appointment board</td>
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<td>7. shower schedule</td>
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<td>8. staff restroom</td>
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<td>9. kardex</td>
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<td>10. chart racks</td>
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<td>11. daily activity record</td>
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<td>12. vital signs flow sheet</td>
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<td>13. treatment record</td>
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<td>14. bed scale</td>
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<td>15. bedside commodes</td>
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<td>16. wheelchairs</td>
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<td>17. Hoyer lifts</td>
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<td>18. geri chairs</td>
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<td>19. shower chairs</td>
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<td>20. bath gurney</td>
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<td>21. shower room</td>
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<tr>
<td>22.</td>
<td>tub room</td>
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<tr>
<td>23.</td>
<td>tube feeding formula</td>
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<tr>
<td>24.</td>
<td>clean supply room: locate</td>
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<tr>
<td></td>
<td>a. clean briefs</td>
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<td></td>
<td>b. condom caths</td>
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<td></td>
<td>c. dressing supplies</td>
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<td></td>
<td>d. tube feeding bags/tubing</td>
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<td></td>
<td>e. sterile gloves</td>
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<td>f. chux</td>
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<td>g. sterile water</td>
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<td>h. normal saline</td>
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<td>25.</td>
<td>bedpans/urinals</td>
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<tr>
<td>26.</td>
<td>IVAC thermometers</td>
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<td>27.</td>
<td>blood pressure cuffs</td>
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<td>28.</td>
<td>clean linens</td>
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<tr>
<td>29.</td>
<td>disposal of dirty briefs</td>
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<tr>
<td>30.</td>
<td>disposal of dirty linens</td>
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<tr>
<td>31.</td>
<td>disposal of infectious trash</td>
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<tr>
<td>32.</td>
<td>day room/TV room</td>
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<tr>
<td>33.</td>
<td>patient dining room</td>
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<td>34.</td>
<td>OT dept.</td>
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<td>35.</td>
<td>PT dept.</td>
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<tr>
<td>36.</td>
<td>Dining area.</td>
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</tbody>
</table>
LONG BEACH CITY COLLEGE  
Associate Degree Program  
(ADN 11A Introduction to Nursing)  

STUDENT CLINICAL EVALUATION

Student Name _______________________________________________  Dates of Course ____________________________________________

<table>
<thead>
<tr>
<th>Theory: _______ %, Course Letter Grade: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Clinical Rating: ________________ ( ) Satisfactory ( ) Marginal ( ) Unsatisfactory</td>
</tr>
<tr>
<td>Dates: <em><strong><strong>/__<strong>/</strong></strong></strong> Through: <em><strong><strong>/</strong></strong></em>/</em>_____</td>
</tr>
</tbody>
</table>

Lab Absences: _______________ Tardies: _______________

Introduction:
The student is expected to satisfactorily participate as a member of the clinical team; to complete all assigned course outcomes while safely, effectively, and consistently using acceptable principles of client care.

Directions:
Both the student and instructor will evaluate each student’s performance. The student evaluates self in the indicated column. If the instructor agrees, no additional mark will be made. If the instructor’s evaluation differs with that of the student, the instructor will circle the student’s mark and initial. The instructor will then mark the column indicating the evaluation of the student.

Criteria:
--Overall Satisfactory Rating
At the end of the course, each student is expected to receive a satisfactory rating on 75% or more of the clinical days to receive a passing grade.

--Overall Clinical Marginal Rating
An overall clinical marginal rating may be based on one overriding area of safety or on a group of behaviors that have been identified as “Marginal” (Must Improve) in 50% to 74% of the behavioral objectives for the course.

--Unsatisfactory Clinical Rating
An unsatisfactory clinical rating will be given for clinical practice whenever the student receives a second Overall Clinical Marginal Evaluation, or whenever the student demonstrates unsafe clinical practice, i.e., patient safety or welfare is compromised, or meets less than 50% of the behavioral objectives for the course. See Student Handbook for explanation of process and options.

Criteria Definition:
- A check in the S (Satisfactory) column indicates that 75% or more of the time, the student demonstrated appropriate behavior, knowledge, and skills consistent with the current level of student experience.
- A check in the M (Marginal) column indicates that 50% to 74% of the time, student behavior does not meet the expected objective(s). Documented comments should clarify the problem area(s).
- A check in the U (Unsatisfactory) column indicates that the student met their objectives less than 50% of the time, and that behavior is below the acceptable level of performance. A behavior compromising the safety of the client will result in an unsatisfactory evaluation. Unsatisfactory areas will be documented in the appropriate section(s) on the evaluation.
- A check in the N (Not Applicable, or not observed) column indicates that the behavior was not evaluated.
Clinical Outcomes
At the completion of this course the student will satisfactorily complete the following clinical outcomes utilizing the nursing process.

<table>
<thead>
<tr>
<th>I. Role: Member of a Profession</th>
<th>S &gt; 75%</th>
<th>M 50-74%</th>
<th>U &lt; 49%</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attendance - follows handbook policy.</td>
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<td>2. Promptness - on duty on time, returns from break on time.</td>
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<td>3. Preparation - comes with proper materials to perform assigned role.</td>
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<td>4. Appearance - follows dress code.</td>
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<td>5. Performs with reasonable composure during stressful situations.</td>
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<td>6. Accepts and responds to constructive criticism and suggestions.</td>
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<td>7. Requests supervision when needed.</td>
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<td>8. Maintains legal and ethical practices.</td>
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<tr>
<td>8a. Maintains confidentiality of information regarding clients.</td>
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<td>9. Shows initiative in meeting learning needs.</td>
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<tr>
<td>9a. Seeks out learning opportunities in clinical setting.</td>
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<tr>
<td>9b. Completes skill requirements per 11A/11AL study guides.</td>
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<tr>
<td>9c. Remediates deficit areas as needed.</td>
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<tr>
<td>10. Communicates relevant information to members of the healthcare team.</td>
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<tr>
<td>10a. Makes contact with assigned licensed (RN/LVN) staff members.</td>
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<td>10b. Makes contact with assigned unlicensed (CAN) staff members.</td>
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<tr>
<td>10c. Obtains proper information prior to patient care.</td>
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<td>10d. At the end of the shift reports off to both licensed and unlicensed staff.</td>
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<tr>
<td>11. Maintains a professional and collegial relationship with the healthcare team.</td>
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</tbody>
</table>
II. Role: Provider of Care

<table>
<thead>
<tr>
<th>A. Assessment - Establishes a Database.</th>
<th>S &gt; 75%</th>
<th>M 50-74%</th>
<th>U &lt; 49%</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Utilizes Dorthea Orem's Model to establish each client's database in a timely manner.</td>
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<tr>
<td>a. Performs thorough baseline physical assessment and document on nursing care plan.</td>
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<tr>
<td>b. Submit complete nursing care plan at agreed upon time.</td>
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<tr>
<td>c. Utilizes available sources to complete data collection.</td>
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<tr>
<td>d. Identifies critical changes in health status.</td>
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<tr>
<td>e. Identifies nursing agency for each USCR assessment.</td>
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</tbody>
</table>

B. Diagnosis - Utilizes Pathophysiology and Nursing Theory

| 1. Selects 2 appropriate NANDA approved nursing diagnosis for each client. |         |          |         |     |          |
| 2. Identifies appropriate R/T factor for each nursing diagnosis. |         |          |         |     |          |
| 3. Supports diagnosis with defining characteristics. |         |          |         |     |          |

C. Planning - Constructs comprehensive plan of care.

| 1. Formulates realistic, measurable short-term goals that correlate with nursing diagnosis |         |          |         |     |          |
| 3. Submits nursing care plans in a timely manner. |         |          |         |     |          |
| 4. Identifies nursing interventions appropriate to achieve goals. |         |          |         |     |          |
| 5. Prepares for safe drug administration. |         |          |         |     |          |

D. Implementation - Initiates safe plan of care.

| 1. Demonstrates safe performance of nursing skills. |         |          |         |     |          |
| 2. Correlates nursing theory, pathophysiology to practice. |         |          |         |     |          |
| 3. Demonstrates effective communication with client, family, healthcare team & instructor. |         |          |         |     |          |
| 4. Reports changes in client status to appropriate personnel |         |          |         |     |          |
| 5. Administers and monitors drug regime. |         |          |         |     |          |
| 6. Demonstrates caring client centered care. |         |          |         |     |          |
7. Implements effective teaching, learning opportunities for clients and families.

8. Gives relevant and complete report to appropriate personnel prior to leaving unit.

9. Documents according to LBCC and agency policy and guidelines.

10. Completes a clinical assignment in an organized, timely manner.

**E. Evaluation-Determining goal achievement**

1. Determine client responses to nursing interventions.

2. Reviews & modifies plan of care.

3. Utilizes critical thinking in providing care.

**III. Role as a Manager**

<table>
<thead>
<tr>
<th></th>
<th>S &gt; 75%</th>
<th>M 50-74%</th>
<th>U &lt; 49%</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establishes priorities in the care of clients.</td>
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<td>2. Serves as a patient advocate.</td>
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<td>4. Demonstrates continuing progress in mastering new skills.</td>
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<td>5. Utilizes critical thinking in the case study presentation.</td>
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<td>6. Performs the group leader role according to behavioral objectives.</td>
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</tbody>
</table>
Student Comments

Strengths:

Areas Needing Improvement:

Instructor Comments:

Problem Areas:

Student __________________________
Date ____________________________
Instructor __________________________