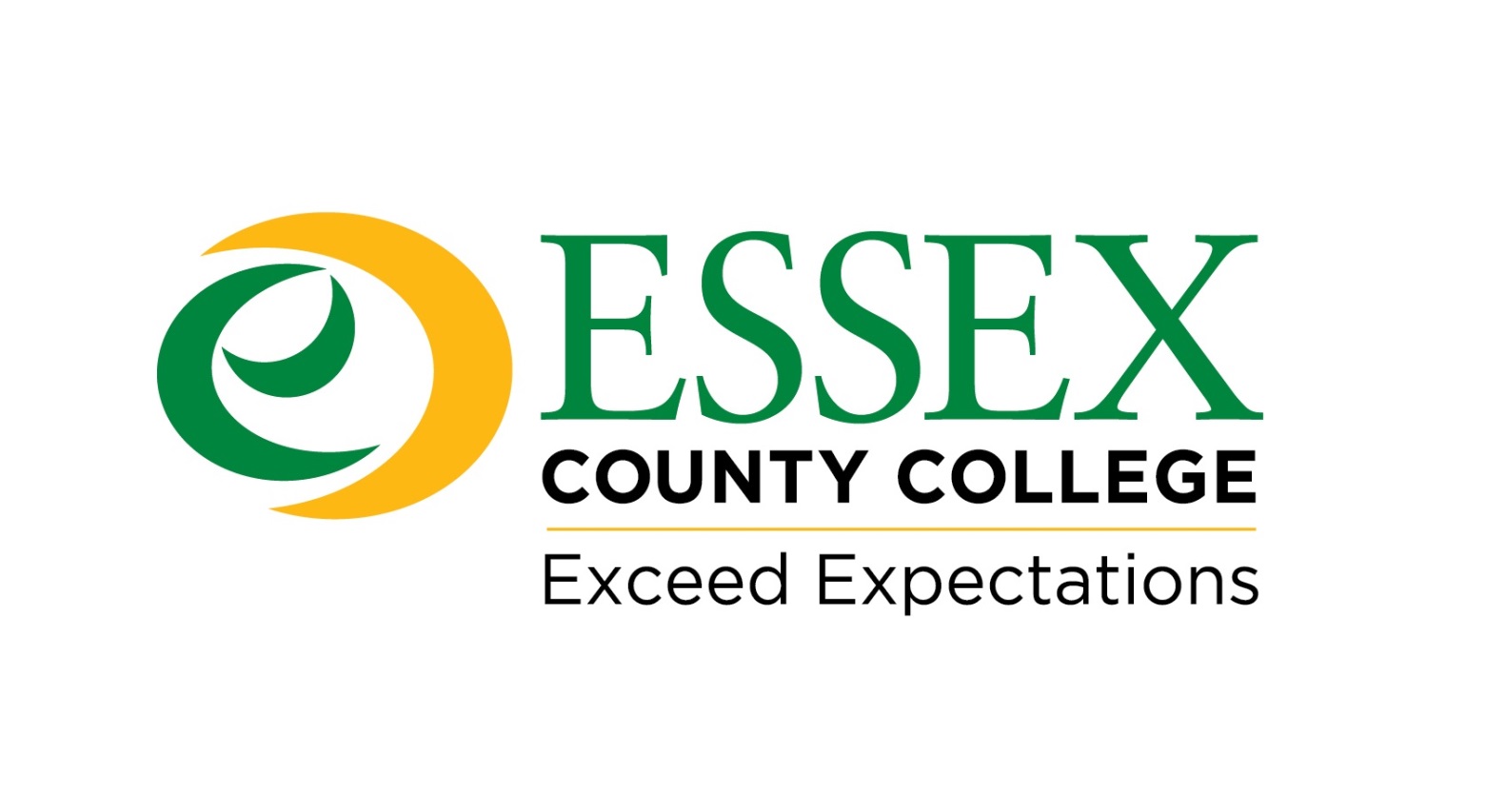
**ESSEX COUNTY COLLEGE**

**DEPARTMENT OF NURSING**

**SIMULATION & SKILLS LABORATORY PRACTICE GUIDE**

**FALL 2020**



**Introduction**

Welcome to the skills lab component of the nursing program. This skills lab practice guide describes the structure and timing of the practiced skills and policies; help provide you (student) with information you need as well as to serve as a reference guide for the skills you need to progress in the nursing program. You must master and demonstrate successfully all nursing skills from fundamentals to senior level in order to progress in the nursing program. These skills will help you develop into competent nurse practitioners. For more information about the nursing program rules and regulations, please refer to the Nursing Handbook.

**Purpose of this Skills Lab Practice Guide**

The nursing students of Essex County College represent the school, and therefore, it is important to present a professional appearance, demonstrate and provide safe competent patient care.

**Policy**

It is the policy of ECC Nursing students to master and demonstrate successfully all nursing skills from fundamentals to senior level in order to progress in the nursing program.

**Students and Instructors Responsibilities**

**STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SCHOOL ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COURSE LEVEL: NRS 104: \_\_\_\_\_NRS 106: \_\_\_\_NRS 111: \_\_\_\_\_NRS 114:\_\_\_\_\_NRS 206: \_\_\_\_\_NRS 216: \_\_\_\_\_\_**

**Practice 1 Date: \_\_\_\_\_\_Practice 2 Date: \_\_\_\_\_\_Practice 3 Date: \_\_\_\_\_Test-Off Date: \_\_\_\_\_\_**

**YOU, THE STUDENT, MUST HAVE A TOTAL OF THREE PRACTICE BEFORE TEST-OFF. EACH PRACTICED SKILL MUST BE DATED & INITIALED BY YOUR FACULTY/INSTRUCTOR. THIS WILL CERTIFY THAT YOU ARE READY FOR YOUR SKILL TEST-OFF**

**Purpose:** This tool is provided to help you keep a record of the skills you practiced and performed in the lab or clinical area. It will aid you in your assessment and planning for each of your clinical rotation; promote and increased your skill acquisition; boost your confidence; and competency. This tool will also facilitate individualized teaching and learning throughout the clinical education process.

**Student Skills Lab Responsibilities:**

* It is your (the student) responsibility to maintain this skills checklist
* You must share your skill list with your clinical/faculty instructor at the beginning and end of each lab or clinical rotation
* Complete your skills self-evaluation prior to the beginning of each clinical rotation
* Document the date when the skill has been successfully demonstrated in the clinical setting or skilled Lab
* Indicate your skill level and initial as student

**Instructors/ Faculty Responsibility:**

* Faculty/Instructor will validate successful returned demonstration of skill by the student in the classroom, skilled lab, or in clinical area
* Document date when the skill has been successfully demonstrated
* Initial and sign each skill procedure witnessed done by student
* Identify area where student need more practice and or remediation
* Ensure that the student is familiar with the appropriate resources and references to assist with remediation or practice

**Objectives:**

At the end of the 3rd practice, the student will be able to:

1. Utilize appropriate PPE for Infection Control
2. State the purpose for each skills demonstrated
3. Identify the different types of nursing skills according to course level.
4. Demonstrate each skills correctly.
5. Use National Patient Safety Goals-Joint Commission standard for client identification
6. Educate & ensure client comfort and provide privacy
7. Dispose of used equipment appropriately
8. Document relevant information in narrative or electronic format

**Practice Guidelines for Test-Off**

1. Please review any specific policies related to course syllabi.
2. NO Test- Off or Practice will be allowed during times that a student is scheduled to attend any other class
3. Schedule required practice appointments via the skills lab schedule
4. Be sure to request testing appointment after 3rd practices in the skills lab
5. Make sure that you have signed up for all test – offs and followed lab requirements
6. Be on time and prepared for test-off appointment.
7. Notify the Skills Lab ASAP if you are unable to keep appointments.

**Call 973-877-3177 (lab)** or contact clinical instructor if cancelling appointment.

1. Reschedule appointment immediately if failed test-off
2. Lack of preparation, including checklist for practice or test-off, incorrect test-off forms, or equipment may result in re-scheduling or delay of test-off and/or practice sessions
3. Bring all necessary ATI Test–Off Forms, any necessary equipment, such as stethoscope or penlight, for testing. May also bring own drug book for IV and Medication check –offs.
4. Most test – offs are independent, but some do require a partner. If a partner is indicated, you still need to sign – up individually. You must have a partner for some test-off skills. However, you will be evaluated on an individual basis.
5. If your *test – off* is unsatisfactory, remediation will be required prior to retesting. See Skills Lab Evaluation form
6. Sign practice sheet each time you practice with date and time. Instructor or lab coordinator must initial each practice visit and amount of time spent practice

**Skills & Simulation Lab Rules**

1. The Nursing Skills Lab is an extension of your clinical and academic programs. Therefore, all the same requirements for maintaining professional behaviors in both Clinical and Skills Lab settings apply (i.e. dress and behavior, etc.). See Nursing Handbooks.
2. **NO FOOD OR DRINK** **IN THE LAB** (may cause damage to equipment)
3. **NO CELL PHONES** during testing or in student work areas (Please turn phones off) (Can be very distracting to students when testing & practicing)
4. Students are required to wear their student ID at all times while in the lab and follow the recommended dress code of the college. If you forget your ID, name tags are available at the sign-in desk.
5. Appropriate attire is required. (Follow college/nursing handbooks).
6. Respect lab personnel and equipment at all times.
7. **Suggestion:** Start a Skills Lab Notebook at the beginning of your nursing program (Organize all skills lab related information (i.e. Procedure sheets, Procedure books, notes). These materials are utilized each semester.
8. Review all Skills Lab Policies and Procedures

* Rescheduling
* No Call No Show
* Skills Testing (Check –offs)
* Remediation Policy
* Competency Testing: Returning Students
* Equipment Fee Policy
* Review and check lab schedules for open and closed times (Posted on Website, Outside of Lab areas)
* Sign in and out of the lab at all times for both practice and testing. Book is located inside skills lab by front doors.
* Put all coats and book bags in room 206 or 209. DO NOT put in practice or testing areas. Keep valuables (purses) with you.
* Failure to meet deadlines – May result in failure to meet course objectives.

**NEW:** *All Students Must Be in Their ECC Uniform at All Time for Clinical and Lab coat for*

*Skills/Simulations Lab*

* No excessive jewelry
* Long hair must be tied back
* No artificial nails
* Uniform and lab jacket must be neat, clean at all times. No crushed-up-dirty-looking uniform or lab jacket allowed.
* Professional attire recommended for psych rotations along with ECC lab jacket.

**Skills Practice Time Rules:**

1. Skills lab resource manuals/reference materials are available for reference. Please DO NOT REMOVE from lab.
2. Practice/Testing areas: Follow directions/signs for use of lab space and equipment. Ask for directions and for location of practice or testing equipment.
3. Students may be assigned equipment for their own use during the semester for certain classes. If you are assigned equipment from the skills lab, it is your responsibility to keep this equipment (i.e. Cath kit or IV tubing) intact and to bring it with you to practice. When you are finished with the supplies for the semester, return them to the lab.
4. If at any time your equipment becomes faulty, please return it to the lab for disposal and for replacement.
5. Designated equipment & supply practice carts and/or cupboards are available. (This helps to contain your lab fees) All equipment and supplies for practice are to be reused unless otherwise instructed. Please **DO NOT ACCESS** other areas unless instructed to do so. **SEE and FOLLOW ALL POSTED SIGNS & DIRECTIONS**
6. Lab Resources: Space, Equipment (manikins, simulators, IV pumps) and Personnel are limited during high usage times, i.e. right before and during testing times. Access is on a first-come first-served basis. Consider using off times to practice. The highest demand for use of space and equipment is right after class.
7. Sharing of resources (space & supplies) when practicing may be necessary. Four – six students per bed/manikin is dependent on skill. Working in groups is also beneficial for learning.

**Care of Manikins:**

1. Use gloves when handling all manikins and parts.
2. **DO NOT MOVE MANIKINS OR MANIKIN PARTS WITHOUT THE HELP OF LAB PERSONNEL.**
3. **DO NOT** use **BETADINE** on manikins. Use soap as lubricant for tubes.
4. Use beds for practice and testing purposes only (Not for sitting-on).
5. Individuals serving as patients are to remove their shoes when lying on the beds.
6. Report any malfunctioning, unsafe, or damaged equipment to lab personnel.
7. New equipment will be issued for most check-offs (F/C kit, Trach Care Kit). This helps to contain your skills lab fees. If you are returning for a repeat check-off, you may not be using new equipment.
8. If you are aware that you have a latex allergy, or suspect that you do, it is your responsibility to notify skills lab personnel. Non-latex gloves and equipment is available upon request.
9. Some equipment such as sphygmomanometers may be signed–out by instructor for community affairs only (NOT FOR CLINICAL SITES). (There are a limited number in the lab). Students are advised to get their own stethoscopes.
10. You have the opportunity to sign out some of the equipment from the skills lab for practice. The items currently available to be signed out are books and some videos for self-study-practice.
11. We do not let any student sign out stethoscopes, sphygmomanometers, IV supplies, or medication supplies (i.e. syringes, needles). Check with lab personnel regarding PPE

STUDENT AGREEMENT

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to abide by the program requirements published in the Essex County Nursing Program Handbook in effect at the time of my enrollment. I also agree to be bound by the policies and protocols contained in the Student Skills Practice Checklist & Test-Off Guide as they may be updated from time to time. The College Nursing Program reserves the right to change any provision, offering, requirement at any time within my enrollment period in the nursing program.

My signature signifies that I have read the information related to the nursing Simulation/Skills Lab Practice, Test-Off, Rules, and Policies.

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKILLS PERFORMANCE CHECKLIST**

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| --- | --- | --- | --- | --- |
| **SKILL ITEMS** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **Practiced Skills Independently** | **Test-Off**  **Pass/Fail** |
| Follow CDC Protocol for Hand Hygiene Donning & Doffing PPE due to COVID-19  ***Hand Washing:***   1. Wet wrist and hands while keeping hands lower than elbow 2. Apply sufficient liquid soap from container, lather hands 3. Apply friction vigorously using firm circular motion while keeping fingers pointing down lower than wrist. Scrub between each finger, palm, front, back of hands, interlocking 4. Cleaned under fingernail 5. Scrubbed all areas 20 – 30 secs 6. Soiled hands 40 – 60 seconds 7. Rinses thoroughly, keeping hands below elbow 8. Thoroughly dry the hands from fingers up to wrists and forearm with paper towels 9. Uses a clean, dry paper towel to close hand faucet or pedal |  |  |  |  |
| **DONNING PPE** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **Practiced Skills Independently** | **Test-Off**  **Pass/Fail** |
| ***Donning Gloves***   1. Remove glove from glove receptacle 2. Inspect package for sterility, dryness, holes, punctures, watermarks, and expiration date 3. Arrange work surface at waist level and within vision 4. Open and remove inner package, placed on clean surface 5. Fold back inner package to expose gloves 6. Arrange inner package for left, right, up and down with cuffs near self, fingers pointing away 7. Grasp glove at wrist edge with thumb and index finger, slip fingers into openings. Pull glove up to wrist 8. Puts on gloves on dominant hand. If some fingers got stuck, left them that way until other glove was on. Did not let outside glove touch nonsterile surface 9. Put on other glove by reaching under cuff of second glove with 4 fingers of gloved hand 10. Adjust each glove with other hand until comfortable 11. Touch only sterile items 12. Hold sterile hands above waist level in front of body |  |  |  |  |
| ***Removing Gloves:***   1. Grasp near cuff of one glove and pull from wrist towards fingertip until the glove folds over 2. Hold and remove glove in palm of gloved hand. Keeping it wadded up as much as possible 3. With ungloved hand, carefully insert two fingers into the cuff of the gloved hand 4. Slide fingers down towards fingertips until glove folds over turning glove inside out while also encasing the other contaminated glove 5. Avoid touching outside of glove 6. Properly dispose gloves in receptacle. |  |  |  |  |
| ***Donning Isolation Gown***   1. Assess need for gown (PPE) 2. Grasps and unfold gown and hold it so the opening is toward your back. 3. Allows to fall open without contaminating 4. Slides both arms into sleeves or place one arm at a time through sleeves 5. Keeps sleeves of gown above waist level 6. Wrap gown around waist covering back of clothing   8. Tie gown in back or fasten gown at  neck snugly |  |  |  |  |
| ***Removing Soiled Isolation Gown***   1. Untie neck strings, bringing them around shoulders so that gown is partially off shoulders 2. Using dominant hand and grasp clean wristlet, pull sleeve over nondominant hand 3. Grasp outside gown through sleeves at shoulders. Pull gown over arms, holding both gown shoulders in one hand 4. Carefully draw other hand out of gown, turning arm of gown inside out. Repeat procedure with other arm 5. Hold gown away from body. Fold gown up inside out 6. Discard in appropriate receptacle |  |  |  |  |
| ***Applying Facial Mask/Goggles***   1. Selected appropriate Mask/Respirator, Goggles, Face Shield 2. Separate mask to open fully 3. Picks up mask with top ties or ear loops 4. Locate thin metal strip that goes over nose bridge 5. Place metal strip over bridge of nose and ties or slips loops around ear 6. Place lower edge below chin and ties 7. Presses metal strip to conform to bridge of nose 8. Gently pre-bends nose piece to conform mask to face 9. Holds mask upside down to expose the two headed bands with index fingers 10. Cups mask under chin with orange side out 11. Ties /elastic bands at middle of head and neck 12. Places first headband at neck, pulls remaining band up and around head to fit 13. Forms nose piece tightly across bridge of nose and face, adjust mask to achieve facial seal and adjust 14. Dons face shield by placing over eyes and secure straps |  |  |  |  |
| ***Exiting Client’s Room Utilizing Standard*** ***Precautions***   1. Remove gloves by grasping outside at wrist with other hand while pull to remove it; Ball gloves up in fist of gloved hand; grasp remaining glove inside wrist; slowly pull it downwards and remove and disposed 2. Remove gown by pulling it off from neckline, or untie back; turn sleeves end up and inside out while peeling off gown 3. Ball the gown and place it into an appropriate receptacle 4. Remove facial 5. Remove goggles 6. Wash hands |  |  |  |  |

**TEST-OFF:** Check Pass \_\_\_\_\_\_\_\_\_\_\_\_\_ (or) Fail \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **VITAL SIGNS** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **Independently** | **Test-Off**  **Pass/Fail** |
| ***Assess Blood Pressure***   1. Position patient sitting, feet on floor, legs uncrossed; alternately, lying down 2. Wait 5 minutes after patient has been inactive before measuring blood pressure 3. Exposes upper part of arm and wraps deflated cuff snugly and smoothly around the upper arm flexed slightly, palm upward 4. Locate & palpates brachial artery with finger tip 5. Places stethoscope earpieces in ears. 6. Position stethoscope over brachial artery and continues to inflate cuff rapidly to 30 mm Hg above level previously determined by palpation; Ensure stethoscope tubing is not touching anything 7. Turning to right to tighten screw valve on the air pump on sphygmomanometer to close for pumping air; Turn screw to left to loosen and release air at 2 – 3 mm Hg/sec 8. Closes sphygmomanometer valve, and inflates cuff to determine mm Hg at which radial artery can no longer be felt 9. Reads Mercury Manometer at eye level 10. Records Systolic (first sound S1{Korotkoff} 110) diastolic (second sound; S2 80; Records level of muffling if possible) 11. Waits at least 2 minutes if repeating 12. Ensure sphygmomanometer gauge is at zero before inflating cuff 13. Explain to patient need to pump cuff to required amount to ensure accurate reading and inflated cuff may cause some discomfort 14. Note the sound heard, or cessation of Korotkoff sounds, through auscultation. Corresponding gauge reading is SBP 15. State last sound heard or cessation of Korotkoff sound sounds via auscultation. Corresponding gauge reading is Diastolic BP 16. Reads pressure with mercury at eye level when using a monometer filled with mercury 17. Continues to deflate cuff slowly, when thumping sound disappears, removes cuff from patient’s arm 18. Records B/P. Reports abnormal findings if >10% 19. (higher or lower from prior Trends) 20. Wait 2 minute if reassessing |  |  |  |  |
| ***Assess Peripheral Pulse:***   1. Correctly locates, and palpates site using 2. fingers (not thumb) 3. Counts Radial pulse for 30 sec. if regular; 60 sec if irregular 4. Notes rate, rhythm, and quality 5. Palpates Carotid pulse only one side at a time and compares bilaterally 6. Correctly locates sites: Radial, Brachial, Carotid, 7. Temporal, Popliteal, Femoral, Posterior, Tibial Dorsalis Pedis |  |  |  |  |
| ***Assess Apical Pulse:***   1. Correctly locates, and palpates Apical site (5th 2. intercostal space at midclavicular line) 3. Place diaphragm of stethoscope over apical area 4. Listen and count for 60 seconds 5. Notes pulse rate, rhythm and quality 6. Identify S1, S2 heart rate |  |  |  |  |
| ***Assess Apical-Radial Pulse Deficit:***   1. Selects, correctly locates, and palpates apical site (5th intercostal space at midclavicular line) name pulse point 2. Obtains another nurse to assist 3. Places watch so it is visible to both nurses 4. One nurse palpates radial pulse; the other uses diaphragm of stethoscope to auscultate apex 5. Identify correct rate for 60 seconds 6. noting rate, rhythm, and quality 7. Identifies S1 and S2 heart sounds 8. Correctly obtains and record pulse deficit (apical rate minus radial 9. rate)   ***Assess Respiration:***   1. After measuring radial pulse, continue to palpate radial artery while beginning to Count Respirations for one full minute by watching chest rise and fall or placing one hand on the pt.’s chest (1 chest rise and one chest fall = one respiration 2. Count 20 seconds and multiply times three, unless abnormal breathing pattern noted, count respiration one full minute 3. Compare inspiration to expiration to note 4. characteristics 5. Observe the depth, pattern, and quality of 6. respirations 7. Report dyspnea, tachypneic, hypoventilation, or hyperventilation |  |  |  |  |
| ***Pain Assessment:***   1. Differentiate between Pain intensity & Pain Distress 2. State meaning of PQRST 3. Assess location, intensity, appearance, quality, onset, duration precipitating, factors, alleviating factors 4. Demonstrate/describe pain intensity using Pain distress 5. Pain Scales:   a. Numerical 10 Point Rating Scale  b. Wong-Baker FACES Rating  Scale  c. FLACC Scale (Face, Legs,  Activity, Cry, Consolability)  d. Poker Chip Tool Instruments for  children  6. Differentiates between Acute and  Chronic pain  7. State Nonpharmacological  therapeutic nursing measures |  |  |  |  |
| ***Assess Oxygen Saturation:***   1. Select appropriate equipment 2. Correctly apply sensor 3. Describe alternate sites and rationale 4. Remove nail polish/acrylic nail, if present 5. Turn on sensor 6. Attach probe to site chosen site 7. Reads SaO2 in 10 – 30 seconds 8. Checks and correlates sensor’s pulse rate with radial pulse rate 9. Record data |  |  |  |  |
| ***Assess Oral Temperature:***   1. Select correct equipment 2. Selects appropriate site and thermometer type 3. Zeros or shakes down glass thermometer designed only for patient (PO or Rectal) 4. Grasp probe at top of stem, rinse in cool H2O if thermometer was in chemical solution 5. Dry with tissue from bulb end toward fingers 6. Grasp thermometer with thumb and forefinger and shake vigorously by flicking wrist in downward motion to lower mercury level 7. Check level if mercury is below 95 – 96 degrees F. 8. Explain procedure to patient 9. Places tip under tongue in posterior sublingual pocket 10. (right or left of frenulum) 11. Ask client to keep lips closed 12. Wait 20-30 mins if pt. ate, drink, smoke, or exercise 13. Leaves glass thermometer recommended time (oral 3 – 5 minutes) 14. Document result |  |  |  |  |
| ***Rectal Temp***   1. Lubricates thermometer 2. Folds back bed linen to expose buttocks 3. Separate buttock so anal sphincter is visible 4. Depends on patient’s age; Inserts 1/2 to 1.5 inches 5. (2.5 – 3.7 cm) 6. Holds rectal thermometer securely in place for 2 minutes 7. Does not leave patient unattended 8. Obtain accurate temperature 9. Holds glass thermometer at eye level to read 10. Shakes down (as needed) and cleans or stores |  |  |  |  |

**TEST-OFF**: Check Pass \_\_\_\_\_\_ (or) Fail \_\_\_\_\_

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ADMINISTERING COMPLETE BED BATH** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **Practiced Independently** | **Test-Off**  **Pass/Fail** |
| 1. Introduce self, inform patient of procedure 2. Provide comfort for privacy 3. Offer bedpan, urinal, or use of bathroom. 4. Prepare supplies and equipment and place bath on table or chair in order of use 5. Wash hands & don clean gloves 6. Loosen top covers at foot of bed. Fold and remove spread blanket leaving top sheet for cover on patient 7. Place bath blankets over the top linen, ask 8. Have patient hold bath blankets while remove top linens or hold bath blanket in place while removing linens if patient unable 9. Remove pillow, place it on back of chair 10. Hold soiled linen away from uniform, place it in hamper 11. Placed patient in semi-Fowler position as   tolerated for oral hygiene   1. Lower side rail, position patient near side of bed, raise to working level 2. Place bath towel under patient’s head, cover patient’s chest with bath blanket 3. Fill basin with water 2/3 full at 110º to 115ºF (43º to 46ºC) 4. Form a mitt with washcloth around hand   without dangling   1. Dip hand with mitt into bath water, squeeze out excess water, apply soap if not contraindicated. Did not leave soap in water 2. Wash face and hairline using firm, gentle   strokes   1. Use different portion of cloth to bathe each eyelid. Clean from inner to outer canthus and pat dry thoroughly 2. Remove gown from uninjured side first,   grasp waist portion of undergarments or  pajama and ease off over feet   1. Fold bath blanket down to waist, wash chest with circular motion, cleanse and dry under breast and skin folds 2. Rinse bath cloth wash ears and neck. Use cotton-tipped applicators to cleanse pinna of ear 3. Remove bath towel from under patient’s   head. Expose arm farthest, place bath towel lengthwise under shoulder and arm   1. Wash arm using long firm strokes from wrist to shoulder, wash arm-pits thoroughly. 25. Rinse and dry, apply deodorant if applicable 2. Place basin on folded towel on bed; immerse patient’s hand in the water 3. Wash hands and nails while encouraging   finger movements   1. Clean and trim fingernails as needed. 2. Remove basin, dry hand. Repeat procedure other arm and hand 3. Fold bath blanket down to pubic area, keeping chest covered with dry towel 4. Wash abdomen including umbilicus using cotton - tipped applicators and skin folds. Dry thoroughly 5. Raise side rail; empty basin. Rinse basin and wash cloth. Change water 6. Expose far leg, draping sheet securely into groin and under thigh. 7. Flexed leg keeping genitalia covered. Wash, rinse, and dry thigh and leg 8. Immersed foot in basin with no pressure on the calf of leg. Wash foot, paying particular attention to skin between toes, heels, and ankles 9. Encourage toe and ankle movement 10. Dry foot thoroughly while rubbing any calloused area with towel to remove dead skin 11. Apply lotion to the foot and ankle, massaging the heel in circular motion with the palm of your hand 12. Change bath water, and rinse washcloth.   Place pt. prone or in lateral recumbent position.   1. Place towel close to the back and lengthwise on the bed 2. Expose and wash entire back and buttocks. Bathe, rinse, and dry the back from the neck to the sacrum back of pelvis, folds of buttocks and anal areas 3. Lotion use firm, gentle, circular movements, start at base of spine, rub with heel of both hands, up and out, and over shoulders, upper spine and nape of neck 4. Turn patient on back to near side of bed, place towel under hips. 5. Prepared and hand patient washcloth, assist washing pubic and genitalia area as necessary. If patient has indwelling catheter, perform total catheter care 6. Dress patient and assist to chair or stretcher. Remove soiled bath equipment to the utility room   ***Making Occupied Bed***   1. Check pt.’s physical limitation 2. Gather linens supplies: bottom sheet, draw sheet, pillow case. Placed on bedside chair in order of use 3. Lift mattress and loosen used linens edges to free linen without tugging or jerking 4. Remove spread and blanket, leaving top sheet as a cover for patient’s privacy and comfort 5. Position patient on side, rolled up all soiled bedding in layers close to patient’s back 6. Place clean bottom sheet on exposed section of mattress with hem seam down, centerfold in midline 7. Go to opposite side of bed, pull rolled linen through keeping clean linen close to patients back. Pulled out soiled linen and placed in linen bag 8. Pulled bottom sheet tight over mattress from head to foot of bed to complete the foundation 9. Secure side rail up before going to opposite side. Pulled folded linen against patient out smoothly. Tuck under top edge miter corner smoothly and tuck side under moving from head to foot of bed 10. Hold linen folds in place in center of bed with one hand, bring rolled protective sheet back over linen fold to clean foundation. Place clean cotton draw sheet over protective sheet, rolling excess folds toward patient 11. Replace protective sheet, if used. Hold linen folds in place in center of bed with one hand, bring rolled protective sheet back over linen folds to clean foundation. Place clean cotton draw sheet over protective sheet, rolling excess folds toward the patient 12. Go to opposite side of bed, pull rolled linen through keeping clean linen close to patients back; remove soiled linen and place it in clothes hamper. Tighten the mattress cover, head to foot to complete foundation 13. Placed protective sheets or draw sheet, pull taut and wrinkle free by tightening center portion first, then upper and lower ends 14. Turn patient to center of bed, center clean top sheet over patient. Instruct patient to hold clean top sheet while remove soiled top sheet, pulling gently from top to bottom, place soiled sheet in clothes hamper 15. Replace blanket and spread, instructing patient to check for free movement of feet for toe movement 16. Complete cuff at head of bed, fold down top bedding to level comfortable for patient 17. Place clean case on pillow, replace pillow under patient’s head. Adjust bed and side rails as needed 18. Place bedside table, call light and personal items within patient’s reach 19. Remove all unnecessary equipment from patient’s room leaving it clean and orderly |  |  |  |  |

**TEST-OFF:** Check Pass \_\_\_\_\_\_\_\_\_\_\_ (or) Fail \_\_\_\_\_\_\_\_\_

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **MEDICATION ADMINISTRATION** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **Practiced Independently** | **Test-Off**  **Pass/Fail** | |
| Prepares and administers medications according to “Medication Guidelines” Apply Nursing Process & 10 rights for administrating Medication |  |  |  |  |
| Demonstrated Medication Calculation using Formula for: Tablet/Capsule/Oral Liquid  Basic Formula:  a. D x Q = X  H  b. D = Desired or Dosage Prescribed  H = Have/on Hand  Q = Quantity  X = Unknown |  |  |  |  |
| ***Administering Oral Medication:***   1. Compare doctor’s order with MAR 2. Store juice, applesauce & supplements on top of cart with date open 3. Separate Optics from Ophthalmic, Internals from External and controlled from over the counter(OTC) meds 4. Date opened containers   ***First check:***   1. Check accuracy of order on MAR with Doctor’s Order (patient’s name, ID #, medication, dose, route, time, allergies, doctors signature, RBV if TO Identify patient using 2 identifiers 2. Identify appropriate assessment needs as per medication order &/or client condition. Assess patient’s ability to take oral medication: (Swallowing, NPO, Low BP, HR, Allergies, and Labs etc.) 3. Follow agency policies for medication administration including time frame. Most agencies 30 minutes before or 30 minutes after indicated time in MAR after 4. State 10 Rights for medication administration 5. Know drug information, including drug action, purpose, recommended dosage, time of onset and peak action, common side effects, contraindications, drug interactions, and nursing implications 6. Identifies special considerations for med prep and administration (crush, open capsule, admin with food or empty stomach) 7. Checks for medication expiration   ***Second check:***   1. Verifies correct medication, date, dose, time, route, expiration date 2. Calculate and prepare dose accurately for appropriate patient’s age and weight 3. Pull medication, check exp. date, dose, route and time (when administering Tablets & Capsules) 4. Pour from multi-dose container, does not touch medication 5. Pours tablet into cap of bottle, then into medication cup 6. Pours correct number into med cup 7. (If giving less than a whole tablet, breaks scored tablet with hands; use pill cutter if necessary. Does not break unscored tablet) 8. Places entire unit dose package into soufflé’ cup 9. Checks if pill can be crushed. Mixes with soft food (apple sauce) 10. Pours all medications scheduled at same time into same cup. 11. Use separate cup for medications requiring pre-administration assessment (Digoxin etc.) 12. Liquids: Gently shake bottle before opening container if necessary 13. Place bottler lid upside down on counter 14. Palm bottle with label in palm of hand 15. Pours medication, slightly twists bottle when finished to prevent dripping 16. Cleans outside bottle lip with tissue 17. Holds medication cup at eye level to measure dosage 18. Draws up parenteral correctly and label   ***Third Check:***   1. Keep med cart locked and in line of vision at all times and when left unattended. 2. Verifies correct patient using two method identification, including armband 3. Opens unit dose medication at the bedside 4. Check for correct medication expiration date, dose, route, time, and Allergies 5. Educate patient 6. Assist if needed with holding cup to patient lips and tips pills into mouth 7. Remains with patient until sure meds are taken and swallowed 8. Provides liquid to swallow pills 9. Sublingual Medication: Places, or have patient place tablet under tongue. Advised patient to hold under tongue until completely dissolved 10. Topical Medication: Inspects skin for areas of lesions, rashes, erythema and ulcers 11. Wear gloves to remove and clean used site 12. Clean site of old medication 13. Wear gloves for applying topical medications 14. Removes and disposes old medication patch safely |  |  |  |  |
| ***PARENTERAL MEDICATION*** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **No Supervision** | **Test-Off**  **Pass/Fail** |
| ***Administering Parenteral Medication***   1. Select appropriate syringe and needle, considering volume and type of medication, and muscle mass 2. Checks label, expiration date, compares meds, when remove from drawer/shelf before withdrawing/pouring with MAR 3. Accurately locates appropriate site, landmarks and rationale for parenteral medication administration   Injection Sites:   * + Deltoid   + Ventrogluteal   + Dorsogluteal   + Vastus Lateralis   + Rectus Femoris   + Abdomen   + Upper & Lower Back |  |  |  |  |
| ***Administering Intramuscular Injection:***   1. Position patient to access site and relax patient 2. Cleans site with alcohol swab using appropriate techniques 3. Remove needle cap 4. Hold syringe between thumb and fingers like pencil or stretches skin taut, dart at 90-degree angle 5. Aspirate for blood for at least 5 seconds after 'stick' before injecting 6. If no blood return noted in syringe, injects medication slowly 5 – 10 seconds per ml 7. If blood return noted in syringe, removes needle, discards, and prepares medication again 8. Withdraw needle appropriately, apply slight pressure or massage site with gauze pad and applies Band Aid as needed 9. Does not give more than 1ml of medication in a site 10. Activates needle safety system prior to dispose equipment into sharps container 11. Observes patient for reaction & reassess 12. Z-Track Administration: 13. Displace skin away from injection site about 1 to 1.5 inches with side of nondominant hand 14. Does not release the skin to stabilize the syringe 15. Aspirate 5 – 10 seconds; injects medication slowly 5 – 10 seconds per ml 16. Waits for 10 seconds, then removes needle smoothly along line of insertion; then immediately releases the skin 17. Does not massage site 18. Subcutaneous Injection 19. Select appropriate syringe and needle, considering volume and type of medication as per adipose tissue |  |  |  |  |
| ***Administering Subcutaneous Injection:***   1. Position patient to access site and relax patient 2. Use Insulin syringe for Insulin ONLY 3. Use Abdomen only for Heparin 1 – 2” away from umbilical area, assess skin at and around injection site 4. Pinch less than 1 inch, inject at 45-degree angle 5. If obese patient, spread skin taut instead of pinching uses 90 degree angle 6. Keep plunger and needle of syringe sterile 7. inject air into the vial before drawing medicine out (equal amount to ordered dose of medicine) 8. Did not aspirate 9. Did not massage 10. Snap needle guard into permanent safe position once drug is administered 11. Use needle guard for safety when transporting needle (without snapping it permanently |  |  |  |  |
| ***Administering Intradermal Injection:***   1. State indication 2. Select appropriate needle and syringe for volume <1 ml in 3cc with 25 – 27 gauge (3/8 – 5/8” needle 3. Select appropriate syringe-3 ml 4. Angle of insertion 5. Did not draw more than 1 ml medication 6. Select appropriate site (inner forearm, Upper back) 7. Stretches skin taut 8. Injects at 10-15-degree angle with bevel up 9. Inject appropriately and slowly until wheal formed |  |  |  |  |
| ***Eye Drops***   1. Assist Patient to Fowler’s position with head tilt slightly backward 2. Cleans edges of eyelid from inner to outer canthus if needed 3. Hold eyedropper, rests dominant hand on patient’s forehead 4. With nondominant hand, pulls lower lid down to expose conjunctival sac 5. Positions eye dropper ½ - ¾ inch (13 – 19 mm) above patient’s eye; does not let dropper touch eye 6. Ask patient to look up; drops correct number of drops into conjunctival sac, not on cornea 7. Ask patient to gently close eyes 8. Gently put pressure on side of nose close to lacrimal ducts for 1 – 2 minutes if medication has systemic effects   ***Administering Eye Ointment***   1. Pulls lower lid down to expose conjunctival sac 2. Ask patient to look up 3. Applies thin strip of ointment (about 1” (2 – 2.5 cm) into conjunctival sac; twist wrist to break off strip 4. Ask patient to close eyes for 2 – 3 minutes 5. Explains to patient that vision will be blurred for short time |  |  |  |  |
| ***DRAWING UP INSULIN*** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **No Supervision** | **Test-Off**  **Pass/Fail** |
| ***Drawing Up Insulin into A Single Syringe***   1. Check for correct Insulin 2. Get insulin and syringes and alcohol wipes 3. Roll NPH insulin between hands 4. Pull air into syringe equal to amount of insulin needed 5. Leave insulin bottle sitting on the counter and wipe the top of the bottle with an alcohol wipe 6. Let the alcohol dry 7. Take the syringe that has air in it and put it into the top of the insulin bottle (keep the bottle on a flat surface) 8. Push all the air from the syringe into the bottle and keep your finger on the plunger of the syringe to keep it from going back up 9. Pick up the insulin bottle with the syringe still in the top, turning it upside down. 10. Pull out the number of units of insulin you need for your dose and administer |  |  |  |  |
| ***Drawing up 2 Different Insulin in Same Syringe:***   1. Add up the 2 Insulin doses: Amt. of NPH (cloudy) + amt. of Novolog/Humalog (clear) = Total amt. Insulin to be administered 2. Pull correct amt. of air into the syringe and inject into vial with NPH 3. Remove syringe from NPH insulin vial 4. Pulls up correct amount of air Regular (Regular Novolog/Humalog) clear insulin vial equal to the amount needed 5. Inject all of the air into the vial with Regular/clear Insulin 6. Pick up the Regular/clear insulin vial with the syringe still inside and turn it upside down. 7. Pull out the amount of insulin (Novolog/Humalog) need 8. Then go to the NPH bottle and put the syringe into the bottle without putting pressure on the plunger 9. Draw up the amount of NPH insulin need 10. Checked Syringe has correct amount of insulin to be administered |  |  |  |  |

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| **PREPARE & ADMINISTERING INTRAVENOUS (IV) SOLUTION** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **No Supervision** | | **Test-Off**  **Pass/Fail** |
| ***IV Drip Calculation:***   1. Demonstrate Knowledge of IV Drip calculation: 2. Reviews the physician’s order for IV solution and rate of infusion 3. Assesses whether IV will infuse by gravity flow or with an IV pump or controller 4. Obtains supplies: 5. Administration set package (for gravity 6. flow) 7. Calculator or pen and paper 8. Assesses for correct drop factor. 9. Checks tubing administration set box for the drop factor if using gravity flow 10. Choose the formula to calculate drip rate: 11. Volume × drop factor = rate of infusion (Volume is the volume of fluid to be infused) 12. b. Correct unit of measurement - 13. mL/hr. for IV pump and gtts/min for gravity flow 14. Showed Time/Minute in which the specified volume of fluid is to infuse 15. State Rate of infusion is measured in mL/hr. if an IV pump is used or in gtts/min if gravity flow is used 16. Multiplies the volume of fluid you want to infuse by the drop factor 17. Divides the total by the number of minutes in which you want this volume of fluid to infuse 18. Uses 60 as the drop fact for pump/controller |  |  |  | |  |
| ***Administering Intravenous Therapy***   1. Check prescribed IV solution, rate per minute/hour, and duration with MAR 2. Explain procedure to patient 3. Assess patient IV site. Note type of line 4. Gathered and prepares necessary supplies 5. Check sterility and integrity of IV solution, tubing, and pump function 6. Calculate hourly volume and record and how many gtts/min 7. Open IV tubing set (primary tubing with clamp and roller following infection control) 8. Move roller clamp 1 – 2 inches below drip chamber and close clamp 9. Remove cover from primary tubing port. Close roller clamp 10. Open IV administration set 11. Remove cap from insertion proximal end of extension tubing and distal end of primary tubing 12. Insert spike into IV bag port 13. Open clamp and fill chamber half-way and Prime the tube. 14. Expelling air bubbles and replaced cover to distal end of IV set (prim line) 15. Open clamp and regulated flow rate 16. Disinfect hub connected to patient and flush line to check patency 17. 000Connect IV tubing to prepared IV catheter hub. Assess IV site for swelling in surrounding tissue 18. Reassessed patient’s HR, RR, B/P, S/S of infection 19. State difference between Hypotonic, Isotonic, Hypertonic Solution |  |  |  | |  |
| **BLOOD TRANSFUSION** | **Practice 1**  **Needs Close**  **Supervision** | **Practice 2**  **Moderate Supervision** | **Practice 3**  **No Supervision** | | **Test-Off**  **Pass/Fail** |
| 1. Verifies physician’s order, noting indication, rate of infusion, and any premedication orders. 2. Verified informed consent and signed 3. Assess and reinforce patient’s knowledge of procedure 4. Administers any pretransfusion medications as prescribed 5. Obtains the blood product from the blood bank according to agency policy. 6. Wears gloves to handle blood product 7. Rechecks the physician’s order, consent for transfusion, labs, and donor blood type with another qualified staff member 8. Identification, as follows: ask patient to state patient state his full name and date of birth (if he is able) and compares it to the name and date of birth located on the blood bank form. 9. Compares patient name and hospital identification number on the patient’s identification bracelet 10. Compare patient name, hospital identification number on the blood bank form attached to the blood product. 11. Compares the unit identification number located on the blood bank form with the identification number printed on the blood product container. 12. Compares the patient’s blood type listed on the blood bank form with the blood type listed on the blood product container. 13. Contacts the blood bank immediately if any discrepancies occur during the identification process; and does not administer the blood product. 14. If all verifications are in agreement, both staff members sign the blood bank form attached to the blood product container. 15. Documents on the blood bank form the date and time that the transfusion was begun. 16. Makes sure that the blood bank form remains attached to the blood product container until removes the blood administration set from the package and labels the tubing with the date and time. 17. Closes the clamps on the administration set. 18. Removes the protective covers from the normal saline solution container port and one of the spikes located on the “Y” of the blood product administration set 19. Places the spike into NS port and opens roller clamp closest to that spike. 20. Hangs the normal saline solution container on the IV pole. 21. Compresses the drip chamber of the administration set and allows it to fill up half way and primes administration set with normal saline. 22. Attaches the blood filter to the second “Y” port on the administration set and primes it with normal saline solution by inverting it. 23. Inspects the tubing for air. If air bubbles remain in the tubing, flicks the tubing with a fingernail to mobilize the bubbles. 24. Gently inverts the blood product container several times. 25. Removes the protective covers from the administration set and the blood product port. Carefully spikes the blood product container through the port. 26. Hangs the blood product container on the IV pole. 27. Slowly opens the roller clamp closest to the blood product. 28. Obtains and records the patient’s vital signs, including temperature, before beginning the transfusion. 29. Using aseptic technique, attaches the distal end of the administration set to the IV catheter. 30. Using the roller clamp, adjusts the drip rate, as prescribed. (Keep in mind that blood administration sets have a drip factor of 10 drops/mL.). 31. Remains with the patient during the first 5 minutes and then obtains vital signs. 32. Makes sure that the patient’s call bell or light is readily available and tells him alert the nurse immediately of any signs or symptoms of a transfusion reaction, such as back pain, chills, itching, or SOB 33. Obtains vital signs in 15 minutes, then again in 30 minutes, and then hourly while the transfusion infuses. 34. After unit has infused, closes the roller clamp closest to the blood product container and opens the roller clamp closest to the normal saline solution to flush the administration set with normal saline solution. 35. Closes the roller clamp and then disconnects the blood administration set from the IV catheter. 36. Discards the empty blood container and administration set in the proper receptacle according to agency policy. 37. If another unit of blood is required, the second unit can be hung with the same administration set (follow facility policies and protocol) |  |  |  | |  |
| **BLOOD TRANSFUSION REACTION** | **PRACTICE # 1**  **REQUIRES CLOSE SUPERVISION** | **PRACTICE # 2**  **MODERATE SUPERVISION** | **PRACTICE # 3**  **NO SUPERVISION** | **TEST-OFF**  **OR**  **REMEDIATION** | |
| 1. Stops the transfusion immediately if signs or symptoms of a transfusion reaction occur 2. Does not flush the tubing with the normal saline solution attached to the blood administration set 3. Disconnects the administration set from the IV catheter 4. Obtains vital signs and auscultates heart and breath sounds 5. Maintains a patent IV catheter by hanging a new infusion of normal saline solution, using new tubing 6. Notifies physician as soon as the blood has been stopped and patient has been assessed 7. Places the administration set and blood product container with the blood bank form attached inside a biohazard bag and sends it to the blood bank immediately. 8. Obtains blood (in the extremity opposite the transfusion site) and urine specimens according to agency policy 9. Continues to monitor vital signs frequently 10. Administers medications as prescribed |  |  |  | |  |

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| **TRACHEAL SUCTIONING** | **PRACTICE # 1**  **REQUIRES CLOSE SUPERVISION** | **PRACTICE # 2**  **MODERATE SUPERVISION** | **PRACTICE # 3**  **NO SUPERVISION** | **TEST-OFF**  **OR**  **REMEDIATION** |
| 1. Assess client for need for suctioning. 2. Gather equipment. Assemble items for suctioning 3. Explain procedure to client 4. Wash hands 5. Place pt. in Semi-Fowler’s position; measure length of trach tube to determine length of insertion 6. Prepare equipment, pour sterile saline into container 7. Don gloves. 8. Attach catheter to suction tubing. Test suction apparatus while lubricating tube. 9. Turn on suction equipment 80 – 120 mm Hg, attach suction catheter end to suction tubing 10. Rinse catheter by suctioning water 11. Hyper oxygenated lungs with 100% Ambu) bag (2-3 times as client inhales) prior to suctioning and between each pass 12. Insert catheter gently without applying suction about 6 inches or until client coughs. 13. Apply suction intermittently and slowly rotate catheter between dominant thumb and forefinger as withdrawing no more than 5-10seconds 14. Rinse secretions through catheter by suctioning water repeat suction based on assessment; limit suctioning to at least 30-second intervals 15. Replaces O2 source if removed to suction 16. Turn off suctioning   machine and disconnect catheter   1. Coils suction catheter in dominant hand, pulls sterile glove off over coiled catheter and discard 2. Empty vacuum bottle as needed, remove gloves and wash hands 3. Provides mouth care 4. Document procedure and client’s response |  |  |  |  |
| **TRACHEOSTOMY CARE** | **PRACTICE # 1**  **REQUIRES CLOSE SUPERVISION** | **PRACTICE # 2**  **MODERATE SUPERVISION** | **PRACTICE # 3**  **NO SUPERVISION** | **TEST-OFF**  **OR**  **REMEDIATION** |
| 1. Place towel or linen-saver pad over pt.’s chest 2. Wash hands, put on clean gloves and remove dressing 3. Loosen caps on hydrogen peroxide and normal saline 4. Don sterile gloves, alternatively puts sterile glove on dominant hand and clean glove on other hand 5. Removes and discards soiled tracheostomy dressing in a biohazard bag; then removes and discards used gloves 6. Open sterile tracheostomy care tray using sterile techniques 7. Place tracheostomy care equipment on over-bed table and prepare equipment using sterile techniques: 8. Pours hydrogen peroxide into one of the sterile solution container and normal saline solution into the other container 9. Open 4x4 gauze package & separate from fenestrated gauze 10. Wets gauze in normal saline container 11. Opens 2 cotton-tipped applicator packages 12. Open package containing new disposable inner cannula if available 13. Open Velcro tracheostomy ties or double and cut T-Will tape on an angle for length of pt. neck 14. Dons sterile gloves 15. Handles sterile supplies with dominant hand only 16. Removes oxygen source with nondominant 17. Unlocks and removes inner cannula with nondominant hand 18. Placed disposable in biohazard receptacle or immerse reusable cannula in container with hydrogen peroxide and normal saline 19. Clean inner cannula with brush 20. Immerse and rinse inner cannula in sterile saline 21. Dry and replace inner cannula and resume oxygen therapy if ordered 22. Use 4x4 damped with normal saline and clean trach plate and outer cannula 23. Assess for evidence of wound erosion around tracheostomy site 24. Clean trach stoma site with cotton tipped applicator or 4x4 moistened with saline, pat dry 25. Apply fenestrated sterile dressing to tracheostomy site 26. Do not remove old ties until new ties are secure. (Tie tightly with head flexed. Insert one finger between tie and neck to check if secure and comfortable 27. Discard equipment, wash hands, and document procedure |  |  |  |  |

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| **Inserting Indwelling Foley Catheter** | **PRACTICE # 1**  **REQUIRES CLOSE SUPERVISION** | **PRACTICE # 2**  **MODERATE SUPERVISION** | **PRACTICE # 3**  **NO SUPERVISION** | **TEST-OFF RECOMMENDED**  **OR**  **REMEDIATION** |
| 1. Check for order 2. Identify patient 3. Gather and prepare supplies 4. Explain the process and steps to the patient and what to expect before beginning 5. Provide comfort and privacy while allowing easy catheter placement 6. Ask or assist patient to lie on his or her back with legs spread apart. Move ankles up to side (recumbent position) 7. Cover patient’s abdomen with towel or drape with bath blanket. Pull top linens under bath blanket down to foot of bed 8. Push blanket and gown toward patient’s abdomen 9. Assess genital area and need for perineal care 10. Check package for expiration date and manufacture’s guide 11. Wash hands 12. Open the catheter and assembly 13. Put on sterile gloves 14. Open packet of antiseptic solution and pour onto cotton ball/open swab package 15. Prepare lubricant 16. Attach prefilled syringe to catheter’s balloon port 17. Check patency of catheter balloon 18. **Female:** With nondominant hand spread labia minora to expose urinary meatus 19. Clean with one downward stroke with each antiseptic-soaked cotton ball or cotton tips 20. ***Male:*** Clean urethral opening in and around penis from inside outward 21. Hold catheter with sterile dominant hand while stabilizing labia majora 22. Apply lubricant to tip of the catheter, coating distal portion of the catheter (the 2-5 cm portion at the tip) with a generous amount of lubricant 23. ***Female****:* Hold catheter your dominant hand and use your non-dominant hand to spread patient's labia to see urethral opening 24. While patient bears down, insert catheter into urethra 25. Gently advance catheter until urine flow 26. Continue to insert catheter in another 1 - 2 inches to make sure catheter is against neck of the bladder 27. Hold the penis in your non-dominant hand and gently pull upward, perpendicular to patient's body 28. Inflate balloon using the 10 cc water-filled syringe. Gently tug catheter 29. Secure the catheter to the patient's thigh 30. Placed drainage bag lower than the patient's bladder 31. Assess and made patient comfortable 32. Document |  |  |  |  |
| ***Removing Indwelling F/C*** |  |  |  |  |
| 1. Move top linen to foot of bed 2. Place water proof pad under patient 3. Lift gown to expose catheter 4. Drain residual urine into bag 5. Remove catheter holder 6. Place paper drape or towel under patient’s perennial area 7. Attach syringe to balloon port of catheter and remove air or fluid from retention balloon 8. Remove catheter slowly with nondominant hand as patient exhale 9. Observe catheter for blood, mucus, or signs of infection 10. Prepare catheter tip or culture if indicated 11. Clean and dry patient 12. Document per Facility Policy: 13. Date, time cauterized 14. Type catheter (indwelling, condom, suprapubic) 15. Catheter patency 16. Urine quality, quantity, odor 17. Patient alertness, orientation, abdominal assessment 18. Patient/family teaching 19. Patient response |  |  |  |  |

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| **CRUTCH WALK** | **PRACTICE # 1**  **REQUIRES CLOSE SUPERVISION** | **PRACTICE # 2**  **REQUIRES MODERATE** | **PRACTICE # 3**  **NO SUPERVISION** | **TEST-OFF RECOMMENDED**  **OR REMEDIATION** |
| 1. Determine patient’s gait, weight bearing status of lower extremities and ability to follow instructions 2. Provide comfort and safety for patient 3. Adjust crutches to proper length and equipped with heavy rubber suction tips 4. Advise pt. to hold head up with eyes look ahead as in normal walking 5. Placed crutch slightly ahead of feet and outside of each foot 6. Place weight on hands, not axillae to support body weight 7. Hold back straight, body slightly bend at hips 8. Move crutch and affected leg together simultaneously 9. Shift weight from crutches to unaffected leg and then to crutches again |  |  |  |  |
| ***Four-point Gait: (***Partial weight bearing on both legs)   1. Place patient in tripod position 2. Move right crutch forward, then left foot forward 3. Move left crutch forward then right foot forward 4. Repeat sequence as tolerated   ***Three-point Gait:*** (No weight bearing on affected leg)   1. Stand with body weight shifted more to unaffected leg 2. Move affected leg and both crutches forward simultaneously 3. Move unaffected , weight bearing leg forward |  |  |  |  |
| ***Two-point Gait Sequence***: (Partial weight bearing on both legs)   1. Move right leg and left crutch forward together 2. Move left leg and right crutch forward together 3. Each sequence even in length with no pause between steps 4. Arms and legs moving in opposition and partial weight bearing on both legs, balance |  |  |  |  |
| ***Swing-through Gait***: (Patient lower extremities are paralyzing or in braces)   1. Move both crutches forward together about 6 inches 2. Move both legs forward beyond crutches together about 6 inches 3. Body weight centered on heel of hands with elbow extended |  |  |  |  |
| ***Straight Cane:***   1. Select cane with rubber tip intact 2. Cane tip is 6 – 10 inches (15- 25 cm) to side and 6 inches (15 cm) and 6 inches (15 cm) in front of the near foot 3. Use cane on unaffected side 4. No weight bearing on or leaning on affected leg 5. Handgrip at hip level, elbow at 15 – 30-degree angle when placing weight on cane 6. Looks straight ahead |  |  |  |  |
| ***Walker Without Wheel:***   1. Select appropriate walker 2. Engage the brakes 3. Move forward and sit as close to the edge of the chair as you feel comfortable. 4. Keep your feet as far under you as possible. Aim to place your toes directly below the edge of the chair. 5. Place both hands on the arms/seat of your chair OR one hand on the chair and one hand on the walker. 6. Do not tip the walker by placing too much weight on one side of the walker as you stand. 7. Lean forward until you feel some of your weight on your feet. 8. Use your legs to stand as much as possible – your arms should only lift what your legs cannot. Use your arms mostly to help keep your balance as you stand. 9. Do not walk forward until you have tested your balance and you feel strong enough to walk. 10. Disengage/unlock the brakes move wheel chair as needed if a*ble.* |  |  |  |  |
| ***Wheeled/Roller Walker:***   1. Place walker ahead before taking steps. 2. Gently roll the walker ahead as walking. Keep the walker close enough for support. 3. Shorten steps are l shorter step if have little balance. 4. To turn around: stay within the width of the walker even if slightly behind. 5. Roll the walker around without twisting back 6. Always face front of walker. 7. Keep walker within reach. |  |  |  |  |

**TEST-OFF:** Check Pass \_\_\_\_\_\_\_\_\_\_ (or) Fail \_\_\_\_\_\_\_\_\_

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Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL PHYSICAL ASSESSMENT**

**Goal and Objective:**

This is a guide to assist you in performing a general assessment on your client/patient. You should ask yourself each question as you enter your client’s room and throughout your clinical day and write an answer.

At end of the page, you will summarize your answers into a nurse’s note (narrative), which would be appropriate to enter on the client’s chart. This type of assessment is done by nurses for each patient initially and throughout the work day

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **General Assessment** | **PRACTICE # 1**  **REQUIRES CLOSE SUPERVISION** | **PRACTICE # 2**  **MODERATE SUPERVISION** | **PRACTICE # 3**  **NO SUPERVISION** | **TEST-OFF RECOMMENDED**  **OR**  **REMEDIATION** |
| 1. Observed patient/client in:  What position? In Bed, Chair,  Ambulating? |  |  |  |  |
| 2. Level of consciousness (LOC):   * Was patient/client Awake, Alert, * Oriented (AAOx3,4 or 5) to Person, * Place, Date, Time, Situation? * Confused? Lethargic? Obtunded? * Semi-comatose? Comatose? |  |  |  |  |
| 3. Did patient/client offer any  complaints?   * Pain? * Fatigue? * Feeling cold? |  |  |  |  |
| 4. What was the appearance of skin?   * Color? * Temp? * Moisture? * Turgor? * Intact? * Lesion? * Decubitus * Surgical |  |  |  |  |
| 5. What are the vital signs:   * Temperature? * Blood Pressure (B/P)? * Apical Pulse (BPM)? * Respiratory Rate per minute? * Pain? * Capillary Refill? * Radial Pulse (BPM)? * Peripheral pulses? |  |  |  |  |
| 6. When you take vital signs, attempt to listen to heart, lungs and Bowel   * Sounds (BS). What did you hear? * Lung Sounds upon auscultation? * Heart sounds upon auscultation? * BS upon auscultation |  |  |  |  |
| 7. Was the patient receiving Intravenous, Infusions or gastrostomy tube feedings?   * Name of Solution * Infusion Rate * Condition of IV Site * Where was the insertion site? * How much fluid remaining in   Bag or bottle? |  |  |  |  |
| 8. Did the patient have any other tubes?   * Such as Oxygen, Surgical drains, * Foley Catheter (F/C), Naso-gastric, * Chest Tubes or Dialysis access. * States name of tube and describe color, consistency and amount of drainage collected. |  |  |  |  |
| 9. What is the patient’s nutrition status:   * What is the diet? * NPO? * How much of food offered did patient eat? * Ate all? 3/4? ½? ¼? Fluid * Restrictions? |  |  |  |  |
| 10. Urine Output?   * Did the patient use the bathroom or bedpan? * Are they incontinent? * What were the color, consistency, and amount of urine output? * Was there any odor? |  |  |  |  |
| 11. Bowel Movement?   * Did the patient/client use the   bathroom or bedpan   * Are they incontinent? * What were the color, consistency, and amount of the bowel movement? * If the client did not have a BM, when was the last BM documented? * Is the client constipated   /Impacted? |  |  |  |  |
| 12. What is the client’s activity level?   * On complete Bedrest? * Bedrest with bathroom Privileges * Chair rest? * Ambulatory AD Lib? * Assess hand grips, foot pushes   and overall muscle strength   * If client is immobile, what additional assessments will you need to make? * How will this affect your nursing care? |  |  |  |  |
| 13. Did the patient/client go for or receive any tests, procedures or therapy such as:   * Physical Therapy * X-Rays   (Document when and where)   * Blood work? |  |  |  |  |
| Formulate a nursing care plan for your patient considering:   * Abnormal findings (if any) from your assessment of the patient. * Any diagnostic test results * Nursing care plans may include: Assessment of the patient after an invasive diagnostic test; or any test which may adversely affect the patient. |  | | | |

**TEST-OFF:** Check Pass \_\_\_\_\_\_\_\_\_\_ (or) Fail \_\_\_\_\_\_\_\_\_

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Objectives:**

* Perform a gross examination of patient
* Differentiate chronic and acute findings
* Describe some special nursing situations which are common to the acute/chronic client

**Neurological Assessment**

1) The student will state in order of importance the parameters for assessing a patient’s neurological status:

1. Level of consciousness 4. Motor function
2. Pupillary observations 5. Sensory function
3. Ocular movements 6. Vital signs

2) The student will state one major cause for alteration in consciousness or metabolic causes as requested by evaluator

3) The student will state the levels of consciousness and be required to assess for each level. The evaluator will select one level to be assessed during the test off period

|  |  |
| --- | --- |
| **LEVEL of CONSCIOUSNESS (LOC)** | **PARAMETERS** |
| Alert |  |
| Lethargic |  |
| Obtunded/Confused |  |
| Semi-Comatose |  |
| Comatose |  |
| Level Assessed |  |

4) The student will assess the characteristic for pupillary observation **(PERRLA)**

**P\_\_\_\_\_\_\_\_\_\_\_E\_\_\_\_\_\_\_\_\_\_\_\_\_R\_\_\_\_\_\_\_\_\_\_\_\_L\_\_\_\_\_\_\_\_\_\_\_\_\_\_A\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

5) The student will be asked to assess the ocular movement of the eye for either the conscious patient (six point of gaze) or unconscious client (Oculocephalic reflex).

The student will state the significance of their findings.

6) The student will be asked to state either decorticate or Decerebrate and their significance to the patient’s pathology. Where in the brain the damage is located?

7) The student will be able to state the normal temperature, pulse range, respiration range and blood pressure range including pulse pressure for a normal patient. The student will then be asked to state the early signs of IICP and or late signs of IICP

The student will be able to state the pathology associated with these vital signs

8) The student will state the parameters of the Glasgow Coma scale and able to interpret its numerical significance

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NEUROLOGICAL ASSESSMENTS** | PRACTICE # 1  REQUIRES CLOSE SUPERVISION | PRACTICE # 2  REQUIRES MODERATE SUPERVISION | PRACTICE # 3  REQUIRES LITTLE OR NO SUPERVISION | TEST-OFF RECOMMENDED  OR  REFERED ATI/ REMEDIATION |
| Cranial Nerve Examination   * Pupils (size, shape, reactivity, visual acuity, etc.) * Special senses (olfactory, taste, etc.) * Facial (symmetry, strength) have patient smile and stick out tongue while gently palpating face * Neck and shoulder strength and movement   Motor System   * General posture and muscle coordination * Gait * Muscles (observe for atrophy, tremors, involuntary movements, fasciculation) strength – hand grasps * Coordination   Sensory System   * Pain (location, type and degree) * Abnormal sensations (numbness, tingling, etc.) * Temperature sensation * Test extremities for differences in sensation * Reflexes * DTR’s (Deep Tendon Reflexes) knee, biceps, triceps, supinator * Superficial reflexes (abdominal, cremasteric) |  |  |  |  |
| Specific Neurological history:   * Seizures * Diplopia * Pain * Muscular Weakness * B/B Incontinence * Headaches * Nervous Disorders, * Blackouts * Syncope |  |  |  |  |
| Questions suggesting a neurological problem: intervene if there is an emergency discovered during the examination:   * Syncope * Pain * Bladder or Bowel Incontinence * Seizures * Diplopia and others |  |  |  |  |
| Obtained information from relatives if patient’s level of coherence is diminished |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Neurovascular Assessment** |  |  |  |  |
| ***Checked Sensation:***   * Sensation: * Normal * Decreased * None |  |  |  |  |
| ***Skin:***   * Temperature (Warm, Cool, Moist) * Color: Normal, Pale, Mottled * Cyanotic |  |  |  |  |
| ***Check Pulse:***   * Bounding, Strong, Weak, None   Doppler |  |  |  |  |
|  |  |  |  |  |
| **Motor function**   * Full range of motion (ROM) * Movements in the extremities * Mild resistance * Spontaneous movements * Changes in muscle tone * Change in body posture * Position of head and/or neck * Paresthesia: tingling and numbness of lower extremities * Face difficulty chewing, swallowing, talking, facial muscle paralysis can occur * Incontinence loss of sphincter control; bladder and rectum * Deep Tendon Reflexes may be absent |  |  |  |  |
| ***Sensory abnormalities:***   * Headache Papilledema * Lethargy * Vomiting Confusion * Motor abnormalities Paralysis |  |  |  |  |
| ***Sensory Motor :***   * Rigidity, Weakness, Lack of coordination, Seizures, CVA * Monroe-Kellie Doctrine * Cushing’s Triad * Cerebral Perfusion Pressure * Mean Arterial Pressure * Decorticate Posture * Decerebrate Posturing * Brain Death * Contusion * Concussion * Doll’s Eye * Glasgow Coma Scale (GCS) |  |  |  |  |
| ***Pain:***   * Note location * duration * severity and relief with medications |  |  |  |  |
| ***Mental status:***  Deterioration of orientation -   * Judgment * Cognition * Speech * level of consciousness (LOC) |  |  |  |  |
| ***Eyes:***   * **PERL:** Perform a complete pupil check with recording the size of pupils   **Speech:** conscious   * Note changes in ability and/or quality of speech   **Reflexes:**   * Assess Deep Tendon * Superficial * Stretch reflex * Cutaneous reflex * Corneal reflex * Gag reflex * Babinski reflex |  |  |  |  |

**Passed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Failed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retest\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Documentation/Charting Update**

Charting is a method of recording that you did take the appropriate action for the situation; “notified MD and no treatment at this time”. This charting protects the patient, and protects the nurse. It lets everyone know that you performed the correct action in response to your abnormal findings. If you are ever in doubt as to how you should chart something; remember to be as objective as possible. Chart the findings (be descriptive), and then chart what you did about it. That is how good charting protects you and the patient.

Handwritten paper medical records are inevitably giving way to electronic medical records (EMRs). Although digital medical records have been around for at least 30 years significant financial investment over the past decade has resulted in data portability and accessibility that was previously not available. Although the velocity of innovation and progress of EMRs is increasing, there are still several hurdles to overcome, and the implementation of new medical data systems has received some criticism from health-care journalists and commentators for its seeming lack of accountability and empowerment.

**EHR vs. EMR**

What is an EMR (Electronic Medical Record) or EHR (Electronic Health Record)?

One Type of Digital Patient Health and Medical Record. Digital records kept by doctor\s office, insurance company or the facilities where patient visits

The two acronyms – EHR and EMR – are often used interchangeably. But as the Office of the National Coordinator for Health Information Technology (ONC) notes, there is a difference between electronic health records (EHRs) and EMRs. EMRs predate EHRs and were intended for clinician use only. EHRs attempt to go further and encompass a broader spectrum of data than EMRs.

Meaningful Use – a set of standards that are supposed to ensure that health dollars spent on EHRs result in productive outcomes – essentially mandates that EHRs be interoperable. This directive requires unlocking health data and connecting different systems creating a “many to many" model (in contrast to "point to point" model) meant to increase the utility of one’s personal medical data.

While most digital health advocates support the goal of information sharing that would presumably improve medical care and save money DeSalvo states, “some individual participants in the health care and health IT industries have strong incentives to exercise control over electronic health information.”

Another cited barrier to successful EMRs interoperability is a complex mix of technological issues and policy interactions. Trotter appeals for one person to be appointed to tackle these highly specialized issues and devote all his or her time to the role.

Portability of one’s personal health data is another important concept that relates to creating standardization among the syntax used to create health records and the ability to easily transport this data across disparate systems. Many studies have shown that portable and easily transferable data can considerably improve health-care services and enhance patient care. However, portability of EMRs is a challenge that has not generally been solved yet and still needs to be perfected to secure a coordinated health-care system.

Safe and secure exchange of digital health information remains one of the priorities of the digital health movement. It has been suggested that cloud storage, password protection and encryption are all measures health-care providers can take to make portable EHRs more secure.

Recent research indicates that digital health is boosting the patient experience. Health information technology has been shown to increase the quality and safety of health interventions, as well as provide additional channels for doctor-patient communication. There has been a lot of progress in this area as digital health continues to be more intuitive and interactive. These advances are leading to reported patient satisfaction increases as well.

Digital health tools are now also reaching our home and enabling better out-of-hospital care. We have become consumers who value convenience and accessibility, and often make our health-care choices based on these parameters. It appears that we are entering an era in which clinical competence alone is not sufficient to attract and retain patients.

Narrative Notes

SOAP

Focus