

THE UNIVERSITY OF TEXAS AT TYLER

College of Nursing

**NURS. 3603: NURSING COMPETENCIES
SYLLABUS – Fall 2008**

**Theory Course Objectives/Lecture Content
Clinical Skills Lab Manual**

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The content of this syllabus / WEB site is subject to change at the discretion of the faculty leaders according to current learning needs.

approved by FO: 10/02

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NURSING COMPETENCIES – CLASSROOM CALENDAR

DATE	LECTURE	Lecturer
Week 1 September 2	Orientation to Nursing Competencies Health Care Continuum, Holistic Care, Nursing Roles Nursing Process	Sacrey Cheek
Week 2 September 9	Infection Control, Safety and Mobility	Sacrey Cheek
Week 3 September 16	Exam I & Group Test Review Nutrition	Torres
Week 4 September 23	Comfort and Pain Management , Rest and Sleep Math Quiz #1 up on BB	Sacrey
Week 5 September 30	Documentation, Critical Thinking and Planning Nursing Care Math Quiz #2 up on BB	Sacrey Cheek
Week 6 October 7	Exam 2 & Group Test Review Therapeutic Communication Math Quiz #3 up on BB	Cheek
Week 7 October 14	Skin Integrity and Wound Care Math Quiz #4 up on BB	Cheek
Week 8 October 21	Tissue Perfusion (Cardiopulmonary) Math Quiz #5 up on BB	Torres
Week 9 October 28	Tissue Perfusion (Cardiopulmonary)	Torres
October 31 – Last Day to Withdraw with a W		
Week 10 November 4	Exam 3 & Group Test Review <i>Medication Administration Test</i>	
Week 11 November 11	Fluids, Electrolytes	Cheek
Week 12 November 18	Elimination – Bowel Elimination – Bladder	Torres
Week 13 November 25	Grief & Loss Spirituality and Cultural Considerations	Sacrey Deal
ERI EXAM ~ Fundamentals of Nursing <i>Available at www.eriworld.com from November 22 noon- December 8 noon.</i>		
Week 14 December 2	Exam 4 & Group Test Review Stress and Self Esteem	Cheek
ERI exam - down at NOON on Monday December 8		
Week 15 December 9	Case Studies – Application Review	Sacrey Cheek Torres
Week 16 December 17	Final Exam Wednesday Afternoon 1 - 3 Room to be posted on BB	

Nursing Competencies - NURS 3603

Semester Hours - Six (6)

Three (3) Hours Didactic, Three (3) Hours Clinical Practicum

Prerequisite Courses

Student has completed all academic courses required for admission to the College of Nursing

Co-Requisite Courses

Students enrolled in Nurs. 3603: Nursing Competencies must have successfully completed Nurs 3303: Pathophysiology for Acute Care and Nurs3205: Nursing Concepts and Theories and be concurrently be enrolled in:

Nurs. 3410: Health Assessment,

Nurs. 3307: Pharmacology

Progression in Nurs. 3603: Nursing Competencies is dependent on successful progression in the co-requisite courses. If the student is withdrawing from a co-requisite course, the student will be required to drop Nurs. 3603, since components of the co-requisite courses will be applied in the clinical portion of Nurs. 3603.

Course Description

The student is introduced to the process, principles, and techniques related to meeting basic health needs and providing appropriate nursing care to the adult patient are presented. The course focuses on health promotion and risk management across the health illness continuum and is based on core competencies of critical thinking, communication, assessment and technical skills. Students demonstrate assessment skills, fundamental therapeutic nursing interventions, and nursing procedures in the laboratory and selected settings.

Course Objectives

Upon successful completion of the course, the student will:

1. Apply critical thinking skills to provide comprehensive, holistic nursing care to the adult patient.
2. Integrate principles from nursing and other scientific and humanistic disciplines, when applying nursing skills.
3. Utilize the concepts of human caring and holistic care in the delivery of care of the adult patient.
4. Demonstrate accountability in legal, ethical, and moral professional standards in the care of the adult patient.
5. Develop a beginning comprehensive plan of care in collaboration with the adult patient and members of the interdisciplinary health care team in a structured setting.
6. Identify the roles of the professional nurse in selected settings.
7. Perform selected technical skills required for the delivery of safe, competent nursing care.

Required and Recommended Texts

Required:

Personal Data Assistant (PDA) with Pepid Software for access to Drug, Diagnostic, Nursing Process and Medical Terminology Information.

BSN / MSN Guide for Nursing Students, College of Nursing, University of Texas at Tyler
[on-line - blackboard]

Potter, P.A and Perry, A.G. [2008] Fundamentals of Nursing (7th ed)
ISBN 978-0-323-04828-6

Syllabus for N 3603: Nursing Competencies Fall 2008.

Evolve Select – Learning System

Six (6) Scantron score sheets. F-17355-PAR-L.

Recommended:

Baier, Sue. (1985). Bed Number 10. CRC Press. ISBN: 0-8493-4270-8

Barcharts for Quick Study: Medical terminology - Fundamentals: Barcharts.
ISBN: 1572225386 ***required for Health Assessment****

Hoefler, P. (2003). Successful Problem Solving for Beginning Nursing Students. (4th. ed.) Sulfur Springs, Md. Meds Publisher.

ISBN:1565335007

****this resource is highly recommended***

Required supplies:

Stethoscope
Penlight
Watch with a second hand
Bandage Scissors
Stapler
Calculator

Optional Supplies:

Hemostats, straight or curved
Clipboard

Disability Statement

"If you have a disability, including a learning disability, for which you request disability support services/accommodations(s), please contact Ida MacDonald in the Disability Support Services office so that the appropriate arrangements may be made. In accordance with federal law, a student requesting disability support services/accommodation(s) must provide appropriate documentation of his/her disability to the disability Support Services counselor. For more information, call or visit the Student services Center located in the University Center, Room 282. The telephone number is 566-7079 (TDD) 565-5579. Additional information may also be obtained at the following UT Tyler Web address: <http://www.uttyler.edu/disabilityservices>.

Examinations/Assignments and Grading Policy

Completion of NURS 3603 is based on satisfactory attainment of didactic and clinical criteria. Any student who fails to meet the course objectives and expectations in either the classroom or clinical area must repeat the entire course and may not progress to the next level.

The simple average of the exam grades, before weighted calculation is performed, must be 75% or above to pass the course. Grades will not be rounded when calculating the average (74.5 -74.9 is not rounded to 75). Students with an exam average of 75 or higher will have course grades calculated based on the weighted calculation of the exams and other required course work.

<u>Theory:</u>	Four Examinations	70%	
	Final Examination	20%	(The final examination is comprehensive)
	Other Assignments	10%	(2 care plans, 5 on-line math quizzes, group testing points)

Students with an exam grade simple average of 75 or higher will have course grades calculated based on the weighted calculation of the exams and addition of homework weight. A grade of C or better is required prior to progression to the next level of nursing courses.

Any student repeating a course must complete all course requirements or equivalent as determined by the course coordinator during the semester in which the grade will be awarded.

On-line math quizzes will be posted on Blackboard as indicated in the syllabus schedule. Each quiz will be worth 20 points. The five (5) quiz scores will be added to the homework score that will be calculated into the weighted average to determine final grades. The quizzes will be available for ten days. Failure to complete the quiz within this time frame will result in 0 points for that quiz.

The student must score a 90% or better on the medication dosage examination in this course to progress to the next level of nursing courses. See the medication administration policy. (page 9 of syllabus). This is a requirement of all clinical courses.

Theory grades will be assigned on the following scale:

90-100	A
80-89	B
75-79	C
60-74	D
<60	F

<u>Clinical:</u>	Clinical:	Pass / Fail
	Mastery of Clinical Skills	Pass / Fail
	Clinical care plans (2)	*** scores will be counted as homework
	<u><i>Clinical Care Plans are due to clinical instructor on the day and time requested by the clinical faculty in the week following the clinical experience. If submitted after 9 am-points will be deducted for lateness according to previously stated criteria.</i></u>	

Clinical evaluation, formal and/ or informal, will be done at intervals through the clinical experience. A formal evaluation will be completed at the end of the clinical semester. Formal evaluations are written documentation relating to a student's progress toward meeting end of course objectives. Each evaluation is discussed with the student in a private one-on-one discussion of performance. The clinical evaluation tool is included in the supplemental course materials packet available in the University bookstore.

Skills lab is considered a clinical experience and will be evaluated as such. Skills lab worksheets and observational experiences will be part of the skills lab experience.

A Clinical contract will be initiated for the student having difficulty mastering laboratory and clinical experiences. Contracts will include strategies for achieving mastery of the skills and techniques in question.

The clinical instructor will evaluate clinical experiences using the clinical evaluation tool. The student is responsible for being familiar with the content of the tool and the scoring criteria. This tool and criteria is the mechanism for assigning the clinical grade. Failure to attain a passing grade in the clinical section of this course constitutes a full course failure. A score of 0 in any of the critical behaviors during the clinical experience will result in automatic failure in the clinical component of the course.

Grade Replacement

If you are repeating this course for a grade replacement, you must file an intent to receive grade forgiveness with the registrar by the 12th day of class. Failure to file an intent to use grade forgiveness will result in both the original and repeated grade being used to calculate your overall grape point average. A student will receive grade forgiveness (grade replacement) for only three (undergraduate student) or two (graduate student) course repeats during his/her career at UT Tyler. (2006-08 Catalog, p. 35)

ERI Policy:

At the end of the term, all students are required to complete a comprehensive exam. The availability of the exam will be announced on blackboard. This exam is part of the ERI testing program of the CON. The exam can be taken at anytime during the approximately 2 weeks that it is available. The student must meet or exceed the national average on this exam. The student may take the exam multiple times as needed to reach this benchmark during the time the test is available. It is advisable to take the test in the computer labs at the CON to avoid problems with the connections. A copy of the student's printout will be required prior to taking the final exam for the course.

Paper / Assignment Re-grading Policy

Student assignments will not be re-graded, either at the Undergraduate or Graduate level. At the instructor's discretion, a draft may be written for review.

Medication Calculation Policy

1. Students are required to achieve a 90 or higher on the medication calculation exam prior to the first clinical day. Students are permitted two (2) attempts for success on the exam.
2. Students who are unsuccessful on the first attempt of the medication calculation exam must provide written evidence that remediation has taken place before being permitted a second attempt.
3. If a student fails to achieve the required 90% or higher on the second attempt, the student will be required to withdraw from the course for the semester. A grade of W will be posted on the student's transcript, but will be regarded as a nursing course failure in the College of Nursing.
4. Medication calculation is a component of medication administration. Master of medication administration must be demonstrated in the clinical and classroom settings for successful completion of all clinical courses. In addition to the initial medication calculation exam (above), medication questions on unit exams and observation in the clinical setting will be used to assess and evaluate the clinical safety of students on an individual basis. Serious or repetitive medication and/or calculation errors may indicate unsafe clinical practice (See Unsafe Clinical Practice Below)

Medication administration quizzes (5) will be provided on-line in Blackboard. Each of these quizzes will be worth 20 homework points. These quizzes must be completed in the time frames stated in the announcements on Blackboard. The quizzes will be available from Monday morning at 0800 until Friday afternoon at 1500.

Examination and Examination Review Policy:

1. Attendance for exams is **mandatory**.
2. If absence for an exam is necessary, the student is responsible for notifying the faculty **PRIOR** to the exam with an acceptable reason. Failure to meet this requirement may result in denial of opportunity to make up the exam at a later date. Make-up exams will be given one time only at the time designated by the faculty.
3. Students will be allowed entry to the classroom after an exam has started **ONLY** at faculty discretion.
4. Exam will be distributed at the time class is scheduled to begin.
5. **All** hats/caps must be removed during exam time. All personal items, such as purses, books, backpacks, cell phones, pagers, notebooks, and briefcases will be left in the front or back of the room during testing.
6. Silence will be enforced during exam time. In order to avoid distraction during the exam, no one will be permitted to enter the room during the exam.
7. Make-up exams will only be given at the discretion of the faculty member and may be in a different format from the original exam.
8. Students will not share calculators during exams. Calculators will be provided by the college of nursing during the exam period if required.
9. Exam review will be conducted at the discretion of the faculty. Test review may be scheduled with faculty during office hours and within 10 school days from the return of the exam grades.
10. Any student achieving an examination grade less than 75% **must** schedule an appointment with the faculty member within 10 school days from the return of the exam grades.

Group exam will occur immediately after the exam is given. During this time students will work in groups to review the exam. No reference materials are allowed, and students may write only on the provided test booklet. No additional paper, PDA, or computer is allowed during review. Each group will be provided a copy of the exam and the group must come to a consensus on the correct response for each exam item. Individuals in each group will be identified on the test booklet. Thirty minutes will be allotted for this group review. Homework points will be awarded for completion of the exercise. Groups scoring 100% will be given 25 points. 94 – 99% will be given 20 points. 80 – 93 points will be awarded 15 points. Groups scoring 79 – 75% will be given 10 points. Groups scoring below 75% will receive 0 points. All test review points from the 5 unit exams will be added to the homework points.

11. Test scores will be posted on blackboard after faculty analysis and review of the test. Every effort will be made to post the scores in a timely manner.
12. Any student suspected of cheating will be immediately removed from the testing area. Strict enforcement of the CON policy on cheating is maintained.

Academic Integrity

1. Students are expected to assume full responsibility for the content and integrity of all academic work submitted as homework and examinations.
2. Students are advised to review the UT Tyler Academic Dishonesty Policy and Academic Integrity Policy in the Current College of Nursing Student Handbook and Academic Integrity Policy for UT Tyler students at www.uttyler.edu; click on current students, then Vice-President for Student Affairs, then Student Guide for Conduct and Discipline at UT Tyler. These policies are fully endorsed and enforced by all faculty members within the College of Nursing.
3. Plagiarism, cheating, and collusion are unacceptable and if found violating any of these standards the student will be disciplined accordingly (See BSN/MSN Nursing Student Guide for definitions).
4. The College of Nursing reserves the right to dismiss students from the program for any infraction of a legal, moral, social, or safety nature, pursuant to the procedures detailed in the *Regent's Rules*.

Student Dress Code for the University of Texas, College of Nursing :

A. General: It is the philosophy of the College of Nursing that the student has a responsibility to be neatly groomed and modestly dressed. Appearances should promote good health, safety and general well-being of the student. Clothing should avoid brevity and/or design that is offensive to the dignity and rights of others. School officials have the right and responsibility to counsel with the student or take any other corrective action. Types of clothing (other than those specified in this document) may be worn at the direction of the nursing instructor for special events.

B. Classroom: Casual or every day business wear is recommended. This includes but is not limited to the following: Slacks or skirt; sweater, blouse, and shirt. Jeans as well as conservative shorts (mid-thigh or longer) may be worn, but avoid overly frayed or soiled. Shoes must be worn. See items to be avoided below.

C. Professional Presentations, Ceremonies/ Graduation: Business or dressy day social: suit, dress, dressy separates, jacket, ties, nice fabrics. Dress shoes. Avoid denim, jeans, t-shirt or other casual clothes. For workshops/seminars attended by students, business attire will be worn.

D. Laboratory: The school clinical laboratory setting is designed to simulate the health care clinical area. Students will wear clean white lab coats with name tag and UT Tyler school patch on the front left uniform jacket. Classroom attire will be worn under the lab coat.

E. Pre or Post-clinical Experiences in the Health Care Setting: Students may be required to attend conferences or visit the clinical areas as part of their course requirements. Students should wear lab coat with name tag and UTT school patch. The following items will be avoided in the clinical areas: jeans, shorts, sandals, jogging/athletic suits, t-shirts, ball-caps, etc.

F. Clinical Experience: When attending any clinical experience students are required to wear the standardized student uniform and white uniform jacket with name badge and school patch. Street clothes will be worn in appropriate clinical settings as directed by the clinical faculty with the white uniform jacket, name tag and school patch (see items above to be avoided in clinical areas). Students are to remember that whenever they are visiting a clinical agency or any clinical site, they represent UT Tyler and the College of Nursing and are expected to be professional in appearance and behavior at all times.

When student uniforms are required for clinical experiences, as specified by the course, the following guidelines must be adhered to:

- a) School patch on the front left of the uniform jacket and the top of the standardized uniform.
- b) The UTT name badge will be worn in all clinical setting. Name tag must be worn above the waist, so name and title are clearly visible.
- c) White or neutral nylon hose are worn with dress/skirt; nylon hose, knee highs or white socks with pants. Socks must cover ankle.
- d) Clean, white clinical shoes or white leather athletic shoes should be worn (shoes may be mostly white and if stripes or logos are on shoes, these must be minimal and light colored). No canvas shoes or athletic shoes with colored stripes or large logos.
- e) Jewelry: wedding or engagement rings only; single stud earrings and only 1 in each lobe (no dangling or hoops); no rings or studs in the nose, tongue, lip or any other facial or body piercing (other body piercing must be covered or removed); and, no necklaces or bracelets (only Medic Alert). Must have a watch with a second hand.
- f) Make-up, hair, and grooming should be conservative. Hair shoulder length or longer must be pulled neatly back in a pony tail or bun. Hair clips, bands, etc. shall be functional, not decorative (no bows). Mustaches and beards will be neatly groomed, clean and trimmed.
- g) Tattoos must be covered and not visible.
- h) Nails are to be clean and neatly trimmed to no more than fingertip length, with clear or no polish. No artificial nails in OR or L & D.
- i) No perfume, after-shave or other strong scents since this causes nausea and /or difficulty in breathing for many patients.
- j) Gum chewing is not allowed
- k) Any question concerning adherence to the dress code should be directed toward the clinical instructor.

Failure to comply with the above requirements may result in an unexcused clinical absence and/or negative clinical evaluation

If the dress code rules are broken and a change of clothes is not available , the student may be removed from the school-related function for the remainder of the day. Appropriate disciplinary action will be taken for repeated violations of this code.

Items to be Avoided in all School-related Functions (including but not limited to): Overly frayed, worn or soiled garments. Costume look, transparent blouses, bare midriff shirts, tank tops, spaghetti straps, muscle shirts, overtly sexual, gang colors or logos, facial or body piercing, obscene slogans or pictures, bedroom wear, short-shorts, short skirts, or clothing that may be offensive to others.

Course Information

A. General

1. If lecture outlines are used, they will be posted on Blackboard a minimum of two (2) working days prior to class and will be removed at midnight prior to class.
2. The clinical portion of the course syllabus, handouts, and any other required course materials will be placed on Blackboard.
3. All submitted written material (papers, assignments, examinations, etc.) are the property of the College of Nursing. They will be maintained in an archived file in the College of Nursing.
4. The BSN/MSN Nursing Student Guide is available on the CON website at <http://www.uttyler.edu/nursing>. The student must sign the statement indicating they have accessed the guide and return the Student Guide Affirmation Form to the program secretary for placement in the student file.
5. All nursing students are required to use their student email accounts for all correspondence.

approved FO: 2/03

B. Attendance

1. Attendance in class is critical to the learning experience. Failure to attend class will place the student in jeopardy of receiving a satisfactory score on examinations.
2. Students should be aware of the statement in the UT Tyler General Catalogue relating to attendance.
3. Students are responsible for all material discussed and all announcements made if they are absent.
4. Lecture outlines, if offered by faculty, will be posted to blackboard a minimum of three working days prior to class and will be removed at midnight prior to class.
5. Attendance for the learning laboratory and the clinical agency is mandatory. The student must notify the instructor prior to the clinical if an absence is necessary. The clinical instructor must be contacted directly! Messages conveyed by other students, parents, room-mates, or the agency personnel do not constitute appropriate notification of an absence. When in the learning laboratory, the student must leave a message with the instructor, including the telephone number where he/she may be contacted. When in the clinical agency, the student must contact the agency personnel and the instructor at least one hour prior to the scheduled clinical time. If the student is going to be late, the student must notify the agency.
6. Make up time for missed clinical time will be arranged at the discretion of the instructor. A student missing one day in one rotation will present for approval a written plan as to how he/she will meet the clinical objectives.

C. End of Semester Evaluations

Evaluations are a professional responsibility. Constructive evaluation is a valuable tool utilized by the faculty as a method for quality control of the curriculum. Student evaluations are viewed by the faculty and administration as one method for maintaining high, consistent levels of quality education in the College of Nursing. As a professional nursing student, evaluation requires maturity and objectivity. This evaluation tool is the student's opportunity to participate in the on-going evaluation process. The evaluations will be online and links to the tool will be provided on Blackboard toward the end of the term. Evaluations are collated and presented in a composite format. Each student will complete an evaluation tool for:

Classroom Faculty Effectiveness [Sacrey, Cheek, Torres]

Evaluation of Course: Didactic Course Nurs 3603

Clinical Instructor's Effectiveness [your clinical instructor only]

Evaluation of Clinical Facility/ Facilities [your clinical facility only]

D. Attached forms to be Read, Signed and Submitted the First Day of Class

1. Student Affirmation Form (page 61)
 - a. Each line must be initialed, signed and dated for each course every semester.
 - b. The form will be placed in the student file.
2. Audio/Video Recording Agreement (page 62)
 - a. Any student wishing to record a class must sign this agreement no later than the second week of classes each semester. An agreement must be signed for each course every semester.
 - b. Due to the confidential nature of some course content, the student will provide written documentation of the erasure of any recording made during the current semester. Failure to return this written documentation to the faculty by the date of the final examination will result in a grade of "I" (incomplete).

Unit One: Introduction to Nursing, The Health Care Continuum, Holistic Health Care**Preclass activities:**

Read Chapters 1,2,6,8 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Discuss the historical development of professional nursing roles
2. Identify nursing roles, and the primary members of the health care team
3. Describe educational programs available for professional registered nursing education
4. Describe the roles and career opportunities for nurses
5. List the 5 characteristics of a profession and discuss how nursing demonstrates these characteristics
6. Discuss what is meant by the concept "Professional role of the nurse"
7. Explain the rationale for regulatory and competitive approaches used to control health care costs
8. Explain the concept of prospective reimbursement
9. Explain the relationship between levels of health care and the three levels of prevention
10. Differentiate evidence-based practice from research-based practice
11. Discuss the Nurse Practice Act and Standards of Nursing, and identify their effect on the profession
12. Describe the definitions and perceptions of health promotion, wellness, and illness held by individuals, families and communities and activities that support each.
13. Discuss the definition of health
14. Describe the attributes of holistic health care
15. List the two general Healthy People 2010 public health goals for Americans
16. Describe ways to convey caring through presence and touch
17. Describe the therapeutic benefit of listening to patients and clients

Additional Resources:

[www. Healthypeople.gov](http://www.Healthypeople.gov)

Clinical Application:

In the skills lab and clinical area, demonstrate:

1. ability to identify individual health status and factors that influence patient responses.
 2. ability to apply holistic nursing care principles with individual patients
 3. ability to recognize and demonstrate the professional roles of the nurse in specific clinical situations.
 4. the incorporation of patient rights in daily patient care
 5. the incorporation of standards of practice and ethical standards into daily practice.
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-

Unit Two: Nursing Process and Evidence-Based Practice

Preclass activities:

1. Read Chapters [15](#), [16](#), [17](#), [18](#), [19](#), [20](#) in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Describe the elements of the nursing process.
2. Discuss the characteristics of the nursing process.
3. Discuss the process of assessment. Include sources, types of data and method of gathering data.
4. Discuss basic steps in the formulation of a nursing diagnosis.
5. Applies commonly used patterns for data organization.
6. Describe the activities that occur during the planning phase of the nursing process.
7. Explain the development and usefulness of the outcome statement.
8. Uses a mechanism of setting priorities for patient care.
9. Write cogent nursing orders based on patient data.
10. Describe the activities associated with the implementation phase of the nursing process.
11. Discuss the components of the evaluation and how this step relates to the other elements of the nursing process.

Additional Resources:

1. [PDA resources](#)

Clinical Application:

1. Compare and contrast nursing care plans in the clinical area with nursing care plans developed in the course requirements.
 2. Discuss the value of care plans in the post-conference setting.
 3. Document appropriately in the medical record.
-
-

Unit Three: Infection Control

Pre – Post Class activities

Read chapter 34 in Potter and Perry

Upon completion of this unit, the student will be able to:

1. Explain the relationship of the chain of infection to transmission of infection.
2. Identify the body's normal defenses against infection.
3. Discuss the events in the inflammatory response
4. Describe the signs and symptoms of a localized infection and those of a systemic infection.
5. Identify patients most at risk for infection.
6. Explain conditions that promote the transmission of nosocomial infection.
7. Give an example of preventing infection for each element of the infection chain.
8. Explain how infection control measures may differ in the home versus the hospital.

Additional Resources:

[PDA resources](#)

Clinical Application:

1. Consistently follow infection control principles in the clinical area.
 2. Demonstrate ability to identify and correct violations of infection control principles in the clinical area.
 3. Demonstrate ability to explain and follow isolation procedures.
 4. Document appropriately in the medical record.
-
-

Unit Four: Stress Adaptation

Preclass activities:

Read Chapter 31 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Compare and contrast the theories of stress responses.
2. Discuss the stages of the general adaptation response, including characteristic changes.
3. Identifies physiological, psychological and cognitive indicators of stress.
4. Select nursing diagnoses that describe relationship of assessment data to a stress- related patient problem.
5. Write patient centered, measurable outcome statements for a patient demonstrating stress related problems.
6. Discuss types of coping and coping strategies.
7. Apply evidenced based interventions to help patients minimize and manage stress.
8. Discuss the association between laughter and stress.
9. Identify the types and the characteristics of a crisis situation.

Clinical Application:

1. Identify signs and symptoms of stress in assigned patients in the clinical area.
 2. intervene in stress-related situations or crisis
 3. incorporate coping strategies in daily care of self- and patients
 4. Document appropriately in the medical record.
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Unit Five: Safety

Preclass activities:

Read chapter 38 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Identify common safety hazards in the health care setting.
2. Describe characteristics that determine the degree of safety risk in specific patient situations.
3. Describe methods that assess patients at risk for injury.
4. Identify nursing diagnosis that correlate to safety issues in patient care.
5. Select strategies to maintain health care worker and patient safety in health care settings.
6. Explain measures to prevent falls.
7. Discuss the use and legal implications of restraints.
8. Plan evidence-based care alternatives to restraints.

Clinical Application:

1. Locate specific institutional policies relating to safety issues and be prepared to discuss them in post conference.
 2. Participate in safety drills appropriately when the opportunity is presented in the clinical area.
 3. Demonstrate ability to determine patient safety risk and implement strategies to ensure patient safety in a consistent manner.
 4. Document appropriately in the medical record.
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Unit Six: Mobility

Preclass activities:

Read chapter 37, in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Compare and contrast the effects of exercise and immobility on each body system.
2. Describe assessment data, including diagnostic tests that indicate a risk for decreased mobility in a patient.
3. Identify nursing diagnosis that relate to actual and potential complications of immobility.
4. Select nursing strategies to maintain mobility.
5. Select nursing interventions to prevent or diminish complications of immobility in the health care setting.
6. Describe expected patient outcomes for problems with mobility or complications of immobility.

Clinical Application:

1. Consistently demonstrate awareness of immobility risks in each assigned patient in the clinical area.
 2. Consistently implement strategies to reduce immobility risks for each assigned patient in the clinical area.
 3. Document appropriately in the medical record.
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Unit Seven: Skin Integrity – Wound Care**Preclass activities:**

Read chapter 48 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Describe factors affecting skin integrity.
2. Describe phases and types of wound healing.
3. Describe factors that influence wound healing.
4. Discuss the main complications of and factors that affect wound healing.
5. Describe assessment data, including diagnostic tests, pertinent to skin integrity and wound healing.
6. Identify nursing diagnoses that are associated with skin integrity, and wound healing.
7. Write outcome statements that reflect identified problems with patient skin and/or wound issues.
8. Identify patients at risk for development of pressure wounds.
9. Describe staging of pressure wounds and the unique complications of this type of wound.
10. Identify nursing strategies to prevent and treat wounds, including pressure wounds.
11. Identify purposes of commonly used wound dressing materials.
12. Describe expected patient outcomes for problems with skin integrity or wound issues.

Additional Resources:

1. [PDA resources](#)

Clinical Application:

1. Describe assessed skin integrity using appropriate terms for each assigned patient in the clinical area.
 2. Describe wound status and wound care in appropriate terms for each assigned patient in the clinical area.
 3. Provide explanation of antibiotic or other medicinal therapies involved with care of skin or wounds to the assigned patient in the clinical area.
 4. Demonstrate competence in providing appropriate wound care as needed in the clinical area.
 5. Document appropriately in the medical record.
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Unit Eight: Nutrition**Preclass activities:**

Read chapter 44 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Discuss the relationship of healthy nutritional intake and health promotion.
2. Formulate an appropriate patient-centered nursing care plan for common nutritional disorders.
3. Identify potential environmental hazards for a patient with alterations in swallowing, including alternate provision of nutrition.
4. Describe methods for alternate provision of nutrition.
5. Discuss methods to avoid common complications of alternate nutritional therapies.

Additional Resources:

[PDA resources](#)

Clinical Application:

1. Identify patients at risk for inadequate nutritional intake.
 2. Demonstrate ability to intervene appropriately and manage appropriate therapy in assigned clinical patients exhibiting altered nutritional balance.
 3. Discuss alternative strategies for improving nutritional status in clinical and post-conference settings.
 4. Document appropriately in the medical record.
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Unit Nine: Comfort, Rest and Sleep**Preclass activities:**

Read chapter 42, 43 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Define the key terms listed.
2. Compare the characteristics of rest and sleep
3. Explain the effect the 24-hour sleep-wake cycle has on biological function.
4. Discuss mechanisms that regulate sleep.
5. Describe the stages of a normal sleep cycle.
6. Explain the functions of sleep.
7. Compare and contrast the sleep requirements of different age-groups.
8. Identify factors that normally promote and disrupt sleep.
9. Discuss characteristics of common sleep disorders.
10. Conduct a sleep history for a client.
11. Identify nursing diagnoses appropriate for clients with sleep alterations.
12. Identify nursing interventions designed to promote normal sleep cycles for clients of all ages.
13. Describe ways to evaluate sleep therapies.
14. Discuss common misconceptions about pain.
15. Describe the physiology of pain.
16. Identify components of the pain experience.
17. Explain how the physiology of pain relates to selecting interventions for pain relief.
18. Describe the components of pain assessment.
19. Perform an assessment of a client experiencing pain.
20. Explain how cultural factors influence the pain experience.
21. Describe the appropriate nursing diagnoses, outcomes, and interventions for a client with pain.
22. Describe guidelines for selecting and individualizing pain interventions.
23. Explain the various pharmacological approaches to treating pain.
24. Describe applications for use of nonpharmacological pain interventions.
25. Discuss nursing implications for administering analgesics.
26. Identify barriers to effective pain management.
27. Evaluate a client's response to pain interventions. .

Clinical Application:

1. Identify patients at risk for sleep deprivation problems in the clinical area.
 2. Demonstrate ability to intervene appropriately and provide for rest and sleep time in the clinical setting.
 3. Develop a plan for providing adequate sleep time and atmosphere for a patient that is experiencing sleep problems.
 4. Consistently identify and investigate patient complaints of pain and / or non-verbal indications of pain or discomfort.
 5. Select and apply appropriate non-medicinal and medicinal interventions to alleviate pain.
 6. Evaluate effectiveness of pain management interventions.
 7. Document appropriately in the medical record.
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Unit Eleven: Nursing Care Planning, Critical Thinking**Preclass activities:**

1. Re-read chapters [15](#), [16](#), [17](#), [18](#), [19](#), [20](#) in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Use critical thinking throughout the processes of planning nursing care.
2. Use the nursing process as an organizing tool for critical thinking and clinical reasoning.
3. Gather a complete patient database using various sources and techniques.
4. Organize patient data in meaningful ways to provide outline of patient care concerns.
5. Prioritize patient care concerns based on individual patient situations.
6. Determine appropriate nursing diagnosis and support selected diagnosis with patient centered data.
7. Write specific, patient centered, measurable outcomes based on the collected patient data.
8. Discuss sources of diagnostic error and how to avoid these errors.
9. Discuss method to select appropriate nursing interventions for individual patients based on evidence of best practice.
10. Discuss the process of evaluating care provided for a patient.

Additional Resources:

PDA resources

Clinical Application:

1. Compare and contrast nursing care plans in the clinical area with nursing care plans developed in the course requirements.
 2. Discuss the value of care plans in the post-conference setting.
 3. Document appropriately in the medical record.
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Unit Twelve: Documentation

Preclass activities:

Read chapter 26 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Explain the purpose and characteristics of good documentation.
2. Identify significant data that should be documented in the medical record.
3. Describe the usefulness of various types of flow sheets.
4. Discuss the legal parameters of importance of recording patient information in the medical record.
5. Discuss value of planning documentation entries prior to recording the entry into the medical record.
6. Compare and contrast DAR (PIE) formats with other commonly used charting formats.
7. Relate the need for variation in documentation for special populations and facilities.
8. Apply rules of documentation in patient settings.

Clinical Application:

1. For each assigned patient in the clinical area, accurately and comprehensively document assessment and care interventions in DAR format.
 2. Record vital signs on graphic sheet.
 3. Correctly and accurately record intake and output.
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Unit Thirteen: Oxygenation And Tissue Perfusion**Preclass activities:**

1. Read Chapter 40 in Potter and Perry.
2. Complete ABG tutorial online at www.maagnursing.com "ABG tutorial".
3. Read Chapter 35 (pages 755-768) in Potter and Perry.

Unit Objectives:

1. Describe physiologic dynamics of the cardiopulmonary system in terms of ventilation, diffusion, and perfusion.
2. Discuss physiological responses to alterations in stroke volume, preload, afterload, and cardiac output.
3. Identify physiological and psychological responses to hyperventilation, hypoventilation, and hypoxemia.
4. Recognize physiological and psychological processes of common chronic respiratory disorders.
5. Recognize common manifestations of arterial and venous circulatory disorders.
6. Interpret laboratory and diagnostic studies in relation to oxygenation.
7. Formulate an appropriate patient-centered nursing care plan to promote oxygenation.
8. Discuss major categories of cardiac and pulmonary drugs, uses and side effects.

Additional Resources:

[PDA resources](#)

Clinical Application:

1. Identify patients at risk for respiratory and circulatory disorders.
 2. Demonstrate ability to intervene appropriately and manage oxygen therapy in assigned clinical patients.
 3. Document appropriately in the medical record.
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Unit Fourteen: Elimination

Preclass activities:

Read chapters [45](#), [46](#) in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Discuss process of urinary and bowel elimination.
2. Identify physiologic and psychological responses to elimination problems.
3. Interpret laboratory and diagnostic studies in relation to elimination problems.
4. Formulate an appropriate, patient-centered care plan for common elimination disorders.
5. Discuss nursing care interventions to promote bowel and bladder elimination.

Additional Resources:

PDA resources

Clinical Application:

1. Identify patients at risk for bowel and urinary complications.
 2. Demonstrate ability to intervene appropriately and manage appropriate therapy in assigned clinical patients exhibiting bowel or bladder problems.
 3. Discuss interventions and rationales for clinical patients in clinical and post-conference settings.
 4. Document appropriately in the medical record.
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Unit Fifteen: Communication

Preclass activities:

Read chapter 24 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Define the key terms listed.
2. Describe aspects of critical thinking that are important to the communication process.
3. Describe the five levels of communication and their uses in nursing.
4. Describe the basic elements of the communication process.
5. Identify significant features and therapeutic outcomes of nurse-client helping relationships.
6. List nursing focus areas within the four phases of a nurse-client helping relationship.
7. Identify significant features and desired outcomes of nurse-health team member relationships.
8. Describe qualities, behaviors, and communication techniques that affect professional communication.
9. Discuss effective communication techniques for clients at various developmental levels.
10. Identify client health states that contribute to impaired communication.
11. Discuss nursing care measures for clients with special communication needs.

Clinical Application:

In the skills lab and clinical area, demonstrate:

1. ability to create effective communication patterns with patients.
 2. ability to create and maintain effective communication patterns with nurse mentor, and clinical faculty.
 3. ability to provide a cohesive and comprehensive end-of-shift summary to primary nurse mentor.
 4. Document appropriately in the medical record.
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Unit Sixteen: Fluid and Electrolytes

Preclass activities:

Read chapter 41 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will:

1. Discuss the function, distribution, movement, and regulation of fluids and electrolytes in the body.
2. Describe the regulation of acid-base balance in the body, including buffer systems.
3. Identify factors affecting expected body fluid, electrolyte, and acid-base balance.
4. Demonstrate understanding of functions of selected electrolytes (sodium, potassium, calcium, magnesium).
5. Compare and contrast excesses and deficits of body fluid and major electrolytes.
6. Distinguish patients at risk for fluid and electrolyte imbalance.
7. Analyze collected patient data, including diagnostic tests and for alterations in fluid and electrolyte imbalances.
8. Select appropriate nursing diagnosis and write specific outcomes for patients exhibiting fluid and electrolyte imbalances.
9. Implement measures to correct imbalances in fluids or electrolytes.
10. Discuss proper administration of blood products, including assessment for adverse reactions to a transfusion.
11. Evaluate the effect of evidenced-based interventions for correction of imbalances in fluids and electrolytes.

Additional Resources:

1. CDRom – Fluid and Electrolytes I and II
2. CDROM – ABG interpretation
3. [PDA resources](#)

Clinical Application:

1. Identify patients at risk for fluid imbalances and / or electrolyte imbalances.
 2. Demonstrate ability to intervene appropriately and manage appropriate therapy in assigned clinical patients exhibiting fluid or electrolyte imbalances.
 3. Discuss IV fluid replacement therapy and mechanisms of treating electrolyte imbalances in the clinical area and in post-conference settings.
 4. Manage IV therapy, demonstrate ability to detect complications of IV therapy in the clinical area.
 5. Document appropriately in the medical record.
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Unit Seventeen: Grieving**Preclass activities:**

Read chapter 30 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Define key terms.
2. Identify the nurse's role in assisting clients with problems related to loss, death, and grief.
3. Describe and compare the phases of grieving from Kubler-Ross, Bowlby, and Worden.
4. List and discuss the five categories of loss.
5. Describe the types of grief.
6. Describe characteristics of a person experiencing grief.
7. Discuss variables that influence a person's response to grief.
8. Develop a nursing care plan for a client or family experiencing loss and grief.
9. Explain reasons for the need for improved end-of-life care for clients.
10. Discuss principles of palliative care.
11. Describe how to involve family members in palliative care.
12. Describe the procedure for care of the body after death.
13. Discuss the nurse's own loss experience when caring for dying clients.

Clinical Application:

1. Identify patient behavior that may indicate a grieving process.
 2. Demonstrate ability to intervene appropriately and provide culturally appropriate intervention for the grieving patient and/ or family.
 3. Document appropriately in the medical record.
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Unit Eighteen: Spirituality and Spiritual Care

Preclass activities:

Read chapter 29 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Define the key terms listed
2. Discuss research findings that suggest spiritual practices influence clients' health status.
3. Describe the relationship between faith, hope, and spiritual well-being.
4. Explain the concepts of the Framework of Systemic Organization as it applies to spirituality.
5. Compare and contrast the concepts of religion and spirituality.
6. Perform an assessment of a client's spirituality.
7. Explain how a nurse's caring relationship with clients affects their ability to gain spiritual insight.
8. Discuss the risks and benefits of including spiritual intervention in nursing care.
9. Discuss nursing interventions designed to promote spiritual health.
10. Evaluate attainment of spiritual health.

Clinical Application:

1. Identify patients with potential or actual spiritual needs.
 2. Demonstrate ability to intervene appropriately and manage culturally appropriate interventions for assigned clinical patients exhibiting need for spiritual intervention.
 3. Document appropriately in the medical record.
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Unit Nineteen: Self Concept & Self Esteem**Preclass activities:**

Read chapter 27 in Potter and Perry

Unit Objectives:

Upon completion of this unit, the student will be able to:

1. Define self-concept and self esteem.
2. Identify and define the four components of self-concept.
3. Describe factors included in an assessment of self concept and self esteem.
4. Identify alterations in health and illness that can alter self-concept.
5. Discuss common theories of self-concept, and self esteem development.
6. Write appropriate patient centered measurable outcome statements to enhance the components of self-concept.
7. Describe key nursing interventions for each of the four components of self-concept.
8. Describe indications that self-esteem disturbance and body image disturbance are being resolved.
9. Discuss methods used to evaluate patient with self-concept nursing diagnoses.

Clinical Application:

1. Describe the self concept of assigned patients in post conference settings
 2. Demonstrate placement of assigned patient in a hierarchy and define how this influenced care of the patient.
 3. identify and implement mechanisms to enhance self-concept for assigned patients and yourself.
 4. Document appropriately in the medical record.
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*Be very good at
Caring when
Curing is not
possible.*

Clinical Skills Lab Manual

Nursing Competencies 3603

Expectations of Students in Nursing Competencies

A. Unsafe Clinical Practice

Any act of omission or commission, which may result in harm to the patient, is considered unsafe clinical practice. During the clinical practicum, unsafe clinical practice includes but is defined as any one of the following:

When the student:

1. Violates or threatens the physical, psychological, microbiological, chemical, or thermal safety of the patient.
2. Violates previously mastered principles/learning/objectives in carrying out nursing care skills and/or delegated medical functions.
3. Assumes inappropriate independence in action or decisions.
4. Does not adhere to current CDC guidelines for Infection Control.
5. Fails to recognize own limitations, incompetence, and/or legal responsibilities.
6. Fails to accept moral and legal responsibility for his/her own actions, thereby violating professional integrity as expressed in the Code for Nurses.
7. Arrives at clinical setting in an impaired condition as determined by the clinical instructor.

Failure to comply with any of the above requirements may result in an unexcused clinical and/ or negative clinical evaluation.

B. Clinical Objectives

Upon completion of the Nurs. 3603 Clinical Experience, the student will:

PROVIDER OF CARE:

1. Assess the adult patient for health status and health needs.
2. Identify actual and potential problems for the adult patient based on assessment data.
3. Develop an individualized plan of care with appropriate patient outcomes for the adult patient.
4. Implement plan of care in a safe manner according to nursing principles and theoretical rationale.
5. Evaluate the effectiveness of nursing interventions in meeting the patient expected outcomes.

COORDINATOR OF CARE:

1. Perform nursing care for two patients, in collaboration with the individual, family, and other health care providers, utilizing critical thinking and time management.

MEMBER OF THE PROFESSION:

1. Demonstrate responsibility and accountability for own actions.
2. Abide by the laws and standards designated by the University of Texas at Tyler College of Nursing, Texas State Board of Nurse Examiners, and the ANA Code of Ethics.
3. Project a professional image by adhering to the dress code and meeting the attendance requirements.

COMMUNICATION

1. Document in a comprehensive, organized, and clearly stated manner the nursing care delivered.
2. Communicate with the clinical faculty and other health care providers regarding patient status.
3. Establish effective working relationships with clinical faculty, facility personnel, peers, patients, and patient's families.

SAFETY

1. Provide safe care by accurately administering medications in real and simulated situations.
2. Accurately identify safety risks and appropriately intervene to provide a safe patient environment.

Attendance

1. Attendance for the learning laboratory and the clinical agency is **MANDATORY**. The student must notify the instructor prior to the clinical if an absence is necessary. The clinical instructor must be contacted directly! When in the learning laboratory, the student must leave a message with the instructor, including the telephone number where he/she may be contacted. When in the clinical agency, the student must contact the agency personnel and the instructor at least one hour prior to the scheduled clinical time. If the student is going to be late, the student must notify the agency.
2. No student will be allowed to remain in the clinical area for the clinical day without correct and complete patient preparation reflected on the required clinical worksheets. No exceptions! A clinical absence will be recorded and the student will be required to consult the clinical instructor for make-up information.
3. Make time for missed clinical time will be arranged at the discretion of the instructor. A student missing one or more days in one rotation will present for approval a written plan as to how he/she will meet the clinical objectives.

Dress Code Requirements:

Skills Lab

1. Students may wear clothing that is appropriate for lecture. (at campus only, skills labs in hospital require clinical dress)
2. For some sessions, students will serve as "patients" for lab partners and will change into clothing appropriate for the experience.

Clinical Facilities

- a. When attending any clinical experience students are required to wear the standardized student uniform and white uniform jacket with name badge and school patch. The school patch is to be displayed on the left chest area. Street clothes will be worn in appropriate clinical settings as directed by clinical faculty with the white uniform jacket, name badge and school patch.
- b. **NOT ALLOWED (INCLUDING, BUT NOT LIMITED TO THE FOLLOWING):**
Jeans,
shorts, sandals, jogging/athletic suits, transparent blouses, T-shirts, etc.
- c. Students are to remember that whenever they are visiting a clinical agency or any clinical site, they are representing UTT and are expected to be professional in appearance and behavior at all times. The student may be asked to leave the clinical area and return when professionally clothed.
- d. When student uniforms are required for clinical experiences, as specified in course syllabus, the following guidelines must be adhered to:
 1. School patch on front left **side** of the **lab** jacket and uniform **top**.
 2. UTT name pin (ordered at orientation meeting or in the nursing office).
 3. White hose with dress/skirt; nylon hose or knee-highs or white socks with pants. Socks must cover ankles.
 4. Clean, white clinical shoes or white leather athletic shoes. No canvas shoes or athletic shoes with colored stripes or large logos.

5. Jewelry **WILL BE LIMITED TO:** wedding or engagement rings **only**; single stud earrings (**only** one in each earlobe (no dangles or hoops). Other body piercing and/ or tattoos will be covered or removed. Tongue studs will be removed during clinical experiences. **A watch with a second hand is essential.**
6. Makeup, hair, and grooming should be conservative. Uniforms should fit properly. Hair shoulder length or longer must be pulled neatly back into a ponytail or bun. Hair clips, bands, etc., shall be functional only, not decorative (no bows).
7. Nails should be clean and neatly trimmed to no more than fingertip length, with clear or no polish. **NO ARTIFICIAL NAILS.**
8. No perfume or after-shave since this causes nausea and/or difficulty in breathing for many patients.

Any questions concerning adherence to the above dress code should be directed toward the clinical instructor.

Failure to comply with the above requirements may result in an unexcused clinical absence and / or negative clinical evaluations. A negative clinical evaluation can constitute a clinical failure and thus a failure for this course.

Professional Liability Insurance/CPR/ Required Immunizations

Students are responsible for providing proof of coverage, certification, and immunizations prior to hospital experience. Forms are available at orientation.

Clinical Injuries

Hospitals and other health facilities do **NOT** cover any medical expenses as a result of accident or injury; thus, each student is responsible for any medical or hospitalization charges that occur.

Working Prior to Clinical

Students working a shift prior to the assigned clinical experience are at higher risk for unsafe clinical practice and may be sent home by the clinical instructor.

Health Record

A Student Health History form must be completed and a copy of all required immunizations must be in the student's folder prior to hospital experience. The Hepatitis B immunization series must be begun prior to clinical. Documentation of immunity to MMR or MMR immunization needs to be on your record. A current TB skin test is required prior to clinical assignments in the hospital setting. Documentation of significant laboratory studies or the successful treatment of diseases detected must be presented.

Skills Check-off

Students should study the skills outlined in the textbook prior to coming to the skill lab. The student should be able to perform the skill without coaching prior to asking for faculty evaluation. Evaluation of laboratory skills is by means of return demonstration. Skills check-offs will be performed in the skills lab and in the clinical area.

Clinical Forms

Students are expected to complete a Clinical Worksheet packet for each patient in each clinical day. A copy of these worksheets is found in the supplemental course material packet. There are three sets in the packet. Students are responsible for making additional copies. The Preclinical worksheets and medication worksheets are due at the beginning of EACH clinical experience. No student will be allowed to remain in the clinical area for the clinical day without correct and complete patient preparation reflected on the required clinical worksheets. No exceptions! The Post-clinical Nursing care plan sections will be due at the beginning of the didactic class on Tuesday morning or as indicated by individual clinical instructor. These forms are included in the Supplemental Course Materials packet that is purchased from the Bookstore.

Medication Worksheet

For all clinical experiences, the student will have access to information regarding medication prescribed for each assigned patient. The medications are listed on the preclinical worksheet. This worksheet is handed in to the instructor at beginning of clinical experience.

Post Conferences

After each clinical experience, the students will participate in a post-clinical discussion. These discussions will relate to clinical experiences or expectations. Participation in Clinical discussions is mandatory and will be reflected in the clinical evaluation.

Clinical Skills Checklist

Bring the master- level one clinical skills checklist to each clinical experience. At the completion of a skill, ask the instructor or nurse observing the skill performance to initial in the appropriate place on the checklist. At the end of the semester, make a copy of the signed and initialed checklist and bring it with you to the final clinical evaluation conference. This document will go in your file for reference by others as needed. The checklist is found in the supplemental course materials packet.

<p>In the BSN Handbook, a master skills checklist is provided for the student. It is the student's responsibility to maintain this master list throughout the nursing program.</p>

Clinical Skills Lab Supply Pack

A package of supplies needed in the clinical skills lab will be provided the first day of the skills lab experience. A receipt is required to provide this package of materials. A bill showing payment of the skills lab fee is acceptable. This bill can also be printed from Campus Connect. No student will be provided with the needed materials unless a receipt is made available.

NURSING COMPETENCIES - SKILL LAB / CLINICAL CALENDAR

*** Changes in clinical times and content will be at the discretion of the clinical instructor.

WEEK	DATE	SKILL LAB/CLINICAL
1	Week 1 August 27, 28, 29	8-5 Skills Lab: [Units 1,2, 6] Blood borne Pathogens Hand washing Sterile/Non-sterile Gloves Isolation Sterile Gloves General Safety Restraints Body mechanics Transfers Oxygen Delivery *Turn in clinical evaluation form.
2	Week 2 September 3, 4, 5	8-5 Skills Lab: [Units 3,4, 5] Personal hygiene [Bed Bath, Hair Care, Shaving] Oral care and suctioning Nutrition Support and Intake and Output Nasogastric Tube insertion, care and feeding
3	Week 3 September 10, 11, 12	8-5 Skills lab: [Unit 7 & 8] Medication Administration Dosage calculations, preparation and administration of PO, topical and parenteral medications.
4	Week 4 September 17, 18, 19	7-10 Clinical Agency: Focus: personal hygiene, infection control, vital signs, documentation on graphic sheet, mobility, medication administration 11-5 Skills Lab: [Unit 5, 6] Sterile gloving, Wound care, suture and staple removal, amputation care, cast care, traction, hot and cold applications
5	Week 5 September 24, 25, 26	7-10 Clinical Agency: Focus: personal hygiene, infection control, vital signs, documentation on graphic sheet, mobility, medication administration 11-5 Skills lab [Unit 9] Enema administration, ostomy care, specimen collection, glucometer IV drip calculations and IV maintenance / monitoring, suctioning and airway maintenance
6	Week 6 October 1, 2, 3	8-5 Skills lab Urinary Catheterization Review and practice for skills checkoffs.
7	Week 7 October 8, 9, 10	8 - 5 Check-offs
8	Week 8 October 15, 16, 17	6:30 – 3:30 Clinical agency Total care of 1-2 patients
9	Week 9 October 22, 23, 24	6:30 – 3:30 Clinical agency Total care of 1-2 patients <div style="text-align: right;">Care Plan 1</div>
10	Week 10 October 29, 30, 31	6:30 – 3:30 Clinical agency Total care of 1-2 patients
11	Week11 November 5, 6, 7	6:30 – 3:30 Clinical agency Total care of 1-2 patients <div style="text-align: right;">Care Plan 2</div>
12	Week 12 November 12, 13, 14	6:30 – 3:30 Clinical agency Total care of 1-2 patients

13	Week 13 November 19,20,21	6:30 – 3:30 Clinical agency Total care of 1-2 patients ERI EXAMS Available at www.eriworld.com from November 22 – December 8 noon
14	Week 14 November 26,27,28	<i>Happy Thanksgiving Holiday</i>
15	Week 15 December 3, 4, 5	Individual Clinical Evaluations this week – schedule appointment with clinical instructor – bring clinical skills checklist completed and self-evaluation on Clinical Evaluation form ERI EXAMS Available at www.eriworld.com from November 22 – December 8 noon *** Must make equal to or greater than the national average ---You Must have completed this test successfully in order to take the final exam/
16	Week 16 December 10, 11, 12	Finals Week

Guidelines for the Clinical Experience

A. Pre-Clinical Preparation & Instructions (preparation will be completed on your own time the day / evening prior to clinical.

1. Patient selection and preparation requires approximately 3 hours.
 2. Appropriate professional attire is expected [see dress policy]. Lab coat is required.
 3. Consult the charge nurse or assignment sheet for patient selection (ask for the best learning experiences for a beginning student).
 4. Write your patient selections clearly using the UTT sign up sheet and place on the designated area in the unit. [required if patient not assigned by instructor]
 5. Review the chart: pt. history, operative & X-ray reports, vital signs/graphics sheet, lab reports, nursing notes for past 24 hours, doctor's orders and progress notes.
 6. Review the patient's pathophysiology including typical signs & symptoms, assessment findings and appropriate therapy. Begin formulating your plan of care. [the preclinical worksheets are due the morning of clinical experience.]
 7. Look up each medication and record on the preclinical worksheet in the medication area. You are expected to know the mechanism of action, appropriate dose, side effects, any labs or therapeutic levels you need to check prior to administering, and any special considerations). Keep a copy of this page; mark the correct page in the drug manual, or prepare/select appropriate drug information for use in the clinical area. [Drug cards or PDA drug resource is acceptable in the clinical area for reference, but not for the graded care plans.]
 8. Look up the lab values and be ready to discuss the abnormal lab values and what the values indicate in correlation with your patient.
 9. Review any new procedures that might involve your patient (you may look in the unit policy & procedure book.
 10. Orient yourself to the nursing unit prior to beginning patient care.
- You are expected to have read all relevant material in related textbooks for daily clinical preparation before caring for your patient.
 - Students may be questioned daily on their knowledge of this material. Students unprepared for the clinical experience will be deemed unsafe and sent home. This will result in a clinical absence.
 - The student must come to clinical practice prepared to give care, including knowledge of lab work, pertinent diagnostic procedures, and hands-on skills that will be performed.

II. Clinical Guidelines

1. You must report off to the instructor and primary nurse before leaving the unit.
2. Do not do **ANY** procedure or give **ANY** medication without supervision of your clinical instructor. The clinical instructor may direct you to a nurse mentor for observation in specific instances.
3. The clinical instructor prior to administration must check all medications!
4. Students are not to administer blood or blood products; however, you may monitor the patient during the transfusion.
5. DO NOT TOUCH the narcotic keys! You may sign out narcotics with your instructor, but the assigned nurse must open the narcotic box for you!
6. Complete your clinical paper work and give it to your instructor on time. Completed clinical worksheet packet is due on Tuesday morning at the beginning of the didactic class, unless otherwise indicated by your clinical instructor.

Sample of a Clinical Day

Before arriving at the clinical unit: check your attitude. Patients need a cheerful face, a listening ear, helpful hands and open heart. Make sure yours fits the description.

Arrive to clinical unit on time and correctly dressed and prepared. Listen to shift report. Make notes about your patient.

Immediately after report, identify yourself and what care you will be providing to your assigned patient(s) to the primary nurse [nurse mentor] or nurses.

Take vital signs and complete your morning assessment. This means you may need to wake the patient up. It is essential that you establish a baseline assessment once you accept responsibility for the patient. Report any abnormal assessment findings or changes in your patient's condition to the primary nurse and your instructor IMMEDIATELY!

Following your assessment, assist the patient in preparing for breakfast. While they are eating, chart your vital signs and morning assessment. Confirm your documentation with the primary nurse or your instructor before writing in the medical record.

Begin preparing your morning medications. Be ready to discuss each medication with your instructor. Look up any necessary lab values or therapeutic drug levels prior to checking your meds with your instructor- THEY WILL ASK YOU ABOUT THE LAB VALUES and other assessment information!

Begin bed bath / linen changes following morning medications. Work together, it will go much faster!

Implement your nursing care plan, based on your assessment data from this morning. Consult your instructor if you are having difficulty in thinking of appropriate interventions.

Follow the charting policy of the clinical agency. Any narrative notes should be written in the DAR format as discussed in class. Any abnormality assessed should be discussed in the narrative notes. All documentation should be written on a separate sheet of paper until approved by your instructor or primary nurse to be included in the patient's medical record.

Remember any time you give a PRN medication to your patient to evaluate the effectiveness (usually 30 minutes later). (i.e. narcotic- pain response, Tylenol for fever- re-check temp., laxative for constipation- assess BM?)

Take noon vital signs before leaving the unit for lunch. Report off to your instructor and the primary nurse before leaving the unit AT ANY TIME. Make sure that another student is asked to "cover" or watch your patient if you are off the unit.

Evaluate the patient with a brief assessment before reporting off. Evaluate the effectiveness of the interventions in meeting the goals for your patient.

Have your instructor approve your charting and make certain all medications are given and charted before leaving the unit for the day.

STUDENT CHECKLIST BEFORE LEAVING THE UNIT:

- | | |
|--|--|
| 1. Are all meds given and charted appropriately? | 5. Are my vital signs charted on the graphic sheet. |
| 2. Are my patient's rooms clean: meal trays removed, etc.? | 6. Are my nurses' notes updated and signed off correctly? |
| 3. Are my patient's comfortable and safe? | 7. Did I report off to my primary nurse and my instructor? |
| 4. Are my I&O's done and charted appropriately? | 8. Did I tape report for next shift [if applicable]? |

HAVE A SENSE OF ACCOMPLISHMENT AT THE END OF THE DAY! YOU WILL MAKE A DIFFERENCE!

Unit 1: Medical Asepsis and Infection Control**Preclass activities:**

1. Required reading: Potter and Perry Chapter 34
2. Bring Syllabus to lab

Unit Objectives: Upon completion of this unit the student will:

1. Define: reservoir, medical asepsis, surgical asepsis, nosocomial infection, bactericidal, bacteriostatic.
2. Describe the chain of infection.
3. Identify ways to break the infection chain at each phase.
4. Identify the body's normal defenses against infection
5. Identify patients at a high risk for acquiring an infection.
6. Differentiate signs and symptoms of local and systemic infections.
7. Identify conditions that precipitate nosocomial infections.
8. Describe laboratory data that relate to diagnosis and monitoring of infectious processes.
9. Discuss three major types of isolation, and when these precautions are necessary.
10. Demonstrate correct handwashing technique.
11. Demonstrate correct procedure for putting on and removing gloves.
12. Identify and state need for types of Personal Protective Equipment (PPE).
13. Demonstrate correct procedure for putting on and removing isolation clothing.

Class Outline:

1. Skills lab orientation
2. Blood borne pathogens
3. Standard precautions
4. Different types of isolation
5. Putting on nonsterile gloves
6. Putting on isolation equipment and clothing

Critical skills:

1. Handwashing - Potter and Perry, page790
2. Use of isolation Equipment – Potter and Perry – 795, 799

Mastery Skill**Handwashing**

Unit 2: Safety and Mobility**Preclass activities:**

1. Required reading: Potter and Perry, chapters 47
2. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives: Upon completion of this unit the student will:

1. Discuss general safety concerns for hospitalized patients
2. Describe the principles of correct body mechanics.
3. Demonstrate procedures for transferring a patient from bed to chair.
4. Demonstrate correct use of mobility equipment –wheelchair, walker, crutches
5. Discuss common traction devices and indications for use.
6. Describe and demonstrate appropriate positioning of patients. [Fowlers, Sims, Trendelenberg, lithotomy]
7. Describe types of assistive equipment and indications for use.
8. Describe types of restraints and indications for use.
9. Discuss concept of least restrictive environment.
10. Discuss methods of avoiding restraint use.
11. Discuss nursing responsibilities relating to restraint use.
12. Documentation of patient safety and mobility.

Class Outline:

1. Use of restraints
2. Body mechanics
3. Transfer techniques
4. Positioning a patient: Fowlers: high, semi-, low-; Lateral; Prone; Trendelenberg; Lithotomy

Critical skills:

1. Safe and Effective Transfer techniques - Potter and Perry, 1468
 2. Restraints - Potter and Perry, page 984
 3. Positioning – pages 1458
-
-

Unit 3: Personal Hygiene**Preclass activities:**

1. Required reading: Potter and Perry, chapter 39
2. Bring toothbrush and toothpaste, wear a swimsuit or workout clothes to this clinical lab.
3. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives: Upon completion of this unit the student will:

1. Compare and contrast the steps in making an occupied and unoccupied bed.
2. Demonstrate the skill of bed making and folding mitered corners.
3. Demonstrate the steps to administering a total bed bath.
4. Demonstrate application of adult incontinence brief.
5. Outline the steps of morning and evening care.
6. Demonstrate the administration of a back rub.
7. Discuss types of range of motion.
8. Incorporate range of motion exercise into a bathing routine.
9. Documentation of personal hygiene care.

Class Outline:

1. Morning and evening personal hygiene care
2. Oral care - Potter and Perry
3. Hair care / shaving -
4. Nail care
5. Bed bath and bed making
6. Range of motion
7. Moving a patient up in bed avoiding sheer forces

Critical Skills:

1. occupied bed change - Potter and Perry, page 901
 2. bed bath - Potter and Perry, page 869
 3. application of adult incontinence brief - demonstration
-
-

Unit 4: Nutrition

Preclass activities:

1. Required reading: Potter and Perry, chapter 44
2. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives: Upon completion of this unit the student will:

1. Identify patients at risk for swallowing difficulties.
2. Discuss adaptive techniques used with patients with swallowing difficulties.
3. Documentation of swallowing difficulty.
4. Demonstrate techniques of assisted feeding.
5. Discuss alternate types of feeding
6. Demonstrate insertion of a nasogastric tube.
7. Demonstrate safe technique with tube feedings (NG and PEG).
8. Demonstrate calculation of Intake and Output
9. Documentation of Intake and Output.

Class Outline:

1. importance of nutrition in hospitalized or institutionalized patients
2. swallowing difficulties
3. assisted feeding
4. nasogastric tube insertion
5. care of nasogastric tubes
6. tube feedings
7. Intake and Output

Critical skills:

1. Insertion of nasogastric tube - Potter and Perry, page 1113
 2. Tube feeding techniques - Potter and Perry, 1119-1124
 3. Assisted feeding for persons with swallowing difficulties - demonstration
-
-

Unit 5: Wound Care**Preclass activities:**

1. Required reading: Potter and Perry, chapter 48
2. Bring sterile gauze, tape, small bottle of saline, and ABD dressing pads from skills lab pack
3. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives: Upon completion of this unit the student will:

1. Compare and contrast types of wounds, i.e. surgical, traumatic, pressure.
2. Discuss stages of the healing process.
3. Differentiate between primary and secondary intentions.
4. Discuss indications of delayed wound healing.
5. Explain emergency treatment of a dehiscence or evisceration.
6. Compare and contrast types of wound products available and be able to discuss which type is appropriate for specific wounds.
7. Describe closed wound drainage systems.
8. Describe defining characteristics used in staging pressure wounds
9. Discuss the differences between sterile and clean procedure.
10. Compare and contrast the use of hot and cold therapies.

Class Outline:

1. Wounds and healing
2. Sterile technique
3. Sterile dressing change
4. Various types of dressings, drains
5. Suture, staple, clip removal
6. caring for amputations
7. Application of heat and cold therapies

Critical Skill:

1. Demonstrate sterile gloving. Potter and Perry, page 681
2. Demonstrate establishing and maintaining a sterile field. Potter and Perry, page 671
3. Demonstrate wound irrigation procedure. Potter and Perry, page 1326
4. Demonstrate a sterile dressing change. Potter and Perry, page 1314
5. Demonstrate collection of a wound culture. demonstration
6. Demonstrate wrapping of an amputation. Potter and Perry page 1552
7. Demonstrate appropriate and complete documentation of wound care.

Mastery Skill**Sterile Gloving****Sterile Fields**

Unit 6: Oxygenation and Circulation**Preclass activities:**

1. Required reading: Potter and Perry, chapter 40
2. Bring suction catheter and kit from skills lab pack.
3. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives: Upon completion of this unit the student will:

1. Discuss indications for supplemental oxygen therapy.
2. Identify safety precautions and nursing responsibilities for a patient receiving supplemental oxygen therapy.
3. Discuss types of oxygen delivery systems and indications for use of each system.
4. Describe respiratory medication delivery systems and indications for use.
5. Discuss appropriate collection of sputum specimens.
6. Demonstrate technique of oral suctioning.
7. Discuss artificial airways, types and maintenance of each type.
8. Demonstrate sterile suctioning technique.
9. Demonstrate tracheostomy care techniques.
10. Discuss methods of maintaining circulatory integrity.
11. Demonstrate application of antiembolic stockings (TED hose) and sequential compression devices (SCD's).

Class Outline:

1. Oxygen therapy
2. inhaled medication therapy
3. sputum specimen collection
4. artificial airways
5. suctioning: oropharyngeal, tracheal
6. care of tracheostomy

Critical skills:

1. oropharyngeal suctioning - Potter and Perry, 936
2. sterile suctioning techniques - Potter and Perry, page 934
3. tracheostomy care - Potter and Perry, page 946
4. application of antiembolic stockings, Potter and Perry, page 1249
5. Sequential Compression Devices (SCD) – Potter and Perry, page 1248

Mastery Skill:**Sterile suctioning technique****Additional Resources:**

CDROM – ABG interpretation

Unit 7: Medication administration

Preclass activities:

1. Required reading: Potter and Perry, chapter 35
2. Bring a BALL PARK FRANK*** for intradermal injection practice. *** a package has 8 franks in it, go together and buy a package or two for this exercise. These are the only ones that work well.
3. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives: Upon completion of this unit the student will:

1. State the five rights of medication administration.
2. Explain the components of an appropriate medication order.
3. Discuss the procedure of reconciling the medication administration record with the physician order form.
4. Outline the steps in preparing an oral, topical, or parenteral medication for administration.
5. Demonstrate the administration of an intramuscular, subcutaneous, and intradermal injection.
6. State the rationale and method for a Z-track injection.
7. Compare insulin types and demonstrate appropriate steps in mixing insulin for injection.
8. Calculate medication dosages correctly.
12. Discuss safety factors in prevention of medication errors.
13. Document medication administration on MAR.
14. Documentation of PRN medications.

Class Outline:

1. Oral and topical medication administration
 - a. Tablets, pills, capsules
 - b. Elixirs, suspensions
 - c. Eye drops
 - d. Ear drops
 - e. Skin preparations
 - f. Rectal and Vaginal insertions
2. Parenteral medication Administration
 - a. intradermal
 - b. subcutaneous
 - c. intramuscular
 - d. Z-track
3. Selection of Equipment
4. Insulin Administration
 - a. types
 - b. mixing types
5. calculating Drug dosages
6. Documentation of Medication Administration

Mastery Skills:

Dosage calculation - demonstration / practice
 Medication Administration – oral, parenteral
 Insulin mixture and administration

Additional Resources:

CDROM – PO medications

CDROM – IM medications

Unit 8: Fluids and Electrolytes

Preclass activities:

1. Required reading: Potter and Perry, chapter 41
2. Bring small IV fluids and IV tubing's from skills lab pack.
3. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives: Upon completion of this unit the student will:

1. Discuss indications for intravenous fluid infusions.
2. Discuss nursing responsibilities relating to IV therapy.
3. Calculate IV flow rates for infusions regulated with or without an IV pump device
4. Demonstrate correct procedure to initiate IV fluid therapy.
5. Describe the detection of complications of IV therapy, local and systemic.
6. Calculate IVPB infusion rates regulated with and without and IV pumps.
7. Demonstrate technique of saline flush.
8. Demonstrate technique of discontinuing an IV insertion site.
9. Document IV therapy, and complications of IV therapy.
10. Demonstrate use of bedside blood glucose testing device.

Class Outline:

1. Intravenous fluid therapy
2. Calculation of IV fluid rates.
3. Complications of IV fluid replacement.
4. Intravenous medication administration

Critical skills:

1. Calculating IV and IVPB flow rates
2. Monitoring IV therapy
3. Blood glucose monitoring
4. Prepare IV for infusion
5. Discontinuing IV infusions
6. Removing IV catheters

Mastery Skills:

Calculation of IV flow rates – demonstration and practice

Administering IV medications – Potter and Perry, pages 894, 897, 901

IV therapy- Potter and Perry pages 1175, 1184, 1187

Additional Resources:

CDROM – Fluid and Electrolytes I and II

Unit 9: Elimination- Bowel

Preclass activities:

1. Required reading: Potter and Perry, chapter 46
2. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives: Upon completion of this unit the student will:

1. Discuss collection of stool specimens.
2. Demonstrate correct procedure for testing for occult blood in stool.
3. Discuss methods to assist in bowel elimination.
4. Discuss administration of an enema.
5. Discuss ostomy formation.
6. Demonstrate application of ostomy appliance.

Class Outline:

1. Stool specimen collection
2. Enema administration, fleets, large volume Potter and Perry, page 1200
3. Ostomy care

Critical skills:

1. Ostomy appliance application - Potter and Perry, page 1211
 2. Enema Administration – Potter and Perry, pages 1200
-
-

Unit 10: Elimination- Bladder

Preclass activities:

1. Required reading: Potter and Perry, chapter 45
2. Bring Urinary catheterization kit from skills lab pack.
3. Bring Syllabus, and master- level one clinical skills checklist to lab.

Unit Objectives:

Cognitive:

1. Identify signals of urinary tract infection.
2. Compare and contrast types of urinary incontinence.
3. Discuss collection techniques for urine samples, including clean-catch, sampling from closed drainage systems, straining urine, and 24 hour collections.
4. Discuss techniques used to encourage bladder emptying.
5. Discuss techniques used to control bladder emptying.
6. Identify alternatives to indwelling urinary catheters.
7. Describe conditions requiring use of indwelling urinary catheters.
8. Compare and contrast sterile intermittent catheterization and self catheterization techniques.
9. Compare and contrast care of a urostomy as opposed to a colostomy.

Class Outline:

1. Urinary catheterization
2. Urine specimen collection - Potter and Perry, page 1140

Critical skills:

1. Urinary Catheterization: Potter and Perry, page 1154
2. Catheter care: Potter and Perry, page 1162

Mastery Skill:

Urinary Catheterization simulation

Appendices

CONVERSIONS - NEED TO KNOW**EQUIVALENCIES**
SYMBOLS

1L. = 1000 ml.
1ml. = 1cc or 0.001L.
1 ounce = 30 ml

ABBREVIATIONS**Volume measures:**

L. = Liter
ml. = Milliliter
1 tsp = 5ml
1 tbsp = 15ml [Tbsp]

Weight Measures:

1GM = 1000mg. or 15gr.
1mg. = 1000mcg
1kg. = 1000GM.
1kg. = 2.2lbs.
1oz. = 8dr.
1gr. = 60mg.
1Gm. = 15gr.

Gm. = Gram
mg. = Milligram
kg. = Kilogram
mcg. = Microgram
gr. = Grain

MATH PRACTICE PROBLEMS

Use a separate piece of paper and calculate the following problems. Pay attention to conversions. The units have to be the same. And correctly label each part of the problem. This will help you avoid errors. Look at you answer in light of the question and make sure your answer makes sense. You must use dimensional analysis to calculate these problems.

Dimensional Analysis Method : Start the calculation with what you want to end up with, then line up the units so they will cancel out and leave you with the end result you wanted. You must include the dose needed, and the medication amount per unit.

Example:

The doctor orders to give tetracycline syrup 375mg every 6 hours PO. The available medication contains 125mg/tsp. How many tsp will you give?

$$X \text{ tsp} = \frac{1 \text{ tsp}}{125\text{mg}} \times \frac{375 \text{ mg}}{\text{dose}} = \frac{375}{125} = \underline{3 \text{ tsp.}}$$

Now try these:

1. Order: Valium 3 mg. The vial is labeled 10 mg. per 2 ml. How many ml. would you give?
2. Order: Chloromycetin 800 mg. The vial reads 1 Gm. per 10 ml. How many ml. would you give?
3. Order: Phenergan 75 mg. The vial contains 100 mg. per 2 ml. How many ml. would you give?
4. Order: Lanoxin 20 mcg. The ampule reads 0.5 mg. per 2 ml. How many ml. would you give?
5. Order: Tigan 0.2 Gm. The vial reads Tigan 100 mg. per ml. How many ml. would you give?
6. Order: 500,000 units of the antibiotic Sodium Penicillin (Bicillin) IM for a patient with strep throat, Directions: Add 3 ml. to a 500,000 unit vial, (reconstituted) 1 ml = 1,000,000 units. How many ml. would you give?
7. Order: Morphine Sulfate 4 mg. The tubex reads Morphine Sulfate 10 mg. per ml. How many ml. would you give?
8. Order: Solu-medrol 22 mg. The vial reads Solu-medrol 40 mg. per 2 ml. How many ml. would you give?

9. Order: 0.4 Gm. of Streptomycin. On hand: 1 Gm per 2.5 ml. How many ml. would you give?
10. Order: Ampicillin 125 mg. The Ampicillin suspension contains 500 mg. per teaspoon. How many ml's should you give?
11. Order: 0.125 mg. The correct medication tablets contain 0.25mg. per tablet. How many tablets would you give?
12. The correct loading dose of a drug is 10 mg. per kg. of body weight. The patient weighs 88 kg. How many mg. should the patient receive?
13. Ordered: Morphine 4 mg. On hand is $\frac{1}{4}$ gr. per 2 ml. How many ml's should you give?
14. A 44-pound child weighs _____kg?
15. _____mcg is 1 mg?
16. 1 tsp is the same as _____ml?
17. One ml. is _____minims?
18. Order: Gr. $\frac{1}{300}$. The vial contains gr. $\frac{1}{150}$ per ml. How many ml's would you give?
19. Order: Tetracycline 125 mg. The label reads 250 mg. per tsp. How many tsp. would you give?
20. Order: Cleocin 450 mg. The ampule is labeled 600 mg. per 2 ml. How many ml. would you give?
21. Order: Lovenox 62 mg. Sq. The syringe has 100 mg per ml. How many ml. will you give?
22. Order: Thyroxin $\frac{1}{2}$ gr. PO daily. On hand is 30 mg tablets. How many tablets will you give?

BE SURE AND SHOW ALL OF YOUR WORK!

Review how to change equivalent from the various systems...such as mg. to Gm., Gm. to mg. to grains, kg. to lbs., etc. Also know Roman Numerals 1 - 30. **TIP:** When you begin your test: Write your formulas and conversions at the top or bottom of the page. This can lessen the confusion!

Practice Problems

IV drip calculations Nursing 3603

Dimensional Analysis Method : Start the calculation with what you want to end up with, then line up the units so they will cancel out and leave you with the end result you wanted. You must include the dose needed, and the medication amount per unit.

$$\frac{\text{ml}}{\text{hr}} = \frac{\text{volume}}{\text{time in hours}} \quad \left/ \quad \frac{\text{gtts}}{\text{min}} = \frac{\text{tubing drop factor}}{\text{minute}} \times \frac{\text{volume}}{\text{hours of infusion}} \times \frac{1 \text{ hour}}{60 \text{ minutes}} \right.$$

Directions: Calculate each problem using both formulas. Be prepared to show your calculations.

Number	Problem	Drip factor	Answer in drops per minute (free flow)	Answer in mL / hr (pump setting)
1	500cc 5% D/W over 4 hours	12		
2	1000 cc 5% D/W over 12	15		
3	3000 cc NS over 24 hours	20		
4	115 cc IVPB over 45 minutes	12		
5	350 cc blood over 3 hours	10		
6	250 cc NS over 1 ½ hours	60		
7	50 cc of Albumin over 20 minutes	60		
8	750 cc of LR over 6 hours	15		
9	1000 cc TPN over 12 hours	12		
10	500 cc NS over 24 hours	10		
11	2 units of blood [700 cc] over 8 hours	15		
12	250 cc Vancomycin over 2 hours	12		
13	250 cc 5% D/W over 4 hours	10		
14	930 cc of NS over 15 hours	10		
15	100 cc over 40 minutes	60		

University of Texas at Tyler

Clinical Evaluation Tool

College of Nursing

Nurs 3603: Nursing Competencies

Fall _____ Spring _____

Student Name: _____

Clinical Instructor _____

Clinical behaviors are evaluated throughout the required clinical experience.

- 1. A score of 2 or 3 must be obtained for successful completion of the clinical objective of the course.**
- 2. A score below 2 will result in a written contract with expected measures to demonstrate improvement. Failure to demonstrate improvement will result in clinical failure and failure of the clinical course.**
- 3. A score of 0 in any behavior at any time may result in failure in the clinical component of the course and failure of the clinical course.**

Mastery Level Clinical Skills are skills deemed necessary to accomplish in order to satisfactorily complete the clinical component of the course.

University of Texas at Tyler
Clinical Evaluation Tool

College of Nursing
Nurs 3603: Nursing Competencies

****Clinical Evaluation Scoring Criteria Must be attached before placing in Student file.**

Provider of Care: Assess the adult patient fro health status and health needs. Identify actual and potential problems from the adult patient based on assessment data. Develop an individualized plan of care with appropriate patient outcomes for the adult patient. Implement plan of care in a safe manner according to nursing principles and theoretical rationale. Evaluate the effectiveness of nursing interventions in meeting the patient expected outcomes. MIDTERM
FINAL

Expected Behavior	3	2	1	0	3	2	1	0	Comments
1. Assessment data									
2. Diagnostic statement									
3. Patient Outcomes									
4. Delivery of Care									
5. Evaluation of patient outcomes									

Coordinator of Care: Perform nursing care for two patients, in collaboration with the individual, family, and other health care providers, utilizing critical thinking and time management.

Expected Behavior	3	2	1	0	3	2	1	0	Comments
1. Time management									
2. Clinical decision making & clinical judgment									

Member of the Profession: Demonstrate Responsibility and accountability for own actions. Abide by the laws and standards designated by the University of Texas at Tyler College of Nursing, Texas State Board of Nurse Examiners, and the ANA Code of Ethics. Project a professional image by advising to the dress code and meeting the attendance requirements.

Expected Behavior	3	2	1	0	3	2	1	0	Comments
Professional Values									
1. Accountability & responsibility									
2. Professional awareness									
3. Integrity									
4. Advocacy									
5. Moral conduct									
1. Confidentiality									
2. Professional Standards									
Professional Image									
1. Dress Code									
2. Attendance									

Communication: Document in a comprehensive, organized, and clearly stated manner the nursing care delivered. Communicate with the clinical faculty and other health care providers regarding patient status. Establish effective working relationships with clinical faculty, facility personnel, peers, patients, and patient's families.

Expected Behavior	3	2	1	0	3	2	1	0	Comments
1. Written documentation									
2. Verbal communication									
3. Interpersonal / Psychological communication									

Safety: Provide safe care by accurately administering medications in real and simulated situations. Accurately identify safety risks and appropriately intervene to provide a safe patient environment.

Expected Behavior	3	2	1	0	3	2	1	0	Comments
1. Medication Administration / Simulations									
2. Environmental									

Mastery skills: Skills performed in the clinical area are completed following accepted standards of nursing practice.

Expected Behavior	weeks								Comments
	3	2	1	0	3	2	1	0	
1. Medication administration									
2. Wound Care									
3. Foley catheter insertion									
4. Blood sugar monitoring									
5. stool specimen collection									
6.									

Midterm Clinical Evaluation:

Contract Initiated: Yes No

Clinical Faculty

Student

date

Final Clinical Evaluation:

Clinical grade: Pass Fail

Clinical Faculty

Student

date

Nursing Skills Checklist Level 1

Student _____

Skill	Lab	Clinical
Vital Signs / I & O		
T, P, R	HA	
Apical pulse	HA	
Peripheral pulses	HA	
Blood pressure	HA	
Neuro checks	HA	
Weight	HA	
I & O	X	
Head to toe Assessment	HA	
Personal Hygiene		
Bed Bath	X	
Assisted bath	X	
Oral hygiene	X	
Hair / nail care	X	
Perineal care	X	
Shower	X	
Bedmaking	X	
Infection Control		
Handwashing	X	
Standard precautions	X	
Sharps disposal	X	
Biohazard disposal	X	
Sterile field	X	
Isolation procedures	X	
Mobility		
Body mechanics	X	
Turning and positioning	X	
Wound care		
Sterile dressing change	X	
Staple removal	X	
Care of drains	X	
Binders / supportors	X	
Ace wraps	X	
TED hose	X	
SCD's	X	
Intravenous Therapy		
Saline lock flush	X	
IV drip calculation	X	
IV drip monitoring	X	
D/C IV therapy	X	
IV pumps	X	
Other skills		
Admission procedure		
Discharge procedure		
Patient teaching:		
Giving end of shift report		

Skill	Lab	Clinical
Safety		
Restraints	X	
Range of motion	X	
Assisted ambulation	X	
Traction	X	
Institutional Safety responses	X	
Nutrition		
Assisted feeding	X	
% Solid intake	X	
Nasogastric Tubes		
Insertion	X	
Tube feedings	X	
Checking residuals	X	
Feeding pumps	X	
Elimination		
Bedpan/urinal use	X	
Cath insertion	X	
Enema administration	X	
Ostomy care	X	
Oxygenation		
Oxygen administration	X	
Respiratory treatments	X	
Suctioning	X	
Tracheostomy care	X	
Specimen collection		
Urine specimen	X	
Hemocult	X	
Throat cultures	X	
Sputum collection	X	
Glucose monitoring	X	
Documentation		
Graphic sheet		HA
Nurses notes	X	
MAR	X	
Medication Administration		
Oral	X	
Topical / cream or patch	X	
Topical / eye, ear	X	
Inhalation	X	
SQ	X	
IM	X	
Insulin	X	
Dosage calculations	X	
* attempted		

STUDENT AFFIRMATION FORM

_____ I agree to protect the privacy of faculty, peers, patients and family members of patients by not inappropriately disclosing confidential information about faculty, peers, patients or their family members that is disclosed to me in my capacity as a University of Texas at Tyler nursing student. In addition, I agree not to inappropriately disclose confidential information about my agency or institution that is disclosed to me in my capacity as a University of Texas at Tyler nursing student. I will adhere to HIPPA guidelines.

_____ I have / will read the syllabus of this nursing course I am taking this semester, and I understand the criteria established for grading my course work. I understand that my average on exams must be 75 or higher in order to attain a passing grade for the course.

_____ I agree that I will conduct myself in a manner that exhibits professional values and in accordance with the American Nurses Association (ANA) Code of Ethics for Nurses.

_____ I will maintain and uphold the academic integrity policy of the college of Nursing and will not condone or participate in any activities of academic dishonesty including, but not limited to, plagiarism, cheating, stealing or copying another's assigned work.

_____ I will not recreate any items or portions of any exam for y own use, or for use by others during my enrollment in the College of Nursing.

_____ I will not accept of access any unauthorized information related to any exam administered during my enrollment in the College of Nursing.

_____ I will sign my own papers and other documents and will not sign any other student's name to anything, including class rolls.

_____ I will not allow any student access to any of my paperwork for the purpose of copying.

Student's Signature

Date

Student's Printed Name

Nurs 3603
Course Number

Approved UT System - Spring 1996
Approved Faculty Organization - Spring 2004
Revised: May 2004, Summer 2005

AUDIO/VIDEO-RECORDING AGREEMENT

I have been given permission to audio record the following class, **NURS 3603**.

I understand that, the recordings are for **my personal studies only**. I realize that lectures recorded **may not be shared** with other people without the written consent of the faculty member. I also understand that recorded lectures may not be used in any way against the faculty member, other lecturer, or students whose classroom comments are recorded as part of the class activity.

I am aware that the information contained in the recorded lectures is protected under federal copyright laws and may not be published or quoted without the expressed consent of the lecturer and without giving proper identity and credit to the lecturer. I agree to abide by these guidelines with regard to any lectures I record while enrolled as a student at The University of Texas at Tyler.

Due to the confidential nature of some course content, I agree to provide written documentation of the erasure of any recordings made during the current semester. Failure to return this written documentation to the faculty by the date of the final examination will result in a grade of "I" (Incomplete).

Signature of Student

Date

Signature of Witness

Title of Witness

If a student tapes a course they must sign and agree to the terms of this policy

Revised with permission from TCU
Approved FO: 10/06