N127P
Clinical Nursing Skills I
Practicum

Corinne Grimes, PhD, RN, CNE
(Course Facilitator)

Fall 2010
The University of Texas at Austin
School of Nursing
## Course Schedule

<table>
<thead>
<tr>
<th>WEEK</th>
<th>DATES</th>
<th>TOPIC</th>
<th>ASSIGNMENT</th>
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<tbody>
<tr>
<td>1</td>
<td>8/26/10</td>
<td>Orientation to Course</td>
<td>• All students will meet together at beginning of class. Location will be posted on Skills Lab doors. <strong>$</strong></td>
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<tr>
<td></td>
<td>8/27/10</td>
<td>Standard Precautions Hand Hygiene Infection Control</td>
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<tr>
<td>2</td>
<td>*9/2/10</td>
<td>Safe Patient Handling Restraints and Alternatives</td>
<td>• Syllabus PLUS watch videos from week 1. <strong>$</strong></td>
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<tr>
<td></td>
<td>9/3/10</td>
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<tr>
<td>3</td>
<td>* 9/9/10</td>
<td>AM Care: Bathing Personal Hygiene &amp; Grooming Feeding/ I&amp;O</td>
<td>• Syllabus <strong>$</strong></td>
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<td></td>
<td>9/10/10</td>
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<tr>
<td>4</td>
<td>* 9/16/10</td>
<td>AM Care: Bedmaking Bowel Elimination /Bedpan/Enemas Stool Specimen Collection</td>
<td>• Syllabus <strong>$</strong></td>
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<td></td>
<td>9/17/10</td>
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<tr>
<td>5</td>
<td>* 9/23/10</td>
<td>Meds I Safe Medication Administration Nonparenteral Med Administration</td>
<td>• Syllabus</td>
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<td>9/24/10</td>
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<tr>
<td>6</td>
<td>* 9/30/10</td>
<td>Meds II Safe Medication Administration Insulin, Capillary Blood Glucose</td>
<td>• Syllabus</td>
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<td></td>
<td>10/1/10</td>
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<tr>
<td>7</td>
<td>* 10/7/10</td>
<td>Meds III Safe Medication Administration Injections</td>
<td>• Syllabus</td>
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<td></td>
<td>10/8/10</td>
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<tr>
<td>8</td>
<td>+ 10/14/10</td>
<td>PERFORMANCE EXAM I</td>
<td>• Medication Administration (Syllabus)</td>
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<td></td>
<td>10/15/10</td>
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<tr>
<td>9</td>
<td>* 10/21/10</td>
<td>Documentation Oxygenation Heat and Cold Therapies</td>
<td>• Syllabus <strong>$</strong></td>
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<td></td>
<td>10/22/10</td>
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<tr>
<td>10</td>
<td>*10/28/10</td>
<td>Sterile Technique Wound and Pressure Ulcer Care</td>
<td>• Syllabus <strong>$</strong></td>
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<td></td>
<td>10/29/10</td>
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<tr>
<td>11</td>
<td>+ 11/4/10</td>
<td>PERFORMANCE EXAM II</td>
<td>• Sterile Dressing Change (Syllabus)</td>
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<td>11/5/10</td>
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<tr>
<td>12</td>
<td>* 11/11/10</td>
<td>Urinary Elimination/Catheter Management</td>
<td>• Syllabus</td>
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<td>11/12/10</td>
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<tr>
<td>13</td>
<td>+ 11/18/10</td>
<td>PERFORMANCE EXAM III</td>
<td>• Catheterization of a Female (Syllabus)</td>
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<tr>
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<td>11/19/10</td>
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<tr>
<td>14</td>
<td>11/25/10</td>
<td>THANKSGIVING</td>
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<td>11/26/10</td>
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<td>15</td>
<td>12/02/10</td>
<td>Skills practice Course Evaluations</td>
<td>• Syllabus</td>
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<td>12/03/10</td>
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* Quiz in Learning Center prior to class.
+ Skills performance examination. NO FORMAL LAB MEETING. Arrive at skills lab room 10 minutes prior to assigned testing time and wait your turn to perform the skill.
**$** Pick up documentation assignment at end of class.
The University of Texas at Austin

School of Nursing
N127P Clinical Nursing Skills I Practicum
Fall 2010

Course: N127P Clinical Nursing Skills I Practicum

Course Credit: 1 semester hour; 2 skills lab hours per week

Placement in Curriculum: First Semester, Junior Year

Pre-requisite: Concurrent enrollment in N325P

Course Facilitator: Corinne Grimes, PhD, RN, CNE
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E-Mail: cgrimes@mail.nur.utexas.edu

Course Faculty: Carissa Cross Anuar, MSN, FNP-C
Office: 5.142
Phone: 507-9611 (cell)
E-Mail: ccrosstx@gmail.com

Course Description: Laboratory instruction and practice in clinical nursing skills. Once the skill has been learned in the lab, students may perform it under the supervision of the instructor in the clinical setting.

Course Objectives: Upon completion of this course the learner will be able to:

1. Demonstrate knowledge of purpose, procedure, and rationale of varied health assessments and related nursing interventions.

2. Apply knowledge of purpose, procedure, and rationale of varied health assessments and related nursing interventions.
Teaching/Learning Strategies:

1. Textbooks, readings from professional journals, CD-ROMs, videos.
2. Discussion, demonstration of skills and return demonstration by students.
3. Simulated clinical experiences in the Skills Lab and Learning Center.

Student Evaluation:

N127P is graded Credit/No Credit. The following criteria are used for evaluation:

- 9 Computerized Quizzes – Each quiz must receive a minimum passing grade of 70%
- 3 Skills Performance Examinations – Pass or No Pass
- Weekly Evaluation of Professional Behaviors
- Attendance at All Class Meetings Required

A minimum grade of 70% on each quiz, satisfactory performance on both skills performance examinations, and adherence to policy of professional behaviors are necessary to receive credit for this course.

1. Quizzes: Students must have the theoretical knowledge base for the skill(s) prior to the scheduled skills class in order to effectively use their practice time in skills lab. Complete assignments in syllabus (reading and other media) then take the computerized quiz prior to the didactic/practice portion of each of ten classes listed in the course schedule. Dates with an asterisk (*) indicate that a quiz is required prior to attending class. Note: first class day exception on schedule. Each quiz will be based on the pre-laboratory objectives. Please see “Policies Regarding N127P Computerized Quizzes.”

2. Skills Performance Examinations: There are three skills performance examinations that require the student to perform a nursing skill for their professor and/or teaching assistant in a simulated clinical setting. The required skills performance examinations are: (1) intramuscular injection or subcutaneous injection and one non-parenteral medication (oral, topical, drops), (2) sterile dressing change, and (3) intermittent catheterization with specimen collection. The student will be allocated 20 minutes to perform the required skill. This will require the student to practice during open lab sessions in order to become proficient in his/her performance. The performance criteria for these skills are delineated in this syllabus under the sections “Skills Performance Evaluation – Criteria.”

ALL skills taught in this course are pertinent and critical for the student’s growth in this nursing program and growth toward becoming a registered nurse. Logistics preclude faculty from evaluating the student on all skills in this course. Therefore, specific skills have been selected to aid the student in preparing for the Skills Performance Evaluations. Students are expected to be knowledgeable and reasonably competent and independent in performing ALL skills learned in this course by the end of the semester.

The student must pass all three skills performance examinations. If a student receives “no credit” for any skills performance exam, he/she is allowed a maximum of two repeats per exam. A student who fails a skills performance evaluation will do remedial practice in the open skills lab under the supervision of faculty, staff and/or a teaching assistant prior to retaking the skills exam. All repeats must occur within one week from the originally scheduled date of the skills performance evaluation and must be completed prior to the next scheduled lab class. It is the
student's responsibility to schedule an appointment time to repeat the performance evaluation. If a student is unsuccessful after a total of three attempts within one week to pass a skills performance exam, this results in “no credit” for the course.

3. Evaluation of Professional Behaviors: Students will be evaluated by faculty, staff and teaching assistants during each skills class for the following behaviors: safety, knowledge, communication, accountability, technical competence, nursing process, and interpersonal skills/caring. If the instructor is aware of behaviors, which in his or her judgment indicate that the student is not meeting any one of these behaviors at a satisfactory and passing level, the student will not receive credit for this course, regardless of the numerical grade earned on the quizzes or passing of the skills performance evaluations. See “Student Responsibilities” and “N127P Skills Evaluation Form” in this syllabus for further descriptive criteria of expected professional behaviors.

Student Responsibilities:

1. Preparation - Students are required to complete all assignments listed under “Required Reading and Viewing” and be thoroughly familiar with the steps and rationale for skills as noted in Potter & Perry. Students are required to bring the textbook Clinical Nursing Skills & Techniques to all class meetings. Students who do not come prepared will be dismissed from that day’s lab. Students are allowed to take notes during class when the skill is being demonstrated.

Specific class days require the student to bring to class additional materials or special equipment. Students are expected to note these instructions in the syllabus and follow directions. Additional reading and media viewing may be required for certain skills as the semester progresses. Should this be the case, an announcement will be made by email, in class, or on Blackboard and students are fully responsible for completing the assignment.

Schedule, class objectives, and assigned readings/media are subject to change. Students will be notified by and are responsible for announcements posted on Blackboard, by email, and/or by announcements in class.

2. Attendance – This skills course is considered a practicum course and therefore classified as a clinical course. The following information is the attendance policy dictated by the School of Nursing. Students who are absent in practicum courses may not have sufficient time to learn necessary skills and professional responsibilities and therefore faculty may not have sufficient time to evaluate the student.

Attendance is mandatory at all scheduled laboratory sessions and instructors are required to take attendance at the beginning of the class. Students are required to be prompt for class at the scheduled starting time and to stay the full 2 hours of class time to practice, reinforce, and integrate the learning of skills taught in this class. If a student feels he/she have met the class objectives before the end of class, the student must remain in class and assist his/her peers in learning and practicing the skill. Students are required to stay in the lab section and time period for which they are registered.

In the event that special circumstances make it impossible for the student to be present for a quiz, performance examination, or class, the student must notify and make arrangements with the faculty instructor in advance of the class time. If the student will arrive late, the instructor must be notified prior to the scheduled starting time or as soon as possible when emergency circumstances arise. If the instructor cannot be contacted, the student must leave a message on the instructor’s
voice mail. The student is responsible for all material discussed and all announcements made, even if the lab session was missed in part or whole.

“No credit” for the course will result if the student has two unexcused absences or two unacceptable reasons for missing lab class. In the event that a student is absent from a quiz or skills performance examination without having made prior arrangements with the faculty instructor, he/she may not be permitted to take the quiz or skills performance examination and a “No credit” for the course will result.

**Observance of a religious holy day.** A student who is absent from a class or examination for the observance of a religious holy day may complete the work missed within a reasonable time after the absence, if proper notice has been given. Notice must be given at least fourteen (14) days prior to the classes scheduled on dates the student will be absent. For religious holy days that fall within the first two weeks of the semester, notice should be given on the first day of the semester. It must be personally delivered to the instructor and signed and dated by the instructor, or sent certified mail, return receipt requested. A student who fails to complete missed work within the time allowed will be subject to the normal academic penalties. Special regulations of colleges and schools, required by the unique nature of their programs of study, may be enacted through the normal legislative process and printed in The Undergraduate Catalog. These special regulations may not conflict with University regulations on class attendance and absence.

3. **Absence from Lab** - All missed labs and associated quizzes must be made up the same week as the missed lab. It is the responsibility of the student to confer with the faculty instructor to determine on what day the lab and quiz will be completed. This conference between instructor and student must occur within 24 hours of the missed lab or exam.

4. **Open Lab** - Faculty expect students to attend open skills lab regularly during the semester to reinforce learning. This is a necessity if the student desires to gain confidence and competence in skills for implementation in the clinical setting. Open lab hours are announced in class and posted near the Skills Lab.

5. **Clean Up** - Students are required to clean up their practice area before leaving lab for the day. This includes throwing away trash, returning equipment and straightening the bed linens.

6. **Charting** - Students are required to chart after practicing the skill(s) for the day. At the discretion of the instructor, charting requirements may be fulfilled on the computer or using paper and pen. Remember to include your name and date on your charting. Refer to *Clinical Nursing Skills & Techniques* “Recording and Reporting” section at the end of each skill for guidance on what and how to chart.

7. **Clinical Application** - Students are highly encouraged to read the policy and procedure in their assigned clinical area for the skill to be learned during the next scheduled skills class. This learning strategy will strongly reinforce the application of the skill and demonstrate acceptable health care agency modifications in skill performance while still maintaining standards of care.

If a student misses a skills lab class or does not successfully pass the skills performance exam any given week, it is the responsibility of the student to notify his/her N325P clinical professor. Patient safety requires the student to communicate with the clinical professor regarding any remedial issues.

8. **Honor Code** - The profession of nursing has a legacy of public respect and trust. We provide
specialized care for the health needs of individuals and the community with integrity, honesty, compassion, and state of the art knowledge and skills. Learning and practicing responsible and ethical professional behavior is a vital part of professional education. The Institutional Rules on Student Services and Activities given in the General Information Catalog (Chapter 11) and The University of Texas at Austin’s Honor Code apply to all nursing students:

The core values of The University of Texas at Austin are learning, discovery, freedom, leadership, individual opportunity, and responsibility. Each member of the University is expected to uphold these values through integrity, honesty, trust, fairness, and respect toward peers and community.

Additionally, the School of Nursing has its own honor code:
As a student in The University of Texas at Austin’s School of Nursing, I pledge myself to be honest in all of my student activities including, but not limited to, all of my scholastic work and interactions with patients, members of the community, faculty, and peers. Furthermore, I will not use any substance prior to or during my interaction with patients that could alter my judgment or ability to render safe care: this includes but is not limited to any use of alcohol, illegal drugs, and prescription or over-the-counter drugs that may impair my mental and/or physical abilities required to perform safe patient care. I will disclose to my instructor any violations of the above standards of conduct.

9. Student Conduct Policy - Students and faculty in The School of Nursing each have responsibility for maintaining an appropriate learning environment. Faculty have the professional responsibility to treat students with understanding, dignity and respect and to guide the teaching/learning process. Students are expected to refrain from verbal and nonverbal behaviors in the classroom and clinical that may be distracting to others, such as, but not limited to: arriving late or leaving early, side conversations, text messaging, note passing, surfing the internet or answering e-mail on laptops, and answering cell phone or pager. Students who persistently engage in behaviors that are disruptive to the teaching/learning process may be required to leave the setting. For further information refer to General Information, Institutional Rules on Student Services and Activities, Chapter 11: Student Discipline and Conduct.

Behavior Concerns Advice Line (BCAL) - If you are worried about someone who is acting differently, you may use the Behavior Concerns Advice Line to discuss by phone your concerns about another individual's behavior. This service is provided through a partnership among the Office of the Dean of Students, the Counseling and Mental Health Center (CMHC), the Employee Assistance Program (EAP), and The University of Texas Police Department (UTPD). Call 512-232-5050 or visit http://www.utexas.edu/safety/bcal
10. **Scholastic Dishonesty Policy and Professional Integrity** - Refer to the General Information for information on the Scholastic Dishonesty Policy Sec. 11-802. Scholastic dishonesty includes, but is not limited to cheating, plagiarism, collusion, falsifying academic records, and misrepresenting facts. The Dean of Students Office records acts of dishonesty and notifies the School of Nursing of each incident. In addition to all of the University statements and policies relative to academic dishonesty, the School of Nursing recognizes the strong link between honesty in academic work and professional integrity. Any act of academic dishonesty, including fabrication of reports or records of interactions with clients, is considered incompatible with ethical standards of nursing practice. The School of Nursing does not admit students who have a record of violations to the professional sequence. Students who engage in scholastic dishonesty may be subject to dismissal and may jeopardize their eligibility for licensure as a registered nurse.

11. **Academic and Program Accommodations for Students with Disabilities** - Refer to the General Information for information on Academic and Program Accommodations for Students with Disabilities or contact the Services for Students with Disabilities office in the Office of the Dean of Students at 471-6259. The School of Nursing works to ensure that students who have disabilities have equal access to the University’s programs and services.

   If you have any questions about services or accommodations for students with disabilities, please talk with the faculty member, the Assistant Dean for Undergraduate Programs, or the Assistant Dean for Student and Clinical Affairs or directly call the Office of the Dean of Students, Services for Students with Disabilities, 471-6259.

12. **Emergency Evacuation Policy** - Occupants of buildings on the UT Austin campus are required to evacuate and assemble outside when a fire alarm is activated or an announcement is made. Please be aware of the following policies regarding evacuation:
   - Familiarize yourself with all exit doors of the classroom and the building. Remember that the nearest exit door may not be the one you used when you entered the building.
   - If you require assistance to evacuate, inform me in writing during the first week of class.
   - In the event of an evacuation, follow the instructions of class instructors.
   - Be familiar with Building Evacuation Plan in this syllabus (last two pages).

13. **Q drop Policy** - The State of Texas has enacted a law that limits the number of course drops for academic reasons to six (6). As stated in Senate Bill 1231: “Beginning with the fall 2007 academic term, an institution of higher education may not permit an undergraduate student a total of more than six dropped courses, including any course a transfer student has dropped at another institution of higher education, unless the student shows good cause for dropping more than that number.”

14. **Latex Allergy** – notify your instructor and the skills lab director if you have an allergy to latex so that appropriate accommodations can be made.

15. Students are responsible for all procedures and policies identified in the School of Nursing Undergraduate Student Handbook, and all official policies posted by The University of Texas on the web.

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**Progression in the Course:**
The student is expected to use his/her performance on quizzes and exams as an indication of progress in the course. The student whose performance is borderline or failing is encouraged and expected to seek assistance from the professor.

**Course Repeat Policy:**

A student must earn a grade of at least "C" in each nursing course. A student may repeat a nursing course only one time. No more than two nursing courses may be repeated. If the student does not earn a grade of "C" or better the second time he or she takes the course, the student cannot continue in the School of Nursing. If, while repeating the course, the student drops the course or withdraws from the university at a time when the student's performance in the course is considered to be inferior to that required for a grade of "C," the student may not re-enroll in the course or continue in the School of Nursing.

**COMMUNICATION**

**Use of E-Mail for Official Correspondence to Students**

Email is recognized as an official mode of university correspondence; therefore, you are responsible for reading your email for university and course-related information and announcements. You are responsible to keep the university informed about changes to your e-mail address. You should check your e-mail regularly and frequently, preferably daily, but at minimum twice a week-to stay current with university-related communications, some of which may be time-critical. You can find UT Austin's policies and instructions for updating your e-mail address at [http://www.utexas.edu/its/policies/emailnotify.php](http://www.utexas.edu/its/policies/emailnotify.php)

**Blackboard:**

The course syllabus and content materials for individual classes will be posted on Blackboard - a Web-based course management system with password-protected access at [http://courses.utexas.edu](http://courses.utexas.edu) — to distribute course materials, to communicate and collaborate online, to post grades, to submit assignments, and to give you online quizzes and surveys. You can find support in using Blackboard at the ITS Help Desk at 475-9400, Monday through Friday, 8 a.m. to 6 p.m., so plan accordingly. Students are responsible to check for announcements that may be posted on the Blackboard course page prior to all classes.

**Announcements:**

The student is responsible for material presented and announcements made in classes that he/she may have missed. The student is also responsible for information that may be placed in his/her mail folder in the Student Lounge.

**Dress Policy and Photo ID:**

Each student is required to wear scrubs (of choice) with closed toed shoes to lab sessions. This includes hair and jewelry appropriate for the clinical setting. Please wear photo ID to each class.
**Required Textbooks:**


**Textbooks To Be Used in this Course from other J1 Courses:**

Any Current Drug Book
POLICIES REGARDING N127P COMPUTERIZED QUIZZES

1. Computerized quizzes are randomly selected questions by the computer. These may be multiple choice, true/false, matching, or labeling. Each quiz will be based on the pre-lab objectives. Questions are taken from “Required Reading/Viewing” listed on each study guide and from content material in syllabus.

2. Quizzes will be available in the Learning Center on the Friday prior to the scheduled class. All quizzes must be completed by one hour prior to class. Students will not be able to gain computer access to the quiz after one hour prior to the class and the quiz will be password accessible only. Access will be the UTEID and password.

3. Students coming to the Learning Center to take tests need to check in at the Reserve Desk. They should leave their backpacks, books, and purses either at the Reserve Desk or at one of the LC tables. Students will be given a red testing tent which they will place on top of the computer. DO NOT talk to other students sitting next to you or nearby when you are testing or your test may be declared invalid and is considered to be academic dishonesty. Upon completion of the test, return the testing tent to the Reserve Desk and pick up all your personal items. Remember to respect other students taking quizzes in the LC even when you are not taking a test. Refrain from speaking to them and respect the quiet environment.

4. Students who do not take and pass the quiz with a minimum of 70% by one hour prior to class will be required to hand write answers to all pre-lab objectives for that day, and turn in to the lab instructor within 24 hours of the beginning of class. Please note below that one retake is allowed, but that the student is to wait the 30 minutes between test and retake. The student is then allowed to write the objectives and participate in class. Allow time to complete these activities. If the student is unable to give the objectives directly to the instructor, the student must put the assignment in a sealed envelope and turn in to the guard at the School of Nursing front desk to pass on to the instructor. Be sure to ask the guard to put the date and time and his/her signature on the envelope. Failure to meet this requirement will result in a grade of No Credit in the course. Students may not progress to the J2 semester until all J1 nursing courses have been successfully completed.

5. Students are allowed to retake a quiz once if the minimum required score of 70% is not achieved. The student must wait at least ½ hour prior to retake in order to allow time for review. The questions on the retest will be randomly drawn from the test pool; therefore the second quiz will not be a duplicate of the first. Students are required to complete the required readings and carefully study the pre-lab objectives prior to taking the quiz. This will increase the likelihood the student will successfully pass the quiz on the first attempt. The goal is to LEARN!

6. Students are permitted to take the computerized quizzes with the expectation that scholastic and academic honesty will consistently be upheld. This includes, but is not limited to: no open book tests; tests are not printed out by the student; tests are taken as an individual with no discussion about the test items between students during or after the test; once the student passes the test no further computer tests will be accessed by the student on that topic. Failure to adhere to these testing policies will result in dismissal from the course due to academic dishonesty.

7. Each week before class, instructors receive a computerized report indicating when a student has accessed a quiz, the final grade for the quiz accessed, and other information.

*** IMPORTANT - PLEASE NOTE ***
At the completion of your pretest, a dialog box will appear on the computer screen instructing you to “Click Here to Continue.” You must click on this box for your grade to be recorded by the computer. IF YOU DO NOT DO THIS, THE COMPUTER CALCULATES AND REPORTS YOUR GRADE AS ZERO PERCENT. If you have any technical difficulties with the computerized test, notify the Learning Center or Skills Lab staff immediately.
DOCUMENTING AND REPORTING

1. To allow for paced learning throughout the semester, short modules on documentation and reporting will be placed within the Assignments section of Black Board. There is a dollar sign ($$) designation on the schedule (p. 1 of the syllabus) that alerts students that such an assignment will appear during a specified week.

2. Documentation and reporting assignments will be short and precise. They are designed to improve student ease and efficiency with using health care terminology, recognizing abbreviations and symbols, using paper flow sheets and developing skills with computerized documentation systems.

3. Students should complete assignments by the time of the following week's class period. Instructions for return of assignments and due dates and times will appear each week. Upon occasion, students will return assignments in narrative, handwritten form to the Skills Lab.

4. Students will also be alerted to the availability of that week's documentation assignment via e-mail. Students should be sure to check for e-mail messages on a regular basis (see Communication section within syllabus). Students should be sure that their Black Board e-mail addresses are correct since e-mails will be sent only through the Black Board site.

5. For Week 9, students will complete work within the Skills Lab area within the first hour and will be directed to a classroom for additional work with documentation and reporting.
**N127P PERFORMANCE ELEMENTS**

The seven performance elements are a part of safe and effective nursing care. Students are to develop increasing skill in the areas of safety, knowledge acquisition, communication, accountability, technical competence, nursing process, and interpersonal skills and caring.

1. **Safety**
   - Performs simulated nursing skills in the lab that prevent real or potential personal harm to patients.

2. **Knowledge**
   - Demonstrates a theoretical knowledge base necessary for skill performance.

3. **Communication**
   - Demonstrates the use of communication skills appropriate in the professional BSN role.
   - Keeps instructor (Faculty) informed and up-to-date.
   - Recognizes instructor (Faculty) as the primary individual to whom all communication must be initiated.

4. **Accountability**
   - Demonstrates initiative for own performance and learning in a timely manner appropriate to the class schedule.
   - Assumes responsibility for own actions.
   - Follows directions, policies, requirements and expectations of the course.
   - Attends open lab during the semester.
   - Reports to class on time.

5. **Technical Competence**
   - Performs nursing skills with reasonable dexterity and organization.

6. **Nursing Process**
   - Assessment
     - Collects appropriate data in a systematic manner.
   - Nursing Diagnosis
     - Defines nursing diagnoses based on objective and subjective data.
   - Planning
     - States expected patient outcomes following completion of skill.
   - Implementation
     - Independently implements skill to a simulated patient.
     - Makes modifications in skill performance as necessary.
   - Evaluation
     - States evaluation criteria based on patient goals.
   - Charting and Reporting
     - Documents and reports information related to skill performance.

7. **Interpersonal Skills/Caring**
   - Aware of effects of own verbal and nonverbal communication on others.
HOW TO USE N127P STUDY GUIDE FOR EACH CONTENT SECTION

The purpose of the study guide is to provide direction/guidance for the student when preparing for each skills lab class and when practicing each skill. In each class, a minimum amount of time will be used for didactic purposes to allow for more practice time. The student is required to come to class prepared to perform the scheduled skill. The study guide lists pre-lab objectives, lab objectives, and references (required reading and viewing before coming to class) for each skill.

Pre-lab Objectives:
The pre-lab objectives reflect the knowledge the student is expected to possess when arriving at the lab. These objectives serve as the basis for the computerized quizzes.

Lab Objectives:
The lab objectives reflect those activities the student is to perform during class.

Required reading and viewing before coming to class:
The study of all cited references is required as preparation for each class.

For each scheduled lab be sure to read the objectives at the beginning of the chapter(s). They comprise the outline of the content that you should be learning.

“Key Terms” are listed at the beginning of each chapter in Fundamentals with reference page numbers and in Clinical Nursing Skills & Techniques. These may help you better understand the reading and are great vocabulary builders. Know the definitions of these terms.

Guidelines for various skills are provided in Clinical Nursing Skills & Techniques to serve as a ready reference for the student to use when practicing skills in the laboratory.

In addition, the syllabus also includes Skill Performance Examination Criteria for each skill on which the student may be evaluated. The student will find it helpful to bring these examination criteria to the appropriate class and to additional practice sessions to acquire familiarity with the criteria by which his/her performance will be evaluated.

Information in audiovisual materials and supplemental readings occasionally give different values (laboratory test results), amounts (liters of oxygen per minute) or steps in a procedure (setting up for catheterization). Answers to quiz questions are based on information given in your textbook (Potter & Perry) or media assigned.

It is recommended that you begin preparation for each class by reviewing all cited chapters from Fundamentals of Nursing. Review is defined as skimming the assigned chapters, paying particular attention to the bulleted items, tables, boxes, and figures. Then read the content pertinent to that lab. You are only responsible for information that is to be covered in Skills Lab that day (use the Pre-lab Objectives as your guide). You are REQUIRED to read the key concepts at the end of the assigned chapter and answer the NCLEX Style Review Questions.
The University of Texas at Austin  
School of Nursing  
N127P Clinical Nursing Skills I Practicum  
Fall 2010  

WEEK 1 STUDY GUIDE  
Standard Precautions  
Hand Hygiene  
Infection Control

Pre-lab objectives:

1. Define the following:
   - abscess
   - aseptic techniques
     - medical asepsis
     - surgical asepsis
   - carrier
   - exudate
   - flora
   - infection
   - inflammation
   - invasive procedure
   - necrosis
   - nosocomial infection

<table>
<thead>
<tr>
<th>Medical Asepsis</th>
<th>Surgical Asepsis</th>
</tr>
</thead>
<tbody>
<tr>
<td>purulent</td>
<td>pathogenicity</td>
</tr>
<tr>
<td>pathogenicity</td>
<td>perineal</td>
</tr>
<tr>
<td>perineal</td>
<td>personal protective equipment (PPE)</td>
</tr>
<tr>
<td>personal protective equipment (PPE)</td>
<td>residual flora or bacteria</td>
</tr>
<tr>
<td>residual flora or bacteria</td>
<td>reservoir</td>
</tr>
<tr>
<td>reservoir</td>
<td>standard precautions</td>
</tr>
<tr>
<td>standard precautions</td>
<td>susceptibility</td>
</tr>
<tr>
<td>susceptibility</td>
<td>sterile/sterilization</td>
</tr>
<tr>
<td>sterile/sterilization</td>
<td>transient flora or bacteria</td>
</tr>
<tr>
<td>transient flora or bacteria</td>
<td>vector</td>
</tr>
</tbody>
</table>

2. Explain how each element of the infection-control chain contributes to infection.
3. Discuss the relationship between the chain of infection and transmission of infection.
4. Identify patients most at risk for acquiring infection.
5. Explain the difference between medical and surgical asepsis.
6. Apply knowledge of the nursing process to patients with the nursing diagnosis of risk for infection.
7. Give an example for preventing infection for each element of the infection chain.
9. Explain the rationale for standard precautions.
10. Discuss the three categories of isolation: airborne; droplet and contact;
11. Discuss the proper method for putting on (donning) and removing (doffing) isolation attire.
12. Discuss the appropriate isolation attire for each category of isolation.
13. Describe latex allergy symptoms and discuss strategies to minimize exposure.
14. Discuss MRSA, VRE, and C. difficile causes, symptoms, transmission and management.

Lab objectives:

1. Discuss Standard Precautions.
2. Demonstrate the proper method for hand washing.
3. Explain conditions that promote the transmission of healthcare-associated infection.
4. Perform correct isolation techniques.
5. Demonstrate the proper method for donning (putting on) and doffing (removing) isolation attire for each isolation category.
Required reading:

*Clinical Nursing Skills & Techniques*  
Chapter 7; Chapter 8 (only review Boxes 8-2 & 8-3 on Latex allergy at this time)

*Fundamentals of Nursing*  
Chapter 34

Required electronic media:

http://www.cdc.gov/handhygiene/  
View the “Patient Admission Video”  
Complete the “Hand Hygiene Interactive Training Course”

Required viewing:

Skills CD-ROM *Basic* Skills Disk:  
Basic Infection Control: “Performing Hand Hygiene”  
Basic Infection Control: "Using Personal Protective Equipment"

*This Syllabus*  
Latex Glove Alert; Infection Control Fact & Education Sheets: MRSA, *Clostridium difficile*

On-line resources  
www.cdc.gov (briefly explore site at this time and try to locate other guidelines & infection control areas)

View MS Power Point Presentation “Guidance for the Selection and Use of Personal Protective Equipment (PPE) In Healthcare Settings”  
http://www.cdc.gov/ncidod/dhqp/ppe.html

**SPEND SOME TIME AT THIS SITE LOOKING AT ALL OF THE EXCELLENT INFORMATION PROVIDED BY THE CDC.**

Recommended resources:

WX 167 B655 *Bloodborne Pathogens*. (Video, 19 min.) in Learning Center (LC)  
WB 102 143 Prog 1 *Breaking the Chain of Infection* (Video, 25 min.) in LC  
WX 167 M939  *MRSA and VRE Precautions: Battling Superbugs* (in LC)  
WX 167 R454 *Revised Guidelines for Isolation Precautions* (Video, 15 min.)

Chain of Infection interactive program:  
http://www.wisc-online.com/objects/objectmailspec.asp?objid=NUR1603
Latex is a milky sap derived from the rubber tree *Hevea brasiliensis*. Latex can contain up to 250 different proteins, some of which can cause allergic reactions. The chemicals used in the latex manufacturing process can also cause an allergic response.

**Skin Irritation** - The most common reaction may present the following symptoms:

1. Dry, cracking skin
2. Skin sores or bumps
3. Itching or rash under the glove area

**Allergic Contact Dermatitis** - Caused by chemicals in latex - may present the same symptoms as above with the addition of:

1. Itching or rash under the area and up the arm

**Natural Rubber Latex Allergy** - Caused by proteins in the latex - may present the following symptoms:

- Hives
- Skin rash
- Itching
- Swelling
- Sneezing
- Difficulty breathing

In extreme cases, latex allergy can result in anaphylaxis and lead to death. The people most at risk of developing latex allergies are those who have a history of frequent exposure to latex, e.g., people who wear latex gloves for long periods of time. To minimize the risk of latex exposure, the Centers for Disease Control (CDC) recommend the following:

- Use non-latex gloves
- Wear a cloth liner with a latex glove on top
- Wear a vinyl glove with a latex glove on top

A good substitute glove material for latex is nitrile. In addition, if you suspect that you may have developed a sensitivity to latex, consult your healthcare provider. Please let your clinical instructor and Simulation Lab personnel know if you have a latex allergy.

For further information: www.cdc.gov/niosh/topics/latex
Infection Control Fact & Education Sheet

TOPIC: Methicillin Resistant *Staphylococcus aureus* (MRSA)

Background:
*S. aureus* is a gram positive, coagulase positive bacteria that can be found on human skin and mucous membranes. Colonization with *S. aureus* usually results in no symptoms of infection, however, it is a common human pathogen. Infection can occur and can be presented as cellulitis, pustules, boils, carbuncles, impetigo or wound infections. Less common infections can include sepsis, endocarditis, gastroenteritis and toxic shock syndrome. *S. aureus* infections were generally treated with penicillins in the 1950s until the emergence of penicillin-resistant strains. Methicillin then became the drug of choice.

*S. aureus* resistance to methicillin was first reported in Great Britain in 1961. Since that time, it has become resistant to other synthetic penicillins such as ampicillin, oxacillin, cloxacillin, nafcillin and ciprofloxacin. The general term used to describe this resistance pattern is MRSA, or methicillin-resistant *staph. aureus*.

Issues:
Since MRSA is resistant to many antibiotics, it is difficult to treat the infection. The drug of choice is vancomycin. There is concern that MRSA will become resistant to vancomycin as it has to other drugs. Newer antibiotics have been used with some success: trimethoprim/sulfa and Cipro Floxin. However, rapid resistance has developed to Cipro.

MRSA often remains after infection; this is called colonization or the "carrier" state, which may last a long time. Colonization may lead to infection. Treatment for colonization is sometimes given with antiseptic baths and antibiotic ointments, or combinations of antibiotics, but may not be successful in eradication of MRSA.

Humans serve as the major reservoir for MRSA. It is generally accepted that the major mode of transmission of MRSA is from one infected or colonized patient to another by the hands of healthcare workers. The environment as a source has also been implicated in burn unit outbreaks where environmental contamination is high.

Transmission of MRSA via nasal carriage of healthcare workers has been studied. The role it plays in transmission cannot be determined with certainty. Shedding of the bacteria from the nose of a healthcare worker with nasal carriage is possible and has been traced to surgical wound infections in studies.

Airborne transmission must be considered in cases where the patient has staphylococcal pneumonia.

Isolation Precautions:
Patients with MRSA are placed on Contact Precautions until negative cultures are obtained after treatment. However, unknown cases pose the greatest risk of transmission, so hand washing must be performed as though all patients are colonized with MRSA.

Since transfers from nursing homes and long-term care facilities are common ways for MRSA to enter the hospital, all newly admitted patients from such agencies should carefully assessed for potential infected areas. Any open wounds or drains, drainage, or other areas that appear infected should be cultured on admission. If MRSA is identified, the patient should immediately be placed on Contact Precautions. MRSA cases should be readmitted, when known, on Contact Precautions if the infection or colonization is still present.

Treatment:
Vancomycin, IV, is the standard treatment for infection. It is not recommended for decolonization. However, after the infection has been adequately treated, some people remain colonized with MRSA.

http://www.cdc.gov/ncidod/dhqp/ar_mrsa_healthcareFS.html
Infection Control Fact & Education Sheet

TOPIC:  
Clostridium difficile

Background:  
*Clostridium difficile* (and *C. difficile* toxin) is the most commonly recognized agent of antibiotic-associated colitis. This organism produces potent toxins that often can cause pathologic changes in colon mucosa producing symptoms that range from mild diarrhea to the most severe form: Pseudomembranous colitis (PMC). It has recently become recognized as the most common cause of nosocomial gastroenteritis.

*C. difficile* is associated with a majority of nosocomial gastroenteritis cases reported to the CDC. Since January 1986 there has been an increased number of positive *C. difficile* cultures, *C. difficile* toxins, and antibiotic-induced diarrhea in hospitalized patients in many hospitals in the Central Texas region as well as sporadically throughout the USA. The reasons for this are unclear since this organism is usually found in only 3-5% of the general population. However, it should be noted that studies have shown that:

- 13-15% of hospital personnel had positive cultures in one major study
- 20-40% of hospital staff were colonized when infected patients were present in their units
- transmission to newborns from hospital staff has been documented
- nosocomial acquisition by adult patients has occurred in/from many hospital departments

Issues:  
*C. difficile* spores are found in the environment of a patient colonized or infected with *C. difficile*. *C. difficile* can be found on the walls, furniture and all surfaces capable of being touched, in large numbers. These hardy spores can live up to 5 months in the environment, and are very resistant to disinfection with routine cleaning agents. Steam or gas autoclaving are necessary to kill the organism since it is resistant to most common environmental disinfectants. (Effective disinfection can be done with: glutaraldehyde soaking for 3 hours or chlorine solution 1:25 but they are not used for routine environmental cleaning.)

Transmission occurs via contaminated hands and fomites. Although neonatal disease is rare, in one study isolation of *C. difficile* in infants was 7% on day one, 93% by day five and 100% on day 21 giving evidence of acquisition from hospital staff. Vertical transmission has not been proven. Evidence to indicate nosocomial transmission is demonstrated by equal acquisition in infants from both C-section and vaginal deliveries.

Ingestion or inoculum of a single colony of *C. difficile* in the GI tract can cause disease. A single dose of antibiotic has been sufficient to predispose a patient to infection.

The most important risk factors for development of disease are the administration of the following antibiotics: ampicillin, extended range penicillins, most cephalosporins and clindamycin. However, all antibiotics have been associated with this problem at some time; chemotherapy is also associated with *C. difficile* disease.

Abdominal procedures with intestinal manipulation (e.g., surgery, endoscopy, and even enemas) are the most common procedures associated with nosocomial acquisition of *C. difficile*.

Clinical Symptoms:  
Diarrhea is the most common symptom seen. Other symptoms include nausea, decreased appetite, fever, and abdominal pain or tenderness. The incubation period can vary: early onset (most common), occurs 1-10 days after the initiation of antibiotic therapy, and late onset occurs less often, from 2-6 weeks after stopping antibiotic therapy.

The course of the disease may be trivial with self-limited symptoms, or may be abrupt with onset of severe diarrhea, which may or may not stop when antibiotics or chemotherapy are discontinued. Complications can be very serious.
**Diagnosis:**
Diagnostic studies for *C. difficile* disease are indicated for any severe diarrhea with onset after admission or after discharge from a hospital.

Fecal white blood cells are an indicator of colitis due to many pathogens and if positive, a test for *C. difficile* is indicated.

In *C. difficile* disease *C. difficile* toxin test is usually positive; however *C difficile* toxin is very unstable and may be undetectable within two hours after collection of the stool specimen, therefore treatment should **not** be delayed if the clinical indications are present or indicative of disease **even if the lab tests are negative**.

**Isolation Precautions:**
Isolation and handwashing are the primary means of preventing transmission. Start Isolation Precautions (Contact) when symptoms start or when *C. difficile* tests are ordered. Follow the Isolation Policy for determining when to discontinue precautions.

**Treatment:**
Metronidazole therapy is the therapy of choice and has been shown effective in mild to moderate disease. Metronidazole treatment usually ranges from 250-500 mg QID for 7-10 days in adults and 20 mg/kd/day divided every 6 hours (max of 4 gm/day) in children. If the gastroenteritis fails to respond to metronidazole therapy or the gastroenteritis is severe and potentially life threatening, oral vancomycin may be used (HICPAC Recommendations for Preventing the Spread of Vancomycin Resistance).

Antiperistaltic agents should not be used as such use may increase severity of symptoms.

**Outbreak Measures:**
If clusters of cases occur in a single unit or service, stringent policies and procedures may be needed/utilized as authorized by the Infection Control Committee, its chairman, or designee.

**Prevention:**
Handwashing between every patient. **Alcohol-based hand sanitizers are not effective** as they do not kill spores! Standard Precautions for all patients, removing gloves and washing hands before exiting patient’s room. Instructing at-risk patients on frequent hand washing to reduce exposure. Offering patients opportunity to wash hands before eating.

**Nursing Care:**
Contact Precautions are necessary for all patients with suspected or known *C. difficile* disease and whenever *C. difficile* testing is being conducted.
- Gloves must be worn by all who enter the room of a patient on Contact Precautions for *C. difficile* and may have potential exposure to the patient or contaminated surfaces.
- Patients and visitors from Contact Precaution room should be instructed to not use unit kitchens.
- Allow the Contact Precautions sign to remain on the patient's door after discharge in order to notify the Housekeeping Department of contaminated surfaces that require thorough cleaning.
- Exchange bedpans and urinals daily.
- TEACH PATIENTS AND FAMILIES ABOUT HANDWASHING WITH HIBICLENS (4% chlorhexidine) or other agency-approved substance.

**Handwashing is the single most important means for preventing the spread of infection!**

http://www.cdc.gov/ncidod/dhqp/id_Cdiff.html
Pre-lab objectives:

1. Define the following:

<table>
<thead>
<tr>
<th>Abduction</th>
<th>Hemiplegia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adduction</td>
<td>Paraplegia</td>
</tr>
<tr>
<td>Contractures</td>
<td>Supine</td>
</tr>
<tr>
<td>Extension</td>
<td>Prone</td>
</tr>
<tr>
<td>Flexion</td>
<td>Sims' position</td>
</tr>
<tr>
<td>Hyperextension</td>
<td>Fowler's position</td>
</tr>
<tr>
<td>Isotonic</td>
<td>Semi-Fowler's position</td>
</tr>
<tr>
<td>Isometric</td>
<td>Trendelenburg</td>
</tr>
<tr>
<td></td>
<td>Reverse Trendelenburg</td>
</tr>
</tbody>
</table>

2. Identify physiological and pathological influences on body alignment and joint mobility.
3. Describe body mechanics and its importance in caring for patients.
4. Describe normal body alignment for standing, sitting, and lying down.
5. Assess for alterations in body alignment and joint mobility.
6. Describe equipment needed for safe patient handling and movement.
7. Discuss interventions, including use of assistive devices that can be used for maintaining body alignment and joint mobility during positioning, transfer, lifting and gait training.
8. Describe common bed positions (e.g., Trendelenburg).
9. Describe positioning techniques (e.g., assisting the patient from supine position to side-lying).
10. Describe the procedure for moving and/or assisting a patient to move up in bed, repositioning a helpless patient, assisting a patient to a sitting position, logrolling a patient, and transferring a patient from a bed to a chair or a bed to a stretcher.
11. Discuss the importance of no-lift policies for the client and the health care provider.
12. Develop individualized nursing care plans for patients with impaired body alignment and mobility.
13. Compare and contrast active and passive range-of-motion exercises.
14. Identify significant assessment data to be noted before assisting with ambulation and range-of-motion exercises.
15. Describe the four crutch gaits.
16. Describe crutch safety techniques and teaching.
17. Apply the nursing process to clients with actual or potential alterations in body alignment and mobility.
18. Discuss factors that may put a patient at risk for accidents and falls.
19. Discuss the guidelines for the use of restraints.
20. Identify potential problems with the use of restraints.
21. Identify safety precautions and necessary nursing observations when restraints are used.
22. Explain legal implications of using restraints: physician's order, informing patient and family members, and documentation.
23. Discuss alternatives to restraints.

Lab objectives:
3. Position bed in common bed positions.
4. Assess for alterations in body alignment and joint mobility.
5. Assist a patient to move up in bed.
6. Reposition and move a helpless patient up in bed.
7. Logroll a patient.
8. Assist a patient to a sitting position.
9. Position a patient in the supported Fowler’s, supine, prone, 30-degree lateral side-lying, and Sims’ positions and discuss the rationale for these positions.
10. Transfer a patient from bed to chair and back to bed with IV and Foley catheter tubes.
11. Ambulate a patient with a gait belt.
12. Assist a patient with ambulation using a walker and/or cane and crutches.
13. Perform passive and active range-of-motion exercise on a patient: each joint through each motion.
14. Given a specific patient situation, review restraint procedure, choose the appropriate restraint and demonstrate correct application of it.
15. Document the following information about the application of a restraint:
   a. patient behavior before restraint applied, including efforts made to avoid requesting restraints
   b. date/time applied
   c. explanation of action given to client and family
   d. type of restraint and body part to which applied
   e. applied per doctor's order or after consultation with another nurse or supervisor
   f. circulation, sensation and motion assessed every 2 hours
   g. patient's behavior following application of restraint

Required reading before coming to class:
Clinical Nursing Skills & Techniques  Chapters 9, 10, 12, 13
Fundamentals of Nursing  Chapters 37, Ch. 38 (pp. 818-824 on risks in adults; Care Plan p. 825-6; Box 38-8 on p. 828; pp. 828-842) , Ch. 47

Required electronic media before coming to class:
http://www.aha-solutions.org/aha-solutions/content/Benefits/TexasSafePatientHandling.pdf (pp. 2-3)

Required viewing before coming to class:
Skills CD-ROM Basic Skills Disk:
Safe Patient Handling
Restraints and Alternatives

NOTE: Content from Week 1 will be included on the quiz for Week 2.
ALTERNATIVES TO RESTRAINT USE

Providing companionship and supervision
• Ask family, friends, or volunteers to stay with the patient
• Determine when the patient needs one-to-one attention (typically at night) and intervene accordingly.

Changing or eliminating bothersome treatments
• Initiate oral (as opposed to IV or NG feedings).
• Remove catheters and drains as soon as possible.

Modifying the environment
• Increase or decrease the amount of light in the room, depending on glare and the patient’s preference or needs.
• Position the bedside commode so that the patient can use it easily.
• Arrange for patient to be near the nursing station, unless the stimulation triggers agitation or worsens confusion.
• Place the mattress on the floor, so the patient can move about freely in bed without falling.
• Leave the bed rails down if the patient tends to climb over them, or use half rails to prevent rolling out of bed.
• Reduce environmental noise.
• Keep the call button accessible.
• Use special furniture accordingly (a lower bed, a reclining chair.)

Reality orientation and psychosocial intervention
• Involve the patient in conversation. Don’t talk over him. Explain procedures to reduce fear and convey a sense of calm.
• Provide reality links when appropriate (TV, radio, calendar, clock).
• Use relaxation techniques (therapeutic touch, massage, warm baths).
• Use active listening to elicit the patient’s feelings.

Offering diversionary and physical activities
• Use TV, radio, or music for diversion (depending on the patient’s cognition, and individual preferences).
• Enlist the aid of a recreational therapist.
• Provide exercise and ambulating whenever possible.
• Initiate training in activities of daily living
• Use physical and occupational therapists to help the patient increase his strength and endurance and feel a sense of accomplishment.

Designing creative alternatives
• Use music chosen specifically for the patient to reduce agitation or to provide diversion.
• Use a pressure-sensitive bed or chair pads with alarms for alerting staff to an unsteady patient standing without help.
• Develop toileting routines to facilitate elimination and reduce falls related to elimination.
• Consult with other disciplines about appropriate interventions.

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N127P Clinical Nursing Skills I Practicum

WEEK 3 STUDY GUIDE
Bathing, Personal Hygiene, Grooming
Feeding Safety/ I&O

Pre-lab objectives:

1. Discuss guidelines used to provide personal hygiene to clients.
2. Identify principles of aseptic technique applied while administering a bed bath.
3. Describe the types of bathing techniques used depending on the patient’s status and skin condition.
4. Identify factors that influence personal hygiene practices and preferences.
5. Identify functions of the skin and nails and implications for care.
6. Describe normal skin and nail characteristics.
7. Describe nursing interventions for common skin problems.
8. Identify conditions that place a patient at risk for impaired skin integrity.
9. Explain precautions to take when assisting patients with a tub bath or shower.
10. Describe steps and rationale for perineal care.
11. Identify guidelines for administering hair, nail, and foot care.
12. Identify common hair and scalp problems and their related interventions.
13. Identify risk factors for foot and nail problems.
14. Discuss care and cleansing of the eye, ear, and nose.
15. Describe care of piercings.
16. Explain differences in providing oral hygiene to dependent versus unconscious patients.
17. Identify guidelines to follow when administering oral hygiene.
18. Discuss precautions used to prevent breakage of dentures.
19. Discuss the purpose of applying elastic stockings, when they are important to apply and the rationale behind their use.
20. Discuss considerations when feeding a dependent client.
21. Identify aspiration risks and prevention techniques.
22. Identify rationale for measuring and recording Intake and Output (I & O) and sources of all fluids measured.

Lab objectives:

1. Administer a complete bed bath to a patient using appropriate aseptic technique and concluding with appropriate back rub.
2. Demonstrate perineal care with a female and a male patient (mannequin).
3. Demonstrate oral care for the unconscious patient.
4. Administer oral hygiene correctly to a bedridden patient.
5. Remove and reapply a gown for a patient with a peripheral IV.
6. Assist a patient in using a bedpan.
7. Apply elastic stockings to a patient.
8. Document appropriate information regarding hygiene.
10. Document intake and output.

Required reading before coming to class:
Clinical Nursing Skills & Techniques

Chapter 17 (section on bedmaking will be useful for next week for those reading ahead).
Ch. 19 (Guidelines 19-1; 19-2; Skills 19-1, 19-2, 19-3) Chapter 30 (p. 803, p. 809-826; pay special attention to Food Pyramid, p. 810, and BMI material, p. 813), Ch. 6 (p. 165-169), Ch. 4 (Graphic Sheet on p. 50)

Fundamentals of Nursing

Chapters 39, 44


Required viewing before coming to class:

Skills CD-ROM Basic Skills Disk: Bathing
Personal Hygiene and Grooming
Bedmaking
Nutrition and Fluids

NOTE: For this lab, bring the following items:

- Bathing suit or sports bra & shorts
- Bath towel
- Face/hand towel
- Other bath articles, as desired
- Body Lotion
- Washcloth
- Soap
- Deodorant
- Toothbrush and toothpaste
- Disposable razor and shave gel

This is a FULL LAB! Be prepared and work at a reasonable pace on each skill. Pick your partner quickly and get changed into your “I’m going to be bathed in bed today” clothes. Any thing you do not get to in lab today MUST be practiced in Open Lab. Note: After changing bed linens, leave as a closed bed.

STUDENTS PLEASE NOTE:

You are expected to bring the above items to class on this date. You will pick a partner and give a bed bath. ONLY ONE OF YOU WILL BE BATHED! The partner who is bathed will perform all other personal hygiene skills on the partner who was not bathed. This will include oral care, hair care, shaving, nail care, foot care and assistance with bedpan. You are expected to act maturely and professionally with your partner.
The University of Texas at Austin
School of Nursing
N127P Clinical Nursing Skills I Practicum
WEEK 4 STUDY GUIDE
Bedmaking
Bowel Elimination/Bedpans/Enemas
Stool Specimen Collection
Documenting and Reporting*

Pre-lab objectives:

1. Define the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>paralytic ileus</td>
<td></td>
</tr>
<tr>
<td>reflux</td>
<td></td>
</tr>
<tr>
<td>impaction</td>
<td></td>
</tr>
<tr>
<td>incontinence</td>
<td></td>
</tr>
<tr>
<td>Guiac test</td>
<td></td>
</tr>
<tr>
<td>Melena</td>
<td>Constipation</td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
</tr>
<tr>
<td></td>
<td>feces</td>
</tr>
<tr>
<td></td>
<td>defecation</td>
</tr>
</tbody>
</table>

2. Describe the purpose and procedure for making an occupied, unoccupied and surgical bed.
3. Identify safety and comfort measures associated with bedmaking.
4. Identify infection control principles in bedmaking.
5. Explain the physiology of normal defecation.
6. Describe patient assessment prior to administration of an enema.
7. Identify usual causes of the following fecal color characteristics: black or tarry; pale with fat; red; white or clay.
8. List nursing measures aimed at promoting normal defecation.
10. Cite common causes, signs and symptoms of:
    - constipation
    - flatulence
    - incontinence
    - diarrhea
    - impaction

Lab objectives:

1. Make an occupied bed.
2. Make an unoccupied bed (open and closed) and convert to a surgical bed.
3. Apply safety and comfort measures when performing bedmaking.
4. Apply infection control principles in bedmaking.
5. Simulate procedure for obtaining fecal occult blood test.
6. Discuss stool sample collection equipment and procedure.
7. Demonstrate administration of an enema using mannequin.
8. Document the following information post enema administration:
   - date and time
   - type and volume of enema given
   - color, amount and consistency of fecal return
clients’ response
signature

* Note: documentation and reporting will be on pretest (quiz) but will be discussed on Week 9.

**Required reading before coming to class:**

* **Clinical Nursing Skills & Techniques**: Chapter 4; Chapter 17 (pp. 456-463); 33 (p. 863); 34 (897-913); 43 (pp. 1128-1130)

* **Fundamentals of Nursing**: Chapters 26; Chapter 39 (pp. 896-906); Ch. 46; , and pp. 983-985, 1139-1141

* **This Syllabus**: Abbreviations Commonly Used for Documenting; Commonly Used Prefixes and Suffixes; Guidelines for Recording; Guidelines for Change of Shift Report

**Required viewing before coming to class:**

* **Skills CD-ROM Basic Skills Disk**: Elimination Assistance: “Assisting with a Urinal”
  “Assisting with a Bedpan”
  “Administering a Cleansing Enema”

* **Skills CD-ROM Intermediate Skills Disk**: Specimen Collection:
  “Performing Fecal Occult Blood Testing”
## N127P Documentation Module:
### JCAHO “Do Not Use” List

### The Joint Commission

#### Official “Do Not Use” List

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (units)</td>
<td>Mistaken for &quot;u&quot; (zero) the number &quot;1&quot; (one) or &quot;10&quot;</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for &quot;I&quot; (one) or the number &quot;1&quot; (one) or &quot;01&quot;</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>q.d., q.s., q.d. (daily)</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>q.d., q.m., q.d. (every other day)</td>
<td>Period after the Q mistaken for &quot;t&quot; and in &quot;C&quot; mistaken for &quot;T&quot;</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Of zero (0 mg)*</td>
<td>Decimals point misread</td>
<td>Write 0 mg</td>
</tr>
<tr>
<td>MgSO₄</td>
<td>Confused for one another</td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

* Applies to all entries and all medication-related documentation that is handwritten (including free-text computer entry) or pre-printed forms.

**Exception:** A “written zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or colostomy bag sizes. It may not be used in medication orders or other medication-related documentation.

### Additional Abbreviations, Acronyms and Symbols

(Four possible future inclusions in the Official “Do Not Use” List)

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; (greater than)</td>
<td>Confused for one another</td>
<td>Write “greater than”</td>
</tr>
<tr>
<td>&lt; (less than)</td>
<td>Confused for one another</td>
<td>Write “less than”</td>
</tr>
<tr>
<td>Abbreviated for drug names</td>
<td>Mistaken due to similar abbreviations for multiple agents</td>
<td>Write drug names in full</td>
</tr>
<tr>
<td>Apotropia units</td>
<td>Unfamiliar to many practitioners</td>
<td>Use metric units</td>
</tr>
<tr>
<td>@</td>
<td>Confused with metric units</td>
<td>Write “at”</td>
</tr>
<tr>
<td>cc</td>
<td>Mistaken for “C” (centimeter) when incorrectly written</td>
<td>Write “mL” or “milliliters”</td>
</tr>
<tr>
<td>pg</td>
<td>Mistaken for mg (milligrams) requiring one thousand-fold average</td>
<td>Write “mg” or “milligrams”</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Ad lib</td>
<td>As desired</td>
<td></td>
</tr>
<tr>
<td>ADA</td>
<td>American Diabetes Association</td>
<td></td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of daily living</td>
<td></td>
</tr>
<tr>
<td>ASHD</td>
<td>Arteriosclerotic heart disease</td>
<td></td>
</tr>
<tr>
<td>BSC</td>
<td>Bedside commode</td>
<td></td>
</tr>
<tr>
<td>BRP</td>
<td>Bathroom privileges</td>
<td></td>
</tr>
<tr>
<td>C &amp; S</td>
<td>Culture and sensitivity</td>
<td></td>
</tr>
<tr>
<td>CAD</td>
<td>Coronary Artery Disease</td>
<td></td>
</tr>
<tr>
<td>CBC</td>
<td>Complete blood count</td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>Chief complaint</td>
<td></td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive heart failure</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
<td></td>
</tr>
<tr>
<td>CVA</td>
<td>Cerebrovascular accident</td>
<td></td>
</tr>
<tr>
<td>D &amp; C</td>
<td>Dilation and curettage</td>
<td></td>
</tr>
<tr>
<td>EBL</td>
<td>Estimated blood loss</td>
<td></td>
</tr>
<tr>
<td>EENT</td>
<td>Eyes, ears, nose and throat</td>
<td></td>
</tr>
<tr>
<td>ER or ED</td>
<td>Emergency Room or Department</td>
<td></td>
</tr>
<tr>
<td>FBS</td>
<td>Fasting blood sugar</td>
<td></td>
</tr>
<tr>
<td>FOB</td>
<td>Foot of bed</td>
<td></td>
</tr>
<tr>
<td>H &amp; H</td>
<td>Hemoglobin and hematocrit</td>
<td></td>
</tr>
<tr>
<td>H &amp; P</td>
<td>History and physical</td>
<td></td>
</tr>
<tr>
<td>HA</td>
<td>Headache</td>
<td></td>
</tr>
<tr>
<td>HOB</td>
<td>Head of bed</td>
<td></td>
</tr>
<tr>
<td>HOH</td>
<td>Hard of hearing</td>
<td></td>
</tr>
<tr>
<td>HTN</td>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>I &amp; D</td>
<td>Incision and drainage</td>
<td></td>
</tr>
<tr>
<td>I &amp; O</td>
<td>Intake and output</td>
<td></td>
</tr>
<tr>
<td>IS</td>
<td>Incentive spirometer</td>
<td></td>
</tr>
<tr>
<td>KVO</td>
<td>Keep vein open</td>
<td></td>
</tr>
<tr>
<td>LMP</td>
<td>Last menstrual period</td>
<td></td>
</tr>
<tr>
<td>LOC</td>
<td>Laxative of choice</td>
<td></td>
</tr>
<tr>
<td>LOC</td>
<td>Level of Consciousness</td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td>Myocardial infarction</td>
<td></td>
</tr>
<tr>
<td>NKA</td>
<td>No known allergies</td>
<td></td>
</tr>
<tr>
<td>NKDA</td>
<td>No known drug allergies</td>
<td></td>
</tr>
<tr>
<td>NPO</td>
<td>Nothing by mouth</td>
<td></td>
</tr>
<tr>
<td>NWB</td>
<td>Non-weight bearing</td>
<td></td>
</tr>
<tr>
<td>OOB</td>
<td>Out of bed</td>
<td></td>
</tr>
<tr>
<td>ORIF</td>
<td>Open reduction, internal fixation</td>
<td></td>
</tr>
<tr>
<td>OT</td>
<td>Occupational therapy</td>
<td></td>
</tr>
<tr>
<td>PERRLA</td>
<td>Pupils equal, round, &amp; reactive to light and accommodation</td>
<td></td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic inflammatory disease</td>
<td></td>
</tr>
<tr>
<td>PT</td>
<td>Physical therapy</td>
<td></td>
</tr>
<tr>
<td>PT</td>
<td>Prothrombin time</td>
<td></td>
</tr>
<tr>
<td>PTT</td>
<td>Partial thromboplastin time</td>
<td></td>
</tr>
<tr>
<td>PVD</td>
<td>Peripheral vascular disease</td>
<td></td>
</tr>
<tr>
<td>PWB</td>
<td>Partial weight bearing</td>
<td></td>
</tr>
<tr>
<td>ROM</td>
<td>Range of motion</td>
<td></td>
</tr>
<tr>
<td>SOB</td>
<td>Short of breath</td>
<td></td>
</tr>
<tr>
<td>T &amp; C</td>
<td>Type and crossmatch</td>
<td></td>
</tr>
<tr>
<td>TAH, BSO</td>
<td>Total abdominal hysterectomy, Bilateral salpingectomy &amp; oophorectomy</td>
<td></td>
</tr>
<tr>
<td>TENS</td>
<td>Transcutaneous electrical nerve stimulation</td>
<td></td>
</tr>
<tr>
<td>TNTC</td>
<td>Too numerous to count</td>
<td></td>
</tr>
<tr>
<td>TURP</td>
<td>Transurethral resection &amp; Prostatectomy</td>
<td></td>
</tr>
<tr>
<td>TWB</td>
<td>Total weight bearing</td>
<td></td>
</tr>
<tr>
<td>UA</td>
<td>Urinalysis</td>
<td></td>
</tr>
<tr>
<td>URI</td>
<td>Upper respiratory infection</td>
<td></td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary tract infection</td>
<td></td>
</tr>
<tr>
<td>VS</td>
<td>Vital signs</td>
<td></td>
</tr>
<tr>
<td>FWB</td>
<td>Weight bearing/ Full weight bearing</td>
<td></td>
</tr>
<tr>
<td>WC</td>
<td>Wheelchair</td>
<td></td>
</tr>
<tr>
<td>WDL</td>
<td>Within defined limits</td>
<td></td>
</tr>
<tr>
<td>WNL</td>
<td>Within normal limits</td>
<td></td>
</tr>
<tr>
<td>WT</td>
<td>Weight</td>
<td></td>
</tr>
</tbody>
</table>

*Note: More extensive list of abbreviations found in back of Taber’s Medical Dictionary. Also consult P&P texts (both contain "Do Not Use" abbreviations listings in Medication Administration chapters).
Commonly Used Prefixes and Suffixes

Aden-......................... gland: adenitis, inflammation of a gland.
Arthr-.......................... joint: arthritis, inflammation of a joint.

Bi-............................... two: bilateral, affecting two sides.
Bleph-.......................... eyelids: blepharitis, inflammation of an eyelid.
Brady-........................... slow: bradycardia, abnormal slowness of heartbeat.
Bronch-......................... bronchus: bronchiectasis, dilatation of bronchi.

Carcin-......................... cancer: carcinogenic, producing cancer.
Cardi-............................ heart: cardioscope, instrument used to visualize the cardiac chambers.
Cephal-........................... head: cephaloplegia, paralysis of muscles about the head.
Chole-............................. bile: cholecyst, the gallbladder.
Choledoch-....................... gall or common bile duct: choledochotomy, incising the common bile duct.
Chondr-.......................... cartilage: chondrectomy, removal of cartilage.
Colp-.............................. vagina: colposcopy, examination of the fornices of the vagina.
Cost-............................... rib: intercostal, between the ribs.
Crani-............................. skull: craniotomy, surgical opening into the skull.
Cyst-.............................. sac or bladder: cystitis, inflammation of the bladder.

Derm- or dermat-............. skin: dermatoid, skin-like.
Dys-............................... pain or difficulty: dyspepsia, difficulty with digestion.

Ecto-............................. outside: ectopic, out of place or in an abnormal position.
Encephal-....................... brain: encephalitis, inflammation of the brain.
End-............................... within: endothelium, layer of cells lining heart, blood and lymph vessels.
Enter-............................. intestine: enteritis, inflammation of intestine.
Epir-.............................. above, upon, on the outside: epidermis, outermost layer of skin.
Erythro-.......................... red: erythrocyte, red blood cell.
Ex- or E-......................... out: excretion, waste material thrown out from cells, tissues or organs.

Gastro-.......................... stomach: gastrectomy, excision of the stomach.

Hem - or Hemat-......... blood: hemopoiesis, forming blood.
Hemi-............................. half: heminephrectomy, excision of half of a kidney.
Hepat-............................ liver: hepatitis, inflammation of the liver.
Hetero-.......................... other (opposite of homo-): heterotransplant, using tissue or organ from a member of another species.
Homo-............................ same: homotransplant, using tissue or organ from a member of the same species.

Hydr-............................ water: hydrocephalus, abnormal accumulation of fluid in cranium.
Hyper-............................ above, excess of: hyperglycemia, excess of sugar in blood.
Hypo-............................. under, deficiency of: hypoglycemia, deficiency of sugar in blood.
Hyster-.......................... uterus: hysterectomy, excision of the uterus.

Idio-............................ distinct, separate: idiopathic, a disease without recognizable cause.
Laryn- ...................... larynx: laryngitis, inflammation of the larynx.
Leuk- ...................... white: leukocyte, white blood cell.
Lip- ...................... fat: lipoma, fatty tumor.

Macro- ...................... large: macroblast, abnormally large red blood cell.
Meg- or Mega- ............ great or large: megacolon, abnormally large colon.
My- ........................ muscle: myoma, tumor composed of muscle tissue.

Necro- ...................... pertaining to death: necrosis, death of cells adjoining living tissue.
Neo- ........................ new: neoplasms, any new growth or formation.
Neph- ........................ kidney: nephrectomy, surgical excision of a kidney.
Neur- ........................ nerve: neuron, nerve cell.

Olig- ...................... little: oliguria, diminished urinary output.
Oo- ........................ egg: oocyte, immature egg cell.
Oophor- ........................ ovary: oophorectomy, removal of an ovary.
Ophthalm- ........................ eye: ophthalmoscope, an instrument for examining the eyes.
Oste- ........................ bone: osteitis, inflammation of bone.
Ot- ........................ ear: otitis, inflammation of the ear.

Path- ...................... disease: pathology, study of nature and cause of diseases.
Phleb- ........................ vein: phlebotomy, opening into a vein for removal of blood.
Pneum- or Pneumon- .... lung (pneum-air): pneumococcus, organism causing lobar pneumonia.
Poly- ...................... many: polyarthritis, inflammation of several joints.
Proct- ........................ rectum: proctoscope, instrument for inspecting the rectum.
Pseudo- ...................... false: pseudoangina, false angina.
Py- ........................ pus: pyocle, a hernia or cavity containing pus.
Pyel- ........................ pelvis: pyelitis, inflammation of pelvis of kidney.

Retro- ...................... backward: retroversion, turned backward (usually of uterus).
Rhin- ........................ nose: rhinoplasty, plastic surgery of the nose.

Salping- ...................... fallopian tube: salpingitis, inflammation of a fallopian tube.
Sten- ...................... narrow: stenosis, narrowing of a duct or canal.

Tachy- ...................... fast: tachycardia, abnormally fast heart beat.

Uni- ........................ one: unilateral, affecting one side.
Suffixes

-algia ..................... pain: neuralgia, pain in relation to a nerve.

-cele ..................... tumor, hernia: enterocele, hernia of the intestine.
-centesis .................. surgical puncture to remove fluid: amniocentesis, removal of amniotic fluid.
-cyte ....................... cell: leukocyte, white blood cell.

-ectasis .................... dilatation, stretching: bronchiolectasis, dilation of the bronchioles.
-emia ....................... blood condition: glycemia, sugar in the blood.
-esthesia ................... relating to sensation: anesthesia, loss of sensation.

-genic ....................... producing: pyogenic, producing pus.

-itis ......................... inflammation: tonsillitis, inflammation of tonsils.

-logy ......................... science of: pathology, science of disease.

-malacia ..................... softening: osteomalacia, softening of bone.

-oma ......................... tumor: myoma, tumor made up of muscle tissue.
-osis .......................... affected with: leukocytosis, excess number of leukocytes.
-(o)stomy .................... creation of an opening: gastrostomy, creation of an artificial gastric fistula for purpose of introducing food into the stomach.
-(o)tomy ........................ incision: laparotomy, surgical incision into abdomen.

-pathy ......................... disease: myopathy, disease of a muscle.
-penia ........................ lack of: leukopenia, lack of white blood cells.
-pexy ........................ fixation: nephropexy, surgical fixation of a floating kidney.
-phagia ........................ eating: polyphagia, excessive eating.
-phasia ........................ speech: aphasia, loss of power of speech.
-phobia ........................ fear: hydrophobia, fear of water.
-plasty ........................ molding: gastroplasty, molding or re-forming the stomach.
-plegia ........................ paralysis: paraplegia, paralysis of the lower limbs.
-poiesis ........................ making, forming: hematopoiesis, forming blood.
-pnea ........................ air or breathing: dyspnea, difficult breathing.
-ptosis ........................ drooping, falling: enteroptosis, prolapse of intestine.

-rhythmia .................... rhythm: arrhythmia, variation from normal rhythm of heart.
-rrhagia ....................... flowing or bursting forth: menorrhagia, excessive menstrual flow.
-rrhapsy ....................... suture of: herniorrhaphy, the act of suturing to repair a hernia.
-rrhea ........................ discharge: otorrhea, discharge from ear.

-scope ........................ lighted instrument for visual exam: otoscope, an instrument used for examining the ear.

-scopy ......................... looking into a body cavity with a scope: laryngoscopy, examination of interior of larynx.

-uria ........................... pertaining to urine: polyuria, excessive secretion of urine.
Guidelines for Recording

These guidelines vary according to the institution. **Note: Some of these guidelines are appropriate only for paper charting.**

1. Record in ink (non-erasable ball-point pen).
2. Record neatly, legibly and intelligently.
3. Sign your name in full, with your status, after each entry.
4. Make each entry in the appropriate column, on the appropriate sheet. Do not leave blank spaces where others may write in words.
5. Record accurately and only after procedures have been done, because the chart is a legal document.
6. Spell correctly; use only commonly accepted abbreviations.
7. Start each entry with a capital letter.
8. Record as soon as possible to keep chart current.
9. To correct an error, do not erase. Draw a single line through entry. Write "incorrect entry" and initial the error.
10. To recopy a page, draw a diagonal line across it and write the words "original copy" at the top. Write "recopied" on the new page at the top and retain both copies. Sign your name and status at the top of both pages.
11. Do not record for someone else.
12. Record all procedures done for the patient and his response to the procedure.
13. Record all occasions when there is a change in the patient's physical and/or mental condition.
14. Be very specific when describing observations; for example, include:

   a. time
   b. severity
   c. location
   d. duration
   e. amount
   f. size
   g. frequency
   h. relationship to other occurrences
15. Record specific behaviors. Be objective in your observation. Do not interpret.
16. Record all specimens obtained from patient, any abnormal characteristics of the specimen, and whether the specimen was sent to the laboratory or not. Note time.

17. Record all refusals of care and, when possible, the reason(s) for the refusal.

18. Record all visits made to the individual by a health team member.

19. Record all specific instructions given to the individual.

20. With each notation, record the time! (Distinguish between time of entry and time of happening, if significant.)

21. At mealtime, note the type of diet and the type and amount of food and/or fluid consumed.

22. Record the routine vital signs on the graphic sheet. Record the characteristics of the pulse, respirations, and blood pressure and/or any changes in the vital signs, in the nurses' notes.

23. Describe an individual's "output" and include the route, type, amount, and any unusual characteristics. (Output includes emesis, stools, urine, diaphoresis, drainage, nasal discharge, sputum, etc.).

24. All information on an individual's chart is confidential. No information should be discussed with unauthorized personnel.

25. When adding a new sheet to the chart make certain that the sheet is properly identified as to:

   a. name
   b. room number and bed number
   c. address
   d. hospital number
   e. physician's name
Guidelines for Change-of-Shift Report

1. **Background Information.** Include client’s name, sex, age, medical diagnosis (or reason for admission), and brief medical history.

2. **Assessment Data.** Provide objective observations and measurements made by nurse during the shift. Describe client’s condition and stress any recent changes. Include any relevant information reported by client. A systematic approach is to assess and report going from head to toe, i.e., neuro, cardiac, pulmonary, GI, GU, psychosocial.

3. **Nursing Diagnoses.** Identify the nursing diagnoses appropriate for client. Clarify client’s current responses to health problems. As a nursing diagnosis is resolved, it is documented as such and need not be included in subsequent reports.

4. **Interventions and Evaluation.** (Steps can be combined in a report.)
   a. Describe interventions, including when, where, and client response.
   b. Describe instructions given in teaching plan and client’s ability to demonstrate learning. This facilitates reinforcement of teaching and promotes learning.
   c. Report intervention for any deficit noted, i.e., patient confused, reoriented; K+ level 5.8; physician notified, K-Lor 20 mEq held.

5. **Family Information.** Report on family visitation or involvement, specifically as it influenced client. Describe family members’ involvement in care procedures or instruction.

6. **Discharge Plan.** Client’s progress in reaching discharge is reviewed on an ongoing basis. The discharge plan identifies the interventions and outcomes needed to allow the client to have a smooth transition from hospital or health care facility to home.

7. **Current Priorities.** Identify the priorities to which oncoming nurse must attend. This promotes organization and continuity of care. Start with concerns potentially most life-threatening.
Pre-lab objectives:
1. Define the following terms:
   - Aerosol/Inhaler
   - Buccal
   - Capsule
   - Dry Powder Inhaler (DPI)
   - Elixir
   - Emulsion
   - Enteric-coated
   - Instillation
   - Metered Dose Inhaler (MDI)
   - Narcotic
   - Spacer
   - Sublingual
   - Suppository
   - Suspension
   - Syrup
   - Tablet
   - Topical application
   - Transdermal patch

2. Identify the role of the physician, pharmacist, and nurse in prescription, preparation, and administration of medications.
3. List the broad categories of drug information available in official drug publications including The United States Pharmacopoeia (USP) and The National Formulary (NF).
4. Differentiate among the common types of medication orders, i.e., standing orders, PRN orders, single (one-time only) orders and STAT orders.
5. Identify the seven elements of a complete medication order.
6. Recognize common dosage administration schedules and abbreviations pertaining to medication administration (see Commonly Used Abbreviation List).
7. Identify the “six rights” a nurse practices to ensure safe medication administration.
8. Describe methods used to prevent medication administration errors in addition to six rights.
9. Verbalize the process for a registered nurse to report a medication error.
10. Identify seven guidelines for safe narcotic administration and control.
11. Identify the necessary steps for preparing oral medications for administration by traditional and unit dose methods.
12. Describe the different methods for administering skin applications.
13. Identify the necessary steps for the administration of oral, sublingual, and buccal medications, and for topical medications including skin applications, nasal, eye, ear, vaginal and rectal instillation.
14. Identify the necessary steps for administration of medication via dry powder inhaler and multidose inhaler with and without a spacer.
15. Apply the steps of the nursing process to the client receiving an oral or topical medication.
16. Use drug dosage calculations to determine the correct dosage of a medication to be administered.
17. Access textbook Error Prone Abbreviations listings in medication administration chapters.
Lab objectives:

1. List factors to assess before administering medications.
2. List conditions contraindicating the administration of medications.
3. Appropriately "check" the medication orders.
4. Given a specific situation, administer oral medications by either the traditional or unit-dose method.
5. Given a specific situation, demonstrate procedure for crushing medications.
6. Given a specific situation, administer topical medications.
7. Given a specific situation, dispense a controlled substance.
8. Given a specific situation, administer eye, ear, vaginal and rectal medications.
9. Prepare and teach client to self-administer medication via DPI and MDI with and without spacer.
10. For each of the situations above make the appropriate documentation on the patient’s chart.
11. Prepare a teaching plan regarding medication use for a selected medication and selected patient.

Required reading before coming to class:

Clinical Nursing Skills & Techniques  Chapters 20, 21

Fundamentals of Nursing  Chapter 35 (pp. 686-735)

This Syllabus  Commonly Used Abbreviations for Med Administration

Required electronic media before coming to class:

http://www.usp.org/aboutUSP/

Required viewing before coming to class:

Skills CD-ROM Advanced Skills Disk: Safe Medication Administration
Nonparenteral Medication Administration


Just for Fun: http://www.youtube.com/watch?v=ti6jn3jbqGM&feature=related
Commonly Used Abbreviations for Med Administration

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>aa</td>
<td>of each</td>
<td>p</td>
<td>after</td>
</tr>
<tr>
<td>ac</td>
<td>before meals</td>
<td>pc</td>
<td>after meals</td>
</tr>
<tr>
<td>ad lib</td>
<td>as desired</td>
<td>per</td>
<td>by</td>
</tr>
<tr>
<td>*bid</td>
<td>twice a day</td>
<td>PO</td>
<td>by mouth</td>
</tr>
<tr>
<td>c</td>
<td>with</td>
<td>PR</td>
<td>per rectum</td>
</tr>
<tr>
<td>cap(s)</td>
<td>capsule(s)</td>
<td>prn</td>
<td>as needed, when required</td>
</tr>
<tr>
<td>*d/c</td>
<td>discontinue</td>
<td>PT</td>
<td>per tube</td>
</tr>
<tr>
<td>EC</td>
<td>enteric coated</td>
<td>q AM</td>
<td>every morning</td>
</tr>
<tr>
<td>elix</td>
<td>elixir</td>
<td>qh</td>
<td>every hour</td>
</tr>
<tr>
<td>ext</td>
<td>extract</td>
<td>q2h, q3h, etc.</td>
<td>every 2 hours, 3 hours, etc.</td>
</tr>
<tr>
<td>fld or fl</td>
<td>fluid</td>
<td>*qid</td>
<td>four times a day</td>
</tr>
<tr>
<td>g or gm</td>
<td>gram</td>
<td>qs</td>
<td>quantity sufficient</td>
</tr>
<tr>
<td>gt/gtt</td>
<td>drop/drops</td>
<td>Rx</td>
<td>take</td>
</tr>
<tr>
<td>h or hr</td>
<td>hour</td>
<td>s</td>
<td>without</td>
</tr>
<tr>
<td>*hs</td>
<td>hour of sleep, bedtime</td>
<td>subcut</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>ID</td>
<td>intradermal</td>
<td>sig or S</td>
<td>write on label</td>
</tr>
<tr>
<td>IM</td>
<td>intramuscular</td>
<td>SL or sl</td>
<td>sublingual</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
<td>sol, soln</td>
<td>solution</td>
</tr>
<tr>
<td>IVPB</td>
<td>intravenous piggyback</td>
<td>SR</td>
<td>slow release</td>
</tr>
<tr>
<td>kg</td>
<td>kilogram</td>
<td>ss</td>
<td>a half</td>
</tr>
<tr>
<td>mg</td>
<td>microgram</td>
<td>supp</td>
<td>suppository</td>
</tr>
<tr>
<td>mcg</td>
<td>milligrams</td>
<td>syr</td>
<td>syrup</td>
</tr>
<tr>
<td>mg</td>
<td>milligrams</td>
<td>tab(s)</td>
<td>tablet(s)</td>
</tr>
<tr>
<td>mL or ml</td>
<td>milliliters</td>
<td>Tbsp or tbsp</td>
<td>tablespoon</td>
</tr>
<tr>
<td>n, noc, or noct</td>
<td>night</td>
<td>*tid</td>
<td>three times a day</td>
</tr>
<tr>
<td>NGT</td>
<td>nasogastric tube</td>
<td>tsp</td>
<td>teaspoon</td>
</tr>
<tr>
<td>NKDA</td>
<td>no known drug allergies</td>
<td>tinct</td>
<td>tincture</td>
</tr>
<tr>
<td>NPO</td>
<td>nothing by mouth</td>
<td>ung or oint</td>
<td>ointment</td>
</tr>
<tr>
<td>os</td>
<td>mouth</td>
<td>v</td>
<td>five</td>
</tr>
<tr>
<td>oz</td>
<td>ounce</td>
<td>vin</td>
<td>wine</td>
</tr>
<tr>
<td>mL or ml</td>
<td>milliliters</td>
<td>X</td>
<td>times; ten</td>
</tr>
</tbody>
</table>

* some sources say do not use bid (twice a day), tid (three times a day), qid (four times a day), d/c (discharge), and hs (bedtime)
The University of Texas at Austin  
School of Nursing  
N127P Clinical Nursing Skills I Practicum  

**Skill Performance Examination Criteria:**  
Non-Parenteral Medication Administration

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SATIS</th>
<th>UNSAT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSESSMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Compare medication administration record (MAR) with the physician’s order. Clarify any questions regarding the order.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Confirm patient’s most recent blood glucose level and date/time of previous insulin dose if applicable</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. <strong>Review information regarding the medication. Verbalize to instructor pertinent lab work, adverse effects of medications and special nursing considerations.</strong></td>
<td></td>
<td></td>
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<tr>
<td>4. <strong>Assess size and general build of the patient. Assess patient knowledge of drug regimen.</strong></td>
<td></td>
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<tr>
<td>5. <strong>Assess patient for drug allergy and for ability to swallow, if appropriate.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PLANNING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Wash your hands.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Collect appropriate supplies.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IMPLEMENTATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Compare drug label with medication administration record three times during implementation.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Calculate correct dosage.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Using aseptic technique prepare correct dosage of medication.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. <strong>Check expiration date of medication.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. <strong>Recheck medication.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Carry materials to bedside.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. <strong>Identify the patient; check identification bracelet with MAR and ask patient to state name.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. <strong>Assess patient for drug allergy and conduct pre-administration assessment, if appropriate.</strong></td>
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<td></td>
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<td>---</td>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>9.</td>
<td>Explain the procedure to the patient; answer any questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Provide privacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Wash your hands.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>12.</strong></td>
<td><strong>Don clean gloves if appropriate.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>13.</strong></td>
<td><strong>Administer oral, topical med or drops</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Assist patient to proper position for administration or for swallowing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>If topical: palpate the area for nodules and tenderness; inspect for redness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Assist patient to safe, comfortable position.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Remove gloves and wash your hands.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Replenish supplies and clean work area.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EVALUATION**

1. Observe the patient’s response to medication at times that correlate with the medication’s onset, peak and duration.

**DOCUMENTATION**

1. Document the following:
   - date and time
   - name and dosage of medication
   - route and site
   - signature and title

*bold italics* = critical elements; all parts of each critical element must be performed correctly to get credit for the element.
plain print = non-critical elements.
CREDIT = correct performance of all critical elements plus 90% of non-critical elements.
Pre-lab objectives:

1. Define the following terms:
   - Barrel
   - Plunger
   - Hub
   - Bevel
   - Shaft
   - Tip
   - Gauge

2. Identify the parts of a syringe and vial or ampule that must remain sterile when preparing an injection.

3. Differentiate between the various lengths and gauges of needles, listing possible uses for each.

4. Identify the different uses for a 3-ml syringe, an insulin syringe, and a tuberculin syringe.

5. Identify the procedure for the disposal of sharps.

6. Discuss needle-less systems for safety.

7. Describe policy for needle stick follow-up.

8. Describe the steps in the preparation of a medication for injection:
   a. from a single dose vial
   b. from a multiple dose vial
   c. from an ampule
   d. when reconstituting a powder
   e. when mixing two medications.

9. Describe the procedure for use of Tubex and Carpuject syringes.

10. List two sources that can be referred to concerning the compatibility of two drugs.

11. Describe the pharmacological properties of insulin.

12. Distinguish between rapid-acting, intermediate-acting, and long-acting insulins (onset, peak and duration times of each.)

13. Identify the two sizes of insulin syringes.

14. Identify the steps of the nursing process for patients with the nursing diagnosis of knowledge deficit of medication administration.

15. Correctly calculate drug dose based on order and drug on hand.

16. Discuss ways to promote patient comfort while administering an injection.

17. Describe the procedure for measuring blood glucose by finger stick.

18. Identify the range of acceptable blood glucose for an adult.

Lab objectives:

1. Given a specific situation, select the correct syringe and needle and aspirate the medication from a vial and/or ampule.

2. Given a specific situation, prepare a parenteral medication by reconstituting the powdered drug appropriately.

3. Given a specific situation, prepare a parenteral medication that requires mixing of two different medications.

4. Demonstrate drawing up insulin, using correct medication and syringe size.
5. Demonstrate mixing of two types of insulin in the same syringe.
6. Demonstrate the use of Tubex/Carpject syringe setups.
7. Demonstrate the use of bifurcation needles for inoculation therapy.
8. Correctly measure for capillary blood glucose (CBG) from a blood specimen collected on your partner by skin puncture.
9. Correctly document on the appropriate form the CBG of your partner.

**Required reading before coming to class:**

*Clinical Nursing Skills & Techniques*

Chapter 22 (pp. 573-597); Ch. 35 (744-754), Ch. 41 (Skill 41-3 only, pp. 1073-1077), Chapter 43 (pp. 1153-1158); Review Ch 20

*Fundamentals of Nursing*

Chapter 35 (pp. 735-744)

**Required viewing before coming to class:**

*Skills CD-ROM Advanced Skills Disk:*

Safe Medication Administration (yes, again!):

Injections

*Skills CD-ROM Intermediate Skills Disk:*

Specimen Collection

“Performing Blood Glucose Testing”

**Bring your nursing drug guide reference book**

**NOTE:** For this lab, review the following medications:

- Ampicillin IM
- Demerol IM
- Heparin SQ
- NPH Insulin
- Phenergan IM
- Regular Insulin
The University of Texas at Austin
School of Nursing

RELEASE, WAIVER, AND INDEMNITY AGREEMENT

Release executed on __________________________ 2010, by
of __________________________, City of Austin, County of Travis, State of
Texas, referred to as releasor(s), in favor of The University of Texas at Austin School of Nursing, The University of
Texas System, and all officers, representatives and employees thereof, referred to as releasees.

Releasor(s) is/are seeking permission to __________________________

Releasor(s) acknowledge(s) and understand(s) the risks and hazards inherent or to be anticipated in

Releasor(s) voluntarily choose(s) to participate with full knowledge of these risks and hazards.

RELEASE/WAIVER: In consideration of __________________________ being permitted to participate as described above, releasor(s), for herself/himself and her/his personal
representatives, heirs and next of kin, hereby covenant(s) not to sue, release(s), waive(s), and discharge(s) releasees
from all liability to the releasor(s), her/his personal representatives, assigns, heirs and next of kin, for all loss or
damage, and from every claim, demand, action or right of action, of whatsoever kind or nature either in law or in
equity, on account of injury to the person or property of, or resulting in death of the releasor(s), WHETHER
CAUSED BY THE NEGLIGENCE OF RELEASEES OR OTHERWISE while the releasor(s) is/are for any purpose
participating in the activity described above.

INDEMNITY: Releasor(s) agree(s) to indemnify the releasees from any loss, liability, damage or cost releasees may
incur due to the participation of the releasor(s) in __________________________, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES OR OTHERWISE.

Releasor(s) expressly agree(s) that this release, waiver and indemnity agreement is intended to be as broad
and inclusive as permitted by the laws of the State of Texas and that if any portion of this agreement is held invalid,
it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

This release contains the entire agreement between the releasor(s) and releasees and the terms of this
agreement are contractual and not a mere recital.

RELEASOR(S) HAS/HAVE CAREFULLY READ THIS AGREEMENT, FULLY UNDERSTAND ITS
CONTENTS, IS/ARE AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN
THE PARTIES HERETO, AND HAS/HAVE SIGNED OF HIS/HER OWN FREE WILL.

__________________________
Name of Releasor(s)

__________________________
Signature of Student(s)

__________________________
Signature of Faculty/Staff/TA as Witness
UT School of Nursing
1700 Red River
Austin, TX 78701

__________________________
Printed Name of Student
## Diabetes Flow Sheet - Adult and Pediatric

<table>
<thead>
<tr>
<th>BG by Fingerstick</th>
<th>INSULIN</th>
<th>CARBOHYDRATE INTAKE</th>
<th>URINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
<td>Name</td>
<td>Dose</td>
</tr>
<tr>
<td>Serum Lab</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Adult Normal Fasting Glucose Range:
70 - 110 mg/dl

### Children's Goals:
Less than 5 years of age 80 - 180 mg/dl; 5 years and older 60 - 150 mg/dl; Other:

### Infant/Pediatric Information

<table>
<thead>
<tr>
<th>CARBOHYDRATE INTAKE PER MEAL</th>
<th>CARBOHYDRATE SUPPLEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>all - entire meal/snack taken; otherwise chart the grams of carbohydrate not taken (e.g. 15 gms.)</td>
<td>chart volume and type (e.g. 100 cc orange juice or threeTABLES)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Sliding Scale Date: 7/25/03</th>
<th>Initials: KH</th>
<th>Write in Pencil</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 180</td>
<td>0 units, Regular</td>
<td></td>
</tr>
<tr>
<td>181 - 200</td>
<td>2 units</td>
<td></td>
</tr>
<tr>
<td>201 - 240</td>
<td>3 units</td>
<td></td>
</tr>
<tr>
<td>241 - 280</td>
<td>4 units</td>
<td></td>
</tr>
<tr>
<td>&gt; 280</td>
<td>Call MD - Andrews</td>
<td></td>
</tr>
</tbody>
</table>

SETON
AUSTIN, TEXAS 78705
Diabetes Flow Sheet
Adult & Pediatric

26A
WEEK 7 STUDY GUIDE
Meds III
Safe Medication Administration (Continued)
Injections

Pre-lab objectives:
1. Review the various sizes of syringes and needles and their usage in selected situations.
2. Review the structure and relationship of the body tissue layers used for injecting medications (epidermis, dermis, subcutaneous, fat, and muscle).
3. Define intradermal, subcutaneous, and intramuscular injections.
4. Using anatomical terms, locate the sites most commonly used for intradermal (ID), subcutaneous (Subc including insulin, heparin and Lovenox), and intramuscular (IM) injections.
5. Identify the safety precautions utilized in administration of parenteral injections.
6. State the aseptic precautions utilized in administration of parenteral injections.
7. Describe the proper administration techniques for parenteral injections.
8. State the purpose of using the Z-track technique.
9. Discuss the rationale for not using the dorso-gluteal side for IM injections.

Lab objectives:
1. Identify (on a partner) the appropriate landmarks for injections in the following areas: deltoid, vastus lateralis, ventrogluteal.
2. Identify appropriate sites for the administration of an intradermal and subcutaneous injection.
3. Prepare and administer an intradermal, subcutaneous, and intramuscular injection using accepted procedure in a simulated situation.
4. Identify appropriate site for administration of Lovenox and administer injection in a simulated situation.
5. Simulate the procedure for a Z-track injection, utilizing correct equipment and accepted procedure.
6. Make the appropriate documentation on the patient’s chart regarding parenteral drug administration.

Required reading before coming to class:
Clinical Nursing Skills & Techniques Chapter 22 (pp. 598-603); Review Chapter 20.
Fundamentals of Nursing Review injectables in Chapter 35
This Syllabus Guidelines for Nursing Students Following a Contaminated Needle Stick; Incident Report

Required viewing before coming to class:
Skills CD-ROM Advanced Skills Disk: Safe Medication Administration (yes, again)
Injections (yes, watch it again!)

If you choose to participate, you may practice giving a subc injection on your partner in the lab. You are not required to participate. If you choose to participate, you will need to complete and sign the waiver. Stay in your comfort zone however; if you want to stick someone, you should be willing to be stuck.

**Performance Exam #1**

Sign up for your time for the Performance Exam. Come to the Skills Lab 10 minutes prior to your scheduled exam time.

Each student will have 20 minutes to complete the exam, which will be comprised of administration of two medications: one parenteral (either IM or Subc) and one non-parenteral (oral or topical; topical could be skin, eye, ear, rectal, or vaginal). See checklists (*Skill Performance Examination Criteria* this syllabus) for the exam criteria.
The University of Texas at Austin  
School of Nursing  
N127P Clinical Nursing Skills I Practicum

**Skill Performance Examination Criteria:**  
**Intramuscular Injection**

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SATIS</th>
<th>UNSAT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSESSMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Compare medication administration record (MAR) with the physician’s order. Clarify any questions regarding the order.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Review information regarding the medication.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Assess size and general build of patient.</td>
<td></td>
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</tr>
<tr>
<td><strong>PLANNING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Wash your hands.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Collect appropriate equipment.</td>
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<td></td>
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</tr>
<tr>
<td><strong>IMPLEMENTATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Compare drug label with medication administration record three times during implementation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Calculate correct dosage.</td>
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<td></td>
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<tr>
<td>3. Using aseptic technique draw up correct dosage of medication.</td>
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<tr>
<td>4. Clean top of vial and allow to dry; discard alcohol swab.</td>
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<tr>
<td>5. Prepare syringe and needle. Verbalize rationale for needle length/gauge selected.</td>
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<tr>
<td>6. Draw appropriate volume of air into syringe.</td>
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<td></td>
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<tr>
<td>7. Insert needle into vial through rubber stopper.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8. Inject air into vial.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Withdraw correct volume of medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Remove needle from vial.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Replace needle guard by one-handed recapping technique.</td>
<td></td>
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</tr>
<tr>
<td>12. Recheck volume of medication for</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13. Carry materials to bedside.

14. **Identify the patient (name & birthdate)**

15. **Assess patient for drug allergy.**

16. Explain the procedure to the patient; answer any questions.

17. Provide privacy.

18. Wash your hands.

19. **Don clean gloves.**

20. **Select the appropriate site for the injection and give the injection.**

21. Assist patient to proper position

22. Palpate the area for nodules and tenderness; inspect for redness.

23. Clean site using concentric circular motion. Allow site to dry.

24. Place swab between fingers of non-dominant hand.

25. Remove needle guard, pinch or spread tissue as indicated, hold syringe properly and insert needle at appropriate angle.

26. **Aspirate for blood.**

27. Inject medication slowly.

28. Remove needle and check site for bleeding.

29. **Place syringe and needle into sharps container without recapping needle.**

30. Assist patient to safe, comfortable position.

31. Remove gloves and wash your hands.

**DOCUMENTATION**

1. Document the following:
   
   - date and time
   - name and dosage of medication
   - route and site
   - signature and title

**bold italics** = critical elements; all parts of each critical element must be performed correctly to get credit for the element.

plain print = non-critical elements.

CREDIT = correct performance of all critical elements plus 90% of non-critical elements.
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School of Nursing  
N127P Clinical Nursing Skills I Practicum

Skill Performance Examination Criteria:  
Subcutaneous Injection - Insulin

<table>
<thead>
<tr>
<th>Student:</th>
<th>Date:</th>
<th>Score: (Cr/F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor:</td>
<td>Evaluator:</td>
<td></td>
</tr>
<tr>
<td>CRITERIA</td>
<td>SATIS</td>
<td>UNSAT</td>
</tr>
</tbody>
</table>

**ASSESSMENT**

1. *Compare medication administration record (MAR) with the physician’s order.*

2. *Confirm patient’s most recent blood glucose level and date/time of previous insulin dose.*

3. *Review information regarding the medication. Verbalize to instructor onset, peak and duration times of insulin.*

4. Assess size and general build of the patient.

5. *Assess patient for drug allergy.*

**PLANNING**

1. *Wash your hands.*

2. Collect appropriate equipment.

**IMPLEMENTATION**

1. *Compare drug label with medication administration record three times during implementation.*

2. *Calculate correct dosage.*

3. *Using aseptic technique draw up correct dosage of medication.*

4. Check expiration date of vial.

5. If insulin is a suspension, gently roll the vial to mix.

6. Clean top of vial and allow to dry; discard alcohol swab.

7. Verbalize rationale for the size of insulin syringe chosen.

8. Draw appropriate volume of air into syringe.

9. Insert needle into vial through rubber stopper.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>Inject air into vial.</td>
</tr>
<tr>
<td>12.</td>
<td>Remove needle from vial.</td>
</tr>
<tr>
<td>13.</td>
<td>Replace needle guard by one-handed recapping technique.</td>
</tr>
<tr>
<td>14.</td>
<td><strong>Recheck volume of medication for accuracy.</strong></td>
</tr>
<tr>
<td>15.</td>
<td><strong>Have a second nurse verify dosage and document verification on MAR.</strong></td>
</tr>
<tr>
<td>16.</td>
<td>Carry materials to bedside.</td>
</tr>
<tr>
<td>17.</td>
<td><strong>Identify the patient; check identification bracelet with MAR and ask patient to state name.</strong></td>
</tr>
<tr>
<td>18.</td>
<td><strong>Assess patient for drug allergy.</strong></td>
</tr>
<tr>
<td>19.</td>
<td>Explain the procedure to the patient; answer any questions.</td>
</tr>
<tr>
<td>20.</td>
<td>Provide privacy.</td>
</tr>
<tr>
<td>21.</td>
<td>Wash your hands.</td>
</tr>
<tr>
<td>22.</td>
<td><strong>Don clean gloves.</strong></td>
</tr>
<tr>
<td>23.</td>
<td><strong>Select the appropriate site for the injection and give the injection.</strong></td>
</tr>
<tr>
<td>24.</td>
<td>Determine location of prior injections. Rotate site daily for insulin injections.</td>
</tr>
<tr>
<td>26.</td>
<td>Palpate the area for nodules and tenderness; inspect for redness.</td>
</tr>
<tr>
<td>27.</td>
<td>Clean site using concentric circular motion from injection site outward. Allow site to dry.</td>
</tr>
<tr>
<td>28.</td>
<td>Place swab or gauze between fingers of non-dominant hand.</td>
</tr>
<tr>
<td>29.</td>
<td>Remove needle cap, pinch or spread tissue as indicated, hold syringe properly and insert needle at appropriate angle. Verbalize decision to insert needle at 45- or 90-degree angle.</td>
</tr>
<tr>
<td>30.</td>
<td>Inject medication slowly.</td>
</tr>
<tr>
<td>31.</td>
<td><strong>Remove needle and engage needle protection device.</strong></td>
</tr>
<tr>
<td>32.</td>
<td>Check site for bleeding. Apply gauze if needed.</td>
</tr>
<tr>
<td>33.</td>
<td><strong>Place syringe and needle into sharps container without recapping the needle.</strong></td>
</tr>
<tr>
<td>34.</td>
<td>Assist patient to safe, comfortable position.</td>
</tr>
<tr>
<td>35.</td>
<td>Remove gloves and wash your hands.</td>
</tr>
</tbody>
</table>
### EVALUATION

1. Observe the patient’s response to medication at times that correlate with the medication’s onset, peak and duration.

### DOCUMENTATION

1. Document the following:
   - **date and time**
   - **name and dosage of medication**
   - **route and site**
   - **signature and title**

**bold italics** = critical elements; all parts of each critical element must be performed correctly to get credit for the element.

plain print = non-critical elements.

**CREDIT** = correct performance of all critical elements plus 90% of non-critical elements.
WEEK 9 STUDY GUIDE
Oxygenation
Heat and Cold Therapies

Pre-lab objectives:
1. State the goal of oxygen therapy.
2. List three safety precautions to be implemented when oxygen is in use.
3. In relation to nasal cannula and nasal catheter, identify maximal flow rate and describe relevant nursing care.
4. Describe the procedure for obtaining an oxygen saturation.
5. List factors that affect an accurate SaO₂.
6. Discuss the purpose and advantages of Incentive Spirometry (IS)
7. Discuss pulse oximetry: nursing implications of results; significance of decreased SaO₂; additional assessment data to accompany readings; troubleshooting devices.
8. Match approximate FIO2s with various oxygen delivery devices.
9. Identify systemic and local bodily responses to heat and cold.
10. Explain how the body’s adaptive ability to warm and cold may lead to injury.
11. List the therapeutic effects of warm and cold applications.
12. Describe the factors influencing warm and cold tolerance.
13. List the factors to be assessed to determine temperature tolerance.
14. List the safety measures to use for applying warm or cold therapy.
15. Describe the advantages and disadvantages of dry or moist applications.
16. Discuss nursing management of the patient receiving therapy via:
   - aquathermia pad
   - cold moist and dry compresses
   - hot moist compresses
   - ice bag or collar
   - sitz bath
   - warm soak

Lab objectives:
1. Correctly apply: a) nasal cannula; b) simple facemask; nonrebreather mask; Venturi mask.
2. Correctly adjust a flow meter, remove flow meter from wall and attach to wall oxygen outlet.
3. Identify the green connector commonly called a “Christmas Tree.”
4. Obtain a resting oxygen saturation with a pulse oximeter.
5. Document oxygen administration given a situation; include:
   - date, time
   - type of oxygen therapy
   - amount delivered
   - patient’s response
6. Demonstrate use of Ambu bag.
7. Demonstrate correct teaching of Incentive Spirometry.
8. Measure oxygen saturation using pulse oximetry.
9. Document the following information post application of heat or cold:
   - type, location and duration of application
temperature used
condition of wound, skin
patient's response
signature

**Required reading before coming to class:**

**Topic: Oxygenation**

*Clinical Nursing Skills & Techniques*

Chapters 5 (pp. 85-89), Ch. 23 (pp. 628-643), Ch. 40; Chapter 43 (pp. 1139-1142)

*Fundamentals of Nursing*

Chapter 40 (IS topic on pp. 942 and 950; 951 on O2 & safety; 956-965), Chapter 32 (pp. 529-533 on topic of assessing respiratory status)

Review next page on FIO2 and use of oxygen therapy.

**Topic: Heat & Cold Therapy**

*Clinical Nursing Skills & Techniques*

Chapter 40

*Fundamentals of Nursing*

Chapter 48 (1330-1339 on heat & cold therapy)

**Required viewing:**

*Skills CD-ROM Intermediate Skills Disk:*

Respiratory Care

“Ensuring Oxygen Safety”

“Setting Oxygen Flow Rates”

“Applying a Nasal Cannula or Face Mask”

*Skills CD-ROM Basic Skills Disk*

Vital Signs:

“Measuring Oxygen Saturation with Pulse Oximetry”
## Oxygen Therapy

### What will the FIO2 be?

<table>
<thead>
<tr>
<th>Oxygen Delivery Device</th>
<th>Flow Rate (Liters/Minute)</th>
<th>FIO2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal Canula</td>
<td>1</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>44%</td>
</tr>
<tr>
<td>Simple Mask</td>
<td>5</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>45-50%</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>55-60%</td>
</tr>
<tr>
<td>Non-rebreather Mask</td>
<td>6</td>
<td>55-60%</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>60-80%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>80-99%</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>90%</td>
</tr>
<tr>
<td>Partial Rebreather Mask</td>
<td>6</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>45-50%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>60%</td>
</tr>
<tr>
<td>Venturi Mask</td>
<td>Blue - 4</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Yellow - 4</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>White - 6</td>
<td>31%</td>
</tr>
<tr>
<td></td>
<td>Green - 8</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Pink - 8</td>
<td>40%</td>
</tr>
</tbody>
</table>
INDICATIONS FOR USE OF OXYGEN THERAPY

METHODS OF DELIVERING OXYGEN THERAPY

Low Flow Devices
1. Nasal cannula / prong
2. Simple face mask
3. Partial rebreather mask
4. Non-rebreather mask

High Flow Devices
1. Venturi mask
2. Ventilator

COMPLICATIONS OF OXYGEN THERAPY

1. CO2 narcosis
2. Oxygen toxicity
3. Infection

NURSING IMPLICATIONS WITH O2 THERAPY

- Monitor ABGs
- Assess for hypoxemia
- Clean devices
- Monitor flow rate and %
- Monitor risk of O2 toxicity
The University of Texas at Austin  
School of Nursing  
N127P Clinical Nursing Skills I Practicum

WEEK 10 STUDY GUIDE  
Sterile Technique  
Wound and Pressure Ulcer Care

Pre-lab objectives:

1. Compare and contrast surgical asepsis (sterile technique) with medical asepsis (aseptic technique).
2. Describe principles of surgical asepsis (sterile technique).
3. Identify the areas of a sterile field considered sterile and non-sterile.
4. Describe the arrangement of a sterile field.
5. Describe the proper method for donning sterile gloves.
6. Describe the proper method for opening sterile packages.
7. Describe the proper method for using sterile applicators.
8. Describe the proper method for using sterile basins and pouring sterile liquids.
9. State proper body position of the nurse during sterile procedures.
10. Describe observations made when assessing a wound. (You may find it helpful to use the acronym REEDA: Redness, Edema, Ecchymosis, Drainage, and Approximation of wound edges.)
11. Define and describe the following types of wound drainage: serous, purulent, serosanguineous, sanguineous.
12. State management of and factors to be observed regarding Penrose, Jackson-Pratt, and Hemovac wound drains.
13. Describe the proper method for cleaning wounds and applying dry, wet-to-dry, and medicated gauze dressings.
14. Define and describe the following types of dressings and bandages: gauze (e.g., 4x4s), ABD (abdominal dressing pads), transparent films, roll gauze, Montgomery ties, elastic bandages, mesh panties, tubular stockinettes.
15. Describe methods for securing dressings.
16. Describe the proper method for collecting an aerobic specimen for culture from a wound.
17. Apply knowledge of the nursing process to patients with the nursing diagnoses of infection, risk for infection, impaired skin integrity and risk for impaired skin integrity.
18. Discuss the risk factors that contribute to pressure ulcer formation.
19. Describe the pressure ulcer staging system.
20. Describe the differences between nursing care of acute and chronic wounds.

Lab objectives:

1. Don a pair of sterile gloves maintaining sterility.
2. Given a specific situation, set up a sterile field.
3. Set up a sterile irrigation set on a sterile field and demonstrate pouring sterile liquid into the irrigation container.
4. Given a specific situation, demonstrate the components of sterile technique when cleansing a wound and changing a sterile dressing.
5. Demonstrate collection of an aerobic specimen for culture from a wound.
6. Demonstrate figure eight dressing (ace wrap).
7. Demonstrate securing a dressing with tape and with Montgomery ties.
8. Remove staples and apply steri strips on simulated model.
9. Empty a Jackson Pratt drainage system.
10. Document the following regarding a sterile dressing change:
    • date & time
    • type of dressing removed
    • amount and type of drainage on old dressing
    • appearance of wound/incision
    • type of dressing replaced
    • tolerance of patient
    • signature
11. Given a display, examine various wound drainage devices, wound care products and tape.
12. Provide appropriate teaching to a patient and family regarding pressure ulcers.

**Required reading before coming to class:**

- *Clinical Nursing Skills & Techniques* Chapters 8, 18, 38, 39, 43 (pp. 1143-1145)
- *Fundamentals of Nursing* Chapter 34 (pp. 668-685); Chapter 48 (pp. 1278-1341)
- *This Syllabus* Common Taping Problems & Their Remedies

**Required electronic media before coming to class:**

http://www.epuap.org/aberdeen/page4.htm - For your viewing pleasure!

**Required viewing before coming to class:**

*Skills CD-ROM Intermediate Skills Disk:*

- Infection Control
- Wound and Pressure Ulcer Care
- Specimen Collection:
  “Collecting a Specimen for Wound Culture”
# Common Taping Problems and Their Remedies

<table>
<thead>
<tr>
<th>Problem</th>
<th>Cause</th>
<th>Prevention</th>
<th>Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin Stripping</td>
<td>Superficial injury in which the epidermis is stripped away either by the tape adhesive or by repeated applications of tape over the same site.</td>
<td>Use a porous, surgical tape. Rotate sites where tape is applied whenever possible so that you do not reapply tape to the same skin. Reangle the dressing so the tape will fall on new areas of skin. -Apply skin sealant to the skin before applying tape. -Bracket the wound with a solid wafer skin barrier and anchor the tape on the barrier instead of on the skin. -Use Montgomery straps for large wounds that need frequent dressing changes. Do not pull the straps too tightly, since tension can cause skin stripping or tension blisters. May use a solid wafer skin barrier or a skin sealant underneath the Montgomery straps. -Use mesh panties or tubular stockinet to secure dressings in locations such as the perineum, axilla, extremities or abdomen.</td>
<td>Micropore tape&lt;br&gt;Skin prep&lt;br&gt;Protective Barrier Film&lt;br&gt;Premium Barrier Stomahesive&lt;br&gt;Comfeel&lt;br&gt;Montgomery Straps&lt;br&gt;Spandage&lt;br&gt;Durapore&lt;br&gt;Transpore&lt;br&gt;Coban</td>
</tr>
<tr>
<td>Chemical Injury</td>
<td>Prolonged skin contact with irritating chemicals. Common reaction when chemicals are trapped between the skin and the adhesive.</td>
<td>Thoroughly clean and dry the skin before taping. Do not use tincture of benzoin as it is very drying to the skin and often actually causes skin irritation. Allow skin sealant to dry thoroughly before applying tape.</td>
<td>Micropore&lt;br&gt;Coban</td>
</tr>
</tbody>
</table>

Use porous tape rather than occlusive tape whenever possible, since porous tape will not trap moisture against the skin.
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
<th>Management</th>
<th>Tape</th>
</tr>
</thead>
</table>
| **Tension Blisters** | Develop at both ends of the taped surface when tape is stretched or pulled too tightly. Often, tape is applied under tension to achieve compression following surgical or diagnostic procedures.  
Because edema may develop at the site and add even more tension to skin, tape applied with tension should be removed and reapplied within 24 hours. | Apply tape gently with minimal pressure, while working the tape outward from the center.                                                                 | Microfoam Hypafix Mefix |
| **Folliculitis**     | Irritation and inflammation of the hair follicles, such as when the skin is shaved with a razor or if chemicals, adhesive, or bacteria become trapped in the hair shafts. Usually leads to the development of pustules and inflammation.  
Clip hair rather than shaving.  
Use a porous tape that transfers minimal adhesive to the skin surface.  
Avoid applying tape where folliculitis has occurred. | Micropore Coban Ultrapore |
| **Maceration**       | Skin pruning is caused by excessive hydration of the skin from prolonged direct contact with moisture.                                                                                                                                                                                                                             | Micropore Durapore Stomahesive Skin Prep |
| **Adhesive Residue** | Left after tape or other adhesive products have been removed.  
Firmly smooth another freshly cut piece of tape over the affected area and peel it back slowly, repeating the process if necessary.  
Use adhesive solvents; however, the area must be thoroughly cleansed with mild soap and water so the solvent does not remain on the skin. | Micropore Blenderm Ultrapore |
| Non-Tension Mechanical Injury | Caused by applying the tape incorrectly, by improperly removing the tape or by using a tape adhesive that is too strong for the type or location of skin to be covered. | If the wound requires compression, use an elastic tape. Remove tape gently while supporting the skin. When removing tape from areas of thick hair growth, such as the forearm leg or chest peel it back in the direction of hair growth. | Microfoam Elastikon Hypafix |

Skill Performance Examination Criteria:  
**Sterile Dressing Change**

<table>
<thead>
<tr>
<th>Student:</th>
<th>Date:</th>
<th>Score: (Cr/F)</th>
<th>Instructor:</th>
<th>Evaluator:</th>
</tr>
</thead>
</table>

**ASSESSMENT**

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SATIS</th>
<th>UNSAT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Check medical record and Kardex for pertinent information. Determine if a pain medication is needed prior to the dressing change.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Read the patient's record to determine reason for dressing change and to gather pertinent information about the patient.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IMPLEMENTATION**

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SATIS</th>
<th>UNSAT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collect supplies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Position patient, raise bed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Place plastic bag within easy reach.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. With clean glove, remove dressing, one layer at a time and discard in plastic bag. If dressing adheres, do not moisten to remove. Observe dressings for drainage – amount, color and odor.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Remove and dispose of gloves, <em>wash hands.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Visually inspect wound.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Prepare sterile supplies, <em>maintain sterile technique throughout remainder of procedure.</em> Check date on saline.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. <em>Don sterile gloves.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Cleanse wound as prescribed.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12. Obtain sterile wound culture using culturette device.

13. Apply sterile dressing over wound or pack with sterile NS (normal saline) soaked gauze as indicated.

14. Apply several dry, sterile 4x4s over packing.

15. Place ABD over 4x4s.

16. Remove and dispose of sterile gloves.

17. Secure dressings with tape, Kerlix, or Montgomery ties.

18. Date dressing.

19. Assist patient to comfortable position, remove all equipment, and wash hands. Return bed to low position.

**DOCUMENT**

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SATIS</th>
<th>UNSAT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Document the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Date &amp; time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Amount and type of drainage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Appearance of incision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Disposition of specimen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Type of redressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patient response to procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Signature</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**bold italics** = critical elements; all parts of each critical element must be performed correctly to get credit for the element.

plain print = non-critical elements.

CREDIT = correct performance of all critical elements and 90% of non-critical elements.
WEEK 12 STUDY GUIDE
Urinary Elimination/Catheter Management

Pre-lab objectives:

1. Define the following terms/abbreviations:

   - bacteriuria
   - condom (external) catheter
   - culture & sensitivity (C&S)
   - cystoscopy
   - dysuria
   - enuresis
   - hematuria
   - indwelling retention catheterization
   - intermittent/straight (in and out) catheterization
   - intravenous pyelogram (IVP)
   - micturition
   - reflex bladder
   - retention with overflow
   - suprapubic catheterization
   - ureterostomy
   - urinary incontinence:
     - stress, urge, overflow, reflex
   - urinary retention
   - intake & output (I&O)
   - UA
   - UTI
   - voiding

2. List the signs and symptoms of:
   - lower urinary tract infections
   - retention with overflow
   - urinary retention

3. Cite four broad categories of fluid sources that form the basis for fluid intake (are recorded as fluid intake).

4. Regarding urinary output, state the:
   - normal daily (24 hour) urine output
   - minimal hourly urine amount formed by kidneys
   - amount considered a high volume of urine output

5. Describe how you would obtain a midstream (clean-voided) specimen from a male and a female patient.

6. In relation to the nursing measures cited below, describe specific nursing actions the nurse may perform to promote normal micturition:
   - stimulating micturition reflex
   - maintaining elimination habits
   - maintaining adequate fluid intake
   - strengthening pelvic floor muscles

7. State the purposes that the lumens serve in a:
   - double lumen catheter
   - triple lumen catheter

8. Describe the properties of the Coudé catheter (elbowed) that makes it a useful instrument when catheterizing.


10. Identify risks from catheterization and indwelling catheters.

11. State the purpose of a closed urinary drainage system and technique for proper maintenance.
12. State what factors the nurse should assess (over time) following removal of an indwelling catheter.

13. List actions (tips), including promoting adequate intake, that a nurse can perform to prevent infection in patients with an indwelling catheter.

14. State the purpose of irrigation, type and amount of irrigant commonly used and the advantage of using a closed system over an open system for irrigation.

15. Identify the areas of the drainage system which must be kept sterile.

16. Describe how to obtain a urine specimen from a closed urinary drainage system.

17. Describe how to apply a condom (external) catheter.

18. Describe care of the patient with a suprapubic catheter.

19. Describe the process for assessing the amount of urine in the bladder using a bladder scan machine.

Lab objectives:

1. Insert a straight and/or an indwelling catheter in a male and female model.

2. Document the following information post catheterization:
   • date and time
   • type and size of catheter inserted
   • amount of fluid used to inflate balloon (indwelling catheter)
   • characteristics of urine
   • amount of urine
   • patient tolerance
   • disposition of specimen
   • signature

3. Connect a continuous irrigation set up to a closed drainage system.

4. Given the necessary information, calculate and record the urinary output of a patient receiving continuous or intermittent irrigation.

5. Obtain a sterile urine specimen from an indwelling catheter and during an intermittent catheterization; after obtaining a urine specimen document: specimen obtained, sent to lab, and signature.

6. Observe the application of a condom (external) catheter.

7. Empty a urinary drainage bag.

8. Discuss supplies and technique for obtaining a midstream urine sample.

9. Examine equipment used in urinary management: leg bags, Coudé catheter, plug, etc.

Required reading before coming to class:

*Clinical Nursing Skills & Techniques*
Chapter 33 (pp. 860-892); Chapter 43 (pp. 1117-1127)

*Fundamentals of Nursing*
Chapter 45; Review pp. 981-985

Required viewing before coming to class:

*Skills CD-ROM Intermediate Skills Disk:*
Urinary Catheter Management
Specimen Collection
“Collecting a Midstream Urine Specimen”

*Skills CD-ROM Basic Skills Disk:*
Elimination Assistance
“Applying a Condom Catheter”
“Providing Catheter Care”
## Skill Performance Examination Criteria:
### Intermittent Catheterization (Female) with Specimen Collection

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SATIS</th>
<th>UNSAT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSESSMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Read the physician's order.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Read the patient's record to determine reason for catheterization and to gather pertinent information about the patient.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PLANNING

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SATIS</th>
<th>UNSAT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wash your hands.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Collect appropriate equipment.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IMPLEMENTATION

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SATIS</th>
<th>UNSAT</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>1. Identify the patient.</td>
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<tr>
<td>2. Determine if allergic to Betadine.</td>
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<td>3. Explain the procedure; answer any questions.</td>
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<td>4. Ensure privacy.</td>
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<tr>
<td>5. Position and drape the patient.</td>
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<tr>
<td>• place bed in position of comfort for the nurse.</td>
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<tr>
<td>• assist to dorsal recumbent position with knees flexed and thighs externally rotated.</td>
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<tr>
<td>• drape the patient.</td>
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<tr>
<td>• place towel or absorbent pad (Chux) under patient's buttocks.</td>
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<tr>
<td>• if necessary, wearing clean gloves, clean patient's perineal-genitalia area with water and soap and dry area.</td>
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<td>6. Wash hands.</td>
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<tr>
<td>7. Maintain sterile technique throughout the procedure.</td>
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**IMPLEMENTATION (Continued)**

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<tr>
<td>8. Clear work space; may use table or area between patient's legs.</td>
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<tr>
<td>9. Set up receptacle for soiled cleansing swabs.</td>
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<td>11. Extend sterile field with drape, maintaining sterility of drape, if possible.</td>
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<td>12. Don sterile gloves.</td>
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<td>13. Arrange sterile field.</td>
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<td>14. Lubricate the insertion tip of the catheter.</td>
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<td>15. Pour the antiseptic over the swabs or open swab packet.</td>
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<td>16. Remove sterile cap from the specimen container.</td>
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<td><strong>17. Catheterize the patient.</strong></td>
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<tr>
<td>18. Expose the meatus by separating the labia minora with thumb and forefinger of non-dominant hand.</td>
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<td><strong>19. With dominant hand use forceps to pick up cleansing cotton ball or use the swab.</strong> After meatus is identified, cleanse the sides of the urinary meatus first, then the center of the meatus.</td>
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<td><strong>20. Use one swab per wipe, in single, downward stroke; discard soiled swab away from sterile field.</strong></td>
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<td>21. Use sterile hand to move tray containing catheter close to patient and to pick up catheter.</td>
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<td>22. Hold catheter 3 inches from tip. Carefully insert into urinary meatus. Slowly advance catheter into urethra (about 3 inches or until urine begins to flow); advance catheter 1-2 inches more.</td>
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<td>23. Obtain a specimen.</td>
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<td>24. Drain the bladder.</td>
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<td>25. Slowly withdraw the catheter after urine flow stops.</td>
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<td>27. Cleanse the patient's perineum of antiseptic solution; assist patient to comfortable, safe position.</td>
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<td>28. Measure urine, noting characteristics.</td>
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<td><strong>29. Wash hands.</strong></td>
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# DOCUMENTATION

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<tbody>
<tr>
<td>1. Document the following:</td>
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<tr>
<td>• <em>date and time</em></td>
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<tr>
<td>• type and size of catheter</td>
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<tr>
<td>• <em>amount, description of urine</em></td>
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<tr>
<td>• patient's response to procedure</td>
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<tr>
<td>• <em>disposition of specimen</em></td>
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<tr>
<td>• signature and title</td>
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</table>

*bold italics* = critical elements; all parts of each critical element must be performed correctly to get credit for the element.

plain print = non-critical elements.

CREDIT = correct performance of all critical elements and 90% of non-critical elements.
Building Evacuation Plan

IN CASE OF EMERGENCY

IF YOU SEE SMOKE, SEE FLAMES, SMELL SOMETHING BURNING, OR BECOME AWARE OF ANOTHER EMERGENCY THAT MAY REQUIRE EVACUATION OF THE BUILDING, IMMEDIATELY:

1. If possible, ISOLATE the fire or other emergency by closing the door.
2. ACTIVATE the nearest FIRE ALARM PULL STATION.
3. EVACUATE to the PRIMARY or ALTERNATE ASSEMBLY AREA.
4. Dial University Police at 911 or Dispatch 471-4441.

DO NOT CALL 911 UNTIL YOU ARE OUTSIDE THE BUILDING.

IF A FIRE ALARM IS ACTIVATED:

• In a calm and orderly manner, proceed to evacuate the area and follow the instructions of the Fire Wardens or emergency response personnel. Each floor has two designated wardens. Their role is to ensure that everyone on their floor has proceeded to the fire exit stairs.
• Do not rush, push or panic.
• Close your office, classroom, or lab door behind you.
• EVACUATE to the designated ASSEMBLY AREAS. If your progress to the PRIMARY assembly area is impeded, proceed to the ALTERNATE assembly area.
• DO NOT USE ELEVATORS TO EVACUATE. Descend the nearest fire exit stairs in single file down to the GROUND LEVEL (first floor) and exit the building. Fire exit stairs are located on the southwest and northwest ends of the building.
• If there is someone who requires assistance, please provide it.
• Do not reenter the building unless directed by UTPD or an Austin Fire Department Officer in charge.

DO NOT BLOCK ACCESS TO BUILDING FOR EMERGENCY PERSONNEL. Do not exit through the front door of the building unless you are in the lobby areas outside the central elevators/stairwell. If you are in the courtyard outside the second floor lobby, you may exit through the glass doors to the east or west, then out to one of the designated assembly areas.

ASSEMBLY AREAS:

From NORTHWEST FIRE STAIR EXIT—proceed to first floor stairwell exit door to outside of building. DO NOT ENTER FIRST FLOOR HALLWAY AND EXIT THROUGH GLASS DOORS. Primary assembly area is across north bridge toward tennis courts. Alternate assembly area is east end of F23 parking lot near Red River St.

From SOUTHWEST FIRE STAIR EXIT—proceed to first floor stairwell exit door to outside of building. DO NOT ENTER FIRST FLOOR HALLWAY AND EXIT THROUGH GLASS DOORS. Primary assembly area is south to Centennial Park. Alternate assembly area is across south bridge toward tennis courts.