GUIDELINES: PHARMACOLOGY RESEARCH ITEMS
FOR CLINICAL ROTATION

Students are responsible for understanding and properly administering medications to their patients. Listed below are frequently administered maternal – child and pediatric medications. Be prepared to discuss the indications for the medication ordered, therapeutic range, special precautions, side effects, route of administration, etc. **NCLEX:** Know “out of the ordinary” and “very common” side effects **PLUS** the nursing implications. Students will be responsible for additional medications according to individual patient needs.

<table>
<thead>
<tr>
<th>PEDIATRIC Medications</th>
<th>CLASSIFICATION</th>
<th>Maternal – Child Medications</th>
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<tbody>
<tr>
<td>Acetaminophen</td>
<td>CNS Nonnarcotic, Antipyretic</td>
<td>Ancef</td>
<td>Antibiotic</td>
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<td>Acetaminophen with codeine</td>
<td>CNS Narcotic</td>
<td>Ampicillin</td>
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<td>Albuterol</td>
<td>ANS Smooth Muscle Relaxant</td>
<td>Brethine / Terbutatine</td>
<td>Tocolytic Agent</td>
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<td>Ampicillin</td>
<td>Antiinfective</td>
<td>Calcium gluconate</td>
<td>Electrolyte</td>
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<td>Ceftriaxone</td>
<td>Antiinfective</td>
<td>Cervidil</td>
<td>Prostaglandin</td>
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<td>Clindamycin</td>
<td>Antiinfective</td>
<td>Cytotec</td>
<td>Prostaglandin</td>
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<td>Digoxin</td>
<td>Antiarrythmic</td>
<td>Dexamethasone / Betamethasone</td>
<td>Corticosteroid</td>
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<td>Famitodine</td>
<td>GI Agent, Hydrogen Blocker</td>
<td>Ducolax Suppository</td>
<td>Laxative</td>
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<td>Gentamycin</td>
<td>Antiinfective</td>
<td>Duramorph</td>
<td>Narcotic agonist analgesic</td>
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<td>Ibuprofen</td>
<td>CNS Agent, Nonnarcotic Analgesic, Antipyretic</td>
<td>Glyburide</td>
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<td>Morphine</td>
<td>CNS Narcotic Analgesic</td>
<td>Hemabate</td>
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<td>Solumedrol</td>
<td>Antiinflammatory</td>
<td>Indocin</td>
<td>Nonsteroidal anti-inflammatory (NSAID)</td>
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<td>Magnesium sulfate</td>
<td>Anticonvulsant</td>
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<td>Methotrexate</td>
<td>Antineoplastic</td>
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<td>Methergine</td>
<td>Oxytocic</td>
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<td>Narcan</td>
<td>Narcotic antagonist</td>
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<td>Nubain</td>
<td>Narcotic agonist-antagonist analgesic</td>
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<td>Pitocin</td>
<td>Oxytocic, Hormone</td>
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<td>Triple dye</td>
<td>Anti-Infective</td>
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<td>Vitamin K</td>
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<td>Zofran</td>
<td>Antiemetic</td>
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<td>Intravenous Solutions</td>
<td>Primary IV</td>
<td>IVPB</td>
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<td>Is each solution for your patient</td>
<td>What IV is the primary line?</td>
<td>What IV solutions are secondary or piggybacks?</td>
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<tr>
<td>Isotonic, Hypotonic or Hypertonic?</td>
<td>Buretrol</td>
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**SOAP Note**

S = Subjective data  
O = Objective data including client behavior, physical assessment, vital sign’s meds, etc.  
A = Analysis: problems, teaching / learning needs; **nursing diagnosis**  
P = Planned nursing care

**Labor SOAP Note**

S = Subjective data  
O = Objective data including client behavior, vaginal exam data, vital signs, IV’s, etc.  
A = Analysis: stage/phase of labor, problems, teaching/learning needs; Nursing Diagnosis  
P = Planned nursing care

**APIE Note**

A = Assessment  
P = Plan  
I = Intervention  
E = Evaluation

The student picks one problem and applies the APIE note.
GUIDELINES: PRE AND POST CONFERENCE

Pre-conferences

Prior to student rendering of direct patient care a clinical pre-conference will be held. The time and location of the pre-conference is at the discretion of the clinical instructor. The focus will be reviewed, goals for the day established and learning needs identified.

The pre-conference is intended to be a brief, but important, review of the day’s activities. Clinical instructors will assist the clinical group in identifying care priorities, learning opportunities and organizational needs. Nursing care plans for each patient may also be randomly chosen for discussion.

Post Conference

Post conferences are intended to discuss nursing care challenges of interest for the benefit of all the students in the conference group and to share ideas for meeting these challenges. The location and time for clinical post conferences will be scheduled by the clinical instructor.

The clinical instructor will facilitate the post conference discussion. Each student is expected to participate in evaluating the day’s goals and learning experiences. Activities relevant to the clinical focus will be discussed with emphasis on expected and actual outcomes of care, alternative interventions and staff nurse responsibilities in the overall management of care for the client.

Student Objectives

The student will:
1. Identify the client.
2. State client needs.
3. Describe pertinent observations in a review of systems manner.
4. Report situation and potential or real problems experienced.
5. Discuss nursing approach/solution to these.
6. List the drugs administered, and state the action, dose, desired effect, untoward effects and method of administration for each.
7. List treatments, and state the purpose of, and client’s response to each.
8. IV solutions.
9. Labs/pertinent to patient.
10. Teaching.

Student Guide for Discussion

1. Who is my client? (for example: age, marital status, psychosocial history, medical conditions and mental status).

2. State significant events of this hospitalization (admitting diagnosis, surgery, emotional crises, fracture).

3. What are your client’s needs TODAY? (Describe client situation, your observations, potential or real problems and your approach).
Basic daily needs
Needs requiring special attention
Student Guide for Discussion (continued)

4. What medications were administered, or is your client receiving? Why? What were the positive and negative effects? What safety measures were used?

5. What treatments were done? Why were these done? What special principles or safety measures were involved?

6. Did I meet my client’s needs? Explain your answer.

7. What could I do to improve my nursing care of this client?

8. What were my feelings about taking care of this client?

9. Presentation of special topics.
GUIDELINES: CLINICAL ORIENTATION

The student will:

1. Learn the physical layout of the clinical area.

2. Review and be familiar with the OSHA guidelines regarding universal precautions as related to the clinical setting; know where to find protective equipment, sharps disposal boxes and infection control manuals located on the unit.

3. Complete the necessary (education requirements, confidentiality, etc) paperwork from the facility

4. Discuss the ethical, legal issues involved in the nursing care of the members of the OB and Pediatric Units.

5. Identify the chain of command as it relates to the clinical area.

6. Familiarize yourself with usual routines for the unit:
   - vital signs, I &O
   - meal time
   - visiting policies

7. Be introduced to the charting system for the clinical facility.

8. Be introduced to policies related to IV’s and medication administration.

9. Discuss nursing responsibilities related to medication administration.

10. Review school policies as they relate to clinical attendance, e.g. absenteeism, tardiness, etc.

11. Be oriented to clinical assignments, time of clinical experience, location and time of pre and post conferences and other scheduled clinical experiences in this course.

12. Review the clinical evaluation tool.

13. Discuss the role of the associate degree nurse as provider of care, manager of care and member of the profession.

14. Discuss the issues of confidentiality related to the clinical setting.

15. Review the requirements for papers related to this course.

16. Review lab, library and computer assisted tutoring available to assist student learning.
ORIENTATION SCAVENGER HUNT

Locate the Following:

Resources
- Policy and procedure books
- OSHA information
- Infection Control procedures
- Charting guidelines
- Textbooks & other resources

Medication Room
- Pharmacy prepared IVPB’s and IV’s
- IV solutions, tubing and connectors for piggybacks
- IV pumps; syringe pumps; PCA pumps

Emergency (Crash) Cart with defibrillator
- Emergency oxygen
- Emergency equipment
- Restraints
- Suction equipment

Patient Medical Records
- Lab results
- Transcribed orders
- Advanced directive
- Patient teaching information
- Drug information
- Teaching videos

Nutrition Room
- Ice machine
- Infant formula
- Nourishments
- Tube feedings

Treatment Room
- Catheterization and irrigation supplies
- Sterile dressings and supplies, tape, needles & syringes

Equipment
- Wheelchairs
- Backboards
- IV poles
- Accuchek
- Bedside commode
- Fetal monitors
- Cardio-respiratory monitors
- Oxygen saturation monitors
- Epidural cart
- Familiarize yourself with bed/crib controls, sharp containers, lighting & emergency call lights

Locate the following:
- Fire alarms and exits
- Emergency outlets
- Human resources
- Radiology
- Laboratory
- Pharmacy
- Cafeteria
- Emergency Department
- OR
- PICU / NICU / ICU / PACU
- Chapel

Clean Holding
- Linen cart
- Bedpans, urinals, bath, emesis basins
- Diapers
- Breast pumps

Answer the following questions:
- How/where are narcotics dispensed?
- Where are emergency drugs kept?
- What equipment do you need to suction?
- What equipment do you need to initiate a tube feeding?
How are supplies charged to the patient?

**ACUTE CARE SETTING**
**CLINICAL OBJECTIVES**

While on the maternal-child unit the student will satisfactorily complete:

Application of all previously learned skills, as well as NUR 2261L skills.
Application of clinical knowledge for pregnant women, infant and families through the childbearing process.
Multipatient assignments.
Medication calculation and administration with assigned patients.
A holistic assessment of a patient.
Utilization of the nursing process including critical thinking skills in all patient assignments.
Patient care manager experience and written paper, as assigned.

*See clinical computerized documentation requirements located in this syllabus.*

While on the pediatric unit the student will satisfactorily complete:

Application of all previously learned skills, as well as NUR 2261L skills.
Application of clinical knowledge to children and their families.
Multipatient / family assignments.
Utilization of the nursing process including critical thinking skills in all patient assignments.
A holistic assessment of a patient as with focus on growth and development, and family dynamics will be due once in the pediatric rotation.
Medication calculation and administration with assigned patients.
Patient care manager experience and written paper, as assigned.

*See clinical computerized documentation requirements located in this syllabus*
CLINICAL ASSIGNMENTS, FORMAT, GUIDELINES AND DEADLINES

You are required to enter data into the computerized documentation system this term as part of your clinical requirement. All assignments will be submitted on or BEFORE the due date. All assignments are due one week after the experience / assignment, unless otherwise directed by instructor. Since most clinicals are 1 day per week, it is strongly recommended that assignments be submitted as soon as possible after the experience, so that you may receive timely feedback to facilitate your success.

Semester 3 Minimum Paperwork Requirements:

General Requirements:
- Weekly computerized documentation
- Service Learning Experience (1 per semester)*
- Simulation (1 per rotation: 2 total)*
- Patient Care Manager (as assigned)*
- Alternate Clinical Experience (as assigned)*
*The objectives and written assignment requirements can be found in the pages following.

CLINICAL SIMULATION

Learning Outcomes:

Demonstrate critical thinking AEB individual and collaborative performance within the assigned scenario.

Utilize appropriate theory and skills to implement the nursing process individualizing it to meet client unique needs.

Manage complex patient needs in an effective and safe environment.

Preparation: The Simulation day is considered a clinical day, so please be timely and wear your uniform and identification badge. RN2 simulation preparation as assigned. Also, please bring your stethoscope.

Patient Care and Intervention: Students may be divided into 2 groups for the simulation experience. Students will be assigned specific roles for the simulation. Based on the clinical scenario presented, the students must develop a plan of care including nursing actions (interventions) necessary to stabilize the patient. Skills performance will occur at the bedside. (Some information may be only available after the completion of skills). At the end of the scenario, a comprehensive debriefing will take place.

Skill Development: The mannequin / human simulator will be utilized for physical assessment and nursing care. During the simulation, students may be asked to perform any skill previously learned.

Paperwork: Students will individually be required to access their blackboard sites and complete the required assignment listed prior to simulation. The group will then work together during simulation to complete any other additional paperwork required.

**Any discussions or paperwork generated by the simulation experience MUST stay within the simulation group. Sharing of the simulation information (verbal or written) outside of the group will be considered a HIPPA violation and result in a Personal Improvement Plan (PIP).**
ALTERNATIVE CLINICAL EXPERIENCE

Objectives:

1. The student will identify the primary population served.

2. The student will describe the similarities and differences of this population as compared to the primary population on his/her assigned clinical unit.

3. The student will describe the healthcare professional he/she shadowed; in terms of educational requirements (credentialing, certifications, etc.) and essential job responsibilities.

4. The student will discuss how these responsibilities differ from the essential responsibilities of the nurses on his/her assigned clinical unit.

5. The student will discuss the likelihood of pursuing a job in this area.
Alternative Clinical Experience Assignment

Name: ________________________________      Date: ____________________

Alternative Experience: _______________________________________________________

Name and title of nurse shadowed: ______________________________________________

1. Credentials of nurse (advanced degree, certification, years of experience, or training) necessary to perform role.

2. What are the essential job responsibilities of the nurse?

3. How do these responsibilities differ from the essential responsibilities of the nurses on your assigned clinical unit?

4. Describe the primary population served.

5. Describe the similarities and differences of this population as compared to the population on your assigned clinical unit.

6. What did you observe?

7. What was the best / most interesting part of the experience?

8. What did you like least about the experience?

9. Is this an area where you would consider working? Why or Why not?

10. Had you considered working in this area before today?

11. Would you recommend this experience to a fellow student? Why or Why not?
Ralph Waldo Emerson:
"It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself."

What is Service-Learning?

Palm Beach State defines service-learning as “a teaching method that increases student engagement and success through community involvement to apply theories or skills being taught in a course. Service-learning furthers the learning objectives of the academic courses, addresses community and civic needs, and requires students to reflect on their activity in order to gain an appreciation for the relationship between civics and academics.”

At Palm Beach State we envision a College that is a diverse community of active learners where achievement occurs in an environment without boundaries. We envision a responsive collaborative institution committed to the ongoing renaissance and enrichment of its community. Service-learning provides a teaching method to assist faculty, students and the community in fulfilling the College vision.

Albert Schweitzer:
“I don’t know what your destiny will be, but one thing I do know: the only ones among you who will be really happy are those who have sought and found how to serve.”

Students:
Students that participate in service-learning components understand that the “service” performed includes class participation, addressing the community needs, and reflection activities.

Benefits for the Students:

• Enhances Learning
• Connects theory to practice
• Encourages life-long commitment to service
• Fosters civic responsibility
• Explores majors and careers
• Enhances employability
• Receive job offers and scholarships
• Improves self-esteem
• Makes a difference in the community
What is Reflection?

Reflection means the process of thinking about what we do and processing it to draw meaning from our experiences. Reflection is an intentional endeavor to discover specific connections between something we do and the consequences which result.

Reflection exercises connect service to educational theory and larger social issues, foster critical thinking and active citizenship, and help in the evaluation of students' progress.

Objectives of Experience
The student will:
Identify resources in the community to serve client needs.
Suggest innovative methods to meet the needs of the community served.
Determine the impact of the agency/event on the community.
Describe the role and impact of the nurse within the agency/event.

SERVICE LEARNING ASSIGNMENT GUIDELINES

Students will select a service learning activity and obtain approval from their clinical instructor. This activity must be a hands-on experience. Observational experiences do not meet the criteria as outlined by Palm Beach State College or the nursing program. You will participate in at least a six hour experience during the semester.

Once the activity is approved, students can obtain a copy of the Service Learning Log and Evaluation of the experience at the following links:

Student Log Sheet
Student Site Evaluation Form

Each student will access the Nursing Resources website (also available via BB or the library) and secure an appropriate professional article from a Professional Nursing Journal related to the community / service learning experience attended.

Upon completion of this experience the following must be turned into the clinical instructor by the designated due date:

A professional nursing article
A reflection paper on the experience with references (APA format)
The site evaluation log
A site evaluation of the experience

*Service Learning is a requirement in every semester of the Nursing Program.
SERVICE LEARNING SELECTION LIST:

Prenatal / Infant & Child
Pre-natal classes            Breastfeeding classes
Childbirth classes          Children’s Media Services (CMS)
Infant CPR classes
Car seat safety classes
Head Start
Healthy Mothers Health Babies Coalition of Palm Beach County
School Nursing
Early Intervention
Easter Seals
Lung Mobile
Schools
Grandma’s Place
Chef for a Day at Quantum House
Safe Haven for Newborns

Adolescent/Early Adulthood
Migrant Clinics (Lantana)
Diabetic Teaching Classes (Jupiter Hospital)
American Cancer Association “I can cope series” (Jupiter Hospital)
Teen Parenting Classes
Alateen
Alcoholics Anonymous Meetings
Narcotics Anonymous Meetings
Human Trafficking

Middle/Later Adulthood
Out-Client (HH) (Jupiter Hospital)
Diabetic Support Groups
Menopause Support Group
Alzheimer’s Support Groups
Community Senior Center
Out-Patient Gyn Surgery Follow-up (Jupiter Hospital)
American Cancer Society
Lighthouse for the Blind
Cancer Centers
St. Mary’s Boot Camp for Dads
Red Cross
American Heart Association
American Lung Association

***All age groups – Health Fairs, Community Events

Students may also review the United Way of Palm Beach County website site to find other communities services/experiences. Reminder: If you choose an agency or event from the United Way website, you must get it approved by your clinical instructor PRIOR to attending.
PATIENT CARE MANAGER GUIDELINES

Students will be assigned Team Leader (Patient Care Manager) responsibilities on a rotating basis and will be responsible for a team of other students and their assigned patients.

PATIENT CARE MANAGER ACTIVITIES BEFORE THE EXPERIENCE

The student will:

1. With the guidance of the clinical instructor, identify which patients could be presented for case study presentations. Select, organize and assign patient groups to student peers.

2. Contact each student in a timely fashion to explain the patient assignment for daily care plan preparation. Information to be shared includes patient(s) initials, room number, medical diagnoses, general acuity level, meds, IV’s, DNR status (and weights in pediatrics).

RESPONSIBILITIES DURING CLINICAL INCLUDE:

1. Knowledge regarding team members’ assignments – patient(s) name, room number, diagnoses, special treatments/dressing changes, special equipment with patients, general acuity level, meds with lab monitoring (anticoagulants, hypoglycemics, etc.), IVs and times of IV meds, note patients with DNR status.

2. Rounds with team members after Pre-conference report to assess needs or potential problems.

3. Availability to team members throughout day for:
   - Oral medication verification.
   - Assistance as needed with assignment – i.e. to help ambulate the patient who requires 2 assistants or to delegate assisting to another student, etc., NOT TO DO SNs ASSIGNMENT.
   - Participate in assisting SN with performing technical skills necessary for specific patient care
   - Recurring rounds, sharing of instruction/information to members from instructor.
   - Notifying instructor of problems/concerns related to team members’ assignments, patient condition concerns/changes, unusual occurrences, etc.
   - Assuring ordered care administered to patients on team – check MARs and I & O etc. for documentation throughout day, assure ordered treatments completed as scheduled.

4. Make final rounds on team to assure assigned care complete, assure documentation complete at end of shift – assessments and nurses notes present, prn medications documented along with response within 1 hour, I & O totaled and documented, all VS charted, foleys emptied, etc. (Instructor will assess quality of assessment content). Assure team members report off (communicate patient condition and response to nursing interventions and medical treatment) to the patient’s primary nurse by assigned time.

5. Advise instructor when all members assignments’ complete and team members leaving unit for post conference.
PATIENT CARE MANAGER ASSIGNMENT

The purpose of the experience of patient care manager is to begin to understand the complexity of overall nursing care management. The patient care manager assignment will assist you in developing skills of organization, delegation and facilitation of patient management. The aim of patient care manager is to meet patient care goals through the nursing process, while focusing on managing different populations of people.

The secret is:
1. Assess the patients
2. Prioritize
3. Assign and delegate
4. Evaluate and Revise

OBJECTIVES OF PATIENT CARE MANAGER ASSIGNMENT

The student will:

1. Develop leadership skills through the management of selected patient groups assigned to student peers.

2. Assist the patient to attain optimum health and homeostasis utilize the theory of goal attainment by prioritizing patient care goals in collaboration with peers, patients, families, and health team members.

3. Relate the nursing process to the care of the selected group of patients assigned to peers.

4. Identify the principles of growth and development as related to personal, interpersonal and social needs of the selected patients.

5. Identify nutritional needs of the selected patients.

6. Utilize leadership skills with application of appropriate nutritional interventions.

7. Explore ethical/legal issues relevant to the selected patient group.

8. Contrast cultural influences that impact the selected patients’ hospitalization and/or health.

9. Relate knowledge of the principles and safe administration of medications ordered for the groups of patients assigned to peers.

10. Evaluate effective communication skills with peers, patients, families and health team members.

11. Develop accurate and safe technical skills, either by direct performance or by assisting peers.

12. Evaluate health care teaching of groups of patients and families assigned to peers.

13. Describe personal/professional growth achieved through the role of patient care manager.
PATIENT CARE MANAGER EXPERIENCE EVALUATION

Guidelines for Patient Care Manager Required Written Assignment

The evaluation of your experience as a patient care manager is an important part of the experience. As soon as possible after the experience, you must write down your thoughts. The required written assignment must be submitted according to Palm Beach State College Nursing Student Handbook written paper criteria. (The written assignment is due one week after the experience and must include the following: )

1. Discuss your personal and professional goals for this clinical experience as a patient care manager and your success in meeting them.

2. Discuss your anticipated learning needs for your experience as a patient care manager and your success in meeting them.

3. Describe your patient care management activity plan and its usefulness to you during this clinical experience.

4. Evaluate the interactions and activities done with your peers.

5. Evaluate the interactions and activities done with the client you spent the most time with.

6. What would you do differently next time?

7. If you have had the opportunity to be a Patient Care Manager previous to this experience, please compare and contrast that experience to your current experience. Did you manage things differently? Were the outcomes similar?
# PATIENT CARE MANAGER WORKSHEET

<table>
<thead>
<tr>
<th>STUDENT</th>
<th>ROOM &amp; PT</th>
<th>DIAGNOSIS</th>
<th>VS</th>
<th>TREATMENT</th>
<th>LABS</th>
<th>IVs &amp; MEDS ALLERGIES &amp;Wt</th>
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EVALUATION OF CLINICAL PERFORMANCE

These objectives represent the expected minimal outcomes for the student upon completion of the clinical components of the nursing program and reflect the program concepts and threads. Outcomes are based on the student’s ability to apply the nursing process to clinical practice and reflect continuing growth and improvement both within and among courses.

During each course’s orientation to the clinical experience, the evaluation process is reviewed both programmatically and in relation to specifics of the course.

EVALUATION CRITERIA

4. Pass – Self Directed Independent Level
3. Pass – Moving toward Independent Level
2. Unsatisfactory – Needs Improvement (requires completion of a “Performance Improvement Plan”)
1. Failure – Dependent Level (requires completion of a “Performance Improvement Plan”)

(Each of the above areas is defined on page 3 and specifically in relation to the stated outcome).

OUTCOMES

A student must receive a “Pass” (3 or 4) criteria rating on all objectives identified for the current clinical course in order to pass by the end of the term. An “Unsatisfactory/failure” (1 or 2) criteria rating on any clinical course objective means an unsatisfactory grade regardless of the ratings on other items. All objectives identified as 1 or 2 at the mid-term, must improve to a criteria rating of 3 or 4 to successfully pass the clinical course.
DEFINITIONS FOR EVALUATION CRITERIA

4. **Pass - Self-Directed Independent Level**
   √ Performs safely and accurately during the performance* and without* supportive cues from the instructor.
   √ Demonstrates dexterity* and coordination,* while performing the skill.
   √ Completes the skill in minimal amount of time*.
   √ Focuses on the patient* while giving care.
   √ Appears relaxed and confident during performance.
   √ Applies knowledge of the principles of the skill accurately.*

3. **Pass - Moving toward Independent Level**
   √ Performs safely and accurately during the performance* with occasional directive cue* from the instructor.
   √ Demonstrates coordination and dexterity*, but uses some unnecessary energy* to complete the skill.
   √ Generally appears relaxed and confident most of time with occasional display of anxiety.
   √ Completes the skill within a reasonable time* frame.
   √ Focuses on the patient initially, but as the skills progresses, focuses on the task.*
   √ Applies knowledge of the principles of the skill accurately with occasional cue from the instructor.*

2. **Unsatisfactory - Needs Improvement**
   √ Performs safely and accurately with frequent direction or cues from the instructor ** during the performance.
   √ Requires frequent direction or cues * from the instructor.
   √ Demonstrates partial lack of dexterity *; is awkward.
   √ Takes a longer time * to complete the skill.
   √ Wastes energy* due to poor planning/anxiety.
   √ Focuses primarily on the task, not on the client*.
     √ Needs direction in application of the principles of the task*.

1. **Failure - Dependent Level**
   √ Performs the skill in an unsafe* manner.
   √ Requires constant supportive and directive cues* from the instructor.
   √ Takes an unreasonable length* of time to complete the skill.
   √ Lacks organization* due to poor planning.
   √ Wastes energy* due to disorganization or incompetence.
   √ Focuses entirely on the skill or own behavior*.
   √ Unable to identify or apply the principles of the skill.*

* Distinctive Criteria for Competency Level
NUR 2261L: Supporting Documentation

PALM BEACH STATE COLLEGE
NURSING PROGRAM

CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student’s Name: _______________________________  Student ID #: ___________________

NUR 1023L

Course Grade: __________  Absences: ________  Tardiness: ________  Completion Date: ________________

Instructor: ________________________________

MIDTERM COMMENTS: Date: __________  P ________  F ________

Student Signature: ________________________________  Faculty Signature: ________________________________

FINAL COMMENTS: Date: __________  P ________  F ________

Student Signature: ________________________________  Faculty Signature: ________________________________
NUR 2261L: Supporting Documentation

PALM BEACH STATE COLLEGE
NURSING PROGRAM
CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student’s Name: ____________________________  Student ID #: ________________________

NUR 1213L

Course Grade: ____________  Absences: _________  Tardiness: _________  Completion Date: ______________

Instructor: ____________________________

MIDTERM COMMENTS: Date: ____________  P _________  F _________

Student Signature: ____________________________  Faculty Signature: ____________________________

FINAL COMMENTS: Date: ____________  P _________  F _________

Student Signature: ____________________________  Faculty Signature: ____________________________
NUR 2261L: Supporting Documentation

PALM BEACH STATE COLLEGE
NURSING PROGRAM
CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student’s Name: ___________________________  Student ID #: _________________________

NUR 2261L

Course Grade: ___________  Absences: _________  Tardiness: _________  Completion Date: ________________

Instructor: ____________________________

MIDTERM COMMENTS: Date: _____________  P __________  F __________

Student Signature: ____________________________  Faculty Signature: ____________________________

FINAL COMMENTS: Date: _____________  P __________  F __________

Student Signature: ____________________________  Faculty Signature: ____________________________

Palm Beach State College
Revised November 2013
NUR 2261L: Supporting Documentation

PALM BEACH STATE COLLEGE
NURSING PROGRAM
CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student’s Name:______________________________ Student ID #:________________

NUR 2741L

Course Grade:___________ Absences:_________ Tardiness:_________ Completion Date:___________

Instructor:______________________________

MIDTERM COMMENTS: Date:___________ P _________ F _________

Student Signature:_________________________ Faculty Signature:_________________________

FINAL COMMENTS: Date:___________ P _________ F _________

Student Signature:_________________________ Faculty Signature:_________________________

Palm Beach State
College
NUR 2261L: Supporting Documentation

PALM BEACH STATE COLLEGE
NURSING PROGRAM
CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student’s Name: ________________________________________  Student ID #: ____________________

NUR ________

Course Grade: __________ Absences: _________  Tardiness: _________  Completion Date: ________________

Instructor: ____________________________

MIDTERM COMMENTS: Date: __________  P _________  F _________

Student Signature: ____________________________  Faculty Signature: ____________________________

FINAL COMMENTS: Date: __________  P _________  F _________

Student Signature: ____________________________  Faculty Signature: ____________________________
### EVALUATION OF CLINICAL PERFORMANCE

**STUDENT NAME:** ________________________________

**STUDENT ID #:** ________________________________

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**NURSING PROCESS - The Student Will:**

A. Demonstrate biopsychosocial assessment skills in collection and analysis of data to identify the needs of the client.
   1. Has difficulty in observing and assessing data despite guidance and supervision from instructor.
   2. Needs frequent direction in order to assess needs of client.
   3. Observes and assesses data with minimal assistance from the instructor.
   4. Independently observes and assesses data.

B. Formulate goals based on data.
   1. Has difficulty formulating patient behavioral objectives.
   2. Requires frequent input in order to formulate client behavioral objectives.
   3. Formulates patient behavioral objectives with minimal assistance from the instructor.
   4. Independently formulates patient behavioral objectives correctly based on data.

C. Uses critical thinking to formulate a plan of care based on client oriented behavioral objectives.
   1. Unable to use critical thinking to formulate a plan of care.
   2. Requires frequent direction from instructor to use critical thinking to formulate a plan of care.
   3. Applies critical thinking while formulating a plan of care with occasional support from instructor.
   4. Applies critical thinking while formulating a plan of care.

D. Write a plan of care based on patient oriented behavioral objectives.
   1. Has difficulty identifying nursing diagnosis in priority, planning nursing actions, identifying scientific rationale and evaluating the plan, despite guidance and supervision of instructor.
   2. Needs frequent direction in order to write a plan of care based on client behavioral objectives.
   3. Identifies nursing diagnosis in priority, plans nursing actions, identifies scientific rationale and evaluates the plan with minimal assistance from instructor.
   4. Independently identifies nursing diagnosis in priority, plans nursing actions, identifies scientific rationale and evaluates the plan.

E. Implement nursing measures to meet prioritized client need.
   1. Some planning but does not take into consideration patient data; and/or is not able to establish priorities.
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<tr>
<th>Date</th>
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<td><strong>2. Wastes energy due to poor planning in order to implement nursing measures to meet prioritized client need.</strong>&lt;br&gt;3. Assignment planned, priorities established, and usually carried through as intended except for unexpected circumstances.&lt;br&gt;4. Assignment planned and organized so as to afford patient and family maximum comfort.</td>
</tr>
<tr>
<td><strong>MT</strong></td>
<td><strong>Critical to all courses</strong></td>
<td><strong>F. Evaluate the effectiveness of nursing interventions and adapts plan of care accordingly.</strong>&lt;br&gt;1. Requires constant support to evaluate effectiveness of interventions.&lt;br&gt;2. Requires frequent support to evaluate effectiveness of interventions.&lt;br&gt;3. Requires minimal assistance to evaluate effectiveness of interventions.&lt;br&gt;4. Correctly evaluates effectiveness of interventions.</td>
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<td><strong>2.</strong>&lt;br&gt;3. <strong>Assignment planned and organized so as to afford patient and family maximum comfort.</strong></td>
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<tr>
<td><strong>MT</strong></td>
<td><strong>Critical to all courses</strong></td>
<td><strong>G. Report and record nursing process.</strong>&lt;br&gt;1. Has difficulty in observing and recording data, despite guidance and supervision from instructor: database is incomplete.&lt;br&gt;2. Needs frequent direction from instructor during reporting and recording of nursing process.&lt;br&gt;3. Able to observe and record data, with minimal assistance from instructor: database is complete, descriptive and accurate.&lt;br&gt;4. Independently observes and records data; database is complete, descriptive and accurate.</td>
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<tr>
<td><strong>MT</strong></td>
<td><strong>Critical to all courses</strong></td>
<td><strong>H. Performs technical aspects of care.</strong>&lt;br&gt;1. Makes errors, recognizes and corrects a few of them, requires much supervision and/or prompting from instructor.&lt;br&gt;2. Demonstrates partial lack of dexterity while performing technical aspects of care.&lt;br&gt;3. Makes minimal errors or omissions, recognizes and corrects most of them; requires little supervision and/or prompting from instructor.&lt;br&gt;4. Consistently performs skills accurately and efficiently without requiring prompting from instructor.</td>
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</tr>
<tr>
<td><strong>MT</strong></td>
<td><strong>Critical to all courses</strong></td>
<td><strong>I. Explain rationale for performing basic nursing skills and technical procedures.</strong>&lt;br&gt;1. Seldom applies previously learned principles; requires much guidance.&lt;br&gt;2. Occasionally applies previously learned principles; requires frequent guidance.&lt;br&gt;3. Usually applies previously learned principles; requires minimal guidance.&lt;br&gt;4. Consistently and independently applies previously learned principles.</td>
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<td><strong>MT</strong></td>
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<td><strong>J. Calculate, prepare and administer medications accurately.</strong>&lt;br&gt;1. Makes errors in securing correct medications, calculating dosages; preparing and administering medications; and requires prompting to correct errors.&lt;br&gt;2. Performs safely and accurately with frequent direction or cues from the instructor during the performance.&lt;br&gt;3. Makes minimal errors in securing correct medication; calculating dosages; preparing and administering medications; and, recognizes and corrects errors with minimal assistance.&lt;br&gt;4. Is accurate and efficient in securing correct medication, calculating dosages, preparing and administering medications.</td>
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<td><strong>2.</strong>&lt;br&gt;3. <strong>Assignment planned and organized so as to afford patient and family maximum comfort.</strong></td>
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### NUR 2261L: Supporting Documentation

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<th>Date</th>
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</table>
| MT   |       |       |       |       | K. Discuss relevant data regarding medications.  
1. Unable to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs.  
2. Needs frequent direction from instructor in order to state physiologic action of drugs, etc.  
3. Usually able to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs.  
4. Is accurate and efficient in stating physiologic action of drugs, recognizing behavior & behavioral changes to drugs, and adapting nursing care according to the effect.  
| F    |       |       |       |       |  
| MT   |       |       |       |       | Critical to all courses  
| F    |       |       |       |       | Critical to all courses  
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| F    |       |       |       |       | Critical to all courses  
| MT   |       |       |       |       | Critical to all courses  
| F    |       |       |       |       | Critical to all courses  

#### TEACHING-CLIENT/FAMILY - The Student will:

|       |       |       |       |       | L. Perform appropriate teaching with clients and/or families applying principles of learning and teaching.  
1. Rarely able to apply principles of teaching and learning, requires much guidance.  
2. Sometimes able to apply principles of teaching and learning, requires frequent guidance.  
3. Usually able to apply principles of teaching and learning, requires minimal guidance.  
4. Consistently and independently able to apply principles of teaching and learning.  
|       |       |       |       |       | Critical to all courses  
|       |       |       |       |       | Critical to all courses  
|       |       |       |       |       | Critical to all courses  
|       |       |       |       |       | Critical to all courses  

#### COMMUNICATION - The student will

|       |       |       |       |       | M. Collaborate effectively with other members of the health team to promote continuity of care.  
1. Communication is rarely effective and requires much guidance.  
2. Communication is occasionally effective and requires frequent prompting.  
3. Communication is usually effective and requires minimal guidance.  
4. Communication is consistently effective and is done independently.  
|       |       |       |       |       | Critical to all courses  
|       |       |       |       |       | Critical to all courses  
|       |       |       |       |       | Critical to all courses  
|       |       |       |       |       | Critical to all courses  

#### NUR 2261L – Supporting Documents

Revised November 2013

Palm Beach State College
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### JUDGEMENT, RESPONSIBILITY, & ACCOUNTABILITY - The student will

P. Perform nursing measures with respect to client’s dignity, safety and confidentiality.
1. Client’s dignity, safety and confidentiality over-looked; error(s) made were actually or potentially dangerous to the welfare to the patient.
2. Client’s dignity, safety and confidentiality occasionally over-looked; error(s) made were not actually or potentially dangerous to the welfare of the patient.
3. Client’s dignity, safety and confidentiality usually considered and demonstrated; error(s) made were not dangerous to the welfare of the patient.
4. Client’s dignity, safety and confidentiality consistently considered and demonstrated.

Q. Display judgment and objectivity in situations. Makes decisions that reflect both knowledge of fact and sound judgment.
1. Has difficulty functioning after initial direction; needs repeated explanations.
2. Requires frequent directions; occasionally demonstrates acceptable use of judgment and objectivity in some situations.
3. Able to follow initial directions; demonstrates acceptable use of judgment and objectivity in most situations.
4. Rarely needs direction; is consistently able to make judgments independently and with objectivity.

R. Oral and/or written assignments meet established criteria as stated in course syllabus.
1. Preparations/assignments that contain spelling and grammar errors, lack depth, are incomplete and unsatisfactory.
2. Preparations/assignments are occasionally done that meet established criteria.
3. Preparations/assignments are usually complete and satisfactory.
4. Preparations/assignments display consistent in-depth content and usually go beyond the requirements for the assignment.

S. Accept and profit from constructive criticism.
1. Rarely accepts and profits from constructive criticism.
2. Occasionally accepts and profits from constructive criticism.
3. Usually accepts and sometimes profits from constructive criticism.
4. Accepts and profits from constructive criticism.

T. Actively participate in clinical conferences.
1. Seldom participates in post conferences or displays inappropriate behavior.
2. Occasionally participates with frequent cues from instructor.
3. Usually participates in post conferences.
4. Consistently contributes to post conferences.
### Critical to all courses

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**NUR 2261L: Supporting Documentation**

- **U.** Correlate classroom theory to clinical practice.
  1. Shows little or no knowledge beyond immediately defined nursing care.
  2. Occasionally correlates theory to clinical practice.
  3. Usually correlates theory to clinical practice to implement care.
  4. Consistently correlates theory to clinical practice to implement care.

- **V.** Demonstrate self-direction and assume responsibility for his/her own growth and learning.
  1. Lacks initiative; is non-assertive and does not follow through with responsibility.
  2. Needs direction in order to move toward assuming responsibility for his/her own growth and learning.
  3. Usually demonstrates initiative and assertiveness, and usually follows through with responsibility.
  4. Consistently demonstrates initiative, assertiveness, self-direction and creativity; goes beyond required tasks.

- **W.** Organize assignments so that completed in a specified amount of time.
  1. Does not complete assignment on time.
  2. Occasionally completes assignments on time.
  3. Usually completes assignment on time.
  4. Consistently completes assignment on time.

- **X.** Adhere to the nursing department’s and course standards regarding professional behavior.
  1. Does not adhere to these standards.
  2. Occasionally adheres to these standards.
  3. Usually adheres to these standards.
  4. Consistently adheres to standards.

- **Y.** Utilize an appropriate assertive approach to clients, family, health care team, visitors and faculty.
  1. Approach is often inappropriate.
  2. Approach is occasionally appropriate.
  3. Approach is usually appropriate.
  4. Uses appropriate assertive approach.
NUR 2261L: Supporting Documentation

CLINICAL EXPERIENCE RECORD

Student: 

Semester/Year: 

Cluster: 

Area/Instructor: 

In addition to observations made on any date, include any skills, activities and/or competencies completed or checked off.

<table>
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<tr>
<th>Date</th>
<th>Instructor’s Notes</th>
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CONCEPT I: OXYGENATION

Required Reading
\( \sqrt{ } \) Clinical Skills Manual for Maternal & Child Nursing Care (2ndEd) on reserve in the library
\( \sqrt{ } \) Ward & Hisley (and accompanying student CD-ROM and companion website)
\( \checkmark \) OB Skills Packet on Bb

A. Intrapartum Care

Outcomes: The student will:
\( \checkmark \) Demonstrate a basic understanding of the female bony pelvis and landmarks designating fetal engagement.
\( \checkmark \) Understand the meaning and documentation used to describe cervical dilatation, effacement, fetal station and fetal position.
\( \checkmark \) Demonstrate an understanding of rupture of membranes and amniotomy during the labor process.
\( \checkmark \) Become familiar with obstetric instruments frequently used in the obstetrical rotation.
\( \checkmark \) Demonstrate a basic understanding of the intravenous medications used intrapartally as well as calculation of their dosages.

B. Fetal Monitoring

Outcomes: The student will:
\( \checkmark \) Demonstrate a basic understanding of fetal monitoring.
\( \checkmark \) Understand techniques for auscultation of FHR including baseline, variability, acceleration and deceleration.
\( \checkmark \) Placement of external toco and uterus monitors to detect FHR and ct patterns.

C. Newborn Care

Outcomes: The student will:
\( \checkmark \) Demonstrate a comprehensive physical assessment of the newborn including reflexes.
\( \checkmark \) Demonstrate basic understanding of the APGAR scoring system.
\( \checkmark \) Identify initial airway management of newborn thermoregulation and NB procedure at birth.
\( \checkmark \) Demonstrate basic newborn care skills swaddling, positioning, feeding, diaper and burping techniques.
**CRITICAL THINKING EXERCISES: Oxygenation**

**SCENARIO (2 Parts)**

**Part 1**
RN is a 21 yo G1 P1 1001 at 39 wks gestation. She presents to triage with contractions every 4-6 minutes, accompanied by her husband. She reports leaking yellow green fluid 2 hours prior to admission.

- What additional data is important to gather at this point?
- What assessment techniques would be used by the nurse in evaluating the client?
- Discuss cultural considerations for this couple.

**Part 2**
She is moved to a birthing room, assessment reveals VS 110/64 – 82 – 20 – 98⁰. Cervical exam reveals 4/80/vtx/-1, LOP position, FHR 140 bpm ctx ↑ 2-3 mins apart RN is requesting medication for pain.

- Should this pt be monitored continuously or intermittently?
- Is pain medication appropriate at this time?
- Consider the stage and phase of labor.
- What might the nurse anticipate about the course of fetal position and labor?
- What FHR patterns are reassuring in labor what patterns might be cause for concern?
- Is there any data gathered which suggests concern for fetal well being?
CONCEPT I: REGULATION

Required Reading

- Clinical Skills Manual for Maternal & Child Nursing Care (2ndEd) on reserve in the library
- Ward & Hisley (and accompanying student CD-ROM and companion website)
- OB Skills Packet on Bb

A. Antepartum Care

Outcomes: The student will:

- Demonstrate a basic understanding of antepartum care.
- Demonstrate understanding and calculation of the EDC according to Naegles rule and weeks gestation.
- Demonstrate basic Leopold’s maneuvers and fundal height measurement.

B. Postpartum Care

Outcomes: The student will:

- Demonstrate Bubblehee assessment of the postpartum woman (vaginal delivery and caesarean section).
- Perform and state an understanding of fundal massage and lochia evaluation to prevent complications in the postpartum recovery phase.
- Understand basic techniques to promote breastfeeding success and maternal physiologic adaptation.
- Discuss techniques for perineal hygiene, bowel and bladder care along with comfort measures to manage discomfort from perineal lacerations episiotomy and hemorrhoidal pain.
### CRITICAL THINKING EXERCISES: Regulation

#### SCENARIO

PB is a 35 y G 3 P 3 6 hours pp following a NSVD of a 9 # male infant over a midline episiotomy. She is currently interested in trying to breastfeed her son, but her husband is not supportive.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>What nursing assessments are indicated for the immediate pp period?</td>
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<tr>
<td>What immediate learning needs have been identified for PB at 6 hours pp?</td>
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<tr>
<td>What self-care measures could you advise PB about?</td>
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<tr>
<td>What important points can the nurse stress to promote breastfeeding success?</td>
<td></td>
</tr>
</tbody>
</table>
CONCEPT I: OXYGENATION

Required Reading

✓ Clinical Skills Manual for Maternal & Child Nursing Care (2ndEd) on reserve in the library
✓ Ward & Hisley (and accompanying student CD-ROM and companion website)
✓ Pediatric Packet on Bb

A. Pediatric Airway Management

Outcomes: The student will:

✓ Assess the bedside for necessary equipment needed for an infant at risk for aspiration secondary to gastro-esophageal reflux.
✓ Describe GER / aspiration precautions for an infant
✓ Assemble the necessary equipment needed for a patient who is at risk for respiratory arrest
✓ Verbalize the priority of steps to take in a pediatric respiratory arrest
✓ Demonstrate the steps necessary as the first responder in a pediatric respiratory arrest
✓ Demonstrate the use of the equipment used in a pediatric patient with a respiratory arrest

B/C. Pediatric Cardio-Respiratory and Oxygen Saturation Monitoring

Outcomes: The student will:

✓ Discuss which disorders/diseases need cardio-respiratory monitoring.
✓ Become familiar with highs and lows of alarm settings for equipment.
✓ Demonstrate correct placement of electrodes on an infant/child.
✓ Become familiar with pediatric crash cart.

In The Clinical Area

✓ Locate the crash cart is in your clinical area
✓ Know where the airway equipment is stored
✓ Practice setting up the oxygen and suction equipment in the clinical area
✓ Know which drawer houses the airway equipment in the crash cart
✓ Demonstrate the set-up for cardio-respiratory and oxygen saturation monitoring; including the setting of alarms
CRITICAL THINKING EXERCISES: Oxygenation

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Your patient is an infant under 1 year, taking formula feedings. The baby's mother states she doesn't think her baby is breathing. What would you do?</td>
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<tr>
<td>2.</td>
<td>You have a patient on an apnea monitor. What is your responsibility to see that the monitor is functioning properly?</td>
</tr>
<tr>
<td>3.</td>
<td>The patient who is on an apnea monitor has an alarm go off. What would you do first?</td>
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<tr>
<td>4.</td>
<td>A patient is back from surgery and is noted to have shallow respirations with fair chest rise. The oxygen saturation monitor is alarming. The mother is at the bedside and states that she thinks her child has stopped breathing. What would you do?</td>
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<tr>
<td>5.</td>
<td>How many liters of oxygen are used for resuscitation?</td>
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<tr>
<td>6.</td>
<td>List at least 2 nursing diagnoses for an infant with GER and at least 2 interventions for each diagnosis</td>
</tr>
</tbody>
</table>
NUR 2261L: Supporting Documentation

CONCEPT II: CELLULAR INTEGRITY

Required Reading

√ Clinical Skills Manual for Maternal & Child Nursing Care (2nd Ed) on reserve in the library
√ Ward and Hisley readings as assigned
√ Pediatric Intravenous Therapy-Use of the Buretrol: (syllabus)
√ Pediatric Packet on Bb.

Audio Visual

√ VT 11009 Pediatric I.V. Therapy

A. Pediatric Intravenous Therapy-Medication Administration

Outcomes: The student will:

√ Verbalize that the MAP (saline lock)/I.V. is patent and safe to deliver an I.V. medication.
√ Verbalize the “rights”-include checking the physicians order.
√ Verbalize the process needed to safely deliver a pediatric medication.
√ Correctly calculate pediatric medication dosages.
√ Demonstrate the steps in delivering pediatric medications utilizing the buretrol and the syringe pump.
√ Integrate relevant pharmacological data and anticipate the child’s response related to medications.

Pediatric IV Therapy

The Buretrol has two main functions. The first is to safely administer IVF to the pediatric patient. The Standard of Care in pediatrics is to fill the buretrol chamber with two hours of IVF at a time. This practice avoids accidental fluid overload if the IV pump were to malfunction. The roller clamp between the IV bag and the buretrol should be closed and the air vent on the buretrol should be open.

The pump should be set at the prescribed rate and the VTBI (volume to be infused) should be set at twice the rate. This allows only 2 hours of fluid to infuse before the nurse is forced to reassess the IV pump and reset it; as well as assess the IV site. This is especially important in pediatrics since an IV infiltrate can occur quickly and babies are not able to tell us the site hurts.

The second function for the buretrol is as a method to deliver IV medication. The prescribed dose is calculated to ensure a safe therapeutic range. Then the amount of IVF needed to further dilute the medication is calculated and placed in the buretrol along with the medication (make sure that the roller clamp between the IV bag and the buretrol is CLOSED.)

Calculate the necessary rate based on the prescribed time of infusion and/or the volume to be infused. Most pediatric IV antibiotics are administered over 30 minute (1/2 hour). Most IV pumps can only be set for 1 hour. Therefore, if your volume to be infused (VTBI) is 25 mls than your rate would be 50 mls/hr (Rate = 2x (VTBI).

Don’t forget about the medication between the tubing at the end of the buretrol and the patient. Once the medication has been infused then you must “rinse” the line (generally 10-20mls, depending on the manufacturer of the tubing). Once the remaining medication is “rinsed” from the tubing, you will either reset the pump back to the original rate and place 2 hours of IVF in the buretrol and correctly set the VTBI. If your patient is to be “mapped” after the tubing has been rinsed, you will then “flush” the MAP with normal saline to prevent clotting.
**Reminders:**

EVERY time a “port” is entered if MUST first be swabbed with alcohol

Do NOT shut off an IV pump that is alarming. If you cannot figure out how to correct the alarms find the nurse or your instructor

Most IV tubing including the buretrol is good for 4 days (96 hours)

IV bags are good for 24 hours

Do not use any saline or other medication left open in the medication room unless it is properly dated and timed. If in doubt throw it out. (You may want to check with your instructor first).

**CRITICAL THINKING EXERCISES: Cellular Integrity**

1. If the dose for the medication to be delivered did not match the last physicians order for the medication, how would you proceed?

2. If the I.V. / MAP did not flush easily before giving a medication, what would you do?

3. If you placed the wrong medication in the buretrol of a patient, what would you do?

4. How would you deliver a medication in a buretrol which had more fluid in it than needed for the medication?

5. What would you do if you set the pump to deliver the medication and the pump alarmed: “air in the line?”

6. What would you do if the MAP started leaking after the infusion began?

7. What would you do if the pump alarm read: “Occluded” while the medication was infusing?
CONCEPT III: REGULATION

Required Reading

- Clinical Skills Manual for Maternal & Child Nursing Care (2nd Ed) on reserve in the library
- Ward & Hisley readings as assigned (and accompanying student CD-ROM and companion website)
- Pediatric Packet on Bb

A. Pediatric Assessment

Outcomes: The student will:

- Perform a comprehensive physical assessment on the infant and child.
- Accurately document physical assessment, utilizing assessment form and growth chart.
- Accurately assess and document vital signs on the pediatric patient.
- Discuss & demonstrate the various methods of monitoring temperatures and under what circumstances each method would be used.
- Perform and document a brief developmental screening.

B. Procedures

Outcomes: The student will:

- Appropriately place U-bag & obtain specimen.
- Discuss & demonstrate specimen collection as it relates to pediatric patients.
- Document the specimen collection and time sent.
- Demonstrate straight catheterization of infant using a feeding tube or quick cath kit. (if available)
- Accurately measure and record I&O; including the measurement of wet/soiled diapers.
- List at least 5 safety issues in pediatrics.
- Explain why procedures are performed in the treatment room.
<table>
<thead>
<tr>
<th></th>
<th>CRITICAL THINKING EXERCISES: Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Explain the reason for plotting physical parameters (height, weight, head circumference) on the growth charts</td>
</tr>
<tr>
<td>2.</td>
<td>How often is I&amp;O recorded in pediatrics?</td>
</tr>
<tr>
<td>3.</td>
<td>What would you tell a parent of a 3 year old, who requests that her IV be re-started in her bed?</td>
</tr>
<tr>
<td>4.</td>
<td>Your 18 month old patient is “picking” at her IV, what will you do?</td>
</tr>
<tr>
<td>5.</td>
<td>The 18 month old above is in her room alone and she begins to cry, what do you do?</td>
</tr>
</tbody>
</table>
Pediatric Daily Holistic Assessment Tool (DHAT)

<table>
<thead>
<tr>
<th>Client Initials</th>
<th>Age</th>
<th>DOB</th>
<th>Gender</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WT</th>
<th>HT</th>
<th>Admission Date</th>
<th>Allergies</th>
</tr>
</thead>
</table>

Admission Diagnosis / Current Diagnosis:

Secondary Diagnosis:

Pathophysiology (textbook reference):

---

### Initial Assessment

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>P</td>
</tr>
</tbody>
</table>

#### Sensory / Perception / Cognition:

<table>
<thead>
<tr>
<th>LOC / Visual or auditory deficits</th>
<th>Awake</th>
<th>Alert</th>
<th>Oriented</th>
<th>Asleep</th>
<th>Confused</th>
<th>Obtunded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood</td>
<td>Appropriate</td>
<td>Depressed</td>
<td>Anxious</td>
<td>Angry</td>
<td>Euphoric</td>
<td>Labile</td>
</tr>
<tr>
<td>Behavior</td>
<td>Cooperative</td>
<td>Uncooperative</td>
<td>Apprehensive</td>
<td>Agitated</td>
<td>Lethargic</td>
<td></td>
</tr>
<tr>
<td>Speech / Primary language</td>
<td>Clear</td>
<td>Appropriate</td>
<td>Inappropriate</td>
<td>Aphasia</td>
<td>Impaired hearing</td>
<td></td>
</tr>
<tr>
<td>Anterior fontanel</td>
<td>Open</td>
<td>Closed</td>
<td>Flat</td>
<td>Sunken</td>
<td>Bulging</td>
<td>Soft</td>
</tr>
<tr>
<td>Pupils</td>
<td>(L)</td>
<td>(R)</td>
<td>Brisk</td>
<td>Sluggish</td>
<td>Nonreactive</td>
<td>Brisk</td>
</tr>
<tr>
<td>Pain</td>
<td>Score:</td>
<td>Location:</td>
<td>Description:</td>
<td>Medicated</td>
<td>Y*</td>
<td>N</td>
</tr>
</tbody>
</table>

#### Growth & Development (Erikson) Stage

<table>
<thead>
<tr>
<th>(Actual Stage)</th>
<th>AEB</th>
</tr>
</thead>
</table>

* Alteration in S/P/C

#### Cellular Integrity:

<table>
<thead>
<tr>
<th>Skin temperature / moisture</th>
<th>Warm</th>
<th>Cool</th>
<th>Cold</th>
<th>Dry</th>
<th>Moist</th>
<th>Diaphoretic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color / turgor</td>
<td>Pink</td>
<td>Pale</td>
<td>Cyanotic</td>
<td>Mottled</td>
<td>Jaundiced</td>
<td>Elastic</td>
</tr>
<tr>
<td>Edema</td>
<td>None</td>
<td>Present</td>
<td>Location:</td>
<td>Pitting</td>
<td>+1</td>
<td>+2</td>
</tr>
<tr>
<td>Mucous membranes</td>
<td>Pink</td>
<td>Pale</td>
<td>Moist</td>
<td>Dry</td>
<td>Lesions</td>
<td></td>
</tr>
<tr>
<td>Rash / lesion / wound</td>
<td>None</td>
<td>Present</td>
<td>Site</td>
<td>Describe:</td>
<td>Location:</td>
<td></td>
</tr>
</tbody>
</table>

* Alteration in Skin Integrity

#### Oxygenation:

--Respiratory: Effort

<table>
<thead>
<tr>
<th>Unlabored</th>
<th>Dyspneic</th>
<th>Nasal Flaring</th>
<th>Abdominal</th>
<th>Stridor</th>
<th>Grunting</th>
<th>Retractions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular</td>
<td>Irregular</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lung sounds</th>
<th>RUL</th>
<th>RML</th>
<th>RLL</th>
<th>LUL</th>
<th>LLL</th>
<th>Clear</th>
<th>Decreased</th>
<th>Absent</th>
<th>Rales</th>
<th>Rhonchi</th>
<th>Wheezes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>O₂ therapy / O₂ saturation</th>
<th>None</th>
<th>O₂ therapy</th>
<th>lpm</th>
<th>%</th>
<th>NC</th>
<th>Mask</th>
<th>Oxihood</th>
<th>Saturation level</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cough / Respiratory Treatments</th>
<th>Nonproductive</th>
<th>Productive</th>
<th>tx’s</th>
</tr>
</thead>
</table>

* Impaired Gas Exchange

--Cardiovascular: Apical

<table>
<thead>
<tr>
<th>Regular</th>
<th>Irregular</th>
<th>S1</th>
<th>S2</th>
<th>PMI</th>
<th>Murmur</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Extremities: Capillary refill / peripheral pulses</th>
<th>&lt;</th>
<th>&gt;</th>
<th>seconds</th>
<th>R/L brachial</th>
<th>R/L radial</th>
<th>R/L dorsal pedalis</th>
</tr>
</thead>
<tbody>
<tr>
<td>R/L posterior tibial</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

NUR 2261L – Supporting Documents
Revised November 2013
### Monitors

- None
- Specify: ______________________
- O2 saturation
- Cardiorespiratory
- Other
- Alarm parameters verified and on

### *Alteration in tissue perfusion*

- None
- Present R/T ______________________

### Regulation:

#### Abdomen / LBM

- Soft
- Firm
- Rigid
- Distended
- Round
- Flat
- Tenderness / LBM
- Continent
- Incontinent

#### Diet

- RLQ
- RUQ
- LUQ
- LLQ
- + Present
- Absent
- Hyperactive
- Hypoactive

### Bowel sounds

- RLQ
- RUQ
- LUQ
- LLQ
- + Present
- Absent
- Hyperactive
- Hypoactive

### NG / GT

- None
- Specify: __________

### *Alteration in nutrition*

- None
- Present R/T ________________________
- Size
- Gravity
- Suction

### GU

- No problems
- Foley
- Dysuria
- Hematuria
- Frequency
- Continent
- Incontinent
- LMP

### Intravenous Fluids

- None
- Specify/solution & rate: ________________

### *Alteration in elimination*

- None
- For shift: total in __________ total out __________

### Mobility:

#### Muscle tone / strength / Range Of Motion

- Moves All Extremities Well
- Strength equal bilaterally UE and LE
- Weakness (Specify)
- Full Range Of Motion
- Limitations: __________

#### Gait / fall risk

- Steady
- Unsteady
- Pre-ambulatory
- Paralysis
- Describe

#### Functional ability

- Independent
- Total assistance
- Requires assistance (explain)

#### Casts / Assistance devices

- None
- Specify: ________________

### *Alteration in Mobility*

- None
- Present R/T ______________________

### *For abnormal findings, see additional notes*

**SN signature:**

---

**STATE AND PRIORITIZE 3 NURSING DIAGNOSES**

---

**NURSES NOTES:**

(APIE)

---

**SN Signature**
Maternal Newborn/Daily Holistic Assessment Tool DHAT (PILOT)

<table>
<thead>
<tr>
<th>STUDENT’S NAME</th>
<th>Date</th>
<th>ADMIT DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Initials</td>
<td>Age</td>
<td>Circle appropriate client(s) type: Antepartum Postpartum Newborn Labor Triage</td>
</tr>
<tr>
<td>Allergies:</td>
<td>Weight</td>
<td>Current Pounds gained in pregnancy: G P T P A L</td>
</tr>
<tr>
<td>Admission Diagnosis/Current Diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Diagnosis:</td>
<td></td>
<td>Isolation:</td>
</tr>
<tr>
<td>Pathophysiology (textbook reference):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mother**

<table>
<thead>
<tr>
<th>Initial Assessment</th>
<th>Time</th>
<th>Vital Signs: T:</th>
<th>P:</th>
<th>R:</th>
<th>BP:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensory / Perception / Cognition:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOC / Visual or auditory deficits</td>
<td>□ awake □ alert □ oriented □ asleep □ confused □ obtunded</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood</td>
<td>□ appropriate □ depressed □ anxious □ angry □ euphoric □ labile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td>□ cooperative □ uncooperative □ apprehensive □ agitated □ lethargic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech / Primary language</td>
<td>□ preverbal □ clear □ appropriate □ inappropriate □ aphasia □ impaired hearing □ deaf</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pupils</td>
<td>(L) ______mm □ brisk □ sluggish □ nonreactive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(R) ______mm □ brisk □ sluggish □ nonreactive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Pain</em></td>
<td>□ none □ Score: ____________ location: ____________ medicated Y* N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Growth &amp; Development</strong></td>
<td>Actual Stage: ______________________ vs. ______________________ (circle which one)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal/Infant Bonding</td>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal/Infant Bonding</td>
<td>______________ (observations)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cellular Integrity:</strong></td>
<td>Alteration in Skin Integrity □ none □ present R/T ______________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin temperature / moisture</td>
<td>□ warm □ cool □ cold □ dry □ moist □ diaphoretic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color / turgor</td>
<td>□ pink □ pale □ cyanotic □ mottled □ jaundiced □ acrocyanosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edema</td>
<td>□ none □ present □ location ______________________ pitting +1 +2 +3 +4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucous membranes</td>
<td>□ pink □ pale □ moist □ dry □ lesions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash / lesion / wound</td>
<td>□ none □ present □ describe ______________________ location ______________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incision/Wound</td>
<td>Abdomen: □ staples □ steri-strips □ clear dressing □ band-aid REEDA ______________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound/dressing order changes: ______________________ other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perineum</td>
<td>□ intact □ well approximated □ inflamed □ edematous □ ecchymosis □ hematomata</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td>□ yes □ no treatments: □ tucks □ ice pack □ sitz bath</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Alteration in Skin Integrity</em></td>
<td>□ none □ present R/T ______________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breasts</td>
<td>□ Soft □ filling □ engorged □ shields</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nipples</td>
<td>□ Intact □ cracked □ bleeding □ protruding □ flat □ inverted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding type</td>
<td>□ Breast □ Bottle □ Formula type ___________ on breast: right minutes __________, left minutes __________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAST FEED: Time __________ Amount __________ ml □ emesis: □ Yes □ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oxygenation:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory: Effort</td>
<td>□ unlabored □ dyspneic □ nasal flaring □ abdominal □ stridor □ grunting □ retractions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Regular □ irregular</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper airway: □ clear □ congested □ suctioning □ bulb syringe □ suction catheter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung sounds</td>
<td>□ RUL ______ □ RML ______ □ RLL ______ □ LUL ______ □ LLL ______</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Decreased Absent Rhonchi Wheezes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O₂ therapy / O₂ saturation</td>
<td>□ none □ O₂ therapy __________ Liters per minute / % □ NC □ Mask □ Oxyhood saturation level __________%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough / Respiratory Treatments</td>
<td>□ none □ nonproductive □ productive treatments: ______________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Impaired Gas Exchange</em></td>
<td>□ none □ present R/T ______________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular: Apical</td>
<td>□ regular □ irregular □ S1 □ S2 □ PMI location __________ □ Murmur /type __________ □ old □ new</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities Capillary refill / Peripheral pulses</td>
<td>&lt; &gt; __________ seconds {0 – 3} □ brachial R □ L □ radial R □ L □ dorsal pedalis R □ L □</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>posterior tibial R □ L □ femoral R □ L □ pedal R □ L □</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Reflexes/Human’s sign
- Deep Tendon Reflexes’ (flat, 1+, 2+, 3+, 4+, clonus):
  - Homan’s sign: □ R positive □ L positive □ R negative □ L negative

### Alteration in tissue perfusion
- Induration/Augmentation
  - Induction: □ yes □ no Pitocin started at: _______ ____/ml/hr = ______mU/min
  - Cervical ripening agent: □ none □ Cervidil □ Other ________
  - Amniotic fluid: color ______ odor: ________ □ AROM □ SROM time: ______

### Regulation:
- Abdomen / LBM
  - Soft □ flat □ distended □ firm □ rigid □ tenderness
  - Passing flatus / Last Bowel Movement: ______
  - Passing flatus
  - Fundus
    - Postpartum Fundus: □ firm □ boggy □ firm with massage
    - Fundal height: □ above umbilicus □ above umbilicus □ below umbilicus
      □ above umbilicus □ below umbilicus
    - Midline □ deviated from midline treatment: □ void □ catheter □ massage
  - Antepartum client fundal height: ________
  - Size = dates □ Y □ N

### Diet:
- % taken: Breakfast: ______ lunch: ______ dinner: ______

### Bowel sounds
- RUQ □ RLQ □ LUQ □ LLQ □ + present □ absent □ +++ hyperactive □ +/- hypoactive

### NG / OGT/GT
- No □ yes/specify: size: ______ gravity □ suction amount last 4 hrs: ______

### Mobility:
- Muscle tone / strength / ROM
  - Full ROM □ strength equal bilaterally □ upper extremities □ lower extremities
  - Weak □ Y □ N (specify) □ limitations: □ Y □ N (specify) ______

### Gait / fall risk
- Steady □ unsteady □ pre-ambulatory □ paralysis /describe________

### Functional ability
- Independent □ total assistance □ requires assistance (explain)

### Alteration in elimination
- None □ present □ R/T________

### Lochia
- Color: □ rubra □ serosa □ alba # pads/____ past 4 hrs

### Amount on pads
- □ light □ moderate □ heavy □ clots/describe________

### NEWBORN
- Birth Data: APGAR 1min: ____ APGAR 5 min _____ Birth weight: ______ Today’s wt: ______

### Hours OLD______
### Gestational Age______ /Weeks
- Axillary □ Rectal Temp: ______ Respiratory rate: ______ Apical pulse______
- Length: ______ Circumference of: Head ______ Chest ______ Abdomen ______

### Size:
- Appropriately for age □ AGA □ SGA □ LGA

### Activity Level
- Sleep □ awake □ alert □ quiet □ crying

### Tone
- Normal □ hypotonic □ hypertonic

### Head /Fontanels
- Caput □ cephalohematoma □ open □ soft □ closed □ flat □ sunken □ bulging □ tense
  - Sutures: □ normal □ closed □ overriding

### Cry
- Lusty □ weak □ high-pitched □ hoarse

### Color
- Pink □ pale □ jaundice □ ruddy □ acrocyanosis □ cyanotic □ circumoral cyanosis
  - Mottled □ dusky

### Skin
- Warm □ cool □ cold □ dry □ moist □ vernix □ elastic □ dehydrated
  - Edema □ peeling □ milia

### Skin: other Newborn Variations
- Clear □ petechiae □ erythema toxicum □ lesions □ pustules □ ecchymosis □ forceps mark
  - Bruised face □ Mongolian spots □ other Birthmarks where (explain): ______

### Lung Sounds/Respiratory Effort
- Clear □ regular □ irregular □ nasal flaring □ abdominal □ grunting □ retractions
  - Tachypnea □ shallow □ Upper airway: □ clear □ congested □ suctioned

### Cardiovascular/Apical Rhythm:
- Murmur: □ yes □ no □ new □ old □ capillary refill: □ brisk □ > 3 seconds
  - Regular □ irregular

### Peripheral pulses
- Strong □ equal □ weak

### Abdomen
- Bowel sounds: □ yes □ no □ soft □ flat □ firm □ rigid □ distended □ round □ tender
  - Cord care: □ dry □ drying □ moist

### Nutrition
- Breast □ Bottle □ Formula type: ________ FIRST FEEDING (date/time): ________
  - Latch □ good □ poor □ Suck □ good □ poor □ spitty □ emesis

---

**Student Name** __________________________  **Date** __________________

**NUR 2261L – Supporting Documents**

Revised November 2013
<table>
<thead>
<tr>
<th>GI:</th>
<th>Stools: □ meconium □ transitional □ green □ yellow □ soft □ formed □ watery □ seedy</th>
<th>Voiding □ yes □ no</th>
<th>Circumcision: □ yes □ no □ healing □ petroleum gauze: □ yes □ no</th>
</tr>
</thead>
<tbody>
<tr>
<td>GU:</td>
<td>Refluxes: □ Moro □ swallow □ suck □ root □ stepping □ babinski □ trunk incurrence □ grasp</td>
<td>Musculoskeletal Extremities: □ Neck normal □ chest normal □ breast/ nipple normal □ spine normal □ feet normal □ Symmetrical □ ROM normal □ digits normal □ creases normal □ symmetrical gluteal folds □ fractured clavicle/ arm</td>
<td></td>
</tr>
<tr>
<td>Procedures</td>
<td>Circumcision: □ yes □ no □ Phototherapy Care / treatments:___________________________</td>
<td>Pain: □ none □ Score: ______ □ location: __________________ □ medicated Y* □ N</td>
<td></td>
</tr>
<tr>
<td>Concerns</td>
<td>□ maternal fever □ newborn fever □ difficulty latching on □ ABO incompatibility □ RH incompatibility □ diabetic mother □ hypothermia □ other:</td>
<td>Teaching needs identified: Safety: Plan of care: Medications Pain management Newborn care Discharge instructions</td>
<td></td>
</tr>
<tr>
<td>STATE 3 NURSING DIAGNOSES (PRIORITIZED)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSES NOTES:</td>
<td>(SOAP)</td>
<td></td>
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</tr>
</tbody>
</table>

Student Nurse Signature and Title: __________________________
ADMISSION ASSESSMENT: COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (CHAT)

Client Initials: ___________ DOB: ___________ Age: ___________ Wt: ___________

Diagnosis: ____________________________________________  **attach daily assessment

**Patient Admission Information:

I. PERCEPTUAL / SENSORY / COGNITION

Communicating: pattern involving sending messages

Name preferred: _______________________________  Sex: ______  Age: ______  Date: ______
Informant: Patient  Parent  Spouse  Other  Admitted from: Home  ED  OR  Other
At time of interview patient is: alert  appropriate  relaxed  agitated  anxious  tearful  sleepy  other
Primary language: ____________________________  Interpreter needed: ______________________

Relating: pattern involving established bonds

Role: marital status, children, parents, siblings: __________________________________________
Significant others / Primary caregiver: ________________________________________________
Lives with: _______________________________________________________________________
Recent changes in family:  No  if Yes, explain: __________________________________________
History of physical / sexual / emotional abuse: ________________  Do you feel safe at home? ___________
Are you in a relationship in which you or your child have been hurt or threatened? ________
In the past year, has someone close to you hit, kicked, punched, slapped, or shoved you or your child?

Occupation / Educational experience: _________________________________________________
Patient / parent concern related to role responsibilities (school, work, financial, caregiver):

Socialization / support systems: ______________________________________________________

Valuing: pattern involving spiritual growth

Religious preference: ____________________________  Spiritual needs: _______________________
Cultural preferences / needs: ________________________________________________________

Knowing: pattern involving the means associated with information

Medical History:
Chief complaint: _________________________________________________________________

Previous / Ongoing Health problems (symptoms, length of illness, treatment) __________________________________

Previous Hospitalizations / Surgery ___________________________________________________

Immunizations: Up to date  Needs __________________
Infectious Disease Exposure: None  Chicken Pox  Rubella  Measles  Mumps  TB  Hepatitis
List all medications in use (prescription, OTC, herbals) – see attached medication sheet
List all allergies (medications, food, environment and reaction)

<table>
<thead>
<tr>
<th>Medication / Food / Environment</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Risk factors: (smoking, family history, etc.):

Substance use: Alcohol (type) ___________________________ drinks/day  Cigarettes: ___________________________ per day
Illicit drug use: ___________________________ Rx drug use: ___________________________

Perception / Knowledge of Health / Illness:

Readiness to learn (ready, willing, and able):

Comprehension: Ability to grasp concepts and respond to questions: HIGH MEDIUM LOW
Motivational Level: asks questions eager to learn anxious uninterested uncooperative disinterested denies need for education
Memory: No problem Limited short term memory Limited long term memory
Learning Barriers: None Language Cultural / Religious Emotional Hearing Vision Dexterity

Describe: ___________________________

Feeling: pattern involving the subjective awareness of information
Comfort / Pain: (Is patient in pain? Chronic? Acute? What methods relieve pain, provide comfort?): ___________________________

Emotional Integrity: (lonely, sad, depressed, angry, joy):

Perceiving: pattern involving the reception of information:
Sensory Perception: (Able to receive information via all senses? Deficits noted?): ___________________________

Visual: ___________________________ Contacts: ___________________________ Eyeglasses: ___________________________
Hearing: ___________________________ Earaches: ___________________________ Hearing Aids: ___________________________

Choosing: pattern involving the selection of alternatives
Coping / Stress Management Measures:

Support systems:

II. MOBILITY
Moving: pattern involving activity
See daily assessment for physical assessment component
Functional ability: (independent, if not specify deficits and needs):

Assistive devices required: ___________________________
Orthopedic equipment: ___________________________
Physical Therapy: ___________________________
Age related hazards of mobility: ___________________________
Fall Risk: ___________________________
Recreation / Play: ___________________________
Self care: ___________________________
III. OXYGENATION
See daily assessment for physical assessment component
Home nebulizer / O2 / CR monitor: ________________________________

IV. CELLULAR INTEGRITY
See daily assessment for physical assessment component
Skin integrity risk factors: none   obesity   incontinent urine/feces   emaciated   immobility   prematurity   altered LOC   altered sensation   breakdown present   Home treatment plan: ________________________________

V. REGULATION
Exchanging: pattern involving mutual giving and receiving
See daily assessment for physical assessment component
Recent weight loss or gain: ________________________________
Therapeutic diet: ________________________________
Dietary restrictions: ________________________________
Suck quality: __________ Loose teeth: __________ Dentures: __________ Problems: __________
Sleep patterns: ________________________________
Sexually active: __________ Sexual preference: _____
Birth Control: __________ Problems: __________
LMP: _______ Menarche (age): _______ Menopause (age): _______ BSE: _______ Difficulties: _______
Reproductive History: # of pregnancies: _______ # of births: _______ # of living children: _______
Problems: ________________________________
Testes: _______ TSE: _______ Circumcised: __________ Problems: ________________________________

Additional Comments: ________________________________
____________________________________
____________________________________
Discharge Plan: ________________________________
____________________________________
____________________________________
**DEVELOPMENTAL ASSESSMENT**

Patient Initials: _________   Age: _________

Circle current age and mark + or - if -, refer for further assessment.

<table>
<thead>
<tr>
<th>Neonate (&lt;28 days)</th>
<th>2 months</th>
<th>4 months</th>
<th>6 months</th>
<th>9 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal / birth history</td>
<td>___ regards smile</td>
<td>___ social smile</td>
<td>___ playful</td>
<td>___ shy</td>
</tr>
<tr>
<td>gestation</td>
<td>___ follows to midline</td>
<td>___ follows 180'</td>
<td>___ resists toy pull</td>
<td>___ works for toy</td>
</tr>
<tr>
<td>birth wt: ____ length: ___</td>
<td>___ coos</td>
<td>___ laughs</td>
<td>___ babbles</td>
<td>___ mama, dada</td>
</tr>
<tr>
<td>apgars: ____ unknown</td>
<td>___ clear airway in prone</td>
<td>___ lifts head 90' in prone</td>
<td>___ no head lag</td>
<td>___ crawls</td>
</tr>
<tr>
<td>jaundiced ____ / apnea ____</td>
<td>___ cuddle to shoulder when held</td>
<td>___ rolls over</td>
<td>___ sits with support</td>
<td>___ sits alone</td>
</tr>
<tr>
<td>umbilicus / cord: ___ fresh/moist ___</td>
<td>Diet: ___ breast ___ formula (type)</td>
<td>___ reaches and grasp objects</td>
<td>___ transfers objects</td>
<td>___ finger feeds</td>
</tr>
<tr>
<td>dry ___ weeping ____ red ____</td>
<td>___ cereal ___ fruits ___ vegetables ___ other ____ (specify)</td>
<td></td>
<td>___ bears weight</td>
<td>___ pulls to stand</td>
</tr>
<tr>
<td>healed ____ hernia ____</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet: ___ breast ___ formula (type)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ alert ____ responds to auditory stimuli ____ smiles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 months</td>
<td>15 months</td>
<td>18 months</td>
<td>24 months</td>
<td>2 ½ years</td>
</tr>
<tr>
<td>___ follows simple commands</td>
<td>___ drinks from cup</td>
<td>___ uses spoon independently</td>
<td>___ climb stairs</td>
<td>___ imitate vertical line</td>
</tr>
<tr>
<td>___ peek-a-boo</td>
<td>___ walks well</td>
<td>___ kicks, throws ball</td>
<td>___ name 3 – 6 body parts</td>
<td>___ jumps in place</td>
</tr>
<tr>
<td>___ bangs to cubes</td>
<td>___ plays ball</td>
<td>___ 25 word vocabulary</td>
<td>___ 50 word vocabulary</td>
<td>___ identifies 1 color</td>
</tr>
<tr>
<td>___ spoon feed / minimal spillage</td>
<td>___ 5-7 words</td>
<td>___ 2 word phrases</td>
<td>___ 2-3 word sentences</td>
<td>___ puts on simple clothing</td>
</tr>
<tr>
<td>___ finger tip pinch</td>
<td>___ scribbles</td>
<td>___ turns pages in book</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>___ walk with support</td>
<td>___ object permanence</td>
<td>Diet: ___ (type)</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Diet: ___ breast ___ formula (type)</td>
<td>___ bottle ___ cup</td>
<td></td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>___ cows milk (whole)</td>
<td>___ bottle ___ cup</td>
<td></td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>___ cereal ___ fruits ___ veg ___ table food (specify)</td>
<td>___</td>
<td></td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td>4 years</td>
<td>5 years</td>
<td>6 years</td>
<td>7 years</td>
</tr>
<tr>
<td>___ copies circle</td>
<td>___ copies square</td>
<td>___ connects dots</td>
<td>___ counts 13 objects</td>
<td>___ copies</td>
</tr>
<tr>
<td>___ says first &amp; last name</td>
<td>___ dresses self</td>
<td>___ draws 8 part man</td>
<td>___ knows AM/PM</td>
<td>___ repeat 3 words</td>
</tr>
<tr>
<td>___ rides tricycle</td>
<td>___ draws 3 part man</td>
<td>___ prints name</td>
<td>___ knows colors</td>
<td>___ backwards</td>
</tr>
<tr>
<td>___ 4 word sentences</td>
<td>___ knows colors</td>
<td>___ skips</td>
<td>___ likes to draw</td>
<td>___ tells time</td>
</tr>
<tr>
<td>___ plays ball</td>
<td>___ 5-7 word sentences</td>
<td>___ 5 – 8 word sentences</td>
<td>___ colors in lines</td>
<td>___ brush / comb hair</td>
</tr>
<tr>
<td>___ plays colors</td>
<td>___ plays cooperatively</td>
<td>___ express independent ideas</td>
<td>___ express independent ideas</td>
<td>___ uses table knife</td>
</tr>
<tr>
<td>___ control over bladder and bowels</td>
<td>___ uses table knife</td>
<td>___ plays well with others</td>
<td>___ __ hand dominance</td>
<td></td>
</tr>
<tr>
<td>___ buttons up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 – 9 years</td>
<td>10 – 12 years</td>
<td>12 – 14 years</td>
<td>14 – 16 years old</td>
<td>Character of pain</td>
</tr>
<tr>
<td>___ dresses self completely</td>
<td>___ uses telephone</td>
<td>___ problem solving skills</td>
<td>___ possible sexual experimentation</td>
<td>○ sharp</td>
</tr>
<tr>
<td>___ counts backwards from 20</td>
<td>___ simple paintings</td>
<td>___ egocentric</td>
<td></td>
<td>○ dull</td>
</tr>
<tr>
<td>___ knows days of the week</td>
<td>___ wash / dry hair</td>
<td>___ computer / TV are popular</td>
<td>___ abstract thinking</td>
<td>○ throbbing</td>
</tr>
<tr>
<td>___ knows current month and date</td>
<td>___ demonstrates affection</td>
<td>___ likes to listen to music</td>
<td>___ worries about school work</td>
<td>○ aching</td>
</tr>
<tr>
<td></td>
<td>___ likes to talk</td>
<td>___ talks to friends</td>
<td>___ worries about school work</td>
<td>○ constant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>___ withdraws when hurt</td>
<td>○ burning</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>○ intermittent</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Location: ___</td>
</tr>
</tbody>
</table>

As appropriate for each age determine:

* dietary patterns and needs: ____________________________
  * comfort measures: ____________________________
  * safety issues: ____________________________
  * educational needs: ____________________________
  * other: ____________________________________________
  * referral necessary: ____________________________

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>Relaxed or smile</td>
<td>Occasional grimace, frown, withdrawn</td>
<td>Frequent frown, clenched jaw, quivering chin</td>
</tr>
<tr>
<td>Legs</td>
<td>Relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking or legs drawn up</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, moves easily</td>
<td>Squirming, tense</td>
<td>Arched, rigid, or jerking</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Moans, whimper, occasional complaints</td>
<td>Crying, sobbing, screams, frequent complaints</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content or relaxed</td>
<td>Easy to console, distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

Each of the five categories is scored from 0-2, resulting in a total of 0-10

**Pain Scale**

<table>
<thead>
<tr>
<th>Numeric scale</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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</thead>
<tbody>
<tr>
<td><strong>Pain Scale</strong></td>
<td></td>
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</tbody>
</table>

0 No Hurt
1 Hurts Little Bit
2 Hurts Little More
3 Hurts Even More
4 Hurts Whole Lot
5 Hurts Worst

NUR 2261L – Supporting Documents
Revised November 2013
<table>
<thead>
<tr>
<th>TEST</th>
<th>RESULTS</th>
<th>NORMALS</th>
<th>DATES</th>
<th>REASON FOR TEST Specific to this patient</th>
<th>NURSING SIGNIFICANCE/EXPLANATION OF ABNORMAL VALUES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
**NUR 2261L: Supporting Documentation**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Planning Goal</th>
<th>Implementation</th>
<th>Rationale</th>
<th>Evaluation (Goal Met)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pertinent Data:</td>
<td>Patient Will:</td>
<td>Nurse Will:</td>
<td>Why:</td>
<td>What Happened:</td>
</tr>
<tr>
<td>Subjective:</td>
<td>(What did client say – use direct quotations)</td>
<td>(Specific/Measurable)</td>
<td>Nursing Interventions</td>
<td>Reason for Interventions</td>
</tr>
</tbody>
</table>

**Subjective:**

(What did client say – use direct quotations)

**Objective:**

(What did you see/hear/smell/feel – list findings)
## PEDIATRIC MEDICATION SHEET

<table>
<thead>
<tr>
<th>PATIENT:</th>
<th>WT:</th>
<th>DATE:</th>
<th>STUDENT:</th>
<th>Medication</th>
<th>Dose</th>
<th>Time</th>
<th>Route</th>
<th>Mechanism of Action</th>
<th>Reason Given Specific to this patient</th>
<th>Major Side Effects</th>
<th>Nursing Measures / Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Trade:</td>
<td>Ordered:</td>
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<td></td>
<td>Generic:</td>
<td>Therapeutic</td>
<td></td>
<td></td>
<td>mg/kg/24 hr</td>
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<td></td>
<td>Classification:</td>
<td>Therapeutic</td>
<td></td>
<td></td>
<td>mg/kg/24 hr</td>
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<td>Trade:</td>
<td>Ordered:</td>
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5/07tpw
### MATERNAL – CHILD LABWORK AND DIAGNOSTIC STUDIES to be utilized with RN2

Other Pertinent: Add additional labs that are patient specific, for example PIH labs, when applicable.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TEST</th>
<th>RESULTS</th>
<th>NORMAL VALUES</th>
<th>INTERPRETATION</th>
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<td>WHAT do you think caused these values? WHAT is the significance of these values? WHAT are you going to do about these findings?</td>
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<td>Pregnancy spacing, EBL, sickle cell anemia, thalassemia, iron deficiency?</td>
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LABOR CHARTING WORKSHEET: PLEASE INCLUDE NOTES ON EACH LABOR PHASE!

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<th>Fetal / Uterine Monitor Mode &amp; Uterine Position</th>
<th>Epidural</th>
<th>BP</th>
<th>DTR’s</th>
<th>VE</th>
<th>Pitocin mU/min &amp; cc/hr</th>
<th>FH Baseline</th>
<th>FH Variability</th>
<th>Periodic Changes</th>
<th>Episode Changes</th>
<th>Contraction Frequency</th>
<th>Contraction Duration</th>
<th>Contraction Intensity</th>
<th>Uterine Relaxation/Tone</th>
<th>Stage</th>
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Flow Sheet Charting Codes / Guideline

**Monitor** = I for Internal, E for External (For example, I/E = Internal Fetal & External Uterine)

**Epidural** = Yes or No & list meds used in the spaces (one med per space)

**DTR’s** = +1, +2, +3, +4, or clonus

**VE** = Vaginal Exam (for example 8/100/0)

**Pitocin** = must chart in mU/min as well as cc/hr (for example in the space you would record, according to concentration, 24cc/8mU)

**FH Baseline** = Fetal Heart Baseline, this should NOT be a range but one number

**FH Variability** = Absent - undetectable, Minimal < 5, Moderate 6-25, Marked > 25

**Periodic Changes** = Related to contractions, describe in seconds whether accels or decels

**Episodic Changes** = Not related to contractions, describe in seconds whether accels or decels

**Contraction Frequency** = Time from beginning of one contraction to beginning of next contraction, could vary, q2m to q2-4 m

**Contraction Duration** = Time in minutes & seconds that contraction lasts

**Contraction Intensity** = External uterine monitor, charted as mild, moderate or strong. CAN NOT use mm/Hg unless an IUPC is in place, if so chart contraction strength in mm/Hg

**Uterine Relaxation/Tone** = Time in minutes & seconds that uterus rests between contractions, usually determined by subtracting contraction duration from contraction frequency

**Variability**

- Absent - undetectable
- Minimal > undetectable but < 5 bpm
- Moderate 6-25 bpm
- Marked >25 bpm

**FH Accelerations**

- >15 bpm lasting >15 seconds (15x15)

**FH Decelerations**

- Variable – cord compression
- Late – placental insufficiency
- Early – head compression

**Comments**

Include nursing interventions, comfort measures, medications, deceleration treatment measures, O2, Practitioner visits, position changes etc.

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**Stage 1**

- Phase 1 – latent (0-3cm)
- Stage 2
  - Fully dilated / 10cm to deliver of infant
  - Stage 3
    - Delivery of infant to delivery of placenta

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NUR 2261L – Supporting Documents
Revised November 2013