# NRS 225 College Lab/Clinical Manual Spring 2020

## Weekly Course Outline*

| Week - Theory Class Date | Focus Concepts | Assessment |
|---|---|---|
| 1 – January 21, 2020 | Oxygenation/Acid-Base<br>**Course Introduction Quiz**<br>**Dosage Calculation Exam** | **vSim: Jennifer Hoffman due on 1/27/20****<br>**Due: 1/27/2020**<br>**Due: 1/28/2020** |
| 2 – January 28, 2020<br>**Peer Mentoring #1** | Perfusion | |
| 3 – February 4, 2020 | Digestion/Elimination | **Exam #1** |
| 4 – February 11, 2020 | Fluid & Electrolyte | |
| 5 – February 18, 2020 | Cellular Regulation | **vSim: Doris Bowman due on 2/24/20** |
| 6 – February 25, 2020 | Immunity/Inflammation/Infection<br>**HESI Case Study** | **Exam #2**<br>**1) The role of the School Nurse due on 2/28/20** |
| 7 – March 3, 2020<br>**Peer Mentoring #2** | Metabolism/Thermoregulation<br>**HESI Exam** | **Fundamentals V2: 3/5/20 & 3/9/20 during lab** |
| 8 – March 10, 2020 | Mobility/Comfort | **vSim: Lloyd Bennett due on 3/13/20** |
| **Spring Break: 3/16/20-3/22/20** | | |
| 9 – March 24, 2020 | Sensory Perception/ Cognition<br>**HESI Case Studies** | **Exam #3**<br>**2) Psychosis due on 3/25/20**<br>**3) Schizophrenia due on 3/27/20** |
| 10 – March 31, 2020<br>**Peer Mentoring #3** | Mental Health- Stress & Coping<br>**HESI Exam**<br><br>**HESI Case Study** | **vSim: Vincent Brody due on 4/1/20**<br>**Mental Health V1: 4/2/20 & 4/6/20**<br><br>**4) Feeding/Eating Disorders due on 11/3/19** |
| 11 – April 7, 2020 | Mental Health- Violence & Sexuality | **Exam #4** |
| 12 – April 14, 2020 | Mental Health- Addiction & Development<br>**HESI Case Study** | **5) Depression due on 4/17/20** |
| 13– April 21, 2020 | Mental Health- Mood/Affect | **Exam #5** |
| 14- April 28, 2020 | **HESI Exam** | **Mental Health V2: 4/28/20** |
| **Final Exam 5/6/20** | | **Final Exam*** (Room and time to be announced on blackboard)** |

***Weekly course outline, test, and assignment dates are subject to change at instructor's discretion**
****See Course Calendar/Blackboard for exact due dates for *all* assessment methods**
*****Tentative date and subject to change with advance notice**

## College lab:

College lab will consist of discussion which will focus on patient-centered care, teamwork and collaboration, and evidence-based practice guidelines regarding the conceptual approach to the care of clients with a variety of alterations. Students can expect to work using simulated and written case scenarios along with video and live demonstration of skills. Students are expected to return a demonstration of each skill and utilize any available opportunity in the clinical setting to further enhance proficiency of said skill.

Students will be submitting dosage calculations problems at each college laboratory as their ticket to lab. Please review the Medication Calculation Guidelines on the next page as you are expected to complete the problems adhering to these guidelines. These dosage calculation problems are posted on blackboard under the corresponding week's concept.

Please see preparation for college lab written below.

## Clinical:

Please review this manual for all clinical-reasoning enhancement activities. It is strongly recommended students complete these activities at clinical if there is time. Many activities can be completed once clinical is complete. Please reflect on your clinical practice if completing the activities after leaving the clinical site.

## Preparation for college lab/clinical:

1. Review course syllabus related to the current week

2. Review skills textbook as it relates to the current week's lab

3. Bring necessary equipment (stethoscope, blood pressure cuff, penlight) to every skills lab

4. Bring a calculator and pencil for dosage calculation practice (college lab only)

5. Attend all lab/clinical sessions and arrive on time. Please review the course syllabus for instructions regarding a missed lab session and review the policy regarding being absent/late

6. Bring this manual to both lab and clinical

7. Previously learned skills will be reinforced at most college laboratory meetings

# *Mercer County Community College*

# *Division of Health Professions*

# *Nursing Program*

## Medication Calculation Guidelines

1. If weight conversion is needed (pounds/kilograms), calculate that as separate problem first.
2. Convert all items to equal units prior to working problem, if needed.
3. Do not round until the end of the problem.
4. Manual drip rates are always reported in whole numbers.
5. All questions should specify rounding requirements for the answer.
6. Infusion pumps can be rounded to the nearest tenth.
7. Five and up, round up. Four and below, round down.
8. No method of calculation (ratio/proportion, dimension analysis, etc.) is preferred; any is acceptable if the right answer is reached.
9. No half credit is given. If the answer is not rounded correctly or not answered to the requested decimal place, the question is marked incorrect.
10. Trailing zeros are prohibited, e.g. 1.0
11. Leading zeros are required, e.g. 0.1.
12. Label all answers with the correct unit.

# Laboratory Reference Ranges Appendix

NCLEX expects that you can identify normal laboratory values and compare to client laboratory values. The following list is outlined in the NCLEX Detailed Test Plan. **Memorize these normal values; you will be tested on them**. The values listed below are normal adult values.

| Arterial Blood Gasses (ABGs) | |
|---|---|
| pH | 7.35-7.45 |
| PO2 | 80-100 mmHg |
| PaCO2 | 35-45 mmHg |
| SaO2 | Equal or greater than 95% |
| HCO3 | 22-26 mEq/L |

| Basic Metabolic Panel (BMP) | |
|---|---|
| Sodium (Na+) | 135-145 mEq/L; panic value is less than 115mEq/L |
| Potassium (K+) | 3.5-5.0 mEq/L |
| Glucose | 70-105 mg/dL **(fasting)** |
| Creatinine (Cr) | 0.5-1.5 mg/dL |
| Blood Urea Nitrogen (BUN) | 5-25 mg/dL |
| | |

| Complete Blood Count (CBC) | |
|---|---|
| Hematocrit (Hct) | Male: 40%-54%, Female 36%-46% (Concern for values less than 15% or more than 60% |
| Hemoglobin (Hgb) | Male 13.5-18 g/dL, Female 12-15 g/dL |
| Platelets (Plt) | 150,000-400,000 µl |
| White blood cells (WBC) | 4.5-10 µL |

| Coagulation Studies | |
|---|---|
| Prothrombin time (PT) | 10-15 seconds |
| Partial Thromboplastin Time (PTT) | 60-70 seconds |
| Activated Partial Thromboplastin Time (aPTT) | 20-35 second |
| INR: With oral anticoagulant therapy | 2.0-3.0 INR |
| INR: No anticoagulant therapy | 0.8-1.2 INR |

| Other Studies | |
|---|---|
| Cholesterol (total) Adult desirable levels | Less than 200 mg/dL |
| Glycosylated hemoglobin (HgbA1C) | Non diabetic: less than 5.7%<br>Prediabetes: 5.7% - 6.4%<br>Diabetic: 6.5% or greater |

# WEEK 1: Oxygenation

**Skills Lab:**

- Review of the nursing process as it relates to the care of clients with an alteration in oxygenation

**Clinical:**

- Relate the multisystem effects of the client with an alteration in oxygenation

**Clinical reasoning activities**

**Part 1 Instructions:** Perform an oxygenation assessment interview on *each* client using the following as a guide for interviewing.

*Current Respiratory Problems*

- Have you noticed any changes in your breathing pattern (e.g., shortness of breath, difficulty breathing, need to be in an upright position to breathe, or rapid and shallow breathing)?
- If so, which of your activities might cause these symptoms to occur?
- How many pillows do you use to sleep at night?

*History of Respiratory Disease*

- Have you had colds, allergies, asthma, tuberculosis, bronchitis, pneumonia, or emphysema?
- How frequently have these occurred? How long did they last? And how were they treated?
- Have you been exposed to any pollutants?

*Lifestyle*

- Do you smoke? If so, how much? If not, did you smoke previously, and when did you stop?
- Does any member of your family smoke?
- Is there cigarette smoke or other pollutants (e.g., fumes, dust, coal, asbestos) in your workplace?
- Do you drink alcohol? If so, how many drinks (mixed drinks, glasses of wine, or beers) do you usually have per day or per week?
- Describe your exercise patterns. How often do you exercise and for how long*?*

*Presence of Cough*

- How often and how much do you cough?
- Is it productive, that is, accompanied by sputum, or nonproductive, that is, dry?
- Does the cough occur during certain activity or at certain times of the day?

*Description of Sputum*

- When is the sputum produced?
- What is the amount, color, thickness, and odor of the sputum?
- Is it ever tinged with blood?

*Presence of Chest Pain*

- How does going outside in the heat or the cold affect you?
- Do you experience any pain with breathing or activity?
- Where is the pain located?
- Describe the pain. How does it feel?
- Does it occur when you breathe in or out?

- How long does it last, and how does it affect your breathing?
- Do you experience any other symptoms when the pain occurs (e.g., nausea, shortness of breath or difficulty breathing, light-headedness, palpitations)?
- What activities precede your pain?
- What do you do to relieve the pain?

*Presence of Risk Factors*

- Do you have a family history of lung cancer, cardiovascular disease (including strokes), or tuberculosis?
- The nurse should also note the client's weight, activity pattern, and dietary assessment. Risk factors include obesity, sedentary lifestyle, and diet high in saturated fats.

*Medication History*

- Have you taken, or do you take any over-the-counter or prescription medications for breathing (e.g., bronchodilator, inhalant, narcotic)?

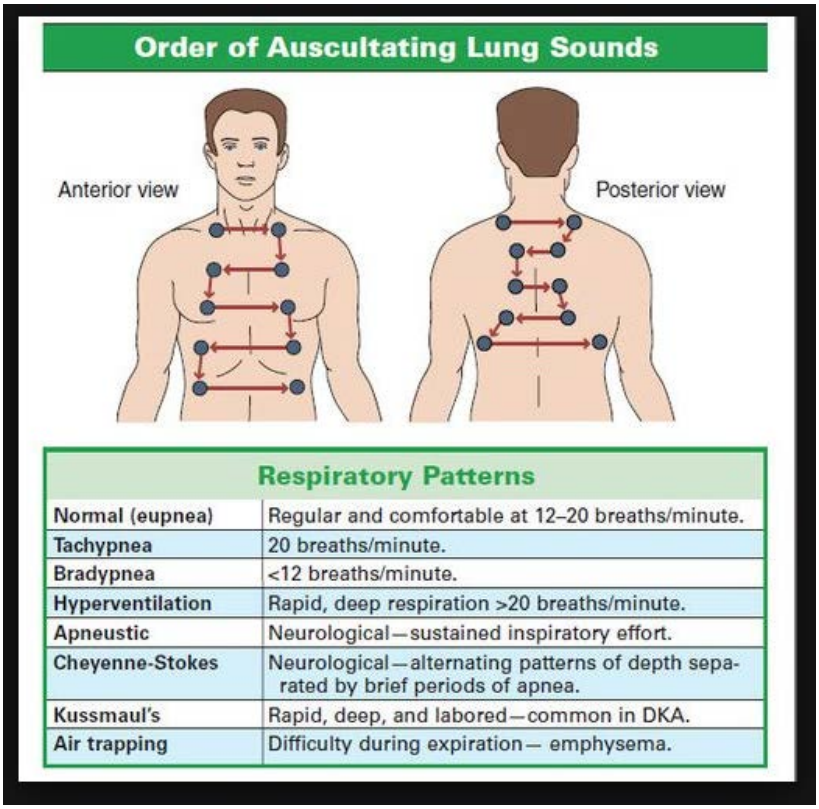
If so, which ones? And what are the dosages, times taken, and results, including side effects? Are you taking them exactly as directed?

**Part 2 Instructions:** Identify the client who is most at risk for alterations in oxygenation and develop at least three priority interventions for the client. Provide rationale for each intervention.

1.

2.

3.



# Week 2: Perfusion

**Skills Lab:**

- Review of the nursing process as it relates to the care of clients with an alteration in perfusion

**Clinical:**

- Relate the multisystem effects of the client with an alteration in perfusion

**Clinical reasoning activities**

**THE BEAT GOES ON: ASSESSING PERFUSION**

The purpose of this activity is to review assessment features of the circulatory system.

**Related Concept Learning Outcomes**

1. Perform common procedures used to assess the pulse.
2. Identify client risk factors related to the cardiovascular system.

**Instructions**: Complete the following:

1. Identify modifiable and non-modifiable risk factors for cardiovascular alterations. Identify whether any of these risk factors apply to your assigned client and interventions to address the risk factors.

| **Modifiable Risk Factors** | **Apply to Your Client?** | | **Non-modifiable Risk Factors** | **Apply to Your Client?** | | **Interventions for Client** |
|---|---|---|---|---|---|---|
| | **yes** | **no** | | **yes** | **no** | |
| | | | | | | |
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| | | | | | | |
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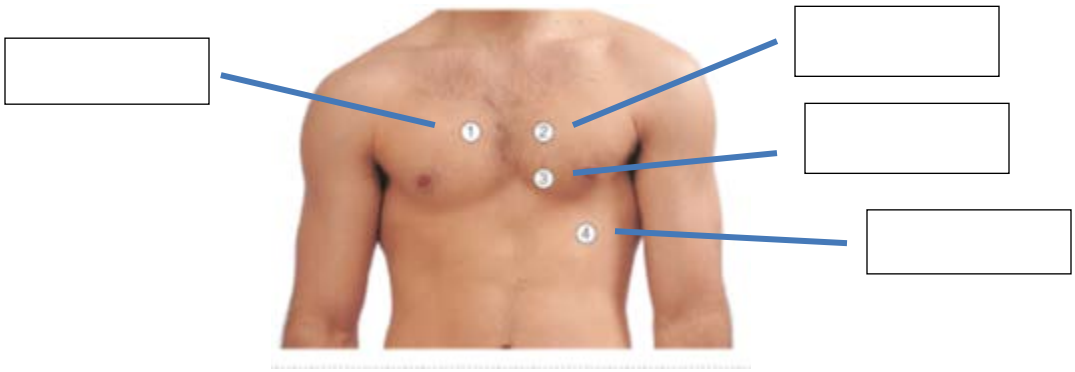
| | | | | | | |
| | | | | | | |

| **Factor Affecting Pulse** | **What Effect** | **Does Effect Impact Your Client?** |
|---|---|---|
| Age | | |
| Gender | | |
| Exercise | | |
| Fever | | |

| | | |
|---|---|---|
| Medications | | |
| Hypovolemia | | |
| Stress | | |
| Position changes | | |
| Disease pathology | | |

2. Identify what normal impact the following factors have on the pulse rate of an individual. Indicate if it is a factor that affects the pulse rate of your assigned client.

3. Label the following with which heart valve is auscultated at each site.

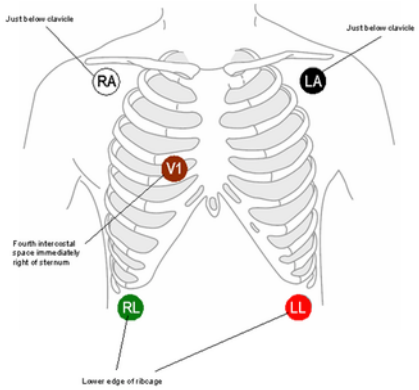


4. Auscultate the heart sounds for three clients at the above sites. Highlight any abnormal findings.

| | **Client 1** | **Client 2** | **Client 3** |
|---|---|---|---|
| $S_1$ | | | |
| $S_2$ | | | |
| Extra sounds | | | |
| Heart murmur | | | |

**Grading systolic murmurs**

| Intensity | Description |
|---|---|
| Grade I/VI | Barely audible |
| Grade II/VI | Audible, but soft |
| Grade III/VI | Easily audible |
| Grade IV/VI | Easily audible and associated with a thrill |
| Grade V/VI | Easily audible, associated with a thrill, and still heard with the stethoscope only lightly on the chest |
| Grade VI/VI | Easily audible, associated with a thrill, and still heard with the stethoscope off of the chest |




***Important Reminders:***

DO make sure the V lead (brown electrode) is in the intercostal space and not over the sternum or rib

DO make sure the red and green electrodes are placed below the rib cage

DO NOT place electrodes over pacemakers or implanted defibrillators

# Week 3: Digestion & Elimination

**Skills Lab:**

- Review of the nursing process as it relates to the care of clients with an alteration in digestion and elimination

**Clinical:**

- Relate the multisystem effects of the client with an alteration in digestion and elimination

**<u>Clinical reasoning activities:</u>**

**Elimination**

The purpose of this activity is to identify actual or potential elimination alterations related to a client's medical diagnosis and analyze the presence of client signs and symptoms related to the alteration in elimination.

**Related Concept Learning Outcomes**

1. Identify commonly occurring alterations in elimination and their related therapies.

2. Examine the relationship between elimination and other concepts/systems.

**Part 1 Instructions:** Compare different diagnoses of the clients in the clinical assignment. Identify the clients' risk factors for alterations in elimination based on their medical diagnosis only. Include both urine and bowel elimination alterations. Fill in the table below.

| **Client Diagnosis** | **Risk Factors for Alterations in Elimination** |
|---|---|
| Example: Total Hip Arthroplasty | Decreased mobility and use of narcotics may cause constipation and decrease bladder function. Immobility can also cause urinary stasis, urinary infections and renal calculi. |
| | |

| | |
|---|---|
| | |
| | |
| | |

**Part 2 Instructions:** Identify all present signs and symptoms of alterations in elimination. Fill out the third column on the table below.

| **Client Diagnosis** | **Risk Factors for Alterations in Elimination** | **Present Sign and Symptoms of Alteration in Elimination** |
|---|---|---|
| Example: Total Hip Arthroplasty | Decreased mobility and use of narcotics may cause constipation and bladder function. Immobility can also cause urinary tract infections and renal calculi. | Client has hypoactive bowel sounds and has not had a bowel movement since surgery 2 days ago. |
| | | |
| | | |
| | | |

# Week 4: Fluid & Electrolyte

**Skills Lab:**

- Review of the nursing process as it relates to the care of clients with a fluid and electrolyte imbalance

**Link the concepts:**

- Describe the pathophysiology of fluid and electrolyte balance and how it impacts perfusion.
- What measures could you implement to promote fluid balance when caring for a client with heart failure?
- Describe the pathophysiology of fluid and electrolyte balance and how it impacts elimination.
- What assessment findings would you expect to see when a client with benign prostatic hypertrophy experiences an alteration in fluid balance?
- Describe the pathophysiology of fluid and electrolyte balance and how it impacts tissue integrity.

**Clinical:**

- Relate the multisystem effects of the client with a fluid and electrolyte imbalance

**<u>Clinical reasoning activities:</u>**

**A LITTLE OFF BALANCE: Part 1**

**Associated Concepts:**

Fluid and Electrolytes

The purpose of this activity is to determine priority nursing diagnoses and identify rationale for each diagnosis.

**Related Concept Learning Outcomes**

1. Demonstrate the nursing process in providing culturally competent and caring interventions across the life span for individuals with common alterations in fluid and electrolyte balance.

2. Compare and contrast common independent and collaborative interventions for clients with alterations in fluid and electrolyte balance.

**Client Diagnosis:**

**Part 1 Instructions:** The nursing diagnoses listed below are related to fluid and electrolyte balance. Choose the diagnoses that are appropriate for your assigned client and provide the "related to" sections for each.

__ Deficient Fluid Volume related to_____.

__ Ineffective Peripheral Tissue Perfusion related to _____.

__ Risk for Injury related to _____.

__ Confusion related to _____.

__ Activity Intolerance related to _____.

__ Excess Fluid Volume related to _____.

__ Risk for Impaired Skin Integrity related to _____.

__ Risk for Impaired Gas Exchange related to _____.

__ Activity Intolerance related to _____.

__ Ineffective Health Maintenance related to _____.

__ Risk for Electrolyte Imbalance related to _____.

__ Decreased Cardiac Output related to _____.

__ Imbalanced Nutrition: Less Than Body Requirements related to _____.

__ Ineffective Renal Tissue Perfusion related to _____.

__ Risk for Altered Cardiac Perfusion related to_____.

__ Risk for Infection related to _____.

__ Compromised Family Coping related to_____.

**A LITTLE OFF BALANCE: Part 2**

**Associated Concepts:**

Fluid and Electrolytes

The purpose of this activity is to determine priority nursing diagnoses, identify rationale for each diagnosis and supporting client signs and symptoms, and identify priority nursing interventions for three priority diagnoses.

**Related Concept Learning Outcomes**

1. Demonstrate the nursing process in providing culturally competent and caring interventions across the life span for individuals with common alterations in fluid and electrolyte balance.

2. Compare and contrast common independent and collaborative interventions for clients with alterations in fluid and electrolyte balance.

**Client Diagnosis:**

**Part 1 Instructions:** The nursing diagnoses listed below are related to fluid and electrolyte balance. Choose the diagnoses that are appropriate for your assigned patient and provide the "related to" sections for each.

__ Deficient Fluid Volume related to _____.

__ Ineffective Peripheral Tissue Perfusion related to _____.

__ Risk for Injury related to _____.

__ Confusion related to _____.

__ Activity Intolerance related to _____.

__ Excess Fluid Volume related to _____.

__ Risk for Impaired Skin Integrity related to _____.

__ Risk for Impaired Gas Exchange related to _____.

__ Activity Intolerance related to _____.

__ Ineffective Health Maintenance related to _____.

__ Risk for Electrolyte Imbalance related to _____.

__ Decreased Cardiac Output related to _____.

__ Imbalanced Nutrition: Less Than Body Requirements related to _____.

__ Ineffective Renal Tissue Perfusion related to _____.

__ Compromised Family Coping related to_____.

**Part 2 Instructions:** Identify your assigned client's signs and symptoms (S&S) related to each of the selected nursing diagnoses.

__ Deficient Fluid Volume S&S:

__ Ineffective Peripheral Tissue Perfusion S&S:

__ Risk for Injury S&S:

__ Confusion S&S:

__ Activity Intolerance S&S:

__ Excess Fluid Volume S&S:

__ Risk for Impaired Skin Integrity S&S:

__ Risk for Impaired Gas Exchange S&S:

__ Activity Intolerance S&S:

__ Ineffective Health Maintenance S&S:

__ Risk for Electrolyte Imbalance S&S:

__ Decreased Cardiac Output S&S:

__ Imbalanced Nutrition: Less Than Body Requirements S&S:

__ Ineffective Renal Tissue Perfusion S&S:

__ Compromised Family Coping S&S:

**Part 3 Instructions:** Choose *three* priority nursing diagnoses and identify *three* priority nursing interventions related to each diagnosis

*#1 Nursing Diagnosis:*

1)
2)
3)

*#2 Nursing Diagnosis:*

1)
2)
3)

*#3 Nursing Diagnosis:*

1)
2)
3)

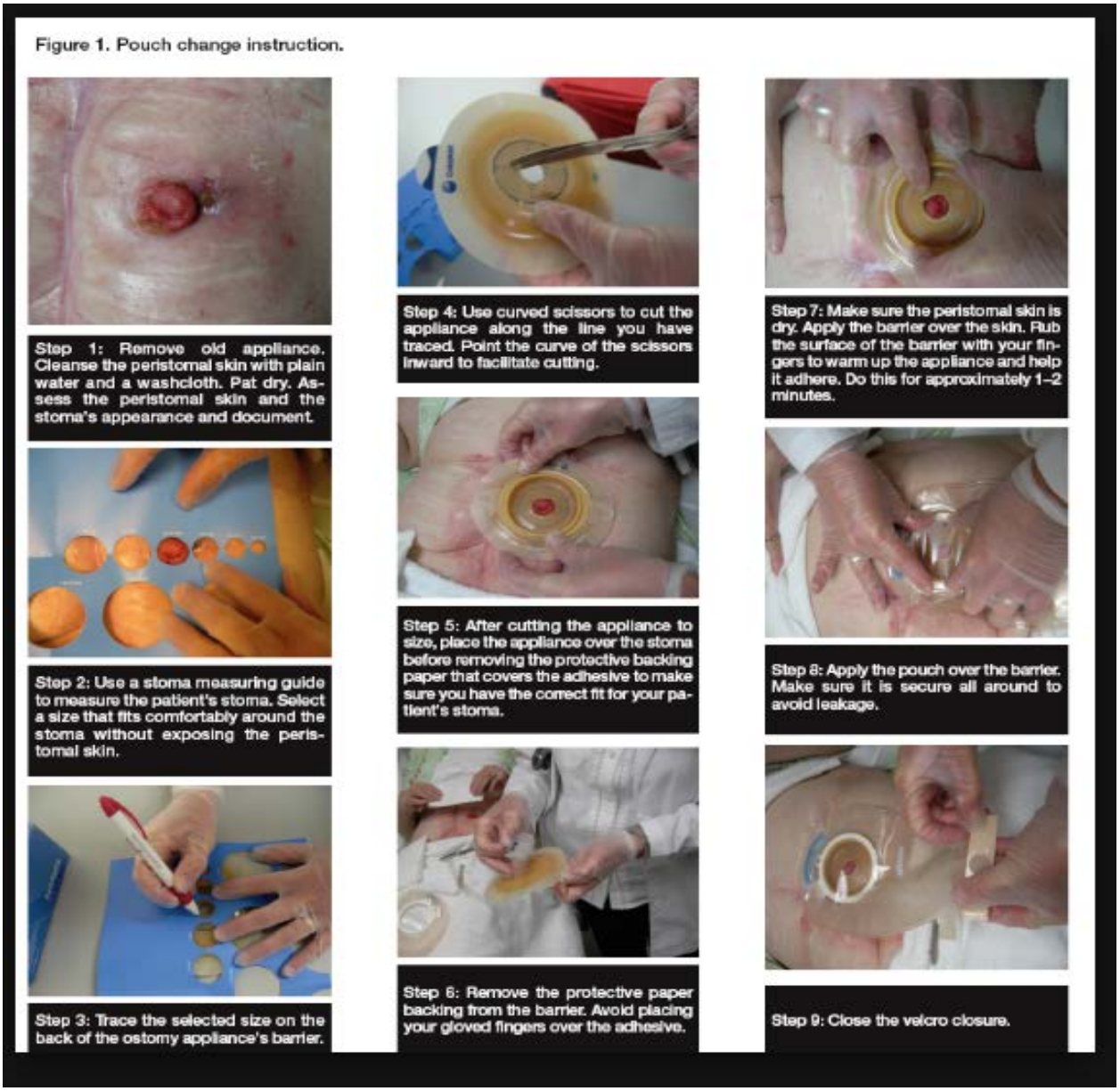
# Week 5: Cellular Regulation

**Skills Lab:**

- Review of the nursing process as it relates to the care of clients with an alteration in cellular regulation

**Clinical:**

- Relate the multisystem effects of the client with an alteration in cellular regulation



# Week 6: Immunity/Inflammation/Infection

**Skills Lab:**

- Review of the nursing process as it relates to the care of clients with an alteration in immunity, inflammation, or infection

**Clinical:**

- Relate the multisystem effects of the client with an alteration in immunity, inflammation, or infection

**Clinical reasoning activities**

**Infection, Immunity**

**PROTECTIVE DETAILS!**

**Part 1: Instructions:** Match the following isolation precautions to the correct descriptions.

| Isolation Precaution | Description |
|---|---|
| a. Standard precautions<br>b. Droplet precautions<br>c. Airborne precautions<br>d. Contact precautions | _____ Used for known or suspected illness transmitted by particles > 5 microns<br>_____ Used for known or suspected illnesses easily transmitted by direct client contact or items in the client environment<br>_____ Used for known or suspected illness transmitted by airborne particles <5 microns<br>_____Used in the care of all hospitalized individuals regardless of diagnosis or possible infection status. Includes protection from blood and body fluids. |

**Part 2: Instructions:** Identify the type of isolation precautions that would be implemented for each case vignette. Complete the table by identifying the PPE that would be implemented. Note that the type of isolation may be used more than once.

| Case vignette | Type of Isolation Precautions | PPE Needed (or per agency protocol) |
|---|---|---|
| 1. You are caring for a 68-year-old client admitted with a cough and fever. | | |
| 2. You are caring for a client with a confirmed diagnosis of influenza. | | |
| 3. You are caring for an 18-month-old diagnosed with otitis media. | | |
| 4. You are caring for a 57-year-old homeless client diagnosed in the emergency department with tuberculosis. | | |

| | | |
|---|---|---|
| 5. You are caring for a postoperative client who is having diarrhea. Lab results show *Clostridium difficile*. | | |

**Part 3: Instructions:** Review the proper steps of applying PPE. Demonstrate correct implementation of PPE by putting on the appropriate PPE indicated for each case. Remember to apply PPE in the correct order and remove and dispose of PPE correctly between cases.

## Week 7: Metabolism & Thermoregulation

**Skills lab:**

- HESI examination administration: Fundamentals V2

**Clinical:**

- Relate the multisystem effects of the client with an alteration in metabolism and thermoregulation

## Week 8: Mobility & Comfort

**Skills Lab:**

- Review of the nursing process as it relates to the care of clients with an alteration in mobility and comfort
- Demonstrate understanding of therapeutic communication techniques

**Clinical:**

- Relate the multisystem effects of the client with an alteration in mobility and comfort

## Therapeutic Communication Techniques

**To *encourage* the expression of feelings and ideas**

**Active Listening**– Being attentive to what the client is saying, verbally and non-verbally. Sit facing the client, open posture, lean toward the client, eye contact, and relax.

**Sharing Observations**– Making observations by commenting on how the other person looks, sounds, or acts. Example:" you look tired" or "I haven't seen you eating anything today".

**Sharing Empathy**– The ability to understand and accept another person's reality, to accurately perceive feelings, and to communicate understanding. Example "It must be very frustrating to know what you want and not be able to do it".

**Sharing Hope–** Communicating a "sense of possibility" to others. Encouragement when appropriate and positive feedback. Example "I believe you will find a way to face your situation, because I have seen your courage in the past".

**Sharing Humor**– Contributes to feelings of togetherness, closeness and friendliness. Promotes positive communication in the following ways; prevention, perception, perspective.

**Sharing Feelings**– Nurses can help clients express emotions by making observations, acknowledging feelings, and encouraging communication, giving permission to express "negative" feelings and modeling healthy anger.

**Using Touch**– Most potent form of communication. Comfort touch such as holding a hand, is especially important for vulnerable clients who are experiencing severe illness.

**Silence–** Time for the nurse and client to observe one another, sort out feelings, think of how to say things, and consider what has been verbally communicated. The nurse should allow the client to break the silence.

**Providing Information**– Relevant information is important to make decisions, experience less anxiety, and feel safe and secure. Example "Susie is getting an echocardiogram right now which is a test that uses painless sound waves to create a moving picture of her heart structures and valves and should tell us what is causing her murmur".

**Clarifying**– To check whether understanding is accurate, or to better understand, the nurse restates an unclear or ambiguous message to clarify the sender's meaning. "I'm not sure I understand what you mean by 'sicker than usual', what is different now?"

**Focusing**– Taking notice of a single idea expressed or even a single word. An example is "On a scale of 0 to 10 tell me the level of the pain you are experiencing in your great toe right now."

**Paraphrasing**– Restating another's message more briefly using one's own words. It consists of repeating in fewer and fresher words the essential ideas of the client. For example, the client says "I can't focus. My mind keeps wandering." The student nurse says," You're having difficulty concentrating?"

**Asking Relevant Questions**– To seek information needed for decision making. Asking only one question at a time and fully exploring one topic before moving to another area. Open-ended questions allow for taking the conversational lead and introducing pertinent information about a topic. For example, "What is your biggest problem now?" or "How has your pain affected your life at home?"

**Summarizing**– Pulls together information for documentation. Gives a client a sense you understand. It is a concise review of key aspects of an interaction. Summarizing brings a sense of closure. Example "It is my understanding that your arm pain is a level 1 since you've taken a Vicodin one hour ago. Taking your pain medication before physical therapy seems to help you complete the activities the doctor wants you to do for your rehabilitation. Is this correct?" Client responds, "Yes It really helps to take the medicine before I do my physical therapy because it helps reduce the pain in my arm."

**Self-Disclosure**– Subjectively true personal experiences about the self, are intentionally revealed to another person for emphasizing both the similarities and the differences of experiences. These exchanges are offered as an expression of genuineness and honestly by the nurse and disclosures should be relevant and appropriate. They are used sparingly so the client is the focus of the interaction: "That happened to me once, too. It was devastating, and I had to face some things about myself that I didn't like. I went to counseling and it really helped.... what are your thoughts about seeing a counselor?"

**Confrontation**– Helping the client become more aware of inconsistencies in his or her feelings, attitudes, beliefs, and behaviors. Only to be used after trust has been established, & should be done gently, with sensitivity: "You say you've already decided what to do, yet you're still talking a lot about your options."

## Non-therapeutic Communication Techniques

**"Blocks" to communication of feelings and ideas**

**Asking personal questions** – Asking person questions that are not relevant to the situation, is not professional or appropriate. Don't ask questions just to satisfy your curiosity. "Why aren't you married to Mary?" is not appropriate. What might be asked is "How would you describe your relationship to Mary.

**Giving personal opinions**– Giving personal opinions, takes away decision-making for the client. Remember the problem and the solution belongs to the patient and not the nurse. "If I were you I'd put your father in a nursing home" can be reframed to say," Let's talk about what options are available to your father."

**Changing the subject– "**Let's not talk about your insurance problems it's time for your walk" Changing the subject when someone is trying to communicate with you is rude and shows a lack of empathy. It ends to block further communication and seems to say that you don't really care about what they are sharing. "After your walk let's talk some more about what's going on with your insurance company."

**Automatic responses**– "Administration doesn't care about the staff," or "Older adults are always confused." These are generalizations and stereotypes that reflect poor nursing judgment and threaten nurse-client or team relationships.

**False Reassurance**– "Don't worry, everything will be all right." When a client is seriously ill or distressed, the nurse may be tempted to offer hope to the client with statements such as "you'll be fine." Or "there's nothing to worry about." When a patient is reaching for understanding these phrases that are not based on fact or based on reality can do more harm than good. The nurse may be trying to be kind and think he/she is helping, but these comments tend to block conversation and discourage further expressions of feelings. A better response would be "It must be difficult not to know what the surgeon will find. What can I do to help?"

**Sympathy**– Sympathy focuses on the nurse's feelings rather than the client's. Saying "I'm so sorry about your amputation, it must be terrible to lose a leg." This shows concern but more sorrow and pity than trying to understand how the client feels. Sympathy is a subjective look at another person's world that prevents a clear perspective of the issues confronting that person. A more empathetic approach would be "The loss of your leg is a major change; how do you think this will affect your life?"

**Asking for Explanations**– "Why are you so upset?" A nurse may be tempted to ask the other person to explain why the person believes, feels or is acting in a certain way. Clients frequently interpret why questions as accusations. "Why" questions can cause resentment, insecurity and mistrust. It's best to phrase a question to avoid using the word "why". "You seem upset. What's on your mind?"

**Approval or Disapproval**– "You shouldn't even think about assisted suicide, it's just not right." Nurses must not impose their own attitudes, values, beliefs, and moral standards on others, while in the professional helping role. Judgmental responses by the nurse often contain terms such as should, ought, good, bad, right or wrong. Agreeing or disagreeing sends the subtle message that nurses have the right to make value judgments about the client's decisions. Approving implies that the behavior being praised is the only acceptable one. Disapproving implies that the client must meet the nurse's expectations or standards. Instead the nurse should help clients explore their own beliefs and decisions. The nursing response "I'm surprised you are considering assisted suicide. Tell me more about it..." gives the client a chance to express ideas or feelings without fear of being judged.

**Defensive Responses**– "No one here would intentionally lie to you." When clients' express criticism, nurses should listen to what they are saying. Listening does not imply agreement. To discover reasons for the client's anger or dissatisfaction, the nurse must listen uncritically. By avoiding defensiveness, the nurse can defuse anger and uncover deeper concerns: "You believe people have been dishonest with you.

It must be hard to trust anyone."

**Passive or Aggressive Responses**– "Things are bad and there is nothing you can do about it." Or "Being is sick is bad and it's all your fault." Passive responses serve to avoid conflict or sidestep issues. They reflect feelings of sadness, depression, anxiety, powerlessness, and hopelessness. Aggressive responses provoke confrontation at the other person's expense. They reflect feelings of anger, frustration, resentment and stress. Assertive communication is a far more professional approach for the nurse to take.

**Arguing**– "How can you say you didn't sleep a wink when I heard you snoring all night long!!" Challenging or arguing again perceptions denies that they are real and valid to the other person. They imply that the other person is lying, misinformed, or uneducated. The skillful nurse can provide information or present reality in a way that avoids argument: "You feel like you didn't get any rest at all last night, even though I thought you slept well since I heard you snoring."

–Author Unknown

## Week 9: Sensory Perception and Cognition

**Skills lab:**

- Mandatory Trenton Psychiatric Hospital Orientation

**Clinical:**

- Relate the multisystem effects of the client with alterations in sensory perception and/or cognition

## Week 10: Mental Health: Stress & Coping

**Skills lab:**

- HESI examination administration: Mental Health V1

**Clinical:**

- Relate the multisystem effects of the client with alterations in mental health involving stress and coping

## Week 11: Mental Health: Violence & Sexuality

**Skills lab:**

- Restraints, Safety & Assessing for Abuse

**Clinical:**

- Relate the multisystem effects of the client with alterations in mental health involving violence and/or issues of sexuality

# Elder Assessment Instrument (EAI)

| I General Assessment | Very Good | Good | Poor | Very Poor | Unable to Assess |
|---|---|---|---|---|---|
| 1. Clothing | | | | | |
| 2. Hygiene | | | | | |
| 3. Nutrition | | | | | |
| 4. Skin integrity | | | | | |
| 5. Additional Comments: | | | | | |

| II Possible Abuse Indicators | No Evidence | Possible Evidence | Probable Evidence | Definite Evidence | Unable to Assess |
|---|---|---|---|---|---|
| 6. Bruising | | | | | |
| 7. Lacerations | | | | | |
| 8. Fractures | | | | | |
| 9. Various stages of healing of any bruises or fractures | | | | | |
| 10. Evidence of sexual abuse | | | | | |
| 11. Statement by elder re: abuse | | | | | |
| 12. Additional Comments: | | | | | |

| III Possible Neglect Indicators | No Evidence | Possible Evidence | Probable Evidence | Definite Evidence | Unable to Assess |
|---|---|---|---|---|---|
| 13. Contractures | | | | | |
| 14. Decubiti | | | | | |
| 15. Dehydration | | | | | |
| 16. Diarrhea | | | | | |
| 17. Depression | | | | | |
| 18. Impaction | | | | | |
| 19. Malnutrition | | | | | |
| 20. Urine burns | | | | | |
| 21. Poor hygiene | | | | | |
| 22. Failure to respond to warning of obvious disease | | | | | |
| 23. Inappropriate medications (under/over) | | | | | |
| 24. Repetitive hospital admissions due to probable failure of health care surveillance | | | | | |
| 25. Statement by elder re: neglect | | | | | |
| 26. Additional Comments: | | | | | |

| IV Possible Exploitation Indicators | No Evidence | Possible Evidence | Probable Evidence | Definite Evidence | Unable to Assess |
|---|---|---|---|---|---|
| 27. Misuse of money | | | | | |
| 28. Evidence of financial exploitation | | | | | |
| 29. Reports of demands for goods in exchange for services | | | | | |
| 30. Inability to account for money/property | | | | | |
| 31. Statement by elder re: exploitation | | | | | |
| 32. Additional Comments: | | | | | |

| V Possible Abandonment Indicators | No Evidence | Possible Evidence | Probable Evidence | Definite Evidence | Unable to Assess |
|---|---|---|---|---|---|
| 33. Evidence that a caretaker has withdrawn care precipitously without alternate arrangements | | | | | |
| 34. Evidence that elder is left alone in an unsafe environment for extended periods of time without adequate support | | | | | |
| 35. Statement by elder re: abandonment | | | | | |
| 36. Additional Comments: | | | | | |

| VI Summary | No Evidence | Possible Evidence | Probable Evidence | Definite Evidence | Unable to Assess |
|---|---|---|---|---|---|
| 37. Evidence of abuse | | | | | |
| 38. Evidence of neglect | | | | | |
| 39. Evidence of exploitation | | | | | |
| 40. Evidence of abandonment | | | | | |
| 41. Additional Comments: | | | | | |

**VII Comments and Follow-up** _____

Adapted from: Fulmer, T., & Cahill, V.M. (1984). Assessing elder abuse: A study. Journal of Gerontological Nursing, 10(12), 16-20; Fulmer, T. (2003). Elder abuse and neglect assessment. Journal of Gerontological Nursing, 29(6), 4-5; Reprinted from Journal of Emergency Nursing, 10(3). Fulmer, T., Street, S., & Carr, K. Abuse of the elderly: Screening and detection, pp. 131-140. Copyright 1984, with permission from The Emergency Nurses Association.

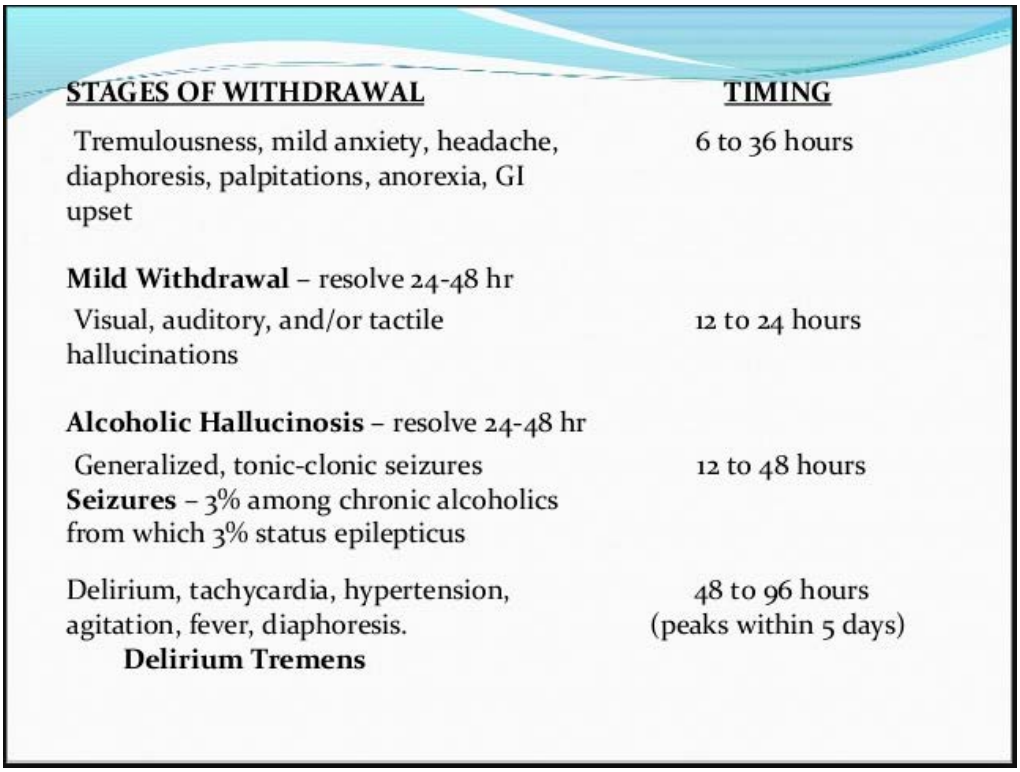
# Week 12: Mental Health: Addiction & Development

**Skills Lab:**

- Assessment and care of clients with addiction
- Assessment and care of clients with alterations in development

**Clinical:**

- Relate the multisystem effects of the client with alterations in mental health involving development and/or addiction



| STAGES OF WITHDRAWAL | TIMING |
|---|---|
| Tremulousness, mild anxiety, headache, diaphoresis, palpitations, anorexia, GI upset | 6 to 36 hours |
| **Mild Withdrawal** – resolve 24-48 hr<br>Visual, auditory, and/or tactile hallucinations | 12 to 24 hours |
| **Alcoholic Hallucinosis** – resolve 24-48 hr<br>Generalized, tonic-clonic seizures<br>**Seizures** – 3% among chronic alcoholics from which 3% status epilepticus | 12 to 48 hours |
| Delirium, tachycardia, hypertension, agitation, fever, diaphoresis.<br>**Delirium Tremens** | 48 to 96 hours<br>(peaks within 5 days) |

**CAGE Substance Abuse Screening Tool**

Directions: Ask your patients these four questions and use the scoring method described

below to determine if substance abuse exists and needs to be addressed.

**CAGE Questions**

1. Have you ever felt you should cut down on your drinking?

2. Have people annoyed you by criticizing your drinking?

3. Have you ever felt bad or guilty about your drinking?

4. Have you ever had a drink first thing in the morning to steady your nerves or to

get rid of a hangover (eye-opener)?

**CAGE Questions Adapted to Include Drug Use (CAGE-AID)**

1. Have you ever felt you ought to cut down on your drinking or drug use?

2. Have people annoyed you by criticizing your drinking or drug use?

3. Have you felt bad or guilty about your drinking or drug use?

4. Have you ever had a drink or used drugs first thing in the morning to steady

your nerves or to get rid of a hangover (eye-opener)?

**Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.**
**The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. Several other screening tools are available.**

*CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener*
*CAGE Source: Ewing 1984*

# Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

**Nausea/Vomiting** - Rate on scale 0 - 7

0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

**Tremors** - have patient extend arms & spread fingers. Rate on scale 0 - 7.
0 - No tremor
1 - Not visible, but can be felt fingertip to fingertip
2
3
4 - Moderate, with patient's arms extended
5
6
7 - severe, even w/ arms not extended

**Anxiety** - Rate on scale 0 - 7
0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

**Agitation** - Rate on scale 0 - 7
0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

**Paroxysmal Sweats** - Rate on Scale 0 - 7.
0 - no sweats
1- barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

**Orientation and clouding of sensorium** - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4
0 - Oriented
1 – cannot do serial additions or is uncertain about date

2 - disoriented to date by no more than 2 calendar days

3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

**Tactile disturbances** - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

**Auditory Disturbances** - Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 - not present
1 - Very mild harshness or ability to startle
2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

**Visual disturbances** - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 - not present
1 - very mild sensitivity
2 - mild sensitivity
3 - moderate sensitivity
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

**Headache** - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie. start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment sheet as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

| **Assessment Protocol**<br>a. Vitals, Assessment Now.<br>b. If initial score ≥ 8 repeat q1h x 8 hrs, then if stable q2h x 8 hrs, then if stable q4h.<br>c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hrs, d/c assessment. If score ≥ 8 at any time, go to (b) above.<br>d. If indicated, (see indications below) administer prn medications as ordered and record on MAR and below. | **Date** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Time** | | | | | | | | | | | | |
| | **Pulse** | | | | | | | | | | | | |
| | **RR** | | | | | | | | | | | | |
| | **$O_2$ sat** | | | | | | | | | | | | |
| | **BP** | | | | | | | | | | | | |
| **Assess and rate each of the following (CIWA-Ar Scale):** | **Refer to reverse for detailed instructions in use of the CIWA-Ar scale.** | | | | | | | | | | | | |
| **Nausea/vomiting** (0 - 7)<br>0 - none; 1 - mild nausea ,no vomiting; 4 - intermittent nausea; 7 - constant nausea , frequent dry heaves & vomiting. | | | | | | | | | | | | | |
| **Tremors** (0 - 7)<br>0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms extended; 7 - severe, even w/ arms not extended. | | | | | | | | | | | | | |
| **Anxiety** (0 - 7)<br>0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state | | | | | | | | | | | | | |
| **Agitation** (0 - 7)<br>0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about | | | | | | | | | | | | | |
| **Paroxysmal Sweats** (0 - 7)<br>0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat | | | | | | | | | | | | | |
| **Orientation** (0 - 4)<br>0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and / or person | | | | | | | | | | | | | |
| **Tactile Disturbances** (0 - 7)<br>0 - none; 1 - very mild itch, P&N, ,numbness; 2-mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning ,numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 – extremely severe hallucinations; 7 - continuous hallucinations | | | | | | | | | | | | | |
| **Auditory Disturbances** (0 - 7)<br>0 - not present; 1 - very mild harshness/ ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle; 4 - moderate hallucinations; 5 severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous.hallucinations | | | | | | | | | | | | | |
| **Visual Disturbances** (0 - 7)<br>0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations | | | | | | | | | | | | | |
| **Headache** (0 - 7)<br>0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe | | | | | | | | | | | | | |
| Total CIWA-Ar score: | | | | | | | | | | | | | |
| PRN Med: (circle one)<br>Diazepam Lorazepam | **Dose given (mg):** | | | | | | | | | | | | |
| | **Route:** | | | | | | | | | | | | |
| **Time** of PRN medication administration: | | | | | | | | | | | | | |
| Assessment of response (CIWA-Ar score 30-60 minutes after medication administered) | | | | | | | | | | | | | |
| RN Initials | | | | | | | | | | | | | |

**Scale for Scoring:**
Total Score =
0 – 9: absent or minimal withdrawal
10 – 19: mild to moderate withdrawal
more than 20: severe withdrawal

**Indications for PRN medication:**
a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method).
b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + prn method)
Consider transfer to ICU for any of the following: Total score above 35, q1h assess. x more than 8hrs required, more than 4 mg/hr lorazepam x 3hr **or** 20 mg/hr diazepam x 3hr required, or resp. distress.

Patient Identification (Addressograph)

| Signature/ Title | Initials | Signature / Title | Initials |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

# Week 13: Mental Health: Mood/Affect

**Skills lab:**

- Assessment and care of clients with alterations in mood/affect

**Clinical:**

- Relate the multisystem effects of the client with alterations in mental health involving mood/affect

**A. Linking the exemplar of depression with the concept of addiction:**

**Question 1**

Why might dependence on alcohol promote depression?

**Question 2**

What impact might dependence on nicotine have on mood and affect?

**Linking the exemplar of depression with the concept of elimination:**

**Question 3**

What aspects of depression increase the risk for constipation?

**Question 4**

How might alterations in elimination put an older client at risk for depression?

**B. QSEN Schizophrenia Unfolding Case Study**

# Week 14: Skills Test Out

**Skills Lab:**

Test out to be completed during the final skills lab of the semester. There are three components to the test out and students must pass all components to receive a passing grade for lab. The components include:

- One dosage calculation (problem, demonstration, or both)
- Performance of a selected focused assessment
- Performance of a previously learned skill

While students are being pulled out in pairs to complete their skills test, a movie will be shown in a separate room on the topic of mental health. Students will be required to watch and complete a set of discussion questions to be turned in at the end of the lab.