



SCIENCE & HEALTH PROFESSIONS

NURSING PROGRAM

NUR 112

GUIDELINES AND WRITTEN REQUIREMENTS

SPRING 2008

MERCER COUNTY COMMUNITY COLLEGE
DIVISION OF SCIENCE & HEALTH PROFESSIONS

GUIDELINE PACKET NUR112

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Revised: May 2007

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NUR112 CLINICAL PREPARATION GUIDE

Name: _____ Date of Client Care: _____

Initials: _____ Age: _____ Religion: _____ Allergies (state) _____

Growth/Development level (Erikson) and anticipated behavior/tasks:

Religion (State briefly description of beliefs. Do any religious beliefs affect health care?):

Diagnoses - Define & describe from Medical-Surgical text (state source & reference pages)
include related A&P:

Identify four basic needs with supportive reason; include order of priority:

Nsg Dx. according to Dx. listed above - modify during/after client care:

Basic NCP - what you plan to do for this client. Be familiar with procedures and tests listed on your assignment sheet. Review lab data and tests the client had performed according to the chart.

Drug Data - Drug cards (5x7 or 8x10) must include: generic name, trade name, classification, action, side effects, adverse effects, contraindications, route, dosage, nursing responsibilities, client teaching.

I.V. - Prepared to calculate rate of flow/hr. or rate of flow per minute.

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NUR112 CLINICAL LEARNING OBJECTIVES/PREPARATION

EMERGENCY ROOM OBSERVATION

Clinical Grading: Satisfactory/Unsatisfactory

Prepare the objectives for the text book and review with clinical instructor prior to the scheduled observation.

1. Identify the concept of emergency room care.
2. Observe the role of the nurse in the emergency room and the concept of triage.
3. Differentiate between medical and surgical asepsis.
4. List factors that increase the risk of infection in various settings.
5. Recognize the role of health care personnel in infection control.
6. Explain ways that increase and decrease exposure to infections.
7. State factors affecting the outcome of emergency care (lifestyles, socioeconomics, culture).
8. Describe the assessment of the client in the emergency room.
9. Identify the emergency nursing care rendered to clients with changes in body system functions including respiratory, cardiac, psychosocial status.
10. Observe treatment modalities implemented by health care personnel.
11. Evaluate the outcome(s) of goal oriented nursing care for the emergency client.
12. Discuss age related considerations in emergency nursing care.

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NUR112 CLINICAL OBJECTIVES/PREPARATION

SAME DAY SURGERY/AMBULATORY CARE CENTER

Clinical Grading: Satisfactory/Unsatisfactory

Prepare the objectives for the text book and review with clinical instructor prior to the scheduled observation.

Overall Objective: To observe the care of preoperative and postoperative clients in the Same Day Surgery/Ambulatory Surgical Care Center.

Learning Objectives:

1. Identify the goals of preoperative nursing care, include physical and psychological preparation
2. Observe the role of the nurse in the Same Day Surgery/Ambulatory Surgical Care Center.
3. Recognize the importance of effective communication between the client and nurse.
4. Discuss preadmission procedures, charting and client education materials used in the Same Day Surgery/Ambulatory Surgical Care Center.
5. Evaluate the client's readiness for surgery.
6. Discuss how age differences, development and culture effect the needs of the surgical client.
7. Utilize the nursing process to develop an individualized plan of care for the surgical client.
8. Discuss nursing assessment and the skills implemented during the postoperative phase of care.
9. Identify information given to clients for care at home.
10. Investigate the discharge criteria used for clients in the Same Day Surgery/Ambulatory Surgical Care Center.
11. Identify the similarities and differences observed in the care of a surgical client in the inpatient surgical setting and the Same Day Surgery/Ambulatory Surgical Care Center (preoperative instruction, admission, anesthesia, family support, postoperative care, recovery and discharge).

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NUR 112 – OPERATIVE OBSERVATION GUIDE
LEARNING OBJECTIVES

Name _____ Date(s) of Observation _____

Health Care Facility _____

Procedure(s) Observed _____
(include age of client)

Grading: Satisfactory/Unsatisfactory

Prepare the objectives from the textbook and review with clinical instructor prior to the scheduled observation.

Objectives

I. To identify the legal implications of nursing care for the surgical client.

- A. Indicate the nurse's legal responsibilities during the pre-operative phase of client care. (Review pre-operative check list, operative consent).

II. To observe the total process of anesthesia.

- A. List the premedication (if any) administered to the client.
- B. Describe any special preparations implemented prior to the administration of the anesthesia.
- C. State the type of anesthesia used.
- D. List any special precautions or safety factors required during surgery when this anesthesia is used. (including I.V. therapy).
- E. Describe how the client's airway was maintained.
- F. Indicate if O₂ was administered. How? When? Identify how O₂ was administered and when.
- G. Indicate how the client's general condition was monitored during surgery and prior to discharge from OR. (Note reflex checks, etc.)

III. To observe aseptic technique.

While in the Operating Room observe the following events:

- A. Identify any skin preparation completed prior to surgery.

- B. Describe the preparation of the operative site for surgery while the client was in the OR.
- C. State how equipment was added to the sterile field.
- D. Discuss how a specimen was handled. Identify if any diagnostic tests were to be performed on the specimen. Include a brief description of the purpose of the test identified.

IV. To observe various functions of the members of the surgical team.

- A. Describe the role and responsibility of the:
 - 1. Scrub Nurse.
 - 2. Circulating Nurse.
 - 3. Anesthetist or anesthesiologist.
 - 4. Surgeon.

V. To observe an operative procedure.

- A. Define and explain the procedure performed.
- B. Identify how the client was positioned for surgery.
- C. Describe the incision **including anatomical site and length.**
- D. Relate how bleeding was controlled during surgery.
- E. Describe the method utilized to close the wound.
- F. State the type of dressing, if any, applied over the wound. Identify if any drains were used (include the type of drain).
- G. At the completion of surgery, state if any other actions were implemented before transferring the client to the Post Anesthesia Care Unit.
- H. List the type and amounts of fluids administered.
- I. Identify if any medications given immediately post surgery (state the medication and purpose).

VI. To demonstrate knowledge of medications.

- A. Prior to this observation, complete drug cards for:
 - 1. Naloxone (Narcan)
 - 2. Neostigmine (Prostigmin)

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NUR 112 – POST ANESTHESIA CARE UNIT OBSERVATION
LEARNING OBJECTIVES

Name _____ Date of Observation _____

Health Care Facility _____

Operative Procedure(s) _____

Age(s) of Clients Observed _____

Grading: Satisfactory/Unsatisfactory

Prepare the objectives from the textbook and review with clinical instructor prior to the scheduled observation.

Objectives

I. To observe the initial assessment of the client upon entry into the Post Anesthesia Care Unit.

A. Observations made by receiving nurse:

1. Client condition: reflex response, level of consciousness, recovery from anesthesia, vital signs.
2. Type(s) of anesthesia.
3. Maintenance of airway: presence of endotracheal tube, plastic airway, use of suctioning.
4. Administration of oxygen.
5. Administration of blood/fluid replacement. (Identify type and amount of fluid therapy).
6. Condition of dressing, wound drains.
7. Presence of drainage tubes.

B. Identify how this information is recorded and reported.

II. To observe the continued assessment of the client in the Post Anesthesia Care Unit.

A. Describe the observations made by the nurse.

1. Client condition: reflex response, level of consciousness, recovery from anesthesia, vital signs.
2. Maintenance of airway: presence of endotracheal tube, plastic airway, use of suctioning.
3. Administration of oxygen.
4. Administration of blood/fluid replacement.
5. Condition of dressing, wound drains.
6. Presence of drainage tubes.
7. Disturbance in G.I. Tract.
8. Assessment of pain/discomfort.

B. Identify the nursing actions which are implemented.

C. List the medications administered. Include the action of the drug, route and dosage.

D. Indicate the method utilized to record and report client data.

III. To observe the discharge of the client from the Post Anesthesia Care Unit and transfer to the Nursing Unit.

A. Identify criteria used to determine when the client may be transferred from the Post Anesthesia Care Unit to the assigned unit.

B. State the information that needs to be reported by the Post Anesthesia Care Unit nurse to the clinical unit nurse.

IV. To identify the role and responsibility of the Post Anesthesia Care Staff.

A. Anesthesiologist

B. Nurse

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NUR 112
Nursing Care Plan Guidelines

I. Purpose of Nursing Care Plan:

To plan for the physical, emotional and cultural needs of a particular client.

II. Requirements:

Use 8 1/2 x 11 inch white bond (lined, onion skin or thin erasable paper is not acceptable) paper. Paper should be thorough, stapled together, typed and placed in a folder. **APA format is required.**

Title page or cover sheet must include student's name, client's initials, date of care and instructor's name.

III. Grading:

The quality of your nursing study reflects your understanding of effective nursing care and accuracy of information.

Percentages:

I. Assessment	25%
II. Analysis and Synthesis of Problems	15%
III. Planning	40%
Implementation	5%
Evaluation	10%
IV. References (Bibliography)	<u>5%</u>
Total	100%

Papers are due on the date stated in the course outline.

FRAMEWORK OF NURSING CARE STUDY

I. Assessment:

1. Collect Data: Interview client, consult health record, family or other health care providers.

A. Demographic data:

1. Biographic data i.e., date of care, initials, age, sex, occupation, diagnosis, marital status, type of living arrangements. primary language.
2. General appearance, facial expression, body language, dress, gait, posture, vital signs, skin tone, and texture, etc.
3. Physician's admission diagnosis.
4. State the growth and developmental level according to Erikson and explain briefly.

B. Health Needs Patterns Assessment/Daily Activity Patterns (past and present)

1. *Hygiene* - ability to bathe oneself, any assistance needed, use of assistive devices, use of makeup, ability to shave, care of fingernails or toenails, include any restrictions, ability to comb and style hair, brush teeth and cleanse mouth.
2. *Nutrition/Fluids*- usual diet, fluid intake, ability to eat, use of dentures, dental condition, nausea/vomiting/indigestion, skin color, condition, tone, edema, height, and weight.
3. *Elimination* - frequency of B.M., use of OTC laxatives, abdominal tenderness, distention, bowel sounds, stoma, usual urinary pattern - frequency character, amount, nocturia, incontinence, catheter(s).
4. *Activity/Exercise* - any ADL/mobility limitations, devices needed, handedness.
5. *Sleep/Rest* - hours of sleep, quality, rituals, alert, yawning, circles under eyes.
6. *Oxygen* - indications of deficiency of oxygen; dyspnea, shortness of breath, respiratory rate and rhythm, nocturnal dyspnea, cough, lung sounds, chest pain, peripheral pulses, capillary refill, pulse rate and rhythm, pacemaker.

7. *Comfort* - assess for the description of comfort. If pain is present, use pain assessment scale (0-10) and describe location, type, intensity onset, duration and method(s) of pain management.
8. *Safety* - cognitive/perceptual level of consciousness, reflexes, pupil size/equal, reaction to light, hand grasp, sight-glasses, hearing-deficit, numbness, or tingling, dizziness, any learning disabilities, reality orientation.
9. *Sexuality* - reproductive history, L.M.P, menopause, use of birth control, self exam (breast or testicle), discharge, lesions.
10. *Psychological Health/Coping* - stress tolerance, coping patterns (how problems are dealt with), self-concept-verbal and non-verbal clues - moods, effect of surgery/hospitalization or disease upon body image.
11. *Sociological Health/Role Relationship* - marital status, significant others, children, live alone, present employment, school, who are the people who help the client most of the time, cultural patterns, ethnic background, food preference, health care patterns recreational patterns, hobbies, sports. Upon discharge will the client be able to afford medications, supplies and medical care.
12. *Spiritual/Value/Belief* - religious beliefs and practice, indicators of values - i.e., orderliness, cleanliness, upkeep of belongings, active listening, open dialogue, praise.

C. Biophysical Health/Health Perception

1. Reason for hospitalization/Chief Complaint (client's own words).
2. Previous hospitalizations or surgeries.
3. Other health problems and how are they managed (knowledge deficits identified regarding health needs).
4. List medications (prescription or non-prescription) that client is taking. **Include drug card for each medication.**

Drug cards must include: Generic Name, Trade Name, Classification, Action, Side Effects, Adverse Effects, Contraindications, Route, Dosage, Nursing Responsibilities, Client Teaching.

Name of Medication	Dose	Schedule	Reason
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5. Tobacco or ETOH (alcohol) use.

6. Allergies.

7. Family health history (diabetes, hypertension, heart disease).

D. Medical diagnosis

1. Define the diagnosis.
2. Identify areas and organs affected. (Include drawing)
3. Explain how body function is involved, or altered, by this pathological condition.

E. Diagnostic studies and Laboratory tests

1. List the diagnostic studies and laboratory tests done on this client.
2. Identify the abnormal findings which were important for establishing the client's diagnosis.
3. Discuss the nurse's responsibilities for the client who has these tests.

F. Surgical intervention

1. Identify any specific risk factors for this client.
2. Discuss the type of anesthesia employed.
3. Discuss the nurse's responsibility in relation to this specific surgery and/or anesthesia.

II. Analysis & Synthesis (see definition sheet)

Review your data collection. Group and analyze the data utilizing three columns.

Basic Need and the data that support an interference/ deviation to that need	Interpretation of the deviation. Compare findings with textbook	Nursing Diagnosis NANDA approved

III. Planning and Care for the Client:

Format of Care Plan - Plan should be developed in a columnar format as follows on the next page.

Planning and Care for the Client

(See requirements for each section below)

Nursing Diagnosis	Client Goals	Nursing Actions	Rationales	Evaluation

A. Nursing Diagnosis:

- ✓ Number all identified nursing diagnosis (Section II) in order of priority. (5 points)
- ✓ Select the client's four most important nursing diagnoses and list in order or priority.
- ✓ Each nursing diagnosis and nursing action/order and rationale must have a footnote/endnote.

B. Client Goals:

- ✓ Establish short term and long term client goals, with **measurement criteria**, for each of these 4 diagnoses. (5 points)

C. Implementation:

- ✓ Plan nursing actions (15 points) with rationales (15 points)
- ✓ Indicate by * those nursing orders/actions implemented during your care of the client. (5 points)

D. Evaluation:

- ✓ Describe those goals that were met and give supportive data.
- ✓ Describe those goals that were not met and give factors that interfered with goal accomplishments. (10 points)

IV. References (Bibliography) and Format: (5 points)

Proper format for references and footnotes (or endnotes) is required. Use the acceptable APA format by referring to the nursing policy packet.

Abbreviations, other than standard medical Latin, are not acceptable.

Note "Requirements", p. 1 of this guideline.

DEFINITIONS

The definition of terms used in nursing care study:

Analysis - the arrangement of data into categories to identify the relationships between basic needs and the data

Assessment - is a systematic way of obtaining data about a client. This should include:

- a. interviewing client and/or family
- b. physical examination
- c. reviewing written records
- d. collaborating with other health team members
- e. observe interpersonal relationships
- f. observe developmental levels

Evaluation - assessing the client's response against predetermined goals.

Goal - a desired outcome that you and your client hope to achieve in order to remedy or to lessen the problem. This should include:

- a. the client - centered goal(s) that are measurable within a time frame
- b. criteria for acceptable performance

Implementation - putting the plan into action.

Nursing diagnosis - is a clear, concise, specific statement about a client's responses to the actual or potential problems that require nursing intervention. This should include:

- a. etiology or contributing factors
- b. scientific explanation of these factors

Planning Care - is the act of determining what can be done to assist the client in restoring, maintaining or promoting health. This should include:

- a. stating nursing diagnosis
- b. stating goals according to priorities
- c. identifying specific strategies or techniques for implementation

Scientific rationale - the knowledge of natural, behavioral, medical, nursing and social sciences that give a purpose and explanation to your study.

Synthesis - the putting together of the relevant data in order to formulate a nursing diagnosis.

This should include:

- a. comparison of client's data with norms
- b. interpretations of the deviations

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NURSING PROGRAM

MATERNITY OBJECTIVES

Clinical Experience Objectives

1. **Orientation** to obstetrical unit.
2. **Utilize** the nursing process to formulate a plan of care for the client during the antepartal, intrapartal and postpartal period with special consideration of various socioeconomic and cultural factors.
3. **Participate** in the prenatal assessment of clients by observing client care in the clinic and/or physician's office. **Perform** a nursing interview and assess the health teaching needs of the expectant mother.
4. **Observe** proper procedure in caring for a client in labor and delivery; including admission procedure, physical preparation, monitoring vital signs, timing of contractions and monitoring fetal heart beats as performed by staff nurse. **Perform** hygienic and basic comfort measures, provide psychological support in the different stages, assist with limited teaching or coaching of breathing exercises. **Review** methods of recording utilized by staff nurses.
5. **Demonstrate** proper procedure in caring for the post-partum client; perineal care and inspection, examination of breast; breast care; observation of lochia, monitoring involution of the uterus, client teaching, psychological support, administering medication, charting.
6. **Demonstrate** proper procedure in caring for newborn in newborn nursery; feeding, bathing, diapering, dressing, measuring, weighing, taking vital signs, observing stool and skin color, transporting baby to mother and assessment of mother's need for guidance with feeding; charting pertinent information. **Complete** newborn assessment guide as outlined and required by Mercer County Community College.
7. **Interact** appropriately with the various members of the health care team.

TERMINOLOGY USED IN OBSTETRICS

Abortion - expulsion of the products of conception before viability

Afterbirth - the structure cast off after expulsion of the fetus, including membranes and placenta with the attached umbilical cord

Afterpains - those pains, more or less severe, after expulsion of the after birth, which result from the contracted efforts of the uterus to return to its normal size

Bulging - the pushing out and swelling of the vulva, perineum and rectum as descent, dilatation and effacement (complete occurs)

Caput - appearance of the top of the infant's head at the vaginal orifice.

Cesarean - the delivery of fetus by an incision through the abdominal wall and the wall of the uterus

Crowning - appearance of the top of the infant's head at the vaginal orifice. This is a progression from caput.

Dilatation - indicates diameter of cervical opening and is expressed in centimeters or fingers, 10 cms or 5 fingers being full dilatation.

EDC - expected date of confinement or due date. Found by adding 7 days to the last menstrual period and subtracting three months

Effacement - gradual thinning out of cervix before or during early labor. Estimates in percentages. Uneffaced cervix being 10%, and paper thin cervix being 100%

Embryo - zygote becomes embryo after implantation takes place

Episiotomy - surgical incision of perineum which enlarges the vaginal orifice and permits easier passage of infant.

FH - fetal heart tones - normal 120 -160

Fetus - embryo becomes fetus at 2 months gestation

Fundus - the upper rounded portion of the uterus

Gravida - a pregnant woman

Lanugo - the fine hair found on nearly all the body surface of the fetus except palms and soles

Lochia - the discharge of blood, mucus and tissue from the vagina during the post partum period.
Types: rubra, serosa, alba

Meconium - the collection of fluid, lanugo and hair that the baby ingests during pregnancy and which is expelled at the first few stools after birth. Is blackish greenish and tarry

Mucus Plug - a plug of mucus that blocks the cervix during pregnancy.

Multip - a woman who has had one or more vaginal deliveries

TERMINOLOGY USED IN OBSTETRICS

continued

Placenta - the circular, flat, vascular structure in the impregnated uterus forming the principal medium of communication between the mother and fetus.

Premature Delivery - expulsion of fetus after viability (28 weeks) and before maturity (38 weeks)

Premature infant - babies weighing less than 2500 grams (5lbs. 6 ozs.)

Primip - a woman who is pregnant for the first time

Puerperium or Post Partum Period - period between childbirth and return of uterus to normal size - 6 weeks

Quickening - the mother's first perception of the movements of the fetus

Show - mucus dropped out of cervix either before labor or in early labor.

Station - relation of presenting part to ischial spines. Is measured in terms of number of centimeters the part is above or below the spines. Quantities are (-1, -2, -3 and floating) and if below the spines (+1, +2, +3 and on the perineum). If part is at the spines it is at 0 station.

Stillbirth - birth of a dead fetus after viability

Three stages of labor and delivery:

First - from onset of true labor contractions to complete dilatation

Second - from beginning of complete dilatation to end of birth of infant

Third - from birth of baby to end of delivery of placenta

Vernix Caseosa - the layer of cheese like material covering the skins of the fetus and infant at birth

Viability - the ability to live. After 28 weeks, the infant should be viable

MATERNITY CLINICAL PREPARATION GUIDE

L&D Observation	Stages of labor Monitoring Breathing techniques Review L&D chapter in text
Triage	Differentiate true and false labor Assessment of maternal client Review L&D chapter in text
Newborn Assessment	Characteristics of the neonate Prepare newborn assessment (MCCC) Select infant or one assigned for assessment Review chapters on newborn in the text Be able to complete assessment clinically Assist in diapering, feeding (OBJ. 6 Maternity Objectives)
Mother/Baby	Nursing Care Plan for c-section client Nursing Care Plan for vaginal delivery client Client teaching (education/discharge instruction sheet) Breast feeding techniques Bottle feeding technique Post partum assessment Assessment of baby Medications - drug cards Review chapters in text

Drug cards for each area assigned as per packet guideline.
Refer to list of meds for each area.

COMMON PHARMALOGICAL AGENTS USED IN MATERNITY NEWBORN CARE

Since you will all be rotating from area to area, it is helpful to complete drug cards on the following medications.

FOR LABOR AND DELIVERY

PITOCIN	NUBAIN (NALBUPHINE)
DEMEROL (MEPERIDINE)	NARCAN (NALOXONE)
VISTARIL (HYDROXYZINE)	MARCAIN/BUPIVACAINE/LIDOCAINE
LASIX (FUROSEMIDE)	APRESOLINE (HYDRALAZINE)
MAGNESIUM SULFATE	DILANTIN (PHENYTOIN)
ATROPINE SULFATE	EPHEDRINE
TERBUTALINE (BRETHINE)	CALCIUM GLUCONATE
PHENERGAN (PROMETHAZINE)	BENADRYL (DIPHENHYDRAMINE)
BICITRA	

FOR POST PARTUM

DERMOPLAST/BENZOCAINE/PROCTOFOAM/CETACAINE GEL/TOPICALS	
PERCOCET	TYLENOL
SUBLIMAZE (FENTANYL)	IMFERON
FeSO ₄	METHERGINE
ERGOTRATE	RHOGAM
DULCOLAX/COLACE/SENOKOT/SURFAK/AGORAL	
HEMABATE	TUCKS
SIMETHICONE	

FOR NURSERY

OPHTHALMIC ILOTYCIN	TRIPLE DYE
AQUAMEPHYTON (VIT K)	NEOSPORIN OINTMENT
ENGERIX -B (HEPATITIS B VACCINE INACTIVATED)	

MATERNAL TASKS IN PREGNANCY

	<i>1st Trimester</i>	<i>2nd Trimester</i>	<i>3rd Trimester</i>
Insuring Safe Passage	Concern for personal safety, since there is no perceptual awareness of the embryo or fetus	Becomes protective of her unseen child, seeks medical attention, reads books, avoids threatening situations	Heightened awareness of vulnerability to danger from the environment. Delivery becomes a hope, as pregnancy becomes too long.
Assuring Acceptance of the Child by Significant Others	Focuses on being pregnant- the child is an abstraction.	Fantasizes about the child, the new relationships and experiences, which will be shared.	In her need for acceptance a woman is highly sensitive to rejection, this sensitivity then increases to vulnerability.
Binding-In	Bind-in to the idea of pregnancy	“Quickening” is a very special, warm experience. Love for the child comes on strong.	Binding-in endures but grows more slowly. The mother wants the child but not the pregnancy.
Giving of Oneself (most intricate task of pregnancy and mothering)	Spent in an evaluation and assessment of the demands of pregnancy and motherhood.	Identifies with the child and explores the meaning of the acts of giving and receiving.	Prepares the child’s room.

Summary:

Ensuring safe passage becomes maternal protectiveness toward the child, producing the characteristic concerns and worries of the new mother.

Ensuring acceptance by the family provides motivation for the task of controlling, guiding, and teaching the child those attitudes, values, behaviors, and skills that are socially acceptable.

Binding-in to the child leads first to maternal identification and claiming behavior and is then transformed into a desire for companionship with the child.

The giving of oneself to a dependent, valued child elaborates into a sustained giving of one's time and interest in the form of nurturance, relief during times of stress, and companionship - to the extent of partnership.

Rubin, Reva, "Maternal Tasks in Pregnancy", Nursing Digest, (Winter, 1976), pg. 91-93.

MATERNITY ASSESSMENT GUIDE

1. History of Current Pregnancy:

- a. LMP _____ EDB _____ Baseline: BP _____ WT _____
- b. Any health problems noted during this pregnancy?
Weight gain _____ Hypertension _____ Bleeding _____ Headaches _____
Edema _____ Nausea/vomiting _____ Varicosities _____ Hemorrhoids _____ Other _____
- c. Any medical complications? Describe pathology related to the mother-infant dyad.
- d. Medications taken during pregnancy. List and give actions.
- e. Substance use/abuse (i.e. smoking, alcohol, etc.)
- f. Prenatal preparation/education.
- g. Medication allergy/sensitivity _____ (identify) _____ None

2. Admission Assessment:

- a. Client's reason for hospitalization.
- b. Admission date _____ Time _____ In Labor? _____
- c. Admission diagnosis
- d. Evaluation of Parturition stage:
Membranes _____ Dilation _____ Effacement _____ Contractions began _____
Frequency _____ Duration _____ BP _____ TPR _____ FHR _____ Position _____
Show _____ Bleeding _____ Amniotic fluid color _____
- e. Admission procedures ordered: Peri Prep _____
- f.

G	T	P	A	L
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3. Student Contact With, and Observation of Client

- a. Date of care _____ Unit area _____
- b. Obstetric phase _____ Delivery type _____

4. Labor Progress:

- a. Initial onset date _____ Time _____ First sign _____
- b. Contractions became regular
- c. Length of first stage (dilatation)
- d. Any fetal or maternal problems noted? V.S., FHT, Meconium, etc.
- e. Medications administered? Analgesic? Oxytoxic? Other? I.V.? Describe actions, side effects, etc.
- f. Describe maternal psychological status during labor.
- g. Length of second stage (expulsion)
- h. Delivery time _____ Placental delivery time _____

5. Delivery Profile:

- a. Type of delivery
- b. Anesthesia used: Local (area, agent, action time), Regional (area, agent, action time), or General.
- c. Surgical intervention--describe procedure(s)
- d. Tissue repair needed? Estimated amount of blood loss.
- e. Completion of third stage of labor (placental delivery)
- f. Any problems noted with condition of mother or infant?
- g. Infant Apgar _____ Weight _____ Sex _____
- h. Nuchal cord? _____ Placental presentation Schulz _____ Duncan _____

6. Recovery/Involutional Period (Post Partum):

a. Recovery V.S. _____ Fundus height _____ Lochia color _____ Amount _____

Clots _____ Anesthesia level _____ Dressing? _____

b. Therapeutic/restorative interventions ordered

Peri care _____ Sitz bath _____ Ice (area) _____ Dressing _____

Binder _____ Other _____

c. Involutional/Physiological Status:

Fundus quality _____ Height _____ Location _____ Lochia color _____

Amount _____ Clots _____ Spontaneous voiding _____ BM _____

Breasts _____ Condition episiotomy or incision _____

d. Involutional Psychological Status:

Describe and identify psychological status observed in client? (i.e., exhaustion/euphoria, etc.) Any signs of impending depression/withdrawal? Bonding process/progress. Identify date of observation and post-partum day.

e. Any problems noted during the post-partum hospital stay?

f. Is client breastfeeding infant? _____ Temperature _____

Breasts: _____ Soft _____ Filling _____ Engorged _____

Nipples: _____ Intact _____ Flat/Inverted _____ Cracked

g. Medications ordered (give actions, side effects and need) during puerperal period, i.e., oxytocics, analgesics, laxatives, antibiotics.

NUR 112 - SUMMARY OF DEVELOPMENTS DURING PREGNANCY

	PHYSICAL SIGNS	PHYSIOLOGICAL CHANGES	FETAL CHANGES
1st	Temperature rises and remains up. Nausea and vomiting, fatigue, breasts tingle, period stops	Ovulation with fertilization. Implantation of fertilized ovum and thickening of the uterine lining (due to increased estrogen and progesterone).	Cell differentiation
2nd	Positive pregnancy test. Pressure on bladder with frequency of urination. Nausea subsides. Profuse thick vaginal discharge. Breasts larger.	Mucous plug forming in cervical canal.	Head (largest part) brain and nervous system forming. Heart developing – starts to beat. Circulation begins. Placenta taking shape and umbilical cord. Facial features, arms & legs with hands, feet, fingers & toes forming.
3rd	Colostrum may be expressed from breasts. Nausea subsides. Bladder pressure less.	Placenta completely formed and secreting estrogen and progesterone. Uterine cavity filled. Uterus rising from pelvic cavity into abdomen.	Nearly 4 inches long. Human appearance (completely formed). Sex distinguishable.
4th	Abdominal appearance of pregnancy. Quickening – feeling of life.	Blood volume start to increase. Greater strain on heart. Height of fundus ½ way between pubis and umbilicus.	Weight ½ pound. Sex easily determined. Weight of placenta – fetus. Hair forming on head. Lanugo on body.
5th	Umbilicus even with skin. Relaxation of smooth muscles.	Placenta covers half of uterine wall.	Weight ¾ lb. Vernix Caseosa (cheese protection coating) forming on skin. Meconium (1 st stool) collecting. Fetal heart may be heard. Eyebrows and lashes visible. Lanugo over body. Iron starts to be stored.
6th	Striae gravidarum (stretch marks) appear. Linea nigra (dark line) down abdomen appears. Chloasma (darkened area around eyes) may appear. Period of greatest weight gain of starts	Height of fundus at umbilicus. Period of lowest hemoglobin (iron level starts).	Weight 1 ½ - 12 inches long. Outline felt abdominally. Skin red and shiny, face wrinkled (old man appearance).
7th	Braxton Hicks contractions palpable.	Blood volume highest.	Period of most rapid growth. Viable (capable of life outside the uterus). Large amount of calcium starts to be deposited. Period of high iron storage. Eyes open.
8th	3-4 pound weight gain this month. Braxton-Hicks stronger. Striae more pronounced. Pelvis point more relaxed.	Longitudinal stretching of uterus.	Weight 3 ½ - 5 pounds. Body rounding out. If born, good to live.
9th	Umbilicus protrudes. Shortness of breath. Varicosities, ankle swelling. Frequency. Engagement (Primip) Easier breathing.	Fundus just under diaphragm (unless engagement has occurred).	Weight 5 – 7 ½ pounds. Body well formed. Lanugo shedding.

MERCER COUNTY COMMUNITY COLLEGE
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NUR 112 – NEWBORN ASSESSMENT GUIDE

Name _____

Clinical Grading: Satisfactory/Unsatisfactory

Objective: Compare observed newborn with expected textbook norms.

Infant's Initials:

Date of Assessment:

General: Birth Date & Time:

Birth Weight:

Birth Length:

Age Day of Assessment:

Weight Day of Assessment:

Vital Signs on Admission:

Temp: Pulse:

Resp:

Apgar at Birth:

Method of Feeding:

Mother's Type & RH:

Type of Delivery:

Anesthesia Employed:

Male _____ Female _____

**TEXTBOOK DATA/RESEARCH
 (AUTHOR, PAGE)**

PHYSICAL ASSESSMENT AND EVALUATION

General Appearance	
Skin: Color	
Texture	
Turgor	

**TEXTBOOK DATA/RESEARCH
(AUTHOR, PAGE)**

PHYSICAL ASSESSMENT AND EVALUATION

Muscle Tone	
Motor Activity	
Jitteriness	
State of Consciousness	
Cry	
Head: Hair Distribution & Texture	
Circumference	
Shape	
Size	
Fontanelles	
Face Eyes	

**TEXTBOOK DATA/RESEARCH
(AUTHOR, PAGE)**

PHYSICAL ASSESSMENT AND EVALUATION

Nose	
Mouth	
Tongue	
Ears and Neck	
Chest: Circumference	
Shape	
Nipples	
Abdomen: Circumference	
Shape	
Umbilical Cord	
Anogential Area: Female	

**TEXTBOOK DATA/RESEARCH
(AUTHOR, PAGE)**

PHYSICAL ASSESSMENT AND EVALUATION

Male	
Elimination: Characteristics of Stool	
Characteristics of Urine	
Skeletal System	
Nervous System: Reflexes Moro	
Rooting	
Sucking	
Palmar Grasp	
Plantar Grasp	
Stepping	
Babinski	

**TEXTBOOK DATA/RESEARCH
(AUTHOR, PAGE)**

PHYSICAL ASSESSMENT AND EVALUATION

Tonic Neck	
Prone Crawl	
Trunk Incurvation	
Special Senses: Touch	
Sight	
Hearing	
Taste	
Smell	
Laboratory Studies Type & Rh	
Hgb & Hct	
*Coombs	

**TEXTBOOK DATA/RESEARCH
(AUTHOR, PAGE)**

PHYSICAL ASSESSMENT AND EVALUATION

*Bilirubin	
*PKU, T ₃ , T ₄	
*Galactosemia	
*Indicate when these tests would be ordered and purpose	
Identify State of N.J. Required Tests and any Other Tests ordered	
Medications – Include Drug Cards Vitamin K	
Erythromycin Ointment	
Triple Dye	
Hepatitis B Vaccine	
Other Medications	

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NUR 112 – CHILDBIRTH EDUCATION OBSERVATION

Objectives: To provide the student with a basic understanding of the need to prepare families for childbirth. To observe the education of expectant parent(s) experiencing the Lamaze method of childbirth.

Clinical Grading: Satisfactory / Unsatisfactory

COMPLETE THE FOLLOWING AND SUBMIT TO YOUR CLINICAL INSTRUCTOR

Date: _____ Location: _____

Educator: _____

Number of Participants: _____ Age Range: _____

Explain the purpose of childbirth education:

Briefly outline the content of the attended class:

Identify the objective(s) of the class you attend:

Explain the ways the educator(s) interacted with the participants:

Describe the behaviors of the parents-to-be exhibited:

What type of exercises were taught or reviewed in the class?

How did the participants interact with educator(s), peers and significant others?

Did everyone participate? _____ If no, please explain _____

From your perspective as a nursing student, describe your feelings and observations about this experience.

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NUR 112 – PRENATAL CARE

Clinical Grading: Satisfactory / Unsatisfactory

Overall Objective: To observe physical assessment of clients during prenatal visits.

After completing this observation, the student will be able to:

1. Identify the components of prenatal assessment including history, physical and psychological behaviors.
2. Outline the medical care needed during sequential visits during pregnancy, including laboratory tests and evaluations.
3. Describe the common physiological and psychological changes and concerns during pregnancy.
4. Compare and contrast the nutritional components needed during pregnancy with nonpregnant requirements.
5. Discuss the role of nursing intervention during prenatal care.

To prepare, the student will:

1. Read the appropriate chapters in Ladewig, P., London, M.L., and Davidson, M. (2006). Contemporary Maternal - Newborn Nursing Care. (6th ed.). Upper Saddle River: Pearson/Prentice Hall
2. Submit written data to the clinical instructor after completing observational visit. Grading is Satisfactory or Unsatisfactory and incorporated in the Clinical Performance Evaluation.
3. Be prepared to discuss appropriate nursing interventions for the antepartal client during all phases of pregnancy.

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NUR 112 – PRENATAL ASSIGNMENT

Clinical Grading: Satisfactory/Unsatisfactory

Assignment

During your visit to the antepartal clinic you are required to research the data from the client research/observation. The data summary is to contain information regarding at least *three* client's seen in the particular setting, preferably one client for each trimester. The following information needs to be included in the data summary on each client seen. (Large index cards may be used or typed report submitted to your clinical instructor)

Data to include for prenatal client (include one client for *each* trimester of pregnancy).

Student Name: _____ Date Submitted: _____

Prenatal Area: _____

Client Initials: _____ Age: _____ Date of Visit: _____

EDB/Weeks Pregnant: _____

Gravida: _____ Para: _____ Abortions: _____

Reason for Visit:

Laboratory tests, procedures, etc. performed on this client.

Significance of test reports received (any further orders/actions).

Identify any significant history.

Health care practitioner's findings.

Identify teaching needs of the client with supportive data/reasons.

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NUR 112 – FAMILY ASSESSMENT PAPER

Grading: Total 100%

Objectives:

1. Identify levels of growth and development related to the family system.
2. Describe family dynamics based upon structure, function and developmental tasks.
3. Analyze family interactions indicating strengths and weaknesses.
4. Discuss goals and interventions needed for the family to cope with problems effectively.

Assignment:

1. Presenting Problem
Give a brief introduction of the family and summarize presenting problem. (5 points)
2. Family Composition and Family Attachment
Draw a genogram. Include name, age and occupation or school grade for each family member. Draw an attachment diagram. Indicate strength and bonding among members. (10 points)
3. Pertinent History
Describe sequence of events leading to current presenting problem. Include the family's previous solutions to cope with the problem and professional help that was utilized. (10 points)
4. Strengths and Problems
Structural (10 points)
 - Subsystems
 - Boundaries
 - Race and Ethnicity
 - Religion and Spirituality
 - EnvironmentDevelopmental (5 points)
 - Stage Identification
 - TasksFunctional (15 points)
 - ADL
 - Communication: Emotional, verbal, non-verbal, circular
 - Differentiate communication between adults/children
 - Problem Solving
 - Roles
 - Control, Alliances/Coalitions

5. Analysis of Data (20 points)
Analyze and summarize the connections between the presenting problem, pertinent history, and family strengths and problems.
6. Goals and Plans (20 points)
Formulate two nursing diagnoses for the family.
Identify measurable goals with outcome criteria.
Indicate plans for interventions and referrals.
Indicate family's reaction and outcome to interventions and referrals.
7. Documentation (5 points)
Support your presentation with appropriate references. Two references should be from professional journals and one from a lay publication.
8. Presentation (S/U)
Collect and present information in an organized, logical and timely manner.

Up to ten points will be assigned for the quality of written work which includes:

- Organization of ideas
- Clarity of communication
- Grammar, punctuation, spelling
- APA format, references