SCIENCE & HEALTH PROFESSIONS

NURSING PROGRAM

NUR 201

COURSE

Information and forms

Volume 2

Spring 2008

Student Name: _____

MERCER COUNTY COMMUNITY COLLEGE
SCIENCE AND HEALTH PROFESSIONS
NURSING PROGRAM
INFORMATION & FORMS

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Information Resources

Classroom – Theory

Classroom theory presentation is based on unit objectives. The focus will be on discussion of relevant theoretical basis of pathophysiology, medical management, and the nursing process for patients with varied psychiatric, pediatric, and medical/surgical problems. The purpose of the theoretical discussions is to update information, to clarify problem areas, to emphasize important concepts, and to assist students to correlate theoretical knowledge into clinical situations; thus strengthening students' critical thinking and problem solving skills. **Students are expected to have completed related readings prior to classroom theory presentation.**

College Lab

College lab will focus on discussion, relevant article review and discussion, skills, video, computer assisted learning, and math calculations. Students are expected to read assigned text and articles prior to the lab and be prepared to work in small groups to discuss pathophysiology, medical management, and the nursing process for assigned topics. **Refer to College Lab Checklist, pp 34**

Clinical Lab

Preparation for clinical lab will focus upon weekly unit clinical objectives. Specific instructions will be given by the clinical instructor. You may be asked to submit selected assignments; these papers, videos and/or oral presentations will be graded satisfactory/unsatisfactory and this notation included in the clinical evaluation.

Medical Surgical Clinical Lab:

One written **Nursing Care Plan or Concept Map** will be submitted during the med/surg rotation. The due date will be announced by the course coordinator. The nursing care plans will be submitted on the due date to the course coordinator during class. The nursing care plan will be graded by the clinical instructor. Nursing Care Plan Guidelines are on page 5

Clinical Post-Conference presentation. See page 4.

Pediatric Clinical Lab: Each student will make one individual oral presentation regarding a pediatric teaching related to a pediatric disease or illness during a post-clinical conference. Evaluation will be incorporated into clinical grade.

Pediatrics: Review the following units in the textbook as basic preparation for this experience:
Ball and Bindler Pediatric Nursing - Chapters 1, 2, 3, 4, and 5.

Psychiatric Clinical Nursing: Each student will make a presentation of a nursing care plan and a mental health status examination of an assigned client. Guidelines will be provided by the clinical faculty.

Clinical - Medical Surgical Nursing

Special Clinical Preparation

Clinical Orientation:

Learning Harbor will be used to complete the annual mandatory education requirements for clinical orientation. You can access the website at **http://learningharbor.sololearning.com**.

- The program may be accessed on-line on any home or work-based computer with Internet access 24 hrs/day, 7 days a week.
- Follow the detailed step-by-step instructions located on the Learning Harbor home page, "Guides".
- As you complete each topic, you will take a short, but simple quiz.
- Your most recent score will be transferred to your education record.

It is your responsibility to complete the mandatory clinical orientation during orientation week prior to beginning your first clinical rotation.

Please submit a completion printout at NUR 201 Orientation.

Clinical Post-Conference

Each student will present an individual oral presentation and lead discussion regarding the nursing process of a client with a selected medical-surgical disease or illness related to clinical experience during a post-clinical conference. A written overview/study guide should be prepared for colleague students. Selected topic should be related to selected client assignments. Evaluation will be incorporated into clinical grade. **Please choose one topic from the following list:**

Medical Surgical Clinical Lab
Post-Clinical Conference Topics

Topic	Student	Date
Fluid & Electrolytes Normal & Disturbances		
Neurological Assessment / Glascow Coma Scale		
Stepped approach to drug therapy for treatment of Hypertension with review of diuretics – action on specific site in kidney, side effects, dosages, and nursing implications.		
Stepped approach to drug therapy for treatment of Hypertension with review of antihypertensive medications – Beta adrenergic Blockers		
Stepped approach to drug therapy for treatment of Hypertension with review of antihypertensive medications – ACE (Angiotensin-Converting Enzyme) Inhibitors		
Stepped approach to drug therapy for treatment of Hypertension with review of antihypertensive medications – Direct vasodilators		
Normal Coagulation and actions of on coagulation by the anticoagulant Coumadin – include actions, indications, dosage, side effects, untoward effects, antidote + lab values to monitor		
Normal Coagulation and actions of on coagulation by the anticoagulant Heparin – include actions, indications, dosage, side effects, untoward effects, antidote + lab value to monitor		
Nursing care of the patient receiving tube feedings via gastrostomy or PEG tube (Nutritional needs & usual types of replacement, procedure, complications, patient assessment, nursing actions with rationale, patient/family education)		
Care of the patient with a central line IV catheter – types of catheters used, types of fluids used, purposes, nursing care: patient assessment, nursing actions, and patient education)		
Acid Base Balance – respiratory & metabolic disturbances		
Care of the patient with tracheostomy—including suction and care		
Differentiate the Motor & Sensory Deficits relate to Cerebrovascular Accident		
Describe the care of the pediatric and adult patient with intestinal obstruction – causes, medical treatment including types of tubes used to decompress the bowel, nursing management including patient assessment, nursing actions, and patient education		
Overview of medications used in the treatment of chronic obstruction lung disease including indications, actions, side effects, dosage, and nursing implications of bronchodilators—long and short acting, anticholinergic drugs , and steroids.		
Overview of medications used during cardiopulmonary resuscitation – Pulseless ventricular tachycardia/ventricular fibrillation, Pulseless asystole		
Other topic (approved by clinical instructor):		

NUR201
NURSING CARE PLAN GUIDELINES

I. Purpose of Nursing Care Plan

To plan for the physical, emotional and cultural needs of a particular client with a major health problem or exacerbation of a chronic illness, who is expected to recover to his/her previous level of function. Planning for homecare should be included.

II. Requirements

Use an 8 ½ x 11" bond paper (lined, onion skin or thin erasable paper is not acceptable). Typing is required. Paper should be thoroughly proofread and all corrections made. All papers must be formatted according to APA, numbered and stapled together.

Title page or cover sheet must include student's name, client's initials, date of care and instructor's name. A copy of the clinical assignment information must be attached as Page 2.

A brief synopsis of a nursing journal article that addresses problems pertinent to your client and how this information will help you in your nursing practice is also required.

III. Grading

The Nursing Care Plan will be graded with 100 points as being the possible maximum points earned. The points are allocated to the various parts of the Nursing Care Plan as follows:

Percentages:

PART I	**Assessment**	**30%**
PART II	**Analysis and Synthesis of Problems**	**25%**
PART III	**Planning** **Outcomes** **Nursing Actions** **Nursing Action Rationales** **Implementation**	**25%**
PART IV	**Community Resources/Referrals**	**5%**
PART V	**Evaluation of Outcomes**	**10%**
PART VI	**Bibliography and Format**	**2%**
PART VII	**Related Journal Article & Synopsis**	**3%**
Total		***100%***

IV. Due Date

The Nursing Care Plan must be submitted by the due date as specified by the course outline and the clinical instructor grading the paper.

V. Clinical Assignment information needed for Page 2.

FRAMEWORK OF THE NURSING CARE PLAN

Part I Assessment (30 points)

1. Data Collection

A. Demographic Data
   1. Biographical data (i.e. date of care, client's initials, age, sex, occupation, diagnosis, marital status, type of living arrangements, wage earner, primary language).
   2. Chief complaint from client and other sources.

B. Psychological Health
   1. Coping patterns (i.e. handling the illness, etc.)
   2. Interaction patterns (i.e. interacting with others, family, MD's, hospital staff).
   3. Cognitive patterns (i.e. reality oriented, understanding one's own illness).
   4. Self concept (i.e. self image and self worth).
   5. Emotional patterns (i.e. stable, moody, etc.)
   6. Family coping patterns (i.e. response to patient's illness by family members).

C. Biophysical Health (document sources if obtained other than from client directly)
   1. General appearance and overall physical assessment.
   2. Growth and development level according to Erickson.
   3. Daily activity patterns, for example:
      - Safety
      - Nutrition/Fluids
      - Elimination
      - Rest/Activity
      - Hygiene/Comfort
      - Sleep
      - Oxygenation (include neurologic, cardiovascular, respiratory)
      - Comfort/Pain
      - Substance Use/Abuse (medications/alcohol)
      - Human Sexuality
   4. Previous biophysical health history
      - Previous hospitalizations/surgeries/illnesses
      - Past restorative interventions (i.e. prescribed medications and interventions)
      - Immunization history
      - Allergies
      - Family health history (diabetes/hypertension/heart disease)
      - Tobacco or alcohol use

D. Socio-Economic Health
   1. Cultural patterns (significant relationships)
   2. Recreational patterns
   3. Financial patterns/economic health

E. Spiritual Health/Values/Beliefs
   1. Religious beliefs and practice
   2. Indicators of values (i.e. orderliness, cleanliness, upkeep of belongings, open dialogue, active listening, praise)
   3. Incorporating values into lifestyle

F. Physician's plan of action for the pathological state
   1. Admission diagnosis

G. Describe the pathology – include trends of lab values – explain all abnormal findings.
   2. Describe the medical/surgical plan (i.e. medications must include generic/trade name, classification, dosage, route, frequency, rationale for med, nursing precautions and/or measures; tests; treatments; surgeries; consultations and recommendations from other Allied Health disciplines).

G. Other contributing diagnosis that have direct affect on client's current illness
   1. Describe pathology and how they affect the client's current illness.
   2. Describe the concurrent medical treatment plan in effect.

Part II Analysis and Synthesis of Data (25 points)

Alteration of Basic Needs	**Textbook Picture of Pathology**	**Compare Client's Data with Text Picture**	**Identify all Nursing Care Problem Areas (Nursing Diagnoses)**
Give relevant data (i.e. signs, symptoms, behavior, etc., that confirms the alterations			

<u>Select top five relevant nursing diagnoses:</u>

Part III Planning the Care for the Client (25 points) for FIVE (5) Nursing Diagnoses

1. Establish the nursing diagnosis (NANDA approved) **according to priority.**
2. Establish client outcomes according to priority, listing **short and long term goals.**
3. Plan **<u>nursing care+ to include what to assess, actions, and patient education with rationales</u>**.

Nursing Diagnosis by Priority	**Client/Goals/Outcomes**	**Nursing Care+***	**Rationale**

Indicate by * those nursing actions implemented during your care of the client.

Part IV Community Resources (5 points)

List your recommended community resource(s) and referral (s) related to each nursing diagnosis with a description of the community resource/referral and a rationale for recommendation.

Community Resource/Referral	**Description**	**Rationale**

Part V Evaluation of Outcomes (10 points)

1. Evaluate each goal/outcome that you have stated, indicating whether or not they were met.
2. Identify factors (other than limited time with your client) that interfered with meeting the goals/outcomes.

Part VI Bibliography and Format (2 points)

1. Format includes:
   A. Use of correct English in complete sentences. Abbreviations, other than the standard medical Latin, are not acceptable. The meaning of the abbreviation must be given upon its initial use.
   B. APA format when referencing.
   C. Correct spelling and punctuation.
   D. Bibliography and references must be current (i.e. within the past five (5) years).

Part VII Nursing Journal Article (3 points)

Review nursing journals/online journals and choose one article that addresses a problem pertinent to your client. Write a **succinct synopsis** of the article and document how this information will help you in your nursing practice. Articles must be a minimum of two (2) pages from a professional nursing journal. Include a copy of the article with your nursing care plan. **Include a copy of the article with your NCP.**

DEFINITIONS

The definition of terms used in the Nursing Care Study:

1. **Analysis** – the arrangement of data into categories to identify the relationship between basic needs and the data.

2. **Assessment** – the systematic way of obtaining data about a client, including:
   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

3. **Evaluation** – assessing the client's response against predetermined goals.

4. **Implementation** – putting the plan into action.

5. **Nursing Diagnosis –** is a clear, concise, specific statement about a client's responses to the actual or potential problems that require nursing interventions. This should include:
   a. Etiology or contributing factors
   b. Scientific explanation to these factors

6. **Outcome** – a desired goal that you and your client hope to achieve in order to remedy or to lessen the problem.

7. **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 to include what to further assess, nursing actions, and client/family education.

8. **Scientific Rationale** – the knowledge of natural, behavioral, medical, nursing and social sciences that give a purpose and explanation of your study.

9. **Synthesis** – the putting 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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DIVISION OF SCIENCE AND HEALTH PROFESSIONS
NUR 201 -- NURSING CARE PLAN GRADE – Spring 2008

PART I	**Assessment**	**%**	**Strengths / Areas to Improve:**	**Student Grade**
	Demographic data	**(1)**		
	Biophysical health (head-to-toe physical assessment) Previous biophysical	**(10)**		
	Psychological health Socio-economic health Spiritual health/values/beliefs	**(7)**		
	Medical Diagnosis(es) Consultation(s) Physician's medical management plan Treatment(s) (surgery, therapies)	**(4)**		
	Medications (actions, indications, nursing implications) **Submit medication cards with NCP**	**(4)**		
	Laboratory Values (analysis of trends) Other testing results that impact client diagnosis: (radiological, cardiac-echo, stress test, cardiac cath)	**(4)**		
			Total 30%	
PART II	**Analysis and Synthesis of Problems**	**%**	**Strengths/Areas to Improve:**	
	Alteration of basic needs in behavioral terms (based on Maslow's Hierarchy of Needs)	**(6)**		
	Textbook picture of pathology	**(5)**		
	Comparison of client's data with textbook picture	**(7)**		
	Identification nursing diagnosis(es) List all possible nursing diagnoses (NANDA approved)	**(7)**		
			Total 25%	
PART III	**Plan of Care:**	**%**	**Strengths/Areas to Improve:**	
	Listing of 5 nursing diagnosis by priority	**(5) for each Nsg Dx & Plan**		
	Client Goals in measurable, behavior terms (as evidenced by…) Short term Long Term			

	Nursing Care should include the following: **Assessment** (what to further assess) **Nursing Actions** (priorities to do for and with the client) **Client Education** **Rationale for each section of nursing care** **Implementation** Nursing care provided by student should be designated by an * asterisk	**Total 25%**	
PART IV	**Community Resources/Referrals Strengths/Areas to Improve:** Describe the resource(s) & explain how it will benefit the client in the home setting.	**Total 5%**	
PART V	**Evaluation of Outcomes Strengths/Areas to Improve:** Evaluate each goal/outcome that you have stated, & describe how the goal was met or not met. Identify factors (other than limited time with your client) that interfered with meeting the goals/outcomes. The Evaluation Section may be **included as an additional column with Part III** **or listed separately with each nursing diagnosis.**	**Total 10%**	
PART VI	**Bibliography and Format Strengths/Areas to Improve:** Correct and appropriate English content APA Format (5th edition) Correct and appropriate English grammar (spelling, punctuation, appropriate abbreviations) Bibliography and references: Current Relative and appropriate Evidence based	**Total 3%**	
PART VII	**Related Journal Article & Synopsis Strengths/Areas to Improve:**	**Total 2%**	
Total		***100%***	

_____

Faculty Signature Date

Concept Map

Guidelines & Scoring Sheet will be distributed at Orientation

MERCER COUNTY COMMUNITY COLLEGE
DIVISION OF SCIENCE AND HEALTH PROFESSIONS
NUR 201

EMERGENCY ROOM OBSERVATION

Students will report to pre-conference, thereafter reporting to the ER Nurse Manager to be assigned a specific RN within whom the student will observe the nursing process in the Emergency Room.

Student objectives:

1. Describe the nurse's role in priority setting when providing nursing care in the Emergency Room.
2. Observe client triage and preparation for diagnostic procedures.
3. Observe client emergency care and transport to hospital unit.
4. Observe monitoring equipment commonly used in client assessment.
5. Observe RN administering emergency medications; describe their effect on the client as it relates to their medical diagnosis.
6. Describe the nursing care pre and post any emergency procedure.

Student Preparation:

Students will review the following chapters in Ignatavicius & Workman Textbook of Medical Surgical Nursing – Critical Thinking for Collaborative Care

Chapter 36 -- Assessment of the Cardiovascular System

Chapter 30 – Nursing Assessment of the Respiratory Function

Chapter 37 – Intervention for Clients with Dysrhythmias and Conduction Problems

Chapter 41 – Intervention for Clients with Acute Coronary Syndromes

Chapter 40 – Intervention for Clients with Shock

Student will also prepare a weekly prep nursing care plan on a selected patient scenario.

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CRITICAL CARE NURSING OBSERVATION

Students will report to pre-conference, thereafter reporting to the Critical Care Nurse Manager to be assigned a specific RN within whom the student will observe the nursing process in the Critical Care Unit.

Student objectives:

1. Describe the nurse's role in priority setting when providing nursing care in the Critical Care Unit.
2. Observe client care for diagnostic procedures including prep and follow-up care.
3. Observe client emergency care—nursing team roles and responsibilities.
4. Observe monitoring equipment commonly used in client assessment.
5. Observe RN administering prescribed and emergency protocol medications; describe medication administration rationale and effect on the client.
6. Describe client's response to prescribed therapy—physical assessment, laboratory studies, radiological results, and status of cardiac rhythm.

Student Preparation:

Students will review the following chapters in Ignatavicius & Workman Textbook of Medical Surgical Nursing – Critical Thinking for Collaborative Care.

Student will also prepare a weekly prep written nursing care plan on a selected patient scenario.

Chapter 32 – Intervention for Clients with Noninfectious Problems of the Upper Respiratory Tract

Chapter 33 – Intervention for Clients with Noninfectious Problems of the Lower Respiratory Tract

Chapter 31 – Interventions for Clients requiring Oxygen Therapy or Tracheostomy

Chapter 37 – Intervention for Clients with Dysrhythmias and Conduction Problems

Chapter 38 -- Intervention for Clients with Cardiac Problems

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TELEMETRY OBSERVATION

Students will report to pre-conference, thereafter reporting to the Telemetry Nurse Manager to be assigned a specific RN within whom the student will observe the nursing process in the Telemetry Unit.

Student objectives:

1. Describe the nurse's role in priority setting when providing nursing care in the Telemetry Unit.
2. Observe client care for diagnostic procedures including prep and follow-up care.
3. Observe client emergency care—nursing team roles and responsibilities.
4. Observe monitoring equipment commonly used in client assessment.
5. Observe RN administering prescribed and emergency protocol medications; describe medication administration rationale and effect on the client.
6. Describe client's response to prescribed therapy—physical assessment, laboratory studies, radiological results, and status of cardiac rhythm.

Student Preparation:

Students will review the following chapters in Ignatavicius & Workman Textbook of Medical Surgical Nursing – Critical Thinking for Collaborative Care.

Chapter 32 – Intervention for Clients with Noninfectious Problems of the Upper Respiratory Tract

Chapter 33 – Intervention for Clients with Noninfectious Problems of the Lower Respiratory Tract

Chapter 31 – Interventions for Clients requiring Oxygen Therapy or Tracheostomy

Chapter 37 – Intervention for Clients with Dysrhythmias

Chapter 38 -- Intervention for Clients with Cardiac Problems

Student will also prepare a weekly prep written nursing care plan on a selected patient scenario.

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CARDIAC SURGERY CLINICAL OBSERVATION

Students will report to Deborah Heart and Lung Center at 8:00am. Observation will continue through 2:30 pm, with a lunch break.

Student objectives:

1. **Describe the nurse's role in priority setting when providing nursing care to clients undergoing cardiac surgery, prior to, during and following the procedure.**
2. **Observe client preparation for cardiac surgery.**
3. **Observe client assessment and treatment during cardiac surgery by the multidisciplinary operating room team.**
4. **Observe monitoring and heart-lung equipment commonly used during cardiac surgery.**
5. **Observe RN administering medications; describe their effect on the client as it relates to his medical diagnosis.**
6. **Observe medical decision-making and the course of events during cardiac surgery.**
7. **Observe the nurse's role in assessment and treatment of any complications that may occur during and immediately following cardiac surgery.**
8. **Describe client's response to cardiac surgery and related procedures—physical assessment, status of coronary perfusion, and status of cardiac rhythm.**

Student Preparation:

Students will review the following chapters in Ignatavicius & Workman Textbook of Medical Surgical Nursing – Critical Thinking for Collaborative Care.

Chapter 36 – Assessment of the Cardiovascular System

Chapter 37 – Interventions for Clients with Dysrhythmias

Chapter 41 – Interventions for Critically Ill Clients with Acute Coronary Syndromes

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CARDIAC CATHETERIZATION CLINICAL OBSERVATION

Students will report to Deborah Heart and Lung Center at 8:00am. Observation will continue through 2:30 pm, with a lunch break.

Student objectives:

1. **Describe the nurse's role in priority setting when providing nursing care to clients undergoing cardiac catheterization prior to, during and following the procedure.**
2. **Observe client preparation for cardiac catheterization.**
3. **Observe client assessment and treatment during cardiac catheterization by the multidisciplinary cardiac team.**
4. **Observe monitoring equipment commonly used in cardiac catheterization.**
5. **Observe RN administering medications; describe their effect on the client as it relates to his medical diagnosis.**
6. **Observe medical decision-making and the course of events during interventional cardiac catheterization.**
7. **Describe client's response to cardiac catheterization and related procedures—physical assessment, status of coronary perfusion, and status of cardiac rhythm.**

Student Preparation:

Students will review the following chapters in Ignatavicius & Workman Textbook of Medical Surgical Nursing – Critical Thinking for Collaborative Care.

Chapter 36 – Assessment of the Cardiovascular System

Chapter 37 – Intervention for Clients with Dysrhythmias

Chapter 38 – Intervention for Clients with Cardiac Problems

Chapter 39 – Interventions for Clients with Vascular Problems

Chapter 41 – Interventions for Critically Ill Clients with Acute Coronary Syndromes

MERCER COUNTY COMMUNITY COLLEGE
NUR 201
Cardiac Catheterization Review

Anatomy & Physiology Review:

Blood returns to the heart from the upper body via the _____.

Blood returns to the heart from the lower body via the _____.

The _____ valve is located between the right atrium and right ventricle. The valve _____ (opens or closes?) when the right ventricle contracts and blood is pumped to the lungs.

The _____ valve is located at the junction between the pulmonary artery and the right ventricle. This valve _____ (opens or closes?) when the right ventricle contracts and blood is pumped into the lungs.

The _____ or bicuspid valve is located between the left atrium and the left ventricle. This valve prevents _____ of blood from the left ventricle to the _____ when the left ventricle _____.

The aortic or _____ valve is located between the _____ and the aorta. The valve is open during _____ and closed during _____.

Define systole:

Define diastole:

Describe the coronary arteries and the purpose of coronary circulation:

The right and left coronary arteries branch from which blood vessel?

Cardiac Output is defined as _____.

In order to calculate cardiac output, we must know the _____ rate and stroke volume.

Stroke volume is defined as _____. The average resting stroke volume is 60-80 m per beat.

Cardiac Output = stroke volume X heart rate

The normal cardiac output is _____ liters per minute.

Calculate cardiac output if stroke volume is 75 ml and heart rate is 75 beats per minute.

Calculate here:

Using the cardiac output you just calculated as a resting normal what is the stroke volume of a marathoner whose resting pulse is 40 beats per minute?

Cardiac output = stroke volume X heart rate

_____ ml = stroke volume X 50 bpm

cardiac output / heart rate = stroke volume

Calculate here:

Right-sided Cardiac Catheterization:

The catheter is inserted through which blood vessel? _____.

The purpose of a right-sided cardiac catheterization is:

Left-sided Cardiac Catheterization:

The catheter is inserted through which blood vessel? _____.

The purpose of a left-sided cardiac catheterization is:

Name three (3) indications for cardiac Catherization.

Name three (3) priority items to include in patient education of the patient prior to the cardiac catherization procedure.

Name five (5) complications of cardiac catheterization.

List priority patient assessment following cardiac Catherization:

List most important nursing action immediately following cardiac catherization:

<u>Complete the following during clinical observation</u>:

What are the priority patient assessments and nursing actions during the cardiac catheterization procedure?

List criteria used for discharge of a patient following cardiac catheterization:

List important patient education topics to discuss with patient prior to discharge after a cardiac catheterization:

Cardiac Catheterization:

The most definitive, but most invasive, test in the diagnosis of heart disease is cardiac catheterization. Cardiac catheterization may include studies of the right or left side of the heart and the coronary arteries.

Indications for Cardiac Catheterization include:

- To confirm suspected heart disease, including coronary artery disease, myocardial disease, valvular disease, and valvular dysfunction
- To determine the location and extent of the disease process
- To assess the following:
    - Stable, severe angina unresponsive to medical management
    - Unstable angina pectoris
    - Uncontrolled heart failure, ventricular dysrhythmias, or Cardiogenic shock associated with acute myocardial infarction, papillary muscle dysfunction, ventricular aneurysm, or septal perforation
- To determine best therapeutic option (percutaneous transluminal coronary angioplasty, stents, coronary artery bypass graft, valvulotomy versus valve replacement)
- To evaluate the effects of medical or invasive treatment on cardiovascular function, percutaneous transluminal coronary angioplasty, or coronary artery bypass graft patency.

Client Preparation:

Many clients express anxiety and fear regarding cardiac catheterization. The nurse assesses their physical and psychosocial readiness and knowledge level.

The nurse reviews the purpose of the procedure, informs the client how long it usually takes, states who will be present, and describes the appearance of the catheterization laboratory. The client is also informed about the sensations that maybe experienced during the procedure, such as palpitations (as the catheter is passed up to the left ventricle), a feeling of heat or a hot flash (as the dye is injected into either side of the heart)s and a desire to cough (as the dye is injected into the right side of the heart). The nurse may use writt4en or illustrated materials or videotapes, if available, to assist in the client's understanding.

The risks of cardiac catheterization are usually explained by the cardiologists. The risks vary with the procedures to be performed and the client's physical status. Right catheterization is less risky than left-sided catheterization. Several complications may follow:

Right-Sided Heart Catheterization:
Thrombophlebitis - Pulmonary embolism - Vagal response

Left-Sided Heart Catheterization & Coronary Arteriography:
Myocardial infarction - Stroke - Arterial bleeding - Thromboembolism - Dysrhythmias

Right or Left Heart Catheterization:
Cardiac tamponade - Hypovolemia - Pulmonary edema
Hematoma or blood loss at insertion site - Reaction to contrast medium

The cardiologist or radiologist obtains a written informed consent from the client or responsible party.

The client may be admitted to the hospital on the day of the catheterization procedure. Standard preoperative tests are performed, which usually include a chest x-ray examination, complete blood count, coagulation studies, urinalysis, and 12-lead electrocardiogram. The client receives nothing by mouth after midnight or has only a liquid breakfast if the catheterization is to take place in the afternoon. The catheterization site is shaved and antiseptically prepared according to policy.

Nursing assessment before the procedure includes measuring the client's vital sings, auscultating the heart and the lungs, and evaluating the peripheral pulses. The nurse questions the client about any history of allergy to iodine-containing substances (e.g., seafood and contrast agents). An antihistamine may be given to a client with a positive history. A mild sedative is administered before the procedure. If the client normally takes a digitalis preparation or diuretic, it is usually withheld before the catheterization.

Post-Procedure Care:

Immediately following the cardiac catherization, point pressure is exerted at the cardiac catherization entry site (usually groin region) for 20-30 minutes. A pressure dressing is placed over the insertion site. Typically the client is restricted to bedrest. The current practice is for clients to remain in bed for 4 to 6 hours. Some cardiologists allow the head of the bed to be elevated up to 30- to 45 degrees during the period of bedrest, whereas other cardiologists prefer that the client remain supine. A 5 to 10 pound sandbag or C-clamp may be applied over the insertion site to ensure Hemostasis.

The nurse has many post catheterization responsibilities. Vital sings are monitored every 15 minutes for 1 hour, then every 30 minutes for 2 hours, or until the vital signs are stable, and then every 4 hours or according to hospital policy. The insertion site is monitored for bloody drainage or hematoma formation. Peripheral pulses in the affected extremity, as well as skin temperature and color, are monitored with every vital sign check.

The nurse must observe for complications of cardiac catheterization. Complains of pain and discomfort at the insertion site, chest pain, nausea, or feelings of lightheadedness should be reported. The client is often attached to a cardiac monitor. If not, the nurse ascultates the hear sounds, noting rhythm and rate to detect dysrhythmias. Because the contrast medium acts as a osmotic diuretic, the nurse monitors urinary output and ensures that the client receives sufficient oral and IV fluids for adequate excretion of the dye. Pain medication for insertion site or back discomfort may be given, as ordered.

If the client experiences chest pain, dysrhythmias, bleeding, hematoma formation, or a dramatic change in peripheral pulses in the affected extremity, the nurse contacts the physician immediately and provides prompt intervention. Neurologic changes, such as visual disturbances, slurred speech, swallowing difficulties, and extremity weakness, should also be reported.

References:

Ignatavicius & Workman, Medical-Surgical Nursing, Critical Thinking for Collaborative Care, 5th edition—attached notes

MERCER COUNTY COMMUNITY COLLEGE
NUR 201
CLINICAL - PEDIATRIC NURSING
PEDIATRIC CLINICAL EXPERIENCE PREPARATION GUIDE

Student Name _____ Date _____

Assigned Child	**Textbook Findings**
1. Diagnosis (es)	Pathophysiology
2. Pertinent lab findings	Significance
3. Medications – use additional sheet as necessary	Action, side effects, safe dosage, calculation, special considerations
4. Diet I&O	Significance Fluid requirements
5. IV Fluids	
6. Immunizations	Up to date?

Assigned Child	**Textbook Findings**
7. Physical Assessment findings	Significance
8. Growth & Development A. Stages Erickson Piaget B. Physical Height & Weight Gross motor Fine motor C. Language D. Play & Socialization (Toys)	
9. Reaction to Hospitalization	
10. Parent-child relationship	
11. Teaching needs	
12. Nursing Diagnosis	

Assigned Child	**Textbook Findings**
Physiological Psychosocial	
13. Nursing Interventions (age appropriate) **Evaluation – post clinical conference**	Rationale

MERCER COUNTY COMMUNITY COLLEGE
PEDIATRIC CLINICAL POST CONFERENCE PRESENTATION
NUR 201

Pediatric Clinical Lab:

Each student will make one individual oral presentation regarding a pediatric teaching related to a pediatric disease or illness during a post-clinical conference. Evaluation will be incorporated into clinical grade.

Subject areas for Pediatric Teaching Projects

Care of the Child with:

Oxygen needs – ventilation
- Asthma, RSV, Pneumonia
- T&A, Otitis media
- Communicable Diseases

Oxygen needs – Diffusion
- Anemias
- Leukemia
- Hemophilia

Rest and Activity
- Hip dysplasia, Legg-Perthes, Club foot
- Scoliosis
- Fractures – casting, traction

Inflammatory/Infection
- Rheumatoid arthritis
- Rheumatic fever

Nutrition
- Nausea, vomiting, dehydration
- Pyloric stenosis
- Cleft lip & cleft palate

GI
- Appendicitis
- Intussusception

Other topic: (with approval of clinical instructor)

Pediatric Long Term Care

NUR 201

Clinical Observational Objectives

1. Explain the purposes of nursing strategies used in the assessment and care of children with chronic illnesses.

2. Utilize principles of effective therapeutic communication in interacting with the children and their families.

3. Discuss the impact of long-term nursing care for children and their families.

4. Identify the socialization needs for children in an extended-care facility.

5. Identify how educational needs are met for children in an extended-care facility.

Clinical - Psychiatric Nursing

Mental Status Exam Form

– form will be distributed by clinical faculty

Nursing Care Plan Presentation Guidelines

– guidelines will be distributed by clinical faculty

MERCER COUNTY COMMUNITY COLLEGE
DIVISION OF SCIENCE AND HEALTH PROFESSIONS

CLINICAL LABORATORY PERFORMANCE EVALUATION

STUDENT'S NAME: _____ CLASS OF 20_____

MERCER ID # _____

PERSONAL AND PROFESSIONAL CHARACTERISTICS	**1st Rotation**	**2nd Rotation**	**3rd Rotation**	**4th Rotation**	**5th Rotation**	**Summary***
1. Arrives promptly for conferences.						
2. Attends clinical lab experiences as required per Nursing Program Information Packet.						
3. Submits assignments on time.						
4. Observes the Nursing Department dress code and policies regarding hospital labs.						
5. Uses judgment regarding the nursing code of ethics by: A. reporting own actions accurately B. maintaining the confidentiality of clients C. expressing no derogatory remarks and/or actions about other members of the health team						
6. Demonstrates courteous, considerate and collaborative behavior with clients, peers, and co-workers.						
7. Accepts suggestions/criticism and offers suggestions for improvement of client's care, the learning experience and one's own learning process.						
8. Makes timely and constructive contributions in conferences.						
9. Demonstrates good health practices.						
10. Initiates new learning experiences with guidance based on clinical objectives.						
11. Utilizes time constructively to achieve clinical objectives with two or more client care assignments.						
PREPARATION – ASSESSMENT OF DATA AND PLANNING OF CARE						
1. By written and oral means, correlates theory and skills by utilizing references in the biological, nursing, behavioral, and social sciences.						

PREPARATION – ASSESSMENT OF DATA AND PLANNING OF CARE	**1st Rotation**	**2nd Rotation**	**3rd Rotation**	**4th Rotation**	**5th Rotation**	**Summary***
2. Collects data from assignment sheets and sorts out pertinent information in relation to the essential diagnosis for assigned clients.						
3. Correlates preparation with client's chart and discusses with instructor.						
4. Incorporates client's age, developmental level, anticipated behaviors and coping mechanisms when planning care for the client.						
5. Identifies appropriate long and short term goals for the client.						
6. Identifies the priorities of the nursing actions for the clients based upon the nursing assessment.						
7. Describes a plan of action in logical sequence for the assigned client or clients.						
8. Uses available resources to prepare for performance of skills.						
9. Incorporates the policies and procedures of the agency including legal implications when planning and implementing client care.						
10. Describes how socio-cultural factors will influence care and health teaching.						
IMPLEMENTATION – ASSESSMENT OF CLIENT, REVISION OF PLAN AND ACTION						
1. Reassesses plan of care based on changes in current client care to one or more clients which demonstrates the use of scientific principles.						
2. Effectively utilizes therapeutic communication skills and techniques when interviewing and providing client care.						
3. Initiates, maintains, and establishes a positive relationship with clients, staff and peers.						
4. Implements nursing care plan utilizing priority of client's needs based on physical, emotional and cultural needs.						
5. Reassesses client's needs by identifying realistic problems and alters the plan of care as the client's needs arise.						

IMPLEMENTATION - ASSESSMENT OF CLIENT, REVISION OF PLAN AND ACTION	**1st Rotation**	**2nd Rotation**	**3rd Rotation**	**4th Rotation**	**5th Rotation**	**Summary***
6. After consulting with the instructor, instructs and correctly prepares the client before, during and after specific treatments.						
7. Accurately observes, records and reports.						
8. Promptly reports pertinent observations to instructor and appropriate hospital personnel.						
9. After consulting with instructor, safely carries out nursing actions without potential injury or danger to the clients, nurse or other personnel.						
10. Seeks appropriate guidance when in doubt.						
11. Recognizes how outside forces (legal, ethical and political trends; socio-cultural/economic/developmental factors) will influence health care and health teaching.						
12. After consulting with instructor, provides teaching which is adapted to meet client's needs.						
13. Consults with instructor, regarding client care assignments, to establish priorities and implement actions concerning decision making.						
14. With instructor guidance, shows flexibility in planning client care.						
15. Demonstrates safe, effective preparation and administration of oral, topical, parenteral and intravenous medications to clients of various age groups reflecting nursing knowledge, skill and critical thinking under instructor supervision.						
EVALUATION - EFFECTIVENESS OF PREPARATION AND IMPLEMENTATION (POST CONFERENCE)						
1. Proper information was gathered.						
2. Appropriate sources of information were utilized.						
3. Reviews the priorities of the client's needs for appropriateness and necessary revision.						
4. Provides appropriate nursing care in a logical sequence.						
5. Evaluates effectiveness of nursing care based upon meeting the client short term goals and contributing to long term goals, revising measurement criteria as needed.						
6. Revises a nursing care plan based on assessment to meet the client's physical, emotional and cultural needs.						

EVALUATION - EFFECTIVENESS OF PREPARATION AND IMPLEMENTATION (POST CONFERENCE)	1st Rotation	2nd Rotation	3rd Rotation	4th Rotation	5th Rotation	Summary*
7. Communicates to the nursing staff, nursing care that was provided.						
8. Identifies client's feelings or underlying meanings of behavior.						

GRADING

0 Behavior Never Seen
1 Behavior Rarely Seen
2 Behavior Sometimes Seen
3 Behavior Consistently Seen
N/A Experience Not Available

FINAL GRADE

All students must achieve at least a "2" for all objectives by the end of the semester.

Week 3

Instructor_____

Student _____

Week 6

Instructor_____

Student _____

Week 9

Instructor_____

Student _____

Week 12

Instructor_____

Student _____

Week 15

Instructor_____

Student _____

Revised 6/03, 06/05
Reviewed 06/04

MERCER COUNTY COMMUNITY COLLEGE
DIVISION OF SCIENCE AND HEALTH PROFESSIONS
COLLEGE LABORATORY PERFORMANCE EVALUATION

STUDENT'S NAME: _____ CLASS OF 20_____

Procedure	Date Mastered & Faculty Initials	Procedure	Date Mastered & Faculty Initials
Therapeutic Communication		**Assessment – Mental Status Examination**	
Tracheostomy Care (Suction, Cleaning inner cannula, hyperoxygenation)		**Assessment – Lung Sounds**	
Oxygen Administration **Nasal Cannula** **Rebreather Mask** **Nonrebreather Mask** **Ventimask**		**Assessment – Heart Sounds**	
Immobility: Orthopedic – **Transfer techniques** **Cast care** **Ambulatory assistive devices:** **Use of walker** **Crutch walking** **Use of cane**		**Assessment – Peripheral Vascular Checks**	
		Assessment – Neurological Checks	
Nutritional Management: **NG tube maintenance** **Gastrostomy/)PEG tube maintenance**		**Assessment -- Abdominal Assessment**	

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STUDENT'S NAME: _____ CLASS OF 20_____

Procedure	Date Mastered & Faculty Initials	Procedure	Date Mastered & Faculty Initials
Intravenous Therapy: Preparing large volume IV solutions		**Central Venous Lines: Triple lumen catheter care & dressing change**	
Intravenous Therapy: Adding secondary or piggyback medications to primary IV setups		**Central Venous Lines: Central Ports**	
Intravenous Therapy: Calculating IV Drip Rate		**Central Venous Lines: TPN Administration**	
Intravenous Therapy: Marking IV bags according to hours to be infused		**Blood Transfusion Administration: Packed cells via y-tubing set up**	
Intravenous Therapy: Setting up infusion pumps		**Administration of blood components**	
Intravenous Therapy: Converting a running IV to a capped IV (heparin lock)		**Blood Administration Complications: Monitoring**	
Intravenous Therapy: Removing an IV catheter			
Central Venous Lines: PICC Care and dressing change (peripherally inserted central catheter – single & double lumen)			