

**SUPPLEMENTARY MATERIALS****INDEX**

<b>DESCRIPTION</b>	<b>PAGE</b>
<b>Pediatric Simulation</b>	<b>27</b>
<b>Pediatric Pre-Clinical Worksheet</b>	<b>28</b>
<b>Medication for Pediatric Rotation</b>	<b>28-29</b>
<b>Pediatric Clinical Paperwork</b>	<b>30</b>
<b>Obstetrical Clinical Worksheet</b>	<b>41</b>
<b>Postpartum Assessment Form</b>	<b>42</b>
<b>Obstetrical Simulation</b>	<b>45</b>
<b>Nursing Care Plan</b>	<b>46</b>
<b>Medications for Women's Center</b>	<b>47</b>
<b>Prep for Newborn Nursery</b>	<b>48</b>
<b>Prep for Labor/Postpartum Patient</b>	<b>49</b>
<b>Fetal Heart Monitor Worksheet</b>	<b>50</b>
<b>Assessment of the Newborn</b>	<b>51</b>
<b>Surgery Prep Sheet</b>	<b>53</b>
<b>Diagnostic Recovery Prep Sheet</b>	<b>54</b>
<b>Evidence Based Family Paper Agreement</b>	<b>56</b>
<b>Evidence Based Family Paper Guidelines</b>	<b>57</b>

## **Pediatric Simulation**

### Simulation 1

1. Complete Respiratory case study as assigned.
2. Complete Pain Scales worksheet and quiz as assigned.
3. Review Infant and Pediatric CPR.
4. Review and practice using SBAR with practitioner in simulation.
5. Discuss various respiratory medications and selected pediatric respiratory conditions.
6. Discuss various airways used in pediatrics (nasal and oral).

### Simulation 2

1. Complete GI case study as assigned.
2. Review and define hypovolemic shock (risk factors, identification, and treatment).
3. Review Infant and Pediatric choking.
4. Discuss various types of shock most commonly seen in pediatrics.
5. Practice SBAR with practitioner in simulation.
6. Calculate the minimum 24-hour fluid requirement for pediatric patients under 70 kg.

### Simulation 3

1. Complete a Cardiac case study as assigned.
2. View video(s) over various congenital cardiac conditions in pediatrics.
3. Practice CPR and introduce PALS in simulation setting with cardiac conditions.
4. Practice SBAR with practitioner in simulation.
5. Identify various cardiac rhythm strips.
6. Discuss various medications and administration methods used in the pediatric code setting.

**ARKANSAS TECH UNIVERSITY**  
Department of Nursing  
NUR 3805 – Practicum in Nursing II  
**Pediatric Pre Clinical Worksheet**

1. Read Chapters 34, 40 and 41.
2. Familiarize self with current immunization recommendations - Print and attach: <http://www.cdc.gov/vaccines/recs/schedules/downloads/child/0-18yrs-pocket-pr.pdf>
3. Create vital sign flashcards for normal temperature (rectal vs axillary), heart rate, respiratory rate and blood pressure in children for the following age groups: Newborn, < 2years, 2-6 years, 6-10 years, and 10+ years.
4. Review how to take a temperature with oral, rectal, and axillary thermometers.
5. List and describe Erikson’s psychosocial stages through adolescence.
6. Define the role of play therapy. Give appropriate examples of play for the hospitalized child for each of the age groups: (Infant, Toddler, Pre-school & School-age)
7. Develop communication skills with children of varying ages: You are administering a flu vaccination. How do you communicate this to an infant? A toddler? A preschooler? A school-age child? An adolescent?
8. Pain Scales: Print off a copy of following pain scales – FLACC, FACES, COMFORT and 0-10.
  
9. **EXPLAIN WHY THE FOLLOWING LABS ARE DONE FOR PATIENTS IN AN ICU SETTING. INCLUDE HOW THEY ARE DRAWN AND A SHORT DEFINITION.**  
RSV, FLU, MRSA, PCR, ELECTROLYTES, ABG, VBG, CBG, BLOOD CULTURES, BRONCHIAL ALVEOLAR LAVAGE AND CBC.

**MEDICATIONS FOR PEDIATRIC ROTATION**

The following list includes some commonly prescribed pediatric medications. The student is required to prepare a completed medication sheet before their first day of pediatric practicum and maintain throughout the clinical rotation.

Acetaminophen
Albuterol
Ampicillin
Ancef
Ativan

Claforan
Ibuprofen
Gentamycin
Methadone
Morphine
Prelone Syrup/Prednisone Tabs
Pulmicort
Rifampin
Rocephin
Singulair
Solu-Medrol
Q-Var
Tobramycin
Vancomycin
Xopenex
Zantac
Zithromax

Important Pediatric Measurement Conversions:

5cc = 1 teaspoon
3 tsp = 1 tablespoon
15 cc = 1 tablespoon

30 cc = 1 ounce
1 kg = 2.2 pounds
2.5 cm = 1 inch
1 mcg = 0.001mg
1mL = 1cc
1 gram = 1cc

Pediatric Dosage Calculation EXAMPLE:

Amoxil 40mg/kg/day divided TID

The patient weighs 15 kg.

This drug comes in the concentration of 250mg/5cc.

How many mg per dose? How many cc's per dose?

$$40 \text{ mg} \times 15 \text{ kg} = 600 \text{ mg per day}$$

$$600 \text{ mg} \div 3 = 200 \text{ mg per dose}$$

$$200 \text{ mg} \div 250 \text{ mg} = 0.8 \text{ mg}$$

$$0.8 \text{ mg} \times 5 \text{ cc} = 4 \text{ cc per dose}$$

Student Name: \_\_\_\_\_

**ARKANSAS TECH UNIVERSITY**  
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**Pediatric Clinical Paperwork**

Patient Initials: \_\_\_\_\_ Age: \_\_\_\_\_ Male or Female

Allergy & Reactions: \_\_\_\_\_  NKA

Medical Diagnose(s) for this hospitalization: \_\_\_\_\_

Chronic Illness: \_\_\_\_\_  N/A

Event(s) that brought patient to the hospital:

Birth History IF <2 years of age:

What is the expected outcome for this patient long term?

List all procedures this patient has had since admission (List most current for long term patients)

WEIGHT	KG	% Growth Chart
HEAD CIRCUMFERENCE <2yo		% Growth Chart
HEIGHT/LENGTH		% Growth Chart

## **NUTRITION**

WHAT TYPE OF NUTRITION OR DIET IS THE PATIENT RECEIVING? BE SPECIFIC – FEEDING SCHEDULE, TYPE OF FORMULA, ROUTE, RATE... IF NOT RECEIVING FEEDS WHAT OTHER NUTRITION IS THE PATIENT RECEIVING?

## INTAKE & OUTPUT

<p><u>24 Hour Fluid Requirement:</u>      <b>SHOW YOUR MATH:</b></p> <p>100cc FIRST 10kg          50cc NEXT 10kg          20cc REMAINDER OF WT kg</p> <p><input type="checkbox"/> N/A if &gt;70kg</p>	<p>What is the hourly fluid requirement?</p>
<p>What was your patient's total shift intake?</p> <p>_____ cc</p>	<p>Was the intake adequate?</p> <p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>Rationale:  <b>If inadequate</b></p>
<p>Type of IV Fluid:</p> <p>_____ @ _____ hour</p>	<p>Why is the patient receiving IV fluids?</p> <p><input type="checkbox"/> No IV      <input type="checkbox"/> Saline Lock</p>
<p>24 Hour Output Requirement &amp; Shift Total          (1cc/kg/hour)</p> <p><input type="checkbox"/> N/A if &gt; 30cc/hour</p>	<p>Was the output adequate?</p> <p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>Rationale:  <b>If inadequate</b></p>



**VITAL SIGNS**

<b>VITAL SIGNS</b>	<b>MORNING</b>	<b>AFTERNOON</b>	<b>INTERPRET</b>	<b>NURSING INTERVENTIONS</b>
Temperature			<b>NORMAL HIGH LOW</b>	
Pulse			<b>NORMAL HIGH LOW</b>	
Respiration			<b>NORMAL HIGH LOW</b>	
Blood Pressure			<b>NORMAL HIGH LOW</b>	
Oxygen Saturation			<b>NORMAL HIGH LOW</b>	

**PAIN**

**CIRCLE** Pain Scale Utilized: 0-10 FLACC FACES COMFORT OTHER: \_\_\_\_\_

Pain Score: \_\_\_\_\_

Interventions (What would be used if no pain?) \_\_\_\_\_

Effectiveness: \_\_\_\_\_  N/A

**FAMILY**

Who cares for the child? And who is at the bedside?

\_\_\_\_\_

Siblings: \_\_\_\_\_

Do you observe any abnormal family interaction?       YES       NO

EXPLAIN: \_\_\_\_\_

INTERVENTIONS NECESSARY: \_\_\_\_\_

**TEACHING**

What did you teach the child or family today? What teaching could be done if not?

## **PLAY THERAPY**

What type of play did you initiate or observe? What toys were used?

Complete a head to toe assessment and write this up as follows:

-Skin

-Eyes

-Mouth

-Heart

-Abdomen

-Genitals

-Extremities

-Head

-Face

-Ears

-Nose

-Lungs

**LAB & DIAGNOSTIC TESTING**

<b>IDENTIFY THE LAB OR DIAGNOSTIC TEST</b>	<b>WHY WAS IT ORDERED?</b>	<b>IDENTIFY ABNORMAL RESULTS &amp; CAUSE</b>	<b>NURSING INTERVENTIONS</b>

# MEDICATIONS

BRAND & GENERIC NAME & DRUG DOSE	DOSAGE + ROUTE	WHY IS DRUG PRESCRIBED	RECOMMENDED DOSAGE	WEIGHT BASED (MG/KG) DOSAGE CALCULATION (SHOW YOUR MATH)	SAFE Y OR N	MAJOR SIDE EFFECTS
BRAND						
GENERIC						
CLASS						
BRAND						
GENERIC						
CLASS						
BRAND						
GENERIC						
CLASS						

Weight: \_\_\_\_\_ kg

## MEDICATIONS

BRAND & GENERIC NAME & DRUG DOSE	DOSAGE + ROUTE	WHY IS DRUG PRESCRIBED	RECOMMENDED DOSAGE	WEIGHT BASED (MG/KG) DOSAGE CALCULATION (SHOW YOUR MATH)	SAFE Y OR N	MAJOR SIDE EFFECTS
BRAND						
GENERIC						
CLASS						
BRAND						
GENERIC						
CLASS						
BRAND						

Wt \_\_\_\_\_ Kg

## CRITICAL THINKING

1. During your first interaction with the child/family, what did you notice (odors/smell, general appearance, location and position of child, family & visitor interaction, equipment in room)? What were your initial thoughts about the child and family? What emotions did you feel? What came to mind?
2. What things are connected to or inserted in your patient? Make a list of all dressings, tubes, lines, monitors, and equipment that are being utilized for patient care. For each item, list separately and explain: (If in ICU setting, address central lines, chest tubes and feeding tubes only)
  - a. Purpose of item?
  - b. How you know the item is accomplishing its intended result?
  - c. What about the item or patient should be reported to the instructor and staff, why, & how soon?
3. What interventions did you implement for your patient/family? Include a rationale for each intervention.
4. Were your interventions effective? Explain. What other interventions could have been implemented?
5. In your opinion, what did you do well today? What do you need to improve upon?  
How could your clinical day be improved?

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**Obstetrical Clinical Worksheet**

**1. You will be assigned to all three areas usually on different clinical days (L &D, Nursery, & postpartum) during your rotation.**

**2. Please complete the following prep work before your OB rotation starts**

- a. Prep for Newborn Nursery
- b. Prep for Labor/Postpartum Patient
- c. Normal/Abnormal Column of Newborn Assessment
- d. EFM Worksheet \*areas

**Bring ALL of your prep work with you to EVERY clinical day. (You may need to check the filing cabinet in the nursing office to locate your folder that has been graded the day before clinicals).**

**3. You will complete**

- a. One Nursing Care Plan during your rotation (NO PAIN or INFECTION).
- b. Newborn Assessment Findings Column
- c. Postpartum Assessment (preferably for postpartum patient, but may be on labor/delivery patient)
- d. Complete EFM worksheet

**4. Please also bring your gestational age assessment sheet provided in class to clinical.**

**5. Be prepared to answer questions related to your prep work as well as your suggested medication list.**

**6. You will have 2 quizzes and 2 articles due during this rotation.**

**7. Please turn in your completed post clinical paperwork in a folder with your name and KEEP each previous week's work in the folder along with your new work.**



## POSTPARTUM ASSESSMENT

Student Name: \_\_\_\_\_

### IDENTIFYING DATA

Date: \_\_\_\_\_ Pt initials: \_\_\_\_\_

Age: \_\_\_\_\_ Race: \_\_\_\_\_

Allergies: \_\_\_\_\_

Occupation: \_\_\_\_\_ Medical Diagnosis: \_\_\_\_\_

Delivery Type: \_\_\_\_\_

Gravida: \_\_\_\_\_ Para: \_\_\_\_\_ Abortions: \_\_\_\_\_

Term: \_\_\_\_\_ Preterm: \_\_\_\_\_ Living: \_\_\_\_\_

Complications (maternal/fetal): \_\_\_\_\_

Prepregnancy wt: \_\_\_\_\_ Pregnancy wt: \_\_\_\_\_

Height: \_\_\_\_\_

### ASSESSMENT

General Appearance: \_\_\_\_\_

Skin/Hair: \_\_\_\_\_

Respirations: Rate \_\_\_\_\_

Breath Sounds and effort: \_\_\_\_\_

Smoker: Y/N Pk/day: \_\_\_\_\_ No. of years \_\_\_\_\_

Hx of Drug Use: Y/N Current Drug Use: Y/N Positive drug screen for: \_\_\_\_\_

Temperature \_\_\_\_\_

B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_ Regular/Irregular

Heart Sounds: \_\_\_\_\_

Peripheral Pulses (1-4+): Radial: \_\_\_\_\_ Dorsalis pedis: \_\_\_\_\_

Edema(grade/location): \_\_\_\_\_

Skin turgor: \_\_\_\_\_ Mucous membranes: \_\_\_\_\_

Nausea/Vomiting: \_\_\_\_\_

Prescribed diet: \_\_\_\_\_ Food restrictions: \_\_\_\_\_

Current IV solution and rate: \_\_\_\_\_

24 hour I and O (if ordered/has IV/ or PIH): Input \_\_\_\_\_ Output \_\_\_\_\_

Meal %: \_\_\_\_\_ Last bowel movement: \_\_\_\_\_

Bowel sounds: \_\_\_\_\_ Hemorrhoids: Y/N  
Difficulty voiding: Y/N Bladder palpable: Y/N Foley catheter: Y/N  
Estimated Blood Loss: \_\_\_\_\_

PAIN/COMFORT

Location: \_\_\_\_\_ Quality: \_\_\_\_\_ Duration: \_\_\_\_\_  
Precipitating factors: \_\_\_\_\_ Guarding: \_\_\_\_\_ Facial Grimace: \_\_\_\_\_  
Pain Scale: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

NEUROSENSORY

Hearing Aid: \_\_\_\_\_ Glasses: \_\_\_\_\_ Contacts: \_\_\_\_\_  
Headaches: Location: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Seizures: \_\_\_\_\_ Reflexes: \_\_\_\_\_  
Epigastric pain: \_\_\_\_\_

Lab:

Hgb&Hct: Pre Delivery \_\_\_\_\_ Post Delivery: \_\_\_\_\_  
WBC \_\_\_\_\_ Platelets \_\_\_\_\_ Blood Type: \_\_\_\_\_  
If mother Blood type O or Rh-: Baby's Blood Type \_\_\_\_\_ Coombs: \_\_\_\_\_  
HIV: \_\_\_\_\_ Hep. B: \_\_\_\_\_ Group B Strep: \_\_\_\_\_  
Rubella Titer: \_\_\_\_\_ VDRL/Syphillis: \_\_\_\_\_  
Urinalysis if ordered: \_\_\_\_\_

Feeding: Breast or Bottle Feeding

If breastfeeding, complete the following – poor, fair, well

Bra: \_\_\_\_\_ Nipples (shape, condition): \_\_\_\_\_  
Latching on: \_\_\_\_\_ Any referral to Lactation specialist \_\_\_\_\_

UTERUS

Fundus: Consistency: \_\_\_\_\_ Height: \_\_\_\_\_ Position: \_\_\_\_\_  
Lochia: Color: \_\_\_\_\_ Amount: \_\_\_\_\_ Clots: \_\_\_\_\_  
Episiotomy/Lacerations: Type \_\_\_\_\_ Swelling \_\_\_\_\_ Redness/or  
drainage: \_\_\_\_\_

Surgical incision: Appearance: \_\_\_\_\_

Type: \_\_\_\_\_ Dressing: \_\_\_\_\_

**MENSTRUAL HISTORY**

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Amount: \_\_\_\_\_ LMP: \_\_\_\_\_

Pap smear: \_\_\_\_\_ Contraceptive Plan: \_\_\_\_\_

Pregnancy planned (Y/N) Marital Status: \_\_\_\_\_

Living With: \_\_\_\_\_ Financial Concerns: \_\_\_\_\_

Extended family/other support: \_\_\_\_\_

Religion: \_\_\_\_\_ Cultural Factors: \_\_\_\_\_

Report stress factors: \_\_\_\_\_

Verbal/nonverbal communication with family/significant other:

\_\_\_\_\_

Hx of Postpartum Depression: Y/N Patient Demeanor: \_\_\_\_\_

Bonding behavior (including father): \_\_\_\_\_

**MEDICATIONS (List all routine and prn meds given)**

Drug name/mg	How prescribed	Purpose
--------------	----------------	---------

_____	_____	_____
_____	_____	_____
_____	_____	_____

**TEACHING/LEARNING**

Educational background (mother/father): \_\_\_\_\_

Previous childbirth experience: \_\_\_\_\_

In Hospital/Discharge Teaching:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Obstetrical Simulation

### Simulation 1

1. Watch Postpartum Assessment YouTube videos and Gestation Assessment Videos on Blackboard under NUR 3805
2. Review Postpartum BUBBLE He sheet provided in class
3. Describe the proper nursing assessment techniques utilized during the first 24 hours using BUBBLE HE for vaginal and cesarean section.
4. Define Fundus and discuss techniques and deviations to assess.
  - a. Discuss Involution and expected progression.
  - b. Define Lochia and discuss stages?

### Simulation 2

1. Complete asterisk\* areas on Fetal Heart Monitor Strip Worksheet if you have not done so already for clinical.
2. Discuss Spinal versus Epidural for a C-section. Discuss nursing interventions for a patient undergoing a cesarean section.
3. Discuss pre and post-op teaching related to the patient undergoing a cesarean section.
4. Discuss the nursing care related to the patient undergoing elective induction.

### Simulation 3

1. Discuss nursing interventions related to Pregnancy Induced Hypertension.
2. Discuss nursing assessments and interventions for Post-Partum hemorrhage
3. Complete a care plan with your clinical group for Pregnancy Induced Hypertension and Post-Partum hemorrhage

### NURSING CARE PLAN

DATE	NURSING DIAGNOSIS	PLAN (Outcome)	IMPLEMENTATION	RATIONALE	EVALUATION

The student is expected to maintain a drug card, or mark in drug book, on each of the medications ordered for their assigned client. It is the responsibility of the student to know and understand the drugs. The following lists are some of the common drugs used.

DRUGS		
Nursery Meds	Post-partam/Labor & Delivery Meds	Post-partam/Labor & Delivery Meds
Ampicillin	Alka-Seltzer Gold	* MMR
* Aquamephyton/Phytonadione (Vit K)	* Anaprox DS/Anaprox	Morphine
Claforan	Aldomet	Naltrexone
* Erythromycin ointment	Apresoline	* Penicillin G
Gentamycin	Benadryl	Peri-Colace
* Hep B	Ancef	* Phenergan
Narcan (Naloxone)	Brethine (Terbutaline)	* Pitocin (Oxytocin)
	* Calcium Gluconate	* Reglan
		* Rhogam
	* Cytotec	Stadol
	Methergine	* Tylox/Percocet
	Duramorph	Vistaril
	Hemabate	Vicodin
	Ephedrine	Xylocaine
	Dulcolax	Zofran
	FESO4	* TDAP
	Procardia	Clindamycin
	Labetalol	Dilaudid
	* Magnesium Sulfate	* Fentanyl
	Cervidil	Nubain

The above medications with an asterisk (\*) should be reviewed in detail. Expect to administer and verbalize drug information to instructor. You will be giving these medications more frequently.

**PREP FORM FOR NEWBORN NURSERY**

<b>1.</b>	<b>Discuss the risk for heat loss in the newborn and what nursing interventions are used to prevent them.</b>
<b>2.</b>	<b>Discuss the pathophysiology in regards to newborn jaundice. Also discuss the different types/causes of jaundice and treatment.</b>
<b>3.</b>	<b>Discuss elimination patterns of the newborn (voiding and stooling). Also discuss the difference in stooling between breast vs. bottle feeding.</b>
<b>4.</b>	<b>Complete the clinical significance for the assessment of the newborn including normals and abnormal. (PRIOR TO CLINICAL)</b>
<b>5.</b>	<b>Describe the process of assigning APGARS at birth including the five criteria of assessment.</b>
<b>6.</b>	<b>Summarize the indication and use of Vitamin K, Hepatitis B, and Erythromycin. (Including site of administration and proper equipment)</b>  <b>(Discuss why the infant needs vitamin K and Erythromycin)</b>
<b>7.</b>	<b>Identify teaching and learning needs of the new mother and family of a newborn.</b>
<b>8.</b>	<b>Discuss hypoglycemia criteria and treatment in the newborn.</b>
<b>9.</b>	<b>Discuss feeding methods and timing in the newborn. (breast, bottle, gavage)</b>
<b>10.</b>	<b>Discuss common skin conditions found in the newborn.</b>

**Be prepared to answer questions, verbally or by quiz, during the clinical day.**

## LABOR/POSTPARTUM PATIENT

The information should be written on additional pages.

1. Discuss a postpartum assessment for a vaginal and a cesarean section patient (including fundus, lochia, bladder...)
2. Complete asterisk\* areas on Electronic Fetal Monitoring(EFM) Worksheet. Be ready to discuss early, variable, and later decelerations in clinical.
3. List normals in the following statistics:  
Blood pressure:                      Temp:  
Pulse:  
Fetal heart rate:  
Respirations:
4. Be able to define terms: Presentation, position, dilation, station, effacement, contraction, duration, frequency , intensity and variability.
5. Discuss the different types of anesthesia (spinal, epidural, general) and analgesia (IV narcotics) during labor and possible effects to mother and/or baby.
6. Discuss breast care for the lactating and non-lactating mother.
7. Discuss pitocin for induction vs. use during the recovery period. Discuss Magnesium Sulfate for the pre-eclamptic pt vs. the preterm patient. Discuss assessment and risk factors for both pitocin (oxytocin) and magnesium sulfate. Identify the antidote for magnesium sulfate toxicity
8. Discuss the risks for pre-term labor, the current means for identifying patients at risk, and the identification and protocols for group B strep.
9. Discuss the use of MMR and TDAP vaccines in the Prenatal or Postpartum period. Also discuss the indications, dosing, and administration of Rhogam. (Discuss appropriate sites and needle size and length.)
10. Discuss the care of the episiotomy site, including comfort measures.

Be prepared to answer questions, verbally or by quiz, during the clinical day.



<b>WORKSHEET</b> <b>Electronic Fetal Monitoring (EFM)</b>
--

<b>Patient Initials:</b>	<b>Date</b>
<p><b>1. Fetal Heart Rate - Beats per minute?</b>  <b>Check one of the following: Indicate criteria for all.</b></p> <p style="padding-left: 40px;"> <input type="checkbox"/> <b>Tachycardia</b>    *Criteria:    <input type="checkbox"/> <b>Average</b>        *Criteria:    <input type="checkbox"/> <b>Bradycardia</b>    *Criteria: </p>	
<p><b>2. What is the baseline variability? What is the significance of reading? *</b></p> <p style="padding-left: 40px;"> <input type="checkbox"/> <b>Absent variability: 0 to 2 bpm.</b>  <input type="checkbox"/> <b>Minimal variability: 3 to 5 bpm.</b>  <input type="checkbox"/> <b>Average/Moderate: 6 to 25 bpm.</b>  <input type="checkbox"/> <b>Marked: greater than 25 bpm.</b> </p>	
<p><b>3. Are there any periodic changes in the FHR?</b></p> <p style="padding-left: 40px;"> <input type="checkbox"/> <b>Accelerations</b>    <input type="checkbox"/> <b>Early deceleration -- Usual cause : *</b>    <input type="checkbox"/> <b>Late deceleration -- Usual cause: *</b>    <input type="checkbox"/> <b>Variable Deceleration -- Usual cause: *</b> </p>	
<p><b>4. Looking at uterine contractions, determine the following:</b>  <b>USE ADDITIONAL PAGES</b></p> <p style="padding-left: 40px;"> <input type="checkbox"/> <b>Frequency: Define term: *</b>  <input type="checkbox"/> <b>Duration: Define: *</b> </p>	
<p><b>5. * Nursing interventions utilized for all 3 types of decelerations.</b>  <b>USE ADDITIONAL PAGES</b></p>	
<p><b>6. Summarize the significance of your patient's strip.</b>  <b>USE ADDITIONAL PAGES</b></p>	

**\* Please complete the above noted areas prior to clinicals**

**ASSESSMENT OF THE NEWBORN**

<b>Patient's INITIALS:</b>		<b>DATE:</b>	
<b>IDENTIFICATION PLACEMENT:</b>			
<b>DELIVERY DATE:</b>	<b>EDC:</b>	<b>APGAR: (1 m)      (5 m)</b>	
<b>METHOD OF DELIVERY:</b>		<b>Est. Gest. Age:</b>	
<b>FINDING</b>		<b>CLINICAL SIGNIFICANCE *</b>	
<b>Weight</b>			
<b>Length</b>			
<b>Posture</b>			
<b>Head Circumference</b>			
<b>Chest Circumference</b>			
<b>Temperature</b>			
<b>Resp:Rate, Quality &amp; Effort</b>			
<b>Heart rate</b>			
<b>Sucking, rooting, palate</b>			

**\* Discuss normals and abnormal. Have this column prepared prior to nursery day.**

**NEWBORN ASSESSMENT**  
**(continued)**

<b>ITEM</b>	<b>FINDING</b>	<b>CLINICAL SIGNIFICANCE *</b>
<b>Eyes/Ears</b>		
<b>Moro</b>		
<b>Skin:</b> <b>Color</b>		
<b>Birthmarks</b>		
<b>Lanugo</b>		
<b>Head</b> <b>Fontanelles</b> <b>Size/Shape</b>		
<b>Pulses</b> <b>(Brachial/Femoral)</b>		
<b>Umbilicus</b>		
<b>Genitals</b>		
<b>Plantar creases</b> <b>Reflexes:</b> <b>Grasp</b> <b>Plantar</b> <b>Babinski</b>		

**SAME DAY SURGERY PREP SHEET**

**1. Review Chapter 18, 19, 20 in Brunner & Suddarth**

**2. Prepare drug cards or list for:**

- |                     |           |                    |
|---------------------|-----------|--------------------|
| a. Alka Setzer Gold | d. Valium | g. Atropine        |
| b. Zantac           | e. Zofran | h. Chloral Hydrate |
| c. Versed Syrup     | f. Reglan | i. Phenergan       |
|                     |           | j. Lovenox         |

**Include action, major side effects, and reason given to surgical patients.**

**List references used**

**3. Prepare a pre and postoperative teaching plan for a child undergoing a tonsillectomy. All interventions must have a referenced rationale. Information can be found in Brunner & Suddarth, London & Ladewig and on-line. You must use APA format for listing sources and references.**

**4. Calculate the preoperative medication for a child weighing 22 lbs.**

**PAM 0.5 ml per kilogram  
available premixed in 10 ml syringe**

**Atropine 0.01 mg per kilogram  
available in 0.4 mg/ml vial**

**5. Include discharge teaching for four patients, the discharge teaching must have rationales that are referenced. Briefly discuss procedure and patient history rationales that are referenced. Briefly discuss procedure and patient history and instructions for self care at home.**

**6. Include a log for each day of clinical.**

### Diagnostic Recovery Paperwork

1. Prior to your **first day in Diagnostic Recovery (DR)**, prepare a written drug list for:
  - a. Versed (midazolam)
  - b. Fentanyl (sublimaze)
  - c. Demerol (meperidine)
  - d. Robinul (glycopyrrolate)
  - e. Valium (diazepam)
  - f. Plavix (clopidogrel)
  - g. Decadron / Hexadrol (dexamethasone)
  - h. Benadryl (diphenhydramine)
  - i. Narcan (naloxone)
  - j. Romazicon (flumazenil)
  - k. Aspirin (acetylsalicylic acid)
  
2. Review how to place a peripheral IV and a foley catheter. You will start several IVs and may be required to place a foley in DR. Be prepared to answer questions prior to being allowed to perform these procedures.
  
3. Look up the Aldrete (or modified Aldrete) score. Be familiar with its purpose.
  
4. **Start working on the following teaching plans prior to first clinical day in DR.** You will fine tune these during DR clinical time. Turn completed plans in on Monday (by 0830) after **last clinical day in DR**:
  - a. Prepare a pre- and post-procedure teaching plan for a patient undergoing a colonoscopy.
  - b. Prepare a pre- and post-procedure plan for a patient undergoing a cardiac catheterization for shortness of breath, chest pain, and abnormal ECG.
  
5. Review and be able to discuss administration of packed red blood cells (PRBC) during clinicals. **Include the following in your written paperwork to be turned in after clinical rotation:**
  - a. Explain what labs should be drawn prior to administration of PRBCs.
  - b. Most patients who are going to receive blood products are also given diphenhydramine and/or dexamethasone IV prior to administration. Please give a brief explanation as to why these drugs are given.
  - c. Describe signs and symptoms of a transfusion reaction and what you as a nurse would need to do if this were to happen to your patient. What is the absolute most important thing to do if a reaction is suspected?
  
6. Cardiac cath patients have the following labs drawn prior to their procedure: CBC, BMP (basic metabolic panel), lipids, PT/PTT with INR. Give a brief explanation of what you think they are looking for in these labs and why they are important. Also, why is it important to do an ECG prior to a cardiac cath? **Include this information with the teaching plans and transfusion information listed above.**
  
7. **During clinicals**, explore how to write an RN note for recovery following a GI procedure (these are done on paper, not on the computer, at St. Mary's).

**\*Prep work must be completed and turned in the morning of your first day in DR! Failure to bring completed prep work may result in you being sent home from clinicals.**

ARKANSAS TECH UNIVERSITY  
 Department of Nursing  
 Evidence Based Family Paper Agreement

NOTE: Agreement due to Assigned Faculty member on or before assigned date.

**You May Not Use a Family Member or Another Nursing Student's Family.**

Name of Student \_\_\_\_\_ Assigned Faculty Member \_\_\_\_\_

Name of Male Head of Household \_\_\_\_\_

Name of Female Head of Household \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. No. \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Telephone Numbers \_\_\_\_\_ Best Time to Call \_\_\_\_\_

In the table below, list the names of all persons living in this household, their ages, and relationship to the Head(s) of the household. If additional space is needed, use the back of this form.

Name of Each Individual Living in Household	Age	Relationship to Head(s) of Household

Head(s) of Household, please read the following statement and sign below:

I/We agree to allow the Arkansas Tech University Nursing Student named above to visit us in our home for the purpose of meeting his/her educational objectives in the Nursing Program at Arkansas Tech University. We understand that the student will be interviewing us and may carry out teaching programs and/or other nursing actions provided that we give consent. We understand that the information we provide the student will be kept confidential and will be handled in a professional manner. We understand that we may refuse any teaching or other nursing care at any time. We understand that the student will be visiting us in our home from four to six times over the period of the next several weeks. We understand that this agreement will be terminated the last scheduled visit, or when requested, whichever comes first.

I/We agree to the above statement \_\_\_\_\_ Date \_\_\_\_\_

I agree to the above statement \_\_\_\_\_ (Student) Date \_\_\_\_\_

**ARKANSAS TECH UNIVERSITY**  
NUR 3805 Practicum in Nursing II  
Evidence Based Family Paper

**Objective:**

1. Utilize the nursing process to plan and deliver care to individuals and families.
2. Practice the role of caregiver, communicator, collaborator and teacher in the delivery of holistic care to a family unit.
3. Utilize current evidence based literature to assist families in making positive lifestyle changes.

**Selecting a Family:**

Seek help from family, friends, church and/or community members to locate a suitable family. The selected family needs to include either children and/or a pregnant family member. Family members, friends, or classmates' families may not be used.

**Number of Visits:**

The student will visit the family from 4 to 6 times in person.

**Written Requirements:**

The student will submit a written comprehensive professional paper of between 5 and 8 pages (not including title and reference pages). Current APA guidelines must be followed.

**Process:**

**After selecting a family to use for the paper, the student should:**

Contact the family to schedule the initial visit and obtain a signed "*Family Paper Agreement Contract*."

The "*Family Visit Log*" should be initiated on the first visit and updated after each visit throughout the project.

Initiate the "*Family Assessment*" to determine the needs of the family. Complete the assessment and submit the assessment guide by the due date. Your assessment will determine your planning and intervention for each subsequent visit.

Identify THREE priority needs for the family from your completed family assessment. These are not nursing diagnoses.

Utilize journal articles and reputable internet sources (government guidelines, etc.) to gather **evidence-based educational materials** to address the family's priority needs. You will utilize these materials during each planned family visit. Teaching must be based on evidence (evidence based practice). You may use your textbook only for introductory support.

Evaluate the effectiveness of the intervention for each priority need (three required).

Terminate the relationship on the last visit and ensure that the family has appropriate referrals in place.

Complete your family paper by submitting an electronic copy online within the Blackboard practicum course, a paper copy to your instructor along with a grade sheet and copy of teaching materials provided to family.



Arkansas Tech University  
 Department of Nursing  
 Evidence Based Family Paper - Level II

Student: \_\_\_\_\_ Grade: \_\_\_\_\_

Instructor: \_\_\_\_\_

Evaluation: (Total Possible Points - 100%)	POINTS
<b>Introduction and Conclusion (5%)</b> Describe family type, purpose and organization of paper. No abstract is necessary.	___ points
<b>Family Visit Log (10%)</b> Detailed description of each visit & plan for future visits (see form)	___ points
<b>Family Assessment Guide (20%)</b> Completed assessment form. Student will make revisions based on instructor comments.	___ points
<b>Family summary and identification of three priority needs (15%)</b> Summarize family assessment and identify three priority needs with supportive evidence.	___ points
<b>Intervention using evidence-based practice and education (30%)</b> Identify interventions for each need utilizing evidence based-practice and education reference materials appropriately in the document and provide a copy of all teaching materials - Must use reputable sources.	___ points
<b>Evaluation and Adaptations (20%)</b> What worked, what didn't, any adaptations made, and why.	___ points
<b>APA Format, Grammar and Spelling</b> As many as 5 points can be deducted	___ points
<b>Total</b>	___ points

FAMILY VISIT LOG (Make copies- will be longer than one page)

<b>Visit# and Date</b>	<b>Detailed summary of visit:</b> What was the purpose of this visit? Did you use any teaching materials? What did/didn't you accomplish (evaluation)? Any adaptation necessary?	<b>Detailed plan and date for future visit(s)</b>