

SUPPLEMENTARY MATERIALS

INDEX

DESCRIPTION	PAGE
V Sim Requirements	26
Pediatric Pre-Clinical Worksheet	27
Pediatric Clinical Paperwork	29
Obstetrical Clinical Worksheet	36
Postpartum Assessment Form	37
Obstetrical Simulation	40
Nursing Care Plan	41
Medications for Women's Center	42
Prep for Newborn Nursery	43
Prep for Labor/Postpartum Patient	44
Fetal Heart Monitor Worksheet	45
Assessment of the Newborn	46
Post-Surgery Prep Work and Post-Clinical Work	48
Clinical Paperwork for Same Day Surgery At SMRMC	49
Diagnostic Recovery Prep Sheet	50
Evidence Based Family Paper Agreement	51
Evidence Based Family Paper Guidelines	52

VSIm requirements: You will need to take the pretest (not graded, but your grade will be reduced if not completed), complete each simulation with a proficiency level of 85%, then take the post-test for a grade. The first attempt for your post-quiz score will be used for your grade – so take your time and do well!

If you have any **xxx** High risk for patient harm in your case summary, you will need to complete an incident report.

OB VSIm due the class period before Test 1

Maternity Case 2: Brenda Patton (Rupture of membranes)

Maternity Case 3: Amelia Sung (Labor induction due to gestational diabetes)

Maternity Case 4: Carla Hernandez (Umbilical cord prolapse)

Peds VSIm due the class period before Test 2

Pediatric Case 2: Sabina Vasquez (Asthma and pneumonia)

Pediatric Case 3: Eva Madison (Gastroenteritis)

OB VSIm due the class before Test 3.

Maternity Case 5: Fatime Sanogo (Moderate postpartum hemorrhage)

Maternity Case 1: Olivia Jones (Severe preeclampsia)

Peds VSIm due the class period before Test 4

Pediatric Case 1: Jackson Weber (Generalized tonic-clinic seizures)

Pediatric Case 4: Brittany Long (Acute pain syndrome)

Pediatric Case 5: Charlie Snow (Anaphylaxis)

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

1. Read and review material from Chapters 32, 35 and 36.
2. Attach to your upload the current immunization recommendations for children birth through 6 years. CDC is good website for this information.
3. Create vital sign references 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. Pain Scales: Print off a copy of following pain scales – FLACC, FACES, COMFORT and 0-10.
8. 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, electrolytes, Blood gasses (ABG, VBG, and 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. Include the various routes to be given – pick one for your dosages. Most common reason(s) medicine is given in pediatrics. Most common side effects. List any important implications for this medicine.

Acetaminophen
Albuterol
Ampicillin
Ativan
Ibuprofen
Gentamycin
Methadone
Morphine

Prelone Syrup/Prednisone Tabs
Pulmicort
Rocephin
Singulair
Solu-Medrol
Tobramycin
Vancomycin
Xopenex
Zantac
Zithromax/Azithromycin

Important Pediatric Measurement Conversions:

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

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

Pediatric Dosage Calculation EXAMPLE:

Amoxil 40mg/kg/day divided TID

The patient weighs 15 kg.

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

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

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

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

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

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

Student Name: _____
Clinical Unit _____

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 3805 – Practicum in Nursing II
Pediatric Clinical Paperwork

Patient Initials: _____ Age: _____

Allergy & **Reactions**: _____ NKA

Medical Diagnose(s) for this hospitalization: _____

Chronic Illness: _____ N/A

Event(s) that brought patient to the hospital:

Significant Birth History **IF** <2 years of age:

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?

FAMILY

Who cares for the child? And who is at the bedside? Who else lives with this family?

Do you observe any abnormal family interaction? YES NO

EXPLAIN: _____

INTAKE & OUTPUT

<p><u>24 Hour Fluid Requirement:</u> SHOW YOUR MATH:</p> <p>100ml FIRST 10kg 50ml NEXT 10kg 20ml REMAINDER OF WT kg</p> <p><input type="checkbox"/> N/A if >70kg</p>	<p>What is the hourly and shift fluid requirement?</p>
<p>What was your patient's total shift intake?</p> <p>_____ ml</p>	<p>Was the intake adequate?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Rationale: If inadequate</p>
<p>Type of IV Fluid:</p> <p>_____ @ _____ hour</p> <p><input type="checkbox"/> N/A if not IV fluids.</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 & Shift Total (1ml/kg/hour)</p> <p><input type="checkbox"/> N/A if > 30ml/hour</p>	<p>Was the output adequate?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Rationale: If inadequate</p>

VITAL SIGNS

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

PAIN

CIRCLE Pain Scale Utilized: 0-10 FLACC FACES COMFORT OTHER: _____

Pain Score: _____

Interventions _____ N/A

Effectiveness: _____ N/A

LAB & DIAGNOSTIC TESTING

IDENTIFY THE LAB OR DIAGNOSTIC TEST	WHY WAS IT ORDERED?	IDENTIFY ABNORMAL RESULTS & CAUSE	NURSING INTERVENTIONS

MEDICATIONS

Weight: _____ kg

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						

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 would 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 significant interventions did you and/or your nurse implement for your patient/family? Please consider any teaching or discharge planning.
4. Were the 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? If you could do this day over, what would you do differently?

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 3805 – Practicum in Nursing II
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.

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 prep and post clinical paperwork online.

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/Syphilis: _____
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(by you or your nurse)

Obstetrical Simulation

Simulation 1

Pre-Simulation

1. Watch Postpartum Assessment YouTube videos and Gestation Assessment Videos on Blackboard under NUR 3805
2. Review Postpartum BUBBLE He sheet provided in class

Simulation 2

Complete V-Sim Scenario 2 and 3 (Brenda Patton and Amelia Sung)

Simulation 3

Complete V-Sim Scenario 1, 4 and 5 (Olivia Jones, Carla Hernandez, and Fatime Sanogo)

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
* Aquamephyton/Phytonadione (Vit K)	Alka-Seltzer Gold	* MMR
* Erythromycin ointment	* Anaprox DS/Anaprox (Naproxen)	Morphine
* Hep B	Benadryl (Diphenhydramine)	* Penicillin G
Narcan (Naloxone)	Ancef (Cefazolin)	Docusate Sodium
	Brethine (Terbutaline)	* Phenergan
	* Calcium Gluconate	*Pitocin(Oxytocin)
	Misoprostol	* Reglan (Metaclopramide)
	Methergine (Methylergonovine)	* Rhogam
	Hemabate (Carboprost Tromethamine)	Stadol
	*Ephedrine	Hydrocodone
	Dulcolax (Bisacodyl)	Oxycodone
	FESO4	Xylocaine
	Procardia Nifedipine	Zofran
	Labetalol	*TDAP
	*Magnesium Sulfate	Dilaudid
	Dinoprostone	*Fentanyl
		Bupivacaine

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

1.	Discuss the risk for heat loss in the newborn and what nursing interventions are used to prevent them.
2.	Discuss the pathophysiology in terms a parent would understand. Also discuss the different types(physiologic and pathologic)/causes of jaundice and treatment. Discuss warning signs of jaundice and risks.
3.	Discuss elimination patterns of the newborn (voiding and stooling). Also discuss the difference in stooling between breast vs. bottle feeding.
4.	Complete the clinical significance for the assessment of the newborn including normals and abnormal. (PRIOR TO CLINICAL)
5.	Describe the process of assigning APGARS at birth including the five criteria of assessment.
6.	Summarize the indication and use of Vitamin K, Hepatitis B, and Erythromycin. (Including site of administration and proper equipment) (Discuss why the infant needs vitamin K and Erythromycin)
7.	Discuss CCHD(Critical Congenital Heart Disease), how to screen for it, and findings in the newborn.
8.	Discuss hypoglycemia criteria and treatment in the newborn.
9.	Discuss feeding methods and timing in the newborn. (breast, bottle, gavage)
10.	Discuss common skin conditions found in the newborn.

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:	Hemoglobin:
Fetal heart rate:	Hematocrit:
Respirations:	Platelets:
- 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.

WORKSHEET Electronic Fetal Monitoring (EFM)
--

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

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

ASSESSMENT OF THE NEWBORN

Patient's INITIALS:		DATE:	
IDENTIFICATION PLACEMENT:			
DELIVERY DATE:	EDC:	APGAR: (1 m) (5 m)	
METHOD OF DELIVERY:		Est. Gest. Age:	
FINDING(Avoid the word normal)		CLINICAL SIGNIFICANCE *	
Weight			
Length			
Posture			
Head Circumference			
Chest Circumference			
Temperature			
Resp:Rate, Quality & Effort			
Heart-rate murmurs			
Sucking, rooting, palate			

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

NEWBORN ASSESSMENT
(continued)

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

Post-Surgery Prep Work (Pre-Clinical)

1. Prepare a drug list for:
 - a. Alka Seltzer Gold
 - b. Zantac
 - c. Versed syrup
 - d. Valium
 - e. Zofran
 - f. Reglan
 - g. Atropine
 - h. Phenergan
 - i. Lovenox
 - j. Hydromorphone
 - k. Morphine

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

2. Review how to place peripheral IVs and foley catheters.
3. Review informed consent.
4. Review pre-operative checklist.
5. Review postoperative complications, including pneumonia, paralytic ileus, surgical incision dehiscence and evisceration.

Post-Surgery Post-Clinical Work

Must be turned in Monday (by 0830) after last clinical day in SDS

1. Include discharge teaching for four patients.
 - a. Must have rationales that are referenced.
 - b. Briefly discuss patient history, procedure performed, and instructions for self-care at home.
2. 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.
3. Calculate the preoperative medication for a child weighing 22 lbs.
 - a. PAM 0.5 mL per kilogram
 - i. Available premixed in 10 mL syringe
 - b. Atropine 0.01 mg per kilogram
 - i. Available in 0.4 mg/mL vial
4. Include a reflective journal for each day in clinical.

Clinical Paperwork for Same Day Surgery at SMRMC

This paperwork is due by 0800 on the Monday after your SDS day. *No prep work is due for SDS*

1. List and describe five actions the circulator (RN) is responsible for in the OR in order to ensure safety for the patient during the surgical experience.
2. Describe one of the surgical procedures that you observed while in the OR. Include information about the part of the body involved, how the patient was positioned, whether the procedure was performed laparoscopically or through an open incision, what the purpose of the procedure was, and expected outcomes. List your references.
3. List and define the roles of the health care workers who were working in the OR during the procedure.
4. Journal about your day in the OR. Describe things that you saw and learned. Discuss whether or not you would be interested in working in the OR as a nurse. Why or why not?

Diagnostic Recovery Paperwork (Pre-clinical)

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)

You must include information on the route/dosage, reason for use/indications, action, major side effects, contraindications, and nursing implications. Bring this information with you to clinicals. If you have not completed this information, you may be sent home from clinicals!

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. Explain its use and its purpose.

Post DR Paperwork

1. Complete the following teaching plans. 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.
2. Discuss the steps involved in the administration of packed red blood cells (PRBC). Include this information in your written paperwork to be turned in with your teaching plans on the Monday morning after your last clinical day in DR:
 - 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?
3. 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 the healthcare team is looking for in these labs and why this information is 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.
4. 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). Write a brief note that would be appropriate when discharging a patient from DR following a procedure.
- *You must submit a journal for each day in DR. These are reflective and should include a description of your experiences in DR. Include information about things you learned and did, what went well, and what things you would like to have done differently.**

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
Introduction and Conclusion (5%) Describe family type, purpose and organization of paper. No abstract is necessary.	___ points
Family Visit Log (10%) Detailed description of each visit & plan for future visits (see form)	___ points
Family Assessment Guide (20%) Completed assessment form. Student will make revisions based on instructor comments.	___ points
Family summary and identification of three priority needs (15%) Summarize family assessment and identify three priority needs with supportive evidence.	___ points
Intervention using evidence-based practice and education (25%) 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
Evaluation and Adaptations (20%) What worked, what didn't, any adaptations made, and why.	___ points
APA Format, Grammar and Spelling (5%)	___ points
Total	___ points

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

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