COURSE MANUAL

FOR

NURS 317

CLINICAL APPLICATION

For

ADULT HEALTH NURSING

Name of Student _____ **Student No.** _____

Name Of Teacher _____ **Clinical Area** _____

TABLE OF CONTENTS

COURSE DESCRIPTION & CLINICAL OBJECTIVES

Course title and code: **Clinical Application of Adult Health Nursing (NURS 317)**

Credit hours : 7 (1 hour Lecture; 6 hrs Clinical)

Pre Requisite: NURS 224 / 225

Co Requisite: NURS 316

COURSE DESCRIPTION

This course is focused on the care for adult patients with acute or chronic illness and their responses to actual or potential alterations in health. Application of nursing process, critical thinking and problem solving techniques are stressed. This course also provides students with the needed skills based on a scientific background of knowledge required to care competently and safely for a wide variety of patients in numerous health care settings. Emphasis is placed on nursing interventions directed toward promotion of system stability and maximum functional status.

CLINICAL OBJECTIVES

At the end of the clinical exposure, students are expected to acquire the following competencies :

1. Identify the actual and potential health problems of the patients utilizing the holistic Physical Assessment
2. Assist patients in the performance of diagnostic measures for patients with medical /surgical disorders.
3. State and analyze the abnormalities and significance in the Diagnostic and Laboratory exam results
4. Perform specific nursing procedures for patient with medical or surgical disorders under the supervision of the Preceptor or Nursing Faculty specifically to:
    a) Implement nursing assessment skills for patient.
    b) Monitor Vital signs, Intake and output, laboratory results
    c) Provide health education to patients and significant others
    d) Administer Medications, Tube Feeding
    e) Assess and monitor patients in the Perioperative Period
    f) Assist the Surgical Team in the care of patients in the Operating Room
5. Assist in the performance of treatment modalities necessary for the patient
6. Design a nursing care plan for patient with medical or surgical disorders

7. Evaluate the condition of the client after implementation of the nursing intervention
8. Shape their professional attitudes towards the care of patient with medical /or surgical health conditions
9. Collaborate and communicate with patient, significant others and health team members utilizing effective communication skills

Prepared by:

NUR 317 Faculty

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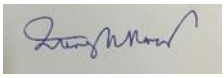

Dr. Irene M. Roco

NURS 317 Course Coordinator

NURS 317 COURSE SYLLABUS

Course title and code: **Clinical Application of Adult Health Nursing (NURS 317)**

Credit hours : 7 (1 hour Lecture; 6 hrs Clinical)

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Course Description:

This course is focused on the care for adult patients with acute or chronic illness and their responses to actual or potential alterations in health. Application of nursing process, critical thinking and problem solving techniques are stressed. This course also provides students with the needed skills based on a scientific background of knowledge required to care competently and safely for a wide variety of patients in numerous health care settings. Emphasis is placed on nursing interventions directed toward promotion of system stability and maximum functional status.

Objectives

Upon completion of this course, the students will be able to:

1. Identify cultural, developmental, and functional patterns, variations in the health status of individuals across the lifespan
2. Assess health history, including environmental exposure, wellness/illness beliefs, values, attitudes, and practices of individuals, and a focused family health history
3. Utilize assessment techniques within the nurse-client relationship.
4. Utilize knowledge from nursing and other disciplines to provide evidence-based plans of care for clients with different disease conditions.
5. Perform specific nursing procedures for patient with medical or surgical disorders under the supervision of the Preceptor or Nursing Faculty specifically to:
    a) Implement nursing assessment skills for patient.
    b) Monitor Vital signs, Intake and output, laboratory results
    c) Provide health education to patients and significant others
    d) Administer Medications, Tube Feeding
    e) Assess and monitor patients in the Perioperative Period
    f) Assist the Surgical Team in the care of patients in the Operating Room
6. Analyze nursing care needs and collaborative solutions which enable safe, effective, personal and family-centered care;
7. Utilizes information effectively, ethically, and responsibly through daily activities
8. Demonstrate effective engagement and responsible communication skills appropriate to a variety of audience and purposes
9. Utilize information technology to assist in the organization and management of nursing

care

10. Examine judgment on the interpretation of abnormalities related to the appearance of body parts by utilizing the different methods of assessment.
11. Employ comprehensive and systematic approaches to assess and plan nursing care
12. Implement and evaluate nursing care in partnership with patients/service users and/or their significant others
13. Document health assessment data in accordance with legal and ethical guidelines.

Time Table Of Activities

Week	THEORY Wednesday Topic for Discussion 12 :00 – 12 :50	CLINICAL (Thursday) 8 :00 am -1 :50 pm
1	**January 24** Orientation to the Course	**Jan. 25, 2018** **(8:00 – 10:00) Orientation to Forms** 1. Clinical Experience Record 2. Clinical Performance Evaluation **Requirements in the Clinical Area** **1. Individual Assignment** • Nursing Process • Progress Notes • Case Study **2. Group Assignment**: • Lab. Values Analysis **11:00 -1:00** **Demonstration:** • Skill 16 – 4 Obtaining an Electrocardiogram (ECG) Monitoring
2	**January 31** **Care of Patients with Pain** • Skill 10-4 Caring for a Patient receiving Patient Controlled Analgesia	**Feb 1, 2018** **(8:00 – 1:00 pm) Demonstration/ Return Demonstration** 1. Performing General Physical Assessment

3	**February 7** **Care of Patient with Neurological Disorders** Skill 13-3 Employing Seizure Precautions And Seizure Management	**February 8, 2018** • ESIHI Orientation - for KKUH group) • **Hospital orientation** for KFM
4	**Feb 14, 2018** **Care of Patient in the Perioperative Period** • Skill 6-3 /6 – 4 Providing preoperative Patient Care	**Feb 15, 2018** • **Hospital orientation** for KKUH grp • Submission of Group Assignment (Lab. Analysis)
5	**February 21, 2018** • Skill 6-5 Providing postoperative Patient Care	**Feb 22, 2018** • **First Day of Actual Patient Care**
6	**February 28, 2018** **QUIZ 1** Caring for a Patient receiving Patient Controlled Analgesia **Care of Patients with Respiratory System Disorders** • Skill 14 – 2 Teaching a Patient to Use an Incentive Spirometer	**March 1, 2018** • Patient Progress Report No.1
7	**March 7,2018** • Skill 5-23 Administering Medication via metered Dose Inhaler (MDI)	**March 8, 2018** • Total Patient Care • Start Choosing patient for Case Study
8	**March 14** **Care of Patients with Endocrine Disorders** • Skill 18 -8 Obtaining Capillary Blood Sample for Glucose Testing	**March 15, 2018** • **Total Patient Care**
9	**March 21** **MIDTERM EXAMINATION** Concepts from week 4- 8	**March 22, 2018** • **Midterm Clinical Performance Evaluation**
10	**March 28, 2018** **Care of Patients with Blood Disorders** • Skill 15-6 Administering a Blood Transfusion	**March 29, 2018** • **Patient Progress Report No. 2**
11	**April 4, 2018** **Care of Patients with Gastrointestinal System Disorders** • Skill 13-6 Changing and Emptying an Ostomy Appliance	**April 5, 2018** • Submission of Case Study for Comments
12	**April 11, 2018** **Care of Patients with Muscular Disorders** • Skill 9 – 19 Caring For A Patient In Skeletal Traction	**April 12, 2018** • **Final Clinical Performance Evaluation** • Submission of Final Copy of Case Study to the Panelists

13	**April 18, 2018** • **Case Presentation**	**April 19, 2018** • **CLINICAL FINAL EXAM**
14	**April 25, 2018** **FINAL EXAM - THEORY**	**April 26, 2018** • **CLINICAL FINAL EXAM**

Required References

- Lynn P. & Lebon M. (2015) . Taylor's Clinical Nursing Skills.A Nursing Process Approach. Wolters Kluwer. 4th Ed
- Lynn P. & Lebon M. (2015) . Skills Checklists for Taylor's Clinical Nursing Skills. A Nursing Process Approach . Wolters Kluwer. 4th Ed

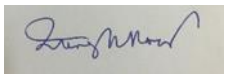
Essential References

1. Smith, Sandra; Duell, Donna; Martin, Barbara. Clinical Nursing Skills Basic to Advanced Skills . 6th Ed.
2. Lippincott Williams & Wilkins. Lippincott Manual of Nursing Practice (2010) 9th Ed
3. Smeltzer S, Bare , L. Brunner and Suddarth (2012). "Textbook of Medical-Surgical Nursing". Lippincott. CO. 12th Ed
4. Craven & Hirnle. Fundamentals of Nursing. Human health and function. Lippincott & Williams. Fourth Ed.
5. Wolters Kluwer & Lippincott Wiliam. " A Nursing Process Approach" 3rd Ed.
6. Lippincott Williams & Wilkins. (2008) Lippincott's Nursing Procedures. "Springhouse, Nursing Procedures" 5thEd. ISBN-13: 978-0781786898
7. Lemone & Burke (2011) Medical Surgical Nursing "Critical in Client Care" 5th Ed. Pearson, Prentice Hall, Pearson education International

EVALUATION

Assessment task	Marks
Theory	
Quiz	5
Midterm Exam	10
TOTAL (Theory)	**15**
Clinical	
• Case Study /Case Presentation	10
• Assignment / Clinical Learning experience Record	5
• Clinical Performance Evaluation Checklist **Grade in Midterm clinical Performance** X 5 marks / 20 Example: 15 X 5 = 75 / 20 = 3.5 marks **Final Clinical Performance Evaluation** X 15 marks / 20 Example: 18 X 15 = 270 / 20 = 13.5 marks Total of 17 marks out of 20 marks	20
• Written Report (Progress Report/ Clinical Package) • Nursing Procedures	10
TOTAL (CLINICAL)	**45**
Total Semestral Evaluation	**60**
Final Exams	**40**
Theory 10	
Clinical 30	
TOTAL MARKS	**100**

Prepared by:



NUR 317 Faculty
January 20, 2018

Dr. Irene M. Roco
NURS 317 Course Coordinator

3.CLINICAL FOCUS

Objectives	Laboratory		Clinical Setting		Evaluative Measurement
	Activities	Schedule	Activities	Schedule	
• Identify cultural, developmental, and functional patterns, variations in the health status of individuals across the lifespan			Patient Care	Starting 4th week all throughout the whole semester	• Procedure Checklist • (General Physical Assessment)
• Assess health history, including environmental exposure, wellness/illness beliefs, values, attitudes, and practices of individuals, and a focused family health history	• Procedure Checklist (General Physical Assessment)	2nd week	Patient Care	Starting 4th week all throughout the whole semester	• Procedure Checklist • (General Physical Assessment) • Patient Progress Notes
• Utilize assessment techniques within the nurse-client relationship.	• Procedure Checklist (General Physical Assessment)	2nd week	Patient Care	Starting 4th week all throughout the whole semester	• Laboratory Values Analysis (Group work)
• Utilize knowledge from nursing and other disciplines to provide evidence-based plans of care for clients with different disease conditions.			Patient Care	Starting 4th week all throughout the whole semester	• Clinical Performance Evaluation
• Perform specific nursing procedures for patient with medical or surgical disorders	• Skill 16 – 4 Obtaining an Electrocardiogram (ECG) Monitoring •	1ST week	Identified Competencies for Level V Students	4th week all throughout the whole semester	• Procedure Checklist • Clinical Performance Evaluation Checklist
	• Performing General Physical Assessment	2ND week			
• Analyze nursing care needs and collaborative solutions which enable safe, effective, personal and family-centered care;	•				• Clinical Performance Evaluation Checklist

• Utilizes information effectively, ethically, and responsibly through daily activities			Patient Care	Starting 4th week all throughout the whole semester	• Clinical Performance Checklist
• Demonstrate effective engagement and responsible communication skills appropriate to a variety of audience and purposes			• Patient Care • Case Presentation	Starting 4th week all throughout the whole semester	• Clinical Performance Checklist • Checklist for Case Presentation
• Utilize information technology to assist in the organization and management of nursing care			• Patient Care • Written Requirements	Starting 4th week all throughout the whole semester	• • Clinical Performance Checklist • Checklist for Written Requirement
• Examine judgment on the interpretation of abnormalities related to the appearance of body parts by utilizing the different methods of assessment.			• Patient Care • Case Study	Starting 4th week all throughout the whole semester	• • Clinical Performance Checklist
• Employ comprehensive and systematic approaches to assess and plan nursing care			• Patient Care • Case Study	Starting 4th week all throughout the whole semester	• • Clinical Performance Checklist
• Implement and evaluate nursing care in partnership with patients/service users and/or their significant others •			• Patient Care • Case Study	Starting 4th week until the whole semester	• Patient Progress Notes • Case Study
• Document health assessment data in accordance with legal and ethical guidelines			• Written Requirements	Starting 4th week until the whole semester	• Patient Progress Notes • Case Study

4.CLINICAL LEARNING EXPERIENCE RECORD

Name of Student _____ **Student No.** _____

Hospital _____ **Teacher** _____

I - SUMMARY OF CLINICAL CASES HANDLED

DATE OF CLINICAL EXPOSURE	CLINICAL AREA	DIAGNOSIS

II –RECORD OF NURSING PROCEDURES PERFORMED / OBSERVED

Nursing Procedures	Performed (Pls check)	Observed (Pls check)	Date	Preceptor's Name & Signature	Preceptor's Remarks
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

III STUDENT'S EVALUATION OF THE CLINICAL EXPERIENCE

a. Give a Brief Discussion of the competencies you have learned / acquired in the clinical area

_____
_____
_____
_____
_____
_____

b. How do you feel about it?

___ Very Satisfied ____ Satisfied
___ Moderately Satisfied ____ Not Satisfied

Cite reasons of your response

_____
_____
_____
_____
_____
_____

c. Comments / Suggestions related to the Clinical Experience

_____
_____
_____
_____
_____
_____

Signature of Student_____
Date _____

Noted by:

_____
Name & Signature of Clinical Instructor
Date _____

5.COURSE REQUIREMENTS

COURSE REQUIREMENTS	Corresponding Marks
1. Laboratory Values Analysis (Group work)	5
2. Patient Progress Notes	10
3. Nursing Procedures	
4. Case Study (Group work)	10
5. Case Presentation (Group work)	

CLINICAL LABORATORY VALUES ANALYSIS
(Group work)

Name of Student _____ **Score: ___/ 5 marks_**

Name of Teacher _____ **Date Submitted _____**

Instruction: Answers must be printed.

BLOOD TESTS	FUNCTION	Normal Value	Significance if decreased	Significance if Increased	NURSING RESPONSIBILITY
1. CBC (COMPLETE BLOOD COUNT) (2 marks)					

2. SERUM ELECTROLYTES (2 marks)	FUNCTION	Normal Value	Significance if decreased	Significance if Increased	NURSING RESPONSIBILITY

3. Blood Coagulati	FUNCTION	Normal Value	Significance if decreased	Significance if Increased	NURSING RESPONSIBILITY

on Profile (1 mark)					

4. ARTERIAL BLOOD GASES (1 mark)	FUNCTION	Normal Value	Significance if decreased	Significance if Increased	NURSING RESPONSIBILITY

5. BLOOD CHEMISTRY (2 marks)	FUNCTION	Normal Value	Significance if decreased	Significance if Increased	NURSING RESPONSIBILITY

6. Cardiac Enzymes (1.5 marks)	FUNCTION	Normal Value	Significance if decreased	Significance if Increased	NURSING RESPONSIBILITY

7. CAPILLARY BLOOD GLUCOSE (.05 mark)	FUNCTION	Normal Value	Significance if decreased	Significance if Increased	NURSING RESPONSIBILITY

Reference: Brunner and Suddarth's Medical Surgical Nursing

Note: To be submitted on the next Clinical exposure Day.

Late Submission will have deduction of 0.5 mark per day

Name of Student _____ **Clinical Area** _____

Date Submitted _____

Patient Progress Notes

Patent Name: _____**Room/bed No.**_____

Medical Diagnosis: _____

MEASURES	CLIENT GENERAL ASSESSMENT	
General Survey: • Physical Appearance/ LOC		
• Body Structure / Nutritional Status		
• Mobility		
• Vital signs: **Start of NPI**	T _____ PR _____ RR _____ BP_____ Pain Scale _____/ 10	
End of NPI	T _____ PR _____ RR _____ BP_____ Pain Scale _____/ 10	
Diet		
Intravenous Lines / Catheters	**IV** _____ **NGT** ___ **Foley Catheter** _____ **Others, specify**_____	
Schedule Today: Medical Treatment / Diagnostic/ Laboratory exam		Pls check: Done __ Not done____
Patient's Priority nursing problem for This day		
Evaluation of the priority nursing problem		

Medications:	**1.**
	2.
	3.

PHYSICAL ASSESSMENT

SYSTEM	PATIENT FINDINGS
1 – NEUROLOGICAL	
• Cognitive	
• Behavioral	
• GCS Score	Eye : ____ + Verbal ____ + Motor____ = _____
Others	
II – CARDIOVASCULAR	
	Pulse: ____ BP _____ Strength _____ Edema _____ Capillary Refill _____ sec. Others _____
III – RESPIRATORY	
	RR _____ O2 Sat _____ O2 Flow ____ FIO2 _____ Work of Breathing _____
IV – GASTROINTESTINAL	
	Abdominal Girth _____cm Firm ___ Soft ____ Tender ____ Bowel Sounds _____ Bowel Movement _____ Nutritional Status _____ Others : _____
V – GENITOURINARY	
	Urination Continent _____ Incontinent _____ Catheter _____ Urine Output _____
VI – MUSCULOSKELETAL	
	Ambulation _____ **Range of Motion** _____ **Abnormalities** **Location** Spasticity _____ Flaccidity _____ Weakness _____ Paralysis _____

	Deformity _____ Others :
VII – INTEGUMENTARY	
	Wound _____ Skin Integrity _____ Pressure ulcer _____ Hair and Nails _____
VIII – PSYCHOSOCIAL	
Cultural Consideration	
Emotional Well Being	
Spiritual Considerations	
Support Systems	
IX – GENERAL	
Pain Scale	
Temperature	
Hygiene	
Intake	
Output	

HOURLY	IVF (ml)	ORAL (ml)
8:00 – 9:00		
9:00 – 10:00		
10:00 – 11:00		
11:00 – 12:00		
12:00 – 1:00		
TOTAL INTAKE		

HOURLY	Urine (ml)	Emesis (ml)
8:00 – 9:00		
9:00 – 10:00		
10:00 – 11:00		
11:00 – 12:00		
12:00 – 1:00		
TOTAL INTAKE		

PRIORITY NURSING PROBLEMS (1 mark)

1. _____
2. _____
3. _____

Nursing Process 1

	Marks	Student Marks
Assessment : Subjective data:	0.25	
Objective data:		
Nursing diagnosis	0.25	
Plan / Goal	0.25	
Interventions 1. _____ _____ 2. _____ _____ 3. _____ _____ 4. _____ _____ 5. _____ _____ 6. _____	2.0	
Evaluation	0.25	
Total Marks	3	

Nursing Process 2

	Marks	Student Marks
Assessment : Subjective data:	0.25	
Objective data:		
Nursing diagnosis	0.25	
Plan / Goal	0.25	
Interventions 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	2.0	
Evaluation	0.25	
Total Marks	3	

MEDICATION # 1

	Mark	Student Marks
Name of Drug : **Dose:** **Route / Frequency:**	**0.25**	
Classification:	**0.25**	
Indication (from the Literature / Book)		
Patient's condition that is indicated in this medication	**0.25**	
Write only the Side effects Observed in the client.	**0.25**	
If NO side effects were observed from the client , write ALL the Side effects based on the Literature	**0.25**	
Nursing Responsibilities Related to the side effects observed in the client 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	**0.5**	
Evaluation	**0.25**	
Total Marks	**2**	

MEDICATION # 2

	Mark	Student Marks
Name of Drug : **Dose:** **Route / Frequency:**	**0.25**	
Classification:	**0.25**	
Indication (from the Literature / Book)		
Patient's condition that is indicated in this medication	**0.25**	
Write only the Side effects Observed in the client.	**0.25**	
If NO side effects were observed from the client , write ALL the Side effects based on the Literature	**0.25**	
Nursing Responsibilities Related to the side effects observed in the client 1. _____ _____ 2. _____ _____ 3. _____ _____ 4. _____ _____ 5. _____ _____	**0.5**	
Evaluation	**0.25**	
Total Marks	**2**	

SUMMARY FOR PROGRESS NOTES:

	Marks	Student Marks
General Assessment :	**2**	
Physical	**2**	
Priority Nursing Problem	**1**	
Average of 2 NCPs	**3**	
Average of 2 Medication Sheet	**2**	
Total	**10 marks**	

TEACHER'S COMMENTS:

_____

_____

_____

_____

Name and Signature of Teacher:_____ **Date** _____

Name and Signature of Student:_____ **Date** _____

CASE STUDY
(Group work)

Note:

1. Submit the Case study **two (2) weeks before** the Case Presentation to the Faculty for initial checking
2. Submit the Final copy to the Assigned Guest Panelists **one week before** the Case Presentation.
3. Schedule of Case Presentation: **One (1) week before** the Clinical Final Examination.

A. INTRODUCTION

- **Patient Profile**
  Patient's name (Initials only)
  Age
  Gender
  Educational attainment
  Attending Physician
  Chief complaint
  Admitting Diagnosis
  Date of Admission

- **Brief Statement of your client's case** (discuss the history (condition, surgery or procedure performed) of your client starting from admission in the hospital until the last day of your interaction)

- **Rationale for choosing the case** (you may add Incidence rate internationally, nationally (Saudi Arabia) or locally (Riyadh)

B. ASSESSMENT (Narrative)

- **General Survey**
- **History of Present Illness** (reason for admission ; Use the PQRSTU)
- **Past Health History** (Immunizations, Previous Illness, Surgery, Allergy)
- **Family History**
- **Psychosocial** (Diet, Lifestyle)
- **Nutritional Assessment** (BMI)

- **Physical Assessment** (Head to Toe, per system)*

Body Part	Normal Findings	Patient Findings	Significance
Skin			
Head, Eyes , Ears , Nose			
Respiratory			
Cardiovascular			
Gastrointestinal			
Urinary			
Musculo skeletal			
Nervous System			

C. Anatomy And Physiology of the Affected Organ or System

D. Pathophysiology / Etiology of the Disease (Narrative as well as Diagram)

(Starting from risk Factors (based on patient history) or causes, ending up with clinical manifestation, as observed from the patient) You may modify the Pathophysiology diagram from the book)

E. Laboratory/ Diagnostic Tests*

Laboratory Tests/ Diagnostic Tests	Normal Range	Patient Findings/ Result	Significance

F. IMPLEMENTATION

- Comprehensive Nursing Process * (Formulate 2 Actual & 1 Potential Nursing Problem)

NURSING DIAGNOSIS:
Nursing Problem:
Related to :
As evidenced by:
GOAL / PLAN:
NURSING INTERVENTION

Evaluation

G. Discussion of Treatment Modalities (Cite Medical or Surgical Interventions done) *

Procedure	Cite Patient Based Indication	Preparation of Patient	Frequency / Schedule Of Treatment	Nursing responsibility	Evaluation
Example: Tracheostomy Care					
Suctioning					
Oxygenation					
Wound Dressing					
IV Therapy					
Specify Other procedure					

H. Drug Study / Pharmacology *

Name of Drug : **Dose:** **Route Frequency:**
Classification: **Action of the Drug:**
Indication (from the Literature / Book)
Patient's condition that is indicated in this medication
<u>Write only the Side effects Observed in the client.</u>
If NO side effects were observed from the client , write ALL the Side effects based on the Literature

Nursing Responsibilities related to <u>the Side effects Observed in the client.</u>
1. _____ _____ 2. _____ _____ 3. _____ _____ 4. _____ _____ 5. _____ _____ 6. _____ _____
Evaluation

I. DISCHARGE PLAN

- Discuss according to the following aspects:
  - ✓ Medications
  - ✓ Exercise
  - ✓ Treatment
  - ✓ Hygiene
  - ✓ Occupation
  - ✓ Diet
  - ✓ Spiritual, Social Aspect

*** Please Follow Table Format**

EVALUATIVE CHECKLISTS

1. Oral Case Presentation Evaluation
2. Clinical Performance Evaluation Checklist

EVALUATION FOR ORAL CASE PRESENTATION

CASE: _____

Name of Student _____ Student No. _____

Topic Presented _____ Name of Evaluator _____

LEGEND:

SCORE	CONTENT	PRESENTATION
2 – Excellent	information are complete, appropriate and accurate	superior: significantly exceeds expectations
1.5 –Satisfactory	information are complete but with minimal errors	exceeds expectations
1.0 - Fair	Information are incomplete , with minimal errors	meets expectations
0.5– Poor	information are incomplete, with many errors	improvement needed: below expectations

Category	Scoring Criteria	Score
Content	1. Adequacy of Significant data	
	2. Availability of sufficient supportive information	
	3. Ability to relate theoretical concepts with clinical situation (patient's findings	
	4. Relevance of Information with each section of the Case study	
	5. Interpretation of patient data	
	6. Prioritization of significant data or interventions related to the patient	
	7. Evaluation of significant data or findings	
	8. Follows the designed format of Written Report	
Presentation	9. Visual aids are well prepared, informative, effective, and not distracting	
	10. Clear, audible speech , with good language skills and pronunciation	
	11. Delivery is poised, controlled, and smooth , maintaining good eye contact with the audience	
	12. Gain students / class mates participation	
	13. Clear explanation/articulation of concepts regarding the questions presented by classmates or Panelist	
Promptness	14. Submits a written report as scheduled	
	15. Presentation is done within the allotted time	
Score	**Total Score X 10 marks** **30**	
REMARKS		

Signature of Evaluator_____ Date :_____

SUMMARY FOR ORAL CASE PRESENTATION EVALUATION

(10 Marks)

CASE PRESENTED: _____

Name of student_____ **Student No. _____**

Topic presented _____ **Date: _____**

Name of Evaluator	Student Marks	Signature of Faculty Evaluator
1.		
2.		
3.		
4.		
Average (10 marks)		

CLINICAL PERFORMANCE EVALUATION

Name of Student _____ Midterm Evaluation ____

Student No. _____ Final Evaluation ____

A - COGNITIVE SKILLS SCORING CRITERIA

LEGEND:

2	**Great Extent of Knowledge**	answered the questions correctly
1	**Great Extent of Knowledge**	answered the questions with errors
0	**Poor; No Knowledge At All**	has not answered any of the questions

A - Cognitive skills Scoring Criteria	Actual Score	REMARKS
Patient's History		
1. Chief Complaint		
2. Past History		
3. Family History		
4. Social History		
Patient's Current State of Health		
1. Present health status / General Survey		
2. Medical Diagnosis		
Medications		
1. Classification/ Mechanism of Action		
2. Indication / Contraindication		
3. Nursing Responsibilities		
Laboratory and Diagnostic Exams		
1. Normal Values		
2. Patient Lab results / Significance		
Nursing Process		
1. Assessment / Nursing Diagnosis		
2. Planning / Expected Outcome		
3. Nursing Intervention / Rationale		
4. Evaluation		
SubTotal Points (2 X 15 = 30)		

B - PSYCHOMOTOR SKILLS SCORING CRITERIA

LEGEND :

2	**Performed correctly with confidence**
1	**Performed with minimal errors**
0	**Performed with many errors**

B - Psychomotor skills Scoring Criteria	**Actual Score**	**REMARKS**
1. Assesses symptoms effectively		
2. Follows aseptic technique		
3. Applies Infection control measures		
4. Monitors Vital signs accurately		
5. Maintains safe environment		
6. Prioritizes nursing interventions		
7. Ensures comfort, and privacy in rendering care		
8. Provides hygienic care		
9. Handles medical technological apparatus appropriately		
10. Performs physical Assessment comprehensively		
11. provides care for elimination problems		
12. Assists patient in laboratory / diagnostic procedures		
13. Provides Patient education		
14. Monitors Intake and output		
15. Ensures proper disposal of wastes		
SubTotal Points (2 X 15 = 30)		

C - AFFECTIVE SKILLS SCORING CRITERIA

LEGEND

2	**High extent of Good Behavior**
1	**Moderate extent of Good behavior**
0	**Poor Extent of Good Behavior**

C – Affective Skills Scoring Criteria	**Actual Score**	**REMARKS**
1. Establishes proper Communication & cooperation with co workers		
2. Displays good and proper grooming		
3. Collaborates with staff, students and Teachers		
4. Follows Instructions appropriately		
5. Prompt and Punctual		
6. Shows honesty in data gathering		
7. Updates oneself with latest trends and development		
8. Accepts Criticisms and suggestions		
9. Shows good leadership and management qualities		
10. Displays critical thinking and good judgment		
Sub Total Points (2 X 10 = 20)		

FINAL SCORING: CRITERIA	**Student's Score**	**Total Points**
1. Cognitive	**____X 8 / 30**	
2. Psychomotor	**____ X 8 / 30**	
3. Affective	**____ X 4 / 20**	
TOTAL (20 marks)		

Name & Signature of Faculty Evaluator_____ Date :_____

Name & Signature of Student _____ Date :_____

CHECKLISTS OF NURSING PROCEDURES

Please Refer to

Skills Checklist for Taylor's Clinical Nursing Skills. Wolters Kluwer. 4th Ed

Note: Students are REQUIRED to perform at least five (5) Nursing Procedures

1. Performing General Physical Assessment
2. Skill 16 – 4 Obtaining an Electrocardiogram (ECG) Monitoring
3. Skill 10 – 4 Caring For A Patient Receiving Patient Controlled Analgesia
4. Skill 13-3 Employing Seizure Precautions And Seizure Management
5. Skill 6-3 /6 – 4 Providing preoperative Patient Care
6. Skill 6-5 Providing postoperative Patient Care
7. Skill 14 – 2 Teaching a Patient to Use an Incentive Spirometer
8. Skill 5-23 Administering Medication via metered Dose Inhaler (MDI)
9. Skill 18 -8 Obtaining Capillary Blood Sample for Glucose Testing
10. Skill 15-6 Administering a Blood Transfusion
11. Skill 13-6 Changing and Emptying an Ostomy Appliance
12. Skill 9 – 19 Caring For A Patient In Skeletal Traction

PERFORMING GENERAL ASSESSMENT

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Perform hand hygiene and put on PPE, if indicated.				
2. Identify the patient.				
3. Close curtains around bed and the door to the room, if possible. Explain the purpose of the health examination and what you are going to do. Answer any questions.				
Perform General Survey				
4. Assess the patient's physical appearance. • Observe if the patient appears his or her stated age. • Note the patient's mental status. • Is the person alert and oriented, responsive to questions and responding appropriately? • Are the facial features symmetric? • Note any signs of acute distress, such as shortness of breath, pain, or anxiousness.				
5. Assess the patient's body structure. • Does the person's height appear within normal range for stated age and genetic heritage? • Does the person's weight appear within normal range for height and body build? • Note if body fat is evenly distributed. • Do body parts appear equal bilaterally and relatively proportionate? • Is the patient's posture erect and appropriate for age?				
6. Assess the patient's mobility. • Is the patient's gait smooth, even, well-balanced, and coordinated? • Is joint mobility smooth and coordinated with a general full range of motion (ROM)? • Are involuntary movements evident?				
7. Assess the patient's behavior. • Are facial expressions appropriate for the situation? • Does the patient maintain eye contact, based on cultural norms? • Does the person appear comfortable and relaxed with you?				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
• Is the patient's speech clear and understandable? • Observe the person's hygiene and grooming. • Is the clothing appropriate for climate, fit well, appear clean, and appropriate for the person's culture and age group? • Does the person appear clean and well groomed, appropriate for age and culture?				
8. Assess for pain.				
9. With shoes off, and standing erect, measure the patient's height using a wall-mounted measuring device or measuring pole. • Compare height and weight with recommended average weights on a standardized chart.				
10. Use the patient's weight and height measurements to calculate the patient's BMI. Body mass index = weight in kilograms / height in meters2				
11. Using the tape measure, measure the patient's waist circumference. Place the tape measure snugly around the patient's waist at the level of the umbilicus.				
12. Measure the patient's temperature, pulse, respirations, blood pressure, and oxygen saturation.				
Assessing the Skin, Hair and Nail				
13. Use the bath blanket or drape to cover any exposed area other than the one being assessed. Inspect the overall skin coloration.				
14. Inspect skin for vascularity, bleeding, or bruising				
15. Inspect the skin for lesions. Note bruises, scratches, cuts, insect bites, and wounds If present, note size, shape, color, exudates, and distribution/pattern				
16. Palpate skin using the backs of your hands to assess temperature. Wear gloves when palpating any potentially open area of the skin				
17. Palpate for texture and moisture. Assess for skin turgor by gently pinching the skin under the clavicle.				
18. Palpate for edema, which is characterized by swelling, with taut and shiny skin over the edematous area. If lesions are present, put on gloves and palpate the lesion				
19. Inspect the nail condition, including the shape and color as well as the nail angle, noting if any clubbing is present . Palpate nails for texture and capillary refill				
20. . Inspect the hair and scalp. Wear gloves for palpation if				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
lesions or infestation is suspected or if hygiene is poor.				
Assessing the Head and Neck				
21. Inspect the head and then the face for color, symmetry, lesions, and distribution of facial hair				
22. Note facial expression. Palpate the skull.				
23. Inspect the external eye structures (eyelids, eyelashes, eyeball, and eyebrows), cornea, conjunctiva, and sclera. • Note color, edema, symmetry, and alignment. • Examine the pupils for equality of size, shape, and reaction to light by darkening the room and using a penlight to shine the light on each pupil • Test for pupillary accommodation and convergence • Test the patient's visual acuity with a Snellen chart. • Assess the six cardinal positions of gaze.				
24. Inspect the external ear bilaterally for shape, size, and lesions. Palpate the ear and mastoid process. • Use a whispered voice to test hearing. Stand about 1 to 2 feet away from the patient out of the patient's line of vision. • Ask the patient to cover the ear not being tested. Perform test on each ear. • Palpate the temporomandibular joint by placing your index finger over the front of each ear as you ask the patient to open and close the mouth				
25. Inspect the lips, oral mucosa, hard and soft palates, gingivae, teeth, and salivary gland openings by asking the patient to open the mouth wide using a tongue blade and penlight • Inspect the tongue. Ask the patient to stick out the tongue. Place a tongue blade at the side of the tongue while patient pushes it to the left and right with the tongue. • Inspect the uvula by asking the patient to say "ahh" while sticking out the tongue. Palpate the tongue for muscle tone and tenderness • Remove gloves.				
26. Palpate from the forehead to the posterior triangle of the neck for the posterior cervical lymph nodes using the finger pads in a slow, circular motion. • Inspect and palpate in front of and behind the ears, under the chin, and in the anterior triangle for the anterior cervical lymph nodes				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
27. Inspect and palpate the left and then the right carotid arteries. Only palpate one carotid artery at a time. Use the bell of the stethoscope to auscultate the arteries. • Inspect the neck for jugular vein distention, observing for pulsations. • Inspect and palpate for the trachea. • Palpate the thyroid gland . Then, if enlarged, auscultate the thyroid gland using the bell of the stethoscope. • Inspect and palpate the supraclavicular area				
28. Inspect the ability of the patient to move the neck. • Ask the patient to touch chin to chest and to each shoulder, each ear to the corresponding shoulder, and then tip the head back as far as possible.				
Assessing the Thorax and the Lungs				
29. Assess the anteroposterior (AP) and lateral diameters of the thorax.				
30. Palpate over the spine and posterior thorax. a. Use the palmar surface of the hand to palpate for temperature, tenderness, muscle development, and masses.				
31. Instruct patient to take a deep breath. Assess for tactile fremitus by using the ball of the hands to palpate over the posterior thorax and while the patient says “ninety-nine				
32. Assess thoracic expansion by standing behind the patient, placing both thumbs on either side of the patient’s spine at the level of T9 or T10. Ask the patient to take a deep breath and note movement of your hands				
33. Percuss over the posterior and lateral lung fields for tone using a zigzag pattern, starting above the scapulae to the bases of the lungs. • Note intensity, pitch, duration, and quality of sounds produced. • Percuss for diaphragmatic excursion on each side of the posterior thorax.				
34. Auscultate the lungs across and down the posterior thorax to the bases of lungs as the patient breathes slowly and deeply through the mouth				
35. Examine the anterior thorax. • With the patient sitting, rearrange the gown so the anterior chest is exposed. • Inspect the skin, bones, and muscles, as well as symmetry of lung expansion and accessory muscle				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
use • Palpate the anterior thorax using the proper sequence. Palpate for tactile fremitus (as the patient repeats the word "ninety-nine"). • Percuss over the anterior thorax using the proper sequence. • Auscultate the lungs through the anterior thorax as the patient breathes slowly and deeply through the mouth.				
36. Inspect the breasts and axillae with the patient's hands resting on both sides of the body, placed on the hips, and then raised above the head. • Palpate the axillae with the patient's arms resting against the side of the body. Assist the patient into a supine position. • Place a small pillow or towel under the patient's back. Palpate the breasts and nipples. • Wear gloves if there is any discharge from the nipples or if a lesion is present.				
Assessing the Cardiovascular System				
37. Inspect the precordium for contour, pulsations, and heaves. Observe for the apical impulse at the fourth to fifth intercostal spaces (ICS) • Use the palmar surface with the four fingers held together and palpate the precordium gently for pulsations. • Assess the chest using specific cardiac landmarks—the aortic, pulmonic, tricuspid, and mitral areas and Erb's point. • Palpate the apical impulse in the mitral area. Note size, duration, force, and location in relationship to the midclavicular line. • Use systematic auscultation, beginning at the aortic area, moving to the pulmonic area, then to Erb's point, then to the tricuspid area, and finally to the mitral area. Ask the patient to breathe normally. • Focus on the overall rate and rhythm of the heart and the normal heart sounds.				
Assessing the Abdomen				
38. Inspect the abdomen for skin color, contour, pulsations, the umbilicus, and other surface characteristics (rashes, lesions, masses, scars).				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
39. Auscultate all four quadrants of the abdomen for bowel sounds by using the diaphragm of the stethoscope. Use a systematic method. • Auscultate the abdomen for vascular sounds by using the bell of the stethoscope.				
40. Percuss the abdomen for tones.				
41. Palpate the abdomen lightly in all four quadrants and then palpate using deep palpation technique. If the patient complains of pain or discomfort in a particular area of the abdomen, palpate that area last. • Palpate for the kidneys on each side of the abdomen. Palpate the liver at the right costal border. • Palpate for the spleen at the left costal border. Assess for rebound tenderness last if the patient reports pain by pressing deeply and gently into the abdomen with the hand and fingers downward and then withdrawing the hand rapidly. • Palpate and then auscultate the femoral pulses in the groin.				
Assessing the Neurologic, Musculoskeletal, and Peripheral Vascular System				
42. Assess the patient's mental status. • Evaluate the patient's orientation to person, place, and time. • Evaluate level of consciousness. • Assess memory (immediate recall and past memory). • Assess abstract reasoning by asking the patient to explain a proverb, such as "The early bird catches the worm." • Evaluate the patient's ability to understand spoken and written word.				
43. Test cranial nerve (CN) function. • Ask the patient to close the eyes, occlude one nostril, and then identify the smell of different substances • Ask the patient to smile, frown, wrinkle forehead, and puff out cheeks. • Test the gag reflex by touching the posterior pharynx with the tongue depressor. Explain to patient that this may be uncomfortable.				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
• Place your hands on the patient's shoulders while he or she shrugs against resistance. Then place your hand on the patient's left cheek, then the right cheek, and have the patient push against it • Inspect the ability of the patient to move his or her neck. Ask the patient to touch his or her chin to chest and to each shoulder, each ear to the corresponding shoulder, and then tip head back as far as possible				
44. Ask patient to extend arms forward and then rapidly turn palms up and down. Ask patient to flex upper arm and to resist examiner's opposing force				
45. Inspect and palpate the hands, fingers, wrists, and elbow joints. Palpate the radial and brachial pulses.				
46. Have the patient squeeze two of your fingers.				
47. Ask the patient to close his or her eyes. Using your finger or applicator, trace a one-digit number on the patient's palm and ask him or her to identify the number. Repeat on the other hand with a different number.				
48. Ask the patient to close his or her eyes. Place a familiar object, such as a key, in the patient's hand and ask him or her to identify the object. Repeat using another object for the other hand				
49. Assist the patient to a supine position. • Examine the lower extremities. Inspect the legs and feet for color, lesions, varicosities, hair growth, nail growth, edema, and muscle mass. • Test for pitting edema in the pretibial area by pressing fingers into the skin of the pretibial area. If an indentation remains in the skin after the fingers have been lifted, pitting edema is present. • Palpate for pulses and skin temperature at the posterior tibial, dorsalis pedis, and popliteal areas. • Have the patient perform the straight leg test with one leg at a time. • Ask the patient to move one leg laterally with the knee straight to test abduction and medially to test adduction of the hips. • Ask the patient to raise the thigh against the resistance of your hand; next have the patient push outward against the resistance of your hand; then have the patient pull backward against the				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
resistance of your hand. Repeat on the opposite side.				
50. Assess the patient's deep tendon reflexes (DTR). • Place your fingers above the patient's wrist and tap with a reflex hammer; repeat on the other arm. • Place your fingers at the elbow area with the thumb over the antecubital area and tap with a reflex hammer; repeat on the other side. • Place your fingers over the triceps tendon area and tap with a reflex hammer; repeat on the other side. • Tap just below the patella with a reflex hammer; repeat on the other side. • Tap over the Achilles' tendon area with reflex hammer; repeat on the other side. • Stroke the sole of the patient's foot with the end of a reflex hammer handle or other hard object such as a key; repeat on the other side. • Ask patient to dorsiflex and then plantarflex both feet against opposing resistance				
51. As needed, assist the patient to a standing position. • Observe the patient as he or she walks with a regular gait, on the toes, on the heels, and then heel to toe. • Perform the Romberg's test; ask the patient to stand straight with feet together, both eyes closed with arms at side. • Wait 20 seconds and observe for patient swaying and ability to maintain balance. Be alert to prevent patient fall or injury related to losing balance during this assessment.				
52. Assist the patient to a comfortable position.				
53. Remove PPE, if used. Perform hand hygiene.				
54. Initiate appropriate referral to other healthcare practitioners for further evaluation, as indicated.				
55. Document Findings				
TOTAL SCORE : 55 X 2 = 110 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
88.2 - 110	Excellent Performance	5
66.4 – 88.1	Very Good	4
44.6 – 66.3	Good	3
22.8 – 44.5	Fair	2
1 – 22.7	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 16 – 4 OBTAINING AN ELECTROCARDIOGRAM (ECG) MONITORING

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: A cardiac electrical tracing is obtained without any complications.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Verify the order for an ECG on the patient's medical record.				
2. Gather all equipment and bring to bedside.				
3. Perform hand hygiene and put on PPE, if indicated.				
4. Identify the patient.				
5. Close curtains around bed and close the door to the room, if possible.				
6. As you set up the machine to record a 12-lead ECG, explain the procedure to the patient.				
7. Tell the patient that the test records the heart's electrical activity, and it may be repeated at certain intervals.				
8. Emphasize that no electrical current will enter his or her body..				
9. Tell the patient the test typically takes about 5 minutes				
10. Ask the patient about allergies to adhesive, as appropriate.				
11. Place the ECG machine close to the patient's bed, and plug the power cord into the wall outlet.				
12. If the bed is adjustable, raise it to a comfortable working height, usually elbow height of the caregiver (VISN 8 Patient Safety Center, 2009).				
13. Have the patient lie supine in the center of the bed with the arms at the sides..				
14. Raise the head of the bed if necessary to promote comfort				
15. Expose the patient's arms and legs, and drape appropriately.				
16. Encourage the patient to relax the arms and legs				
17. If the bed is too narrow, place the patient's hands under the buttocks to prevent muscle tension. Also use this technique if the patient is shivering or trembling..				
18. Make sure the feet do not touch the bed's footboard				
19. Select flat, fleshy areas on which to place the electrodes. Avoid muscular and bony areas. If the patient has an amputated limb, choose a site on the stump.				
20. If an area is excessively hairy, clip the hair. Do not shave hair. Clean excess oil or other substances from the skin with soap and water and dry it completely.				
21. Apply the limb lead electrodes. The tip of each lead wire is lettered and color coded for easy identification.				
The white or RA lead goes to the right arm				
The green or RL lead to the right leg				
The red or LL lead to the left leg				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
The black or LA lead to the left arm.				
22. Peel the contact paper off the selfsticking disposable electrode and apply directly to the prepared site, as recommended by the manufacturer.				
23. Position disposable electrodes on the legs with the lead connection pointing superiorly.				
24. Connect the limb lead wires to the electrodes. Make sure the metal parts of the electrodes are clean and bright.				
25. Expose the patient's chest.				
26. Apply the precordial lead electrodes. The tip of each lead wire is lettered and color coded for easy identification. The brown or V1 to V6 leads are applied to the chest				
27. Peel the contact paper off the self sticking, disposable electrode and apply directly to the prepared site, as recommended by the manufacturer.				
28. Position chest electrodes as follows				
• *V1: Fourth intercostal space at right sternal border*				
• *V2: Fourth intercostal space at left sternal border*				
• *V3: Halfway between V2 and V4*				
• *V4: Fifth intercostal space at the left midclavicular line*				
• *V5: Fifth intercostal space at anterior axillary line (halfway between V4 and V6)*				
•*V6: Fifth intercostal space at midaxillary line, level with V4*				
29. Connect the precordial lead wires to the electrodes. Make sure the metal parts of the electrodes are clean and bright.				
30. After the application of all the leads, make sure the paper speed selector is set to the standard 25 m/second and that the machine is set to full voltage.				
31. If necessary, enter the appropriate patient identification data into the machine.				
32. Ask the patient to relax and breathe normally. Instruct the patient to lie still and not to talk while you record the ECG.				
33. Press the AUTO button. Observe the tracing quality. The machine will record all 12 leads automatically, recording 3 consecutive leads simultaneously. Some machines have a display screen so you can preview waveforms before the machine records them on paper				
34. Adjust waveform, if necessary. If any part of the waveform extends beyond the paper when you record the ECG, adjust the normal standardization to half-standardization and repeat. Note this adjustment on the ECG strip, because this will need to be considered in interpreting the results.				
35. When the machine finishes recording the 12-lead ECG, remove the electrodes and clean the patient's skin, if necessary, with adhesive remover for sticky residue.				
36. After disconnecting the lead wires from the electrodes, dispose of the electrodes. Return the patient to a comfortable position. Lower				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
bed height and adjust the head of bed to a comfortable position.				
37. Clean ECG machine per facility policy. If not done electronically from data entered into the machine, label the ECG with the patient's name, date of birth, location, date and time of recording, and other relevant information, such as symptoms that occurred during the recording (Jevon, 2007b).				
38. Remove additional PPE, if used. Perform hand hygiene.				
TOTAL SCORE : 48 X 2 = 96 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach, 4th* edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
77 - 96	Excellent Performance	5
58 – 76	Very Good	4
39 – 57	Good	3
20 – 38	Fair	2
2 - 19	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 10 – 4 CARING FOR A PATIENT RECEIVING PATIENT CONTROLLED ANALGESIA

Name of Student _____ **Date** _____
Student No. _____ **Name of Teacher** _____

Goal: The patient reports increased comfort and decreased pain; and shows no signs of adverse effects, oversedation, or respiratory depression.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Gather equipment . Check the medication order against the original physician's order according to agency policy. Clarify any inconsistencies. Check the patient's chart for allergies				
2. Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider the appropriateness of the medication for this patient.				
3. Prepare the medication syringe or other container, based on facility policy, for administration				
4. Perform hand hygiene and put on PPE, if indicated				
5. Identify the patient				
6. Show the patient the device, and explain its function and the reason for use. Explain the purpose and action of the medication to the patient				
7. . Plug the PCA device into the electrical outlet, if necessary. Check status of battery power, if appropriate				
8. Close the door to the room or pull the bedside curtain				
9. Complete necessary assessments before administering medication. Check allergy bracelet or ask patient about allergies. Assess the patient's pain, using an appropriate assessment tool and measurement scale.				
10. Check the label on the prefilled drug syringe with the medication record and patient identification. Obtain verification of information from a second nurse, according to facility policy. If using a barcode administration system, scan the barcode on the medication label, if required				
11. . If using a barcode administration system, scan the patient's barcode on the identification band, if required				
12. Connect tubing to prefilled syringe and place the syringe into the PCA device. Prime the tubing..				
13. Set the PCA device to administer the loading dose, if ordered, and then program the device based on the medical order for medication dosage, dose interval, and lockout interval. Obtain verification of information from a second nurse, according				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
to facility policy				
14. Put on gloves. Using antimicrobial swab, clean connection port on IV infusion line or other site access, based on route of administration. Connect the PCA tubing to the patient's IV infusion line or appropriate access site, based on the specific site used. Secure the site per facility policy and procedure. Remove gloves. Initiate the therapy by activating the appropriate button on the pump. Lock the PCA device, per facility policy				
15. Remind the patient to press the button each time he or she needs relief from pain				
16. Assess the patient's pain at least every 4 hours or more often, as needed. Monitor vital signs, especially respiratory status, including oxygen saturation at least every 4 hours or more often as needed				
17. Assess the patient's sedation score and end-tidal carbon dioxide level (capnography) at least every 4 hours or more often as needed				
18. Assess the infusion site periodically, according to facility policy and nursing judgment. Assess the patient's use of the medication, noting number of attempts and number of doses delivered. Replace the drug syringe when it is empty.				
19. Make sure the patient control (dosing button) is within the patient's reach				
20. Remove gloves and additional PPE, if used. Perform hand hygiene.				
TOTAL SCORE : 20 X 2 = 40 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
32.4 – 40	Excellent	5
24.4 – 32.1	Very Good	4
16.6 – 24.3	Good	3
8.8 – 16.5	Fair	2
3 .0- 8.7	Poor	1

Evaluator's Name: _____ Signature:_____

SKILL 13-3 EMPLOYING SEIZURE PRECAUTIONS AND SEIZURE MANAGEMENT

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The patient remains free from injury related to seizure disorder.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Review the medical record and nursing plan of care for conditions that would place the patient at risk for seizures. Review the medical orders and the nursing plan of care for orders for seizure precautions.				
Seizure Precautions				
2. Gather the necessary supplies and bring to the bedside stand or overbed table				
3. Perform hand hygiene and put on PPE, if indicated. 4. Identify the patient				
4. . Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient				
5. Place the bed in the lowest position with two to three side rails elevated. Apply padding to side rails				
6. Attach oxygen apparatus to oxygen access in the wall at the head of the bed. Place nasal cannula or mask equipment in a location where it is easily reached if needed				
7. Attach suction apparatus to vacuum access in the wall at the head of the bed. Place suction catheter, oral airway, and resuscitation bag in a location where they are easily reached if needed.				
8. Remove PPE, if used. Perform hand hygiene				
Seizure Management				
9. For patients with known seizures, be alert for the occurrence of an aura, if known. If the patient reports experiencing an aura, have the patient lie down.				
10. Once a seizure begins, close curtains around bed and close the door to the room, if possible				
11. If the patient is seated, ease the patient to the floor.				
12. Remove patient's eyeglasses. Loosen any constricting clothing. Place something flat and soft, such as a folded blanket, under the head. Push aside furniture or other objects in area.				
13. If the patient is in bed, remove the pillow and raise side rails.				
14. Do not restrain patient. Guide movements, if necessary. Do not try to insert anything in the patient's mouth or open jaws				
15. If possible, place patient on the side with the head flexed forward, head of bed elevated 30 degrees. Begin administration of oxygen, based on facility policy. Clear airway using suction, as appropriate. Provide				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
supervision throughout the seizure.				
16. Establish/maintain intravenous access, as necessary. Administer medications, as appropriate, based on medical order and facility policy.				
17. After the seizure, place the patient in a side-lying position. Clear airway using suction, as appropriate				
18. Monitor vital signs, oxygen saturation, and capillary glucose as appropriate				
19. Allow the patient to sleep after the seizure. On awakening, orient and reassure the patient				
20. Remove PPE, if used. Perform hand hygiene.				
TOTAL SCORE : 20 X 2 = 40 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
32.4 – 40	Excellent	5
24.4 – 32.1	Very Good	4
16.6 – 24.3	Good	3
8.8 – 16.5	Fair	2
4 .0- 8.7	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 6-1 PROVIDING PREOPERATIVE PATIENT CARE: HOSPITALIZED PATIENT

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The patient proceeds to surgery physically and psychologically prepared.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Check the patient's chart for the type of surgery and review the medical orders. Review the nursing database, history, and physical examination. Check that the baseline data are recorded; report those that are abnormal.				
2. Check that diagnostic testing has been completed and results are available; identify and report abnormal results				
3. Gather the necessary supplies and bring to the bedside stand or overbed table.				
4. Perform hand hygiene and put on PPE, if indicated.				
5. Identify the patient				
6. Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient.				
7. Explore the psychological needs of the patient related to the surgery as well as the family. a. Establish the therapeutic relationship, encouraging the patient to verbalize concerns or fears. b. Use active learning skills, answering questions and clarifying any misinformation. c. Use touch, as appropriate, to convey genuine empathy d. Offer to contact spiritual counselor (priest, minister, rabbi) to meet spiritual needs.				
8. Identify learning needs of patient and family. Ensure that the informed consent of the patient for the surgery has been signed, witnessed, and dated.				
9. Inquire if the patient has any questions regarding the surgical procedure.				
10. Check the patient's record to determine if an advance directive has been completed. If an advance directive has not been completed, discuss with the patient the possibility of completing it, as appropriate. If patient has had surgery before, ask about this experience				
11.. Provide teaching about deep breathing exercises				
12. Provide teaching regarding coughing and splinting (providing support to the incision				
13. Provide teaching regarding incentive spirometer				
14. Provide teaching regarding leg exercises, as appropriate.				
15. Assist the patient in putting on antiembolism stockings and demonstrate how the pneumatic compression device operates				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
16. Provide teaching regarding turning in the bed. a. Instruct the patient to use a pillow or bath blanket to splint where the incision will be. Ask the patient to raise his or her left knee and reach across to grasp the right side rail of the bed when turning toward his or her right side. If patient is turning to his or her left side, he or she will bend the right knee and grasp the left side rail.				
b. When turning the patient onto his or her right side, ask the patient to push with bent left leg and pull on the right side rail. Explain to patient that you will place a pillow behind his/her back to provide support, and that the call bell will be placed within easy reach.				
c. Explain to the patient that position change is recommended every 2 hours.				
17. Provide teaching about pain management. a. Discuss past experiences with pain and interventions that the patient has used to reduce pain. b. Discuss the availability of analgesic medication postoperatively. c. Discuss the use of patient controlled analgesia (PCA), as appropriate d. Explore the use of other alternative and nonpharmacologic methods to reduce pain, such as position change, massage, relaxation/diversion, guided imagery, and meditation.				
18. Review equipment that may be used. a. Show the patient various equipment, such as IV pumps, electronic blood pressure cuff, tubes, and surgical drains				
19. Provide skin preparation. a. Ask the patient to bathe or shower with the antiseptic solution. Remind the patient to clean the surgical site				
20. Provide teaching about and follow dietary/fluid restrictions. a. Explain to the patient that both food and fluid will be restricted before surgery to ensure that the stomach contains a minimal amount of gastric secretions. This restriction is important to reduce the risk of aspiration.				
21. Emphasize to the patient the importance of avoiding food and fluids during the prescribed time period, because failure to adhere may necessitate cancellation of the surgery				
22. Provide intestinal preparation, as appropriate. In certain situations, the bowel will need to be prepared by administering enemas or laxatives to evacuate the bowel and to reduce the intestinal bacteria. a. As needed, provide explanation of the purpose of enemas or laxatives before surgery. If patient will be administering an enema, clarify the steps as needed.				
23. Check administration of regularly scheduled medications.				
24. Review with the patient routine medications, over-the counter medications, and herbal supplements that are taken regularly.				
25. Check the physician's orders and review with the patient which medications he or she will be permitted to take the day of surgery.				
26. Remove PPE, if used. Perform hand hygiene.				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
TOTAL SCORE : 28X 2 = 56pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
45 – 56	Excellent	5
34. – 44.9	Very Good	4
23 – 33.9	Good	3
12.0 22.9	Fair	2
1.00 – 11.9	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 6-4 PROVIDING PREOPERATIVE PATIENT CARE: HOSPITALIZED PATIENT (DAY OF SURGERY)

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The patient will be prepared physically and psychologically to proceed to surgery.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Check the patient's chart for the type of surgery and review the medical orders. Review the nursing database, history, and physical examination. Check that the baseline data are recorded; report those that are abnormal				
2. Gather the necessary supplies and bring to the bedside stand or overbed table				
3. Perform hand hygiene and put on PPE, if indicated. 4. Identify the patient				
4. Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient				
5. Check that preoperative consent forms are signed, witnessed, and correct; that advance directives are in the medical record (as applicable); and that the patient's chart is in order.				
6. Check vital signs. Notify primary care provider and surgeon of any pertinent changes (e.g., rise or drop in blood pressure, elevated temperature, cough, symptoms of infection).				
7. Provide hygiene and oral care. Assess for loose teeth and caps. Remind patient of food and fluid restrictions before surgery.				
8. Instruct the patient to remove all personal clothing, including underwear, and put on a hospital gown				
9. Ask patient to remove cosmetics, jewelry including body piercing, nail polish, and prostheses (e.g., contact lenses, false eyelashes, dentures, and so forth). Some facilities allow a wedding band to be left in place depending on the type of surgery, provided it is secured to the finger with tape				
10. If possible, give valuables to family member or place valuables in appropriate area, such as the hospital safe, if this is not possible. They should not be placed in narcotics drawer.				
11. Have patient empty bladder and bowel before surgery.				
12. Attend to any special preoperative orders, such as starting an IV line.				
13. . Complete preoperative checklist and record of patient's preoperative preparation				
14. Question patient regarding the location of the operative site. Document the location in the medical record according to facility policy. The actual site will be marked on the patient when the patient				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
arrives in the preoperative holding area by the licensed independent practitioner who will be directly involved in the procedure				
15. . Administer preoperative medication as prescribed by physician/anesthesia provider				
16. Raise side rails of bed; place bed in lowest position. Instruct patient to remain in bed or on stretcher. If necessary, use a safety belt.				
17. Help move the patient from the bed to the transport stretcher, if necessary. Reconfirm patient identification and ensure that all preoperative events and measures are documented.				
18. Tell the patient's family where the patient will be taken after surgery and the location of the waiting area where the surgeon will come to explain the outcome of the surgery. If possible, take the family to the waiting area.				
19. After the patient leaves for the operating room, prepare the room and make a postoperative bed for the patient. Anticipate any necessary equipment based on the type of surgery and the patient's history.				
20. Remove PPE, if used. Perform hand hygiene.				
TOTAL SCORE : 20 X 2 = 40 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
32.4 – 40	Excellent	5
24.4 – 32.1	Very Good	4
16.6 – 24.3	Good	3
8.8 – 16.5	Fair	2
5 .0- 8.7	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 6-5 PROVIDING POSTOPERATIVE PATIENT CARE WHEN PATIENT RETURNS TO ROOM

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The patient will recover from the surgery with postoperative risks minimized by frequent assessments.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
Immediate Care				
1. When patient returns from the PACU, obtain a report from the PACU nurse and review the operating room and PACU data				
2. Perform hand hygiene and put on PPE, if indicated				
3. Identify the patient. Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient				
4. Place patient in safe position (semi- or high Fowler's or side-lying). Note level of consciousness				
5. Obtain vital signs. Monitor and record vital signs frequently. Assessment order may vary, but usual frequency includes taking vital signs every 15 minutes the first hour, every 30 minutes the next 2 hours, every hour for 4 hours, and finally every 4 hours.				
6. Assess the patient's respiratory status				
7. Measure the patient's oxygen saturation level. 8. Assess the patient's cardiovascular status				
8. Assess the patient's neurovascular status, based on the type of surgery performed.				
9. Provide for warmth, using heated or extra blankets, as necessary. Assess skin color and condition.				
10. Check dressings for color, odor, presence of drains, and amount of drainage. Mark the drainage on the dressing by circling the amount, and include the time.				
11. Turn the patient to assess visually under the patient for bleeding from the surgical site.				
12. Verify that all tubes and drains are patent and equipment is operative; note amount of drainage in collection device. If an indwelling urinary (Foley) catheter is in place, note urinary output				
13. Verify and maintain IV infusion at correct rate				
14. Assess for pain and relieve it by administering medications ordered by the physician. If the patient has been instructed in use of PCA for pain management, review its use. Check record to verify if analgesic medication was administered in the PACU.				
15. . Provide for a safe environment. Keep bed in low position with side rails up, based on facility policy. Have call bell within patient's reach				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
16. Remove PPE, if used. Perform hand hygiene.				
Ongoing Care				
17. Promote optimal respiratory function. a. Assess respiratory rate, depth, quality, color, and capillary refill. Ask if the patient is experiencing any difficulty breathing. b. Assist with coughing and deep breathing exercises c. Assist with incentive spirometry d. Assist with early ambulation. e. Provide frequent position change. f. Administer oxygen as ordered. g. Monitor pulse oximetry				
18. Promote optimal cardiovascular function: a. Assess apical rate, rhythm, and quality and compare with peripheral pulses, color, and blood pressure. Ask if the patient has any chest pains or shortness of breath. b. Provide frequent position changes. c. Assist with early ambulation. d. Apply antiembolism stockings or pneumatic compression devices, if ordered and not in place. If in place, assess for integrity. e. Provide leg and range-of-motion exercises if not contraindicated				
19. Promote optimal neurologic function: a. Assess level of consciousness, motor, and sensation. b. Determine the level of orientation to person, place, and time. c. Test motor ability by asking the patient to move each extremity. d. Evaluate sensation by asking the patient if he or she can feel your touch on an extremity.				
20. Promote optimal renal and urinary function and fluid and electrolyte status. Assess intake and output, evaluate for urinary retention and monitor serum electrolyte levels. a. Promote voiding by offering bedpan at regular intervals, noting the frequency, amount, and if any burning or urgency symptoms. b. Monitor urinary catheter drainage if present. c. Measure intake and output.				
21. Promote optimal gastrointestinal function and meet nutritional needs: a. Assess abdomen for distention and firmness. Ask if patient feels nauseated, any vomiting, and if passing flatus. b. Auscultate for bowel sounds. c. Assist with diet progression; encourage fluid intake; monitor intake. d. Medicate for nausea and vomiting, as ordered by physician				
22. Promote optimal wound healing. a. Assess condition of wound for presence of drains and any drainage. b. Use surgical asepsis for dressing changes. c. Inspect all skin surfaces for beginning signs of pressure ulcer development and use pressure-relieving supports to minimize potential skin breakdown				
23. Promote optimal comfort and relief from pain.				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
a. Assess for pain (location and intensity using scale). b. Provide for rest and comfort; provide extra blankets, as needed, for warmth. c. Administer pain medications, as needed, or other nonpharmacologic methods				
24. Promote optimal meeting of psychosocial needs: a. Provide emotional support to patient and family, as needed. b. Explain procedures and offer explanations regarding postoperative recovery, as needed, to both patient and family members.				
TOTAL SCORE : 24X 2 = 48pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
38.6 – 48	Excellent	5
29.2 – 38.5	Very Good	4
19.8 – 29.1	Good	3
10.4– 19.7	Fair	2
1 – 10.3	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 14 – 2 TEACHING A PATIENT TO USE AN INCENTIVE SPIROMETER

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The patient accurately demonstrates the procedure for using the spirometer.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Review chart for any health problems that would affect the patient's oxygenation status				
2. Bring necessary equipment to the bedside stand or overbed table.				
3. Perform hand hygiene and put on PPE, if indicated				
4. . Identify the patient . Close curtains around bed and close the door to the room, if possible.				
5. Explain what you are going to do and why you are going to do it to the patient				
6. Assist patient to an upright or semi-Fowler's position, if possible. Remove dentures if they fit poorly.				
7. Assess the patient's level of pain. Administer pain medication, as prescribed, if needed. Wait the appropriate amount of time for the medication to take effect. If patient has recently undergone abdominal or chest surgery, place a pillow or folded blanket over a chest or abdominal incision for splinting				
8. Demonstrate how to steady the device with one hand and hold the mouthpiece with the other hand. If the patient cannot use hands, assist the patient with the incentive spirometer.				
9. Instruct the patient to exhale normally and then place lips securely around the mouthpiece				
10. Instruct patient to inhale slowly and as deeply as possible through the mouthpiece without using nose (if desired, a nose clip may be used).				
11. When the patient cannot inhale anymore, the patient should hold his or her breath and count to three. Check position of gauge to determine progress and level attained. If patient begins to cough, splint an abdominal or chest incision.				
12. Instruct the patient to remove lips from mouthpiece and exhale normally. If patient becomes light-headed during the process, tell him or her to stop and take a few normal breaths before resuming incentive spirometry.				
13. Encourage patient to perform incentive spirometry 5 to 10 times every 1 to 2 hours, if possible.				
14. Clean the mouthpiece with water and shake to dry.				
15. Remove PPE, if used. Perform hand hygiene				
TOTAL SCORE : 15X2 = 30 pts				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2011.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
24.2- 30	Excellent	5
18.4- 24.1	Very Good	4
12.6- 18.3	Good	3
6.8 12.5	Fair	2
1 – 6.7	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 5-23 ADMINISTERING MEDICATION VIA METERED DOSE INHALER (MDI)

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The patient receives the medication via an inhaler using the correct technique

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Gather equipment. Check each medication order against the original order in the medical record, according to facility policy. Clarify any inconsistencies. Check the patient's chart for allergies.				
2. . Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider the appropriateness of the medication for this patient				
3. Perform hand hygiene				
4. Move the medication cart to the outside of the patient's room or prepare for administration in the medication area				
5. Unlock the medication cart or drawer. Enter pass code and scan employee identification, if required				
6. . Prepare medications for one patient at a time.				
7. Read the CMAR/MAR and select the proper medication from the patient's medication drawer or unit stock.				
8. Compare the label with the CMAR/MAR. Check expiration dates and perform calculations, if necessary. Scan the bar code on the package, if required				
9. When all medications for one patient have been prepared, recheck the label with the MAR before taking them to the patient.				
10. Lock the medication cart before leaving it.				
11. Transport medications to the patient's bedside carefully, and keep the medications in sight at all times				
12. Ensure that the patient receives the medications at the correct time.				
13. Perform hand hygiene and put on PPE, if indicated.				
14. Identify the patient. Usually, the patient should be identified using two methods. Compare information with the CMAR/ MAR. a. Check the name and identification number on the patient's identification band.				
b. Ask the patient to state his or her name and birth date, based on facility policy. c. If the patient cannot identify him- or herself, verify the patient's identification with a staff member who knows the patient for the second source				
15. Complete necessary assessments before administering medications. Check the patient's allergy bracelet or ask the patient about allergies.				
16. Explain what you are going to do and the reason to the patient				
17. Scan the patient's bar code on the identification band, if required				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
18. Remove the mouthpiece cover from the MDI and the spacer. Attach the MDI to the spacer.				
19. Shake the inhaler and spacer well.				
20. Have patient place the spacer's mouthpiece into mouth, grasping securely with teeth and lips. Have patient breathe normally through the spacer				
21. Patient should depress the canister, releasing one puff into the spacer, then inhale slowly and deeply through the mouth				
22. . Instruct patient to hold his or her breath for 5 to 10 seconds, or as long as possible, and then to exhale slowly through pursed lips.				
23. Wait 1 to 5 minutes, as prescribed, before administering the next puff.				
24. . After the prescribed amount of puffs has been administered, have patient remove the MDI from the spacer and replace the caps on both.				
25. Have the patient gargle and rinse with tap water after using an MDI, as necessary. Clean the MDI according to the manufacturer's directions				
26. Remove gloves and additional PPE, if used. Perform hand hygiene				
27. Document the administration of the medication immediately after administration.				
28. Evaluate the patient's response to medication within appropriate time frame. Reassess lung sounds, oxygenation saturation if ordered, and respirations				
TOTAL SCORE : 28 X 2 = 56 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach*, 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2011.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
45 - 56	Excellent	5
34 – 44	Very Good	4
23 – 33	Good	3
12 – 22	Fair	2
2 - 11	Poor	1

Evaluator's Name: _____

Signature:_____

Skill 18 -8 OBTAINING CAPILLARY BLOOD SAMPLE FOR GLUCOSE TESTING

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The patient receives the medication via an inhaler using the correct technique.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
16. Check the patient's medical record or nursing plan of care for monitoring schedule. You may decide that additional testing is indicated based on nursing judgment and the patient's condition.				
17. Gather equipment.				
18. Perform hand hygiene and put on PPE, if indicated.				
19. Identify the patient. Explain the procedure to the patient and instruct the patient about the need for monitoring blood glucose				
20. Close curtains around bed and close the door to the room, if possible.				
21. Turn on the monitor.				
22. Enter the patient's identification number, if required, according to facility policy				
23. Put on nonsterile gloves.				
24. Prepare lancet using aseptic technique				
25. Remove test strip from the vial. Recap container immediately. Test strips also come individually wrapped.				
26. Check that the code number for the strip matches code number on the monitor screen.				
27. Insert the strip into the meter according to directions for that specific device.				
28. For adult, massage side of finger toward puncture site.				
29. Have the patient wash hands with soap and warm water and dry thoroughly.				
30. Alternately, cleanse the skin with an alcohol swab.				
31. Allow skin to dry completely.				
32. Hold lancet perpendicular to skin and pierce site with lancet.				
33. Wipe away first drop of blood with gauze square or cotton ball if recommended by manufacturer of monitor				
34. Encourage bleeding by lowering the hand, making use of gravity.				
35. Lightly stroke the finger, if necessary, until sufficient amount of blood has formed to cover the sample area on the strip, based on monitor requirements (check instructions for monitor). Take care not to squeeze the finger, not to squeeze at puncture site, or not to touch puncture site or blood.				
36. Gently touch a drop of blood to pad to the test strip without smearing it.				
37. Press time button if directed by manufacturer.				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
38. Apply pressure to puncture site with a cotton ball or dry gauze. Do not use alcohol wipe.				
39. Read blood glucose results and document appropriately at bedside.				
40. Inform patient of test result.				
41. Turn off meter, remove test strip, and dispose of supplies appropriately. Place lancet in sharps container.				
42. Remove gloves and any other PPE, if used.				
43. Perform hand hygiene.				
TOTAL SCORE : 28 X 2 = 56 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2011.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
45 - 56	Excellent	5
34 – 44	Very Good	4
23 – 33	Good	3
12 – 22	Fair	2
3 - 11	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 15 – 6 ADMINISTERING BLOOD TRANSFUSION

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The patient receives the correct blood type and remains free of injury due to transfusion complications and/or reactions.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Verify the medical order for transfusion of a blood product.				
2. Verify the completion of informed consent documentation in the medical record.				
3. Verify any medical order for pre transfusion medication. If ordered, administer medication at least 30 minutes before initiating transfusion.				
4. Gather all equipment and bring to bedside.				
5. Perform hand hygiene and put on PPE, if indicated.				
6. Identify the patient.				
7. Close curtains around bed and close the door to theroom, if possible.				
8. Explain what you are going to do and why you are going to do it to the patient.				
9. Ask the patient about previous experience with transfusion and any reactions. Advise patient to report any chills, itching, rash, or unusual symptoms.				
10. Prime blood administration set with the normal saline IV fluid.				
11. Put on gloves. If patient does not have a venous access in place, initiate peripheral venous access.				
12. Connect the administration set to the venous access device via the extension tubing. Infuse the normal saline per facility policy.				
13. Obtain blood product from blood bank according to agency policy. Scan for bar codes on blood products if required.				
14. Two nurses compare and validate the following information with the medical record, patient identification band, and the label of the blood product: • Medical order for transfusion of blood product • Informed consent • Patient identification number • Patient name • Blood group and type • Expiration date • Inspection of blood product for clots				
15. Obtain baseline set of vital signs before beginning transfusion.				
16. Put on gloves. If using an electronic infusion device, put the device on "hold."				
17. Close the roller clamp closest to the drip chamber on the saline side of the administration set.				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
18. Close the roller clamp on the administration set below the infusion device.				
19. Alternately, if using infusing via gravity, close the roller clamp on the administration set.				
20. Close the roller clamp closest to the drip chamber on the blood product side of the administration set.				
21. Remove the protective cap from the access port on the blood container.				
22. Remove the cap from the access spike on the administration set.				
23. Using a pushing and twisting motion, insert the spike into the access port on the blood container, taking care not to contaminate the spike.				
24. Hang blood container on the IV pole.				
25. Open the roller clamp on the blood side of the administration set.				
26. Squeeze drip chamber until the in-line filter is saturated.				
27. Remove gloves.				
28. Start administration slowly (no more than 25 to 50 mL for the first 15 minutes). Stay with the patient for the first 5 to 15 minutes of transfusion**.**				
29. Open the roller clamp on the administration set below the infusion device.				
30. Set the rate of flow and begin the transfusion.				
31. Alternately, start the flow of solution by releasing the clamp on the tubing and counting the drops.				
32. Adjust until the correct drop rate is achieved.				
33. Assess the flow of the blood and function of the infusion device.				
34. Inspect the insertion site for signs of infiltration. Observe patient for flushing, dyspnea, itching, hives or rash, or any unusual comments.				
35. After the observation period (5 to 15 minutes) increase the infusion rate to the calculated rate to complete the infusion within the prescribed time frame, no more than 4 hours.				
36. Reassess vital signs after 15 minutes. Obtain vital signs thereafter according to facility policy and nursing assessment.				
37. Maintain the prescribed flow rate as ordered or as deemed appropriate based on the patient's overall condition, keeping in mind the outer limits for safe administration. Ongoing monitoring is crucial throughout the entire duration of the blood transfusion for early identification of any adverse reactions.				
38. During transfusion, assess frequently for transfusion reaction. Stop blood transfusion if you suspect a reaction. Quickly replace the blood tubing with a new administration set primed with normal saline for IV infusion. Initiate an infusion of normal saline for IV at an open rate, usually 40 mL/hour. Obtain vital signs. Notify physician and blood bank.				
39. When transfusion is complete, close roller clamp on blood side of the administration set and open the roller clamp on the normal saline side of the administration set.				
40. Initiate infusion of normal saline.				
41. When all of blood has infused into the patient, clamp the administration				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
set.				
42. Obtain vital signs				
43. Put on gloves.				
44. Cap access site or resume previous IV infusion.				
45. Dispose of blood-transfusion equipment or return to blood bank according to facility policy.				
46. Remove equipment. Ensure patient's comfort. Remove gloves. Lower bed, if not in lowest position				
47. Remove additional PPE, if used.				
48. Perform hand hygiene.				
TOTAL SCORE : 48 X 2 = 96 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2011.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
77 - 96	Excellent Performance	5
58 – 76	Very Good	4
39 – 57	Good	3
20 – 38	Fair	2
4 - 19	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 13-6 CHANGING AND EMPTYING AN OSTOMY APPLIANCE

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Bring necessary equipment to the bedside stand or overbed table.				
2. Perform hand hygiene and put on PPE, if indicated.				
3. Identify the patient.				
4. Close curtains around bed and close the door to the room, if possible.				
5. Explain what you are going to do and why you are going to do it to the patient. Encourage the patient to observe or participate, if possible.				
6. Assist patient to a comfortable sitting or lying position in bed or a standing or sitting position in the bathroom.				
Emptying an Appliance				
7. Put on disposable gloves.				
8. Remove clamp and fold end of pouch upward like a cuff				
9. Empty contents into bedpan, toilet, or measuring device				
10. Wipe the lower 2 inches of the appliance or pouch with toilet tissue.				
11. Uncuff edge of appliance or pouch and apply clip or clamp, or secure Velcro closure. Ensure the curve of the clamp follows the curve of the patient's body.				
12. Remove gloves.				
13. Assist patient to a comfortable position				
14. . If appliance is not to be changed, remove additional PPE, if used.				
15. Perform hand hygiene				
Changing an Appliance				
16. Place a disposable pad on the work surface.				
17. Set up the wash basin with warm water and the rest of the supplies.				
18. Place a trash bag within reach.				
19. . Put on clean gloves				
20. Place waterproof pad under the patient at the stoma site.				
21. Empty the appliance as described previously				
22. Gently remove pouch faceplate from skin by pushing skin from appliance rather than pulling appliance from skin.				
23. Start at the top of the appliance, while keeping the abdominal skin				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
taut				
24. Apply a silicone-based adhesive remover by spraying or wiping with the remover wipe.				
25. Place the appliance in the trash bag, if disposable.				
26. If reusable, set aside to wash in lukewarm soap and water and allow to air dry after the new appliance is in place.				
27. Use toilet tissue to remove any excess stool from stoma.				
28. Cover stoma with gauze pad				
29. Clean skin around stoma with mild soap and water or a cleansing agent and a washcloth.				
30. . Remove all old adhesive from skin; use an adhesive remover, as necessary. Do not apply lotion to peristomal area				
31. Gently pat area dry. Make sure skin around stoma is thoroughly dry.				
32. Assess stoma and condition of surrounding skin				
33. Apply skin protectant to a 2-inch (5 cm) radius around the stoma, and allow it to dry completely, which takes about 30 seconds.				
34. Lift the gauze squares for a moment and measure the stoma opening, using the measurement guide.				
35. Replace the gauze. Trace the same-size opening on the back center of the appliance. Cut the opening 1/8 inch larger than the stoma size				
36. Remove the backing from the appliance.				
37. Quickly remove the gauze squares and ease the appliance over the stoma.				
38. Gently press onto the skin while smoothing over the surface.				
39. Apply gentle pressure to appliance for 5 minutes				
40. Close bottom of appliance or pouch by folding the end upward and using the clamp or clip that comes with the product, or secure Velcro closure. Ensure the curve of the clamp follows the curve of the patient's body				
41. Remove gloves..				
42. Assist the patient to a comfortable position.				
43. Cover the patient with bed linens.				
44. Place the bed in the lowest position				
45. Put on clean gloves..				
46. Remove or discard equipment and assess patient's response to procedure				
47. Remove gloves and additional PPE, if used.				
48. Perform hand hygiene.				
TOTAL SCORE : 48 X 2 = 96 pts				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2011.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
77 - 96	Excellent Performance	5
58 – 76	Very Good	4
39 – 57	Good	3
20 – 38	Fair	2
5 - 19	Poor	1

Evaluator's Name: _____

Signature:_____

SKILL 9 – 19 CARING FOR A PATIENT IN SKELETAL TRACTION

Name of Student _____ **Date** _____

Student No. _____ **Name of Teacher** _____

Goal: The traction is maintained with the appropriate counterbalance and the patient is free from complications of immobility.

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
1. Review the medical record and the nursing plan of care to determine the type of traction being used and the prescribed care				
2. Perform hand hygiene. Put on PPE, as indicated				
3. Identify the patient. Explain the procedure to the patient, emphasizing the importance of maintaining counterbalance, alignment, and position				
4. Perform a pain assessment and assess for muscle spasm. Administer prescribed medications in sufficient time to allow for the full effect of the analgesic and/or muscle relaxant				
5. Close curtains around bed and close the door to the room, if possible. Place the bed at an appropriate and comfortable working height.				
6. Ensure the traction apparatus is attached securely to the bed. Assess the traction setup, including application of the ordered amount of weight. Be sure that the weights hang freely, not touching the bed or the floor				
7. Check that the ropes move freely through the pulleys. Check that all knots are tight and are positioned away from the pulleys. Pulleys should be free from the linens				
8. Check the alignment of the patient's body, as prescribed				
9. Perform a skin assessment. Pay attention to pressure points, including the ischial tuberosity, popliteal space, Achilles' tendon, sacrum, and heel				
10. Perform a neurovascular assessment. a. Assess the extremity distal to the traction for edema and peripheral pulses.				
b. Assess the temperature and color and compare with the unaffected limb.				
c. Check for pain, inability to move body parts distal to the traction, pallor, and abnormal sensations.				
d. Assess for indicators of deep-vein thrombosis, including calf tenderness, and swelling				
11. Assess the site at and around the pins for redness, edema, and odor.				
12. Assess for skin tenting, prolonged or purulent drainage, elevated body temperature, elevated pin site temperature, and bowing or bending of the pins				
13. Provide pin site care.				

Procedure	Done Correctly 2	Done with Assistance 1	Not done 0	Remarks
a. Using sterile technique, open the applicator package and pour the cleansing agent into the sterile container.				
b. Put on the sterile gloves.				
c. Place the applicators into the solution.				
d. Clean the pin site starting at the insertion area and working outward, away from the pin site.				
e. Use each applicator once. Use a new applicator for each pin site.				
14. Depending on physician order and facility policy, apply the antimicrobial ointment to pin sites and apply a dressing				
15. Remove gloves and any other PPE, if used. Perform hand hygiene				
16. Perform range-of-motion exercises on all joint areas, unless contraindicated.				
17. Encourage the patient to cough and deep breathe every 2 hours.				
TOTAL SCORE : 25X 2 = 50 pts				
OVER ALL REMARKS				

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

Score	Level of Performance	Marks
40.2 – 50	Excellent	5
30.4 – 40.1	Very Good	4
20.6 – 30.3	Good	3
10.8– 26.5	Fair	2
1 - 10.79	Poor	1

Evaluator's Name: _____

Signature:_____