

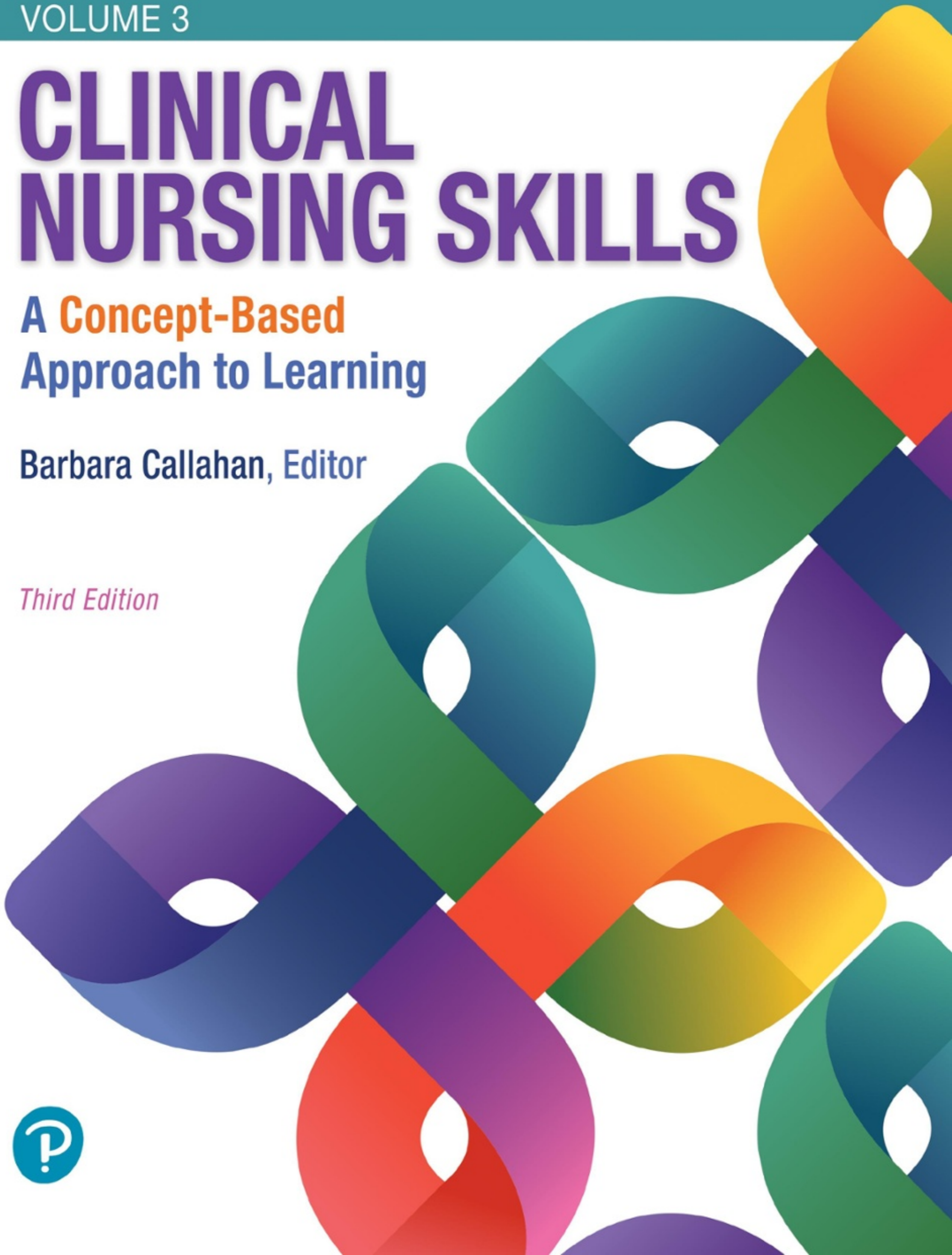
VOLUME 3

CLINICAL NURSING SKILLS

**A Concept-Based
Approach to Learning**

Barbara Callahan, Editor

Third Edition





Pearson

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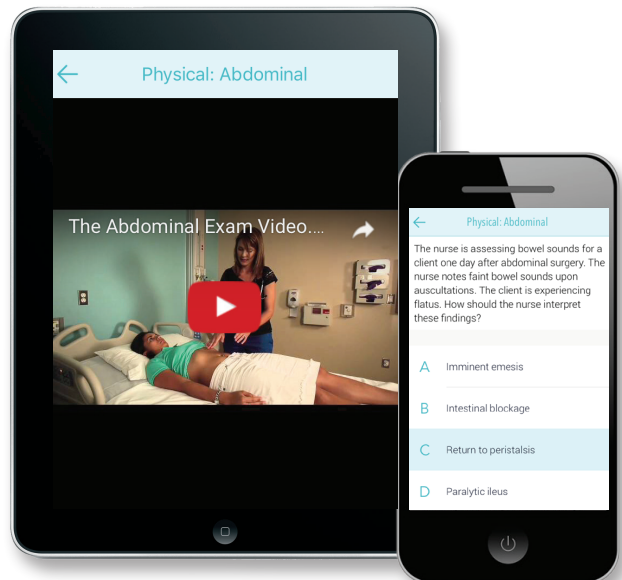


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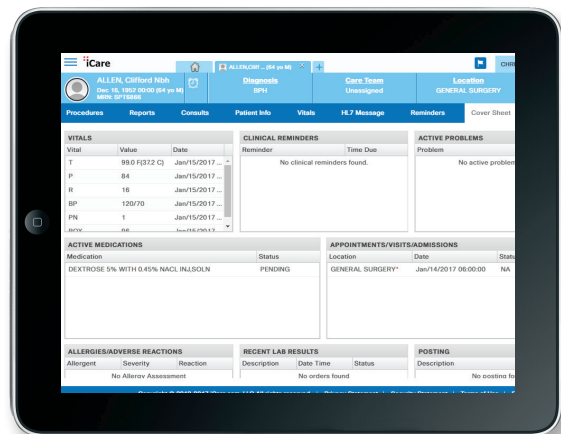


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Preface

Nursing: A Concept-Based Approach to Learning is the number one choice for nursing schools employing a concept-based curriculum. The *only* true concept-based learning solution developed from the ground up, this three-volume learning suite equips you to deliver an effective concept-based program and to develop practice-ready nurses. Available as a digital or a print experience, this solution meets the needs of today's nursing student.

What Makes Pearson's Solution Different?

Nurses perform skills that apply knowledge, psychomotor dexterity, and critical thinking necessary for effective clinical practice. Pearson's *Nursing: A Concept-Based Approach to Learning*, Third Edition, is the *only* resource solution to dedicate a volume exclusively to nursing skills. Showcasing 277 skills with nearly 250 minor skills embedded in them, *Clinical Nursing Skills: A Concept-Based Approach to Learning*, the third volume in this suite, builds proficiency in the know-how and the rationales to execute psychomotor skills, delegate appropriately, provide patient teaching, and support individualized nursing care.

The previous edition of *Clinical Nursing Skills: A Concept-Based Approach to Learning* met the learning needs of tens of thousands of students and instructors in concept-based nursing programs. The Third Edition builds on that foundation and Pearson's commitment to excellence. We solicited and examined feedback on every skill and every feature that you—our customer—recommended in order to produce the best learning resource. This uniquely integrated solution provides students with a consistent design of content and assessment that specifically supports a concept-based curriculum.

Our goal for the Third Edition is to help students learn the essential knowledge they will need for patient care. The cover showcases a Möbius strip, which represents the relationships among the concepts and how they are all interconnected. By understanding important connections of concepts, students are able to relate topics to broader contexts.

Why Teach Concept-Based Learning?

University and college nursing programs across the United States and Canada evaluated how their programs can meet the needs of today's nursing students effectively. Nursing students felt overwhelmed by the amount of knowledge and skills they required to become proficient practitioners. As a result, many programs moved or are moving to the model of concept-based learning. A concept-based curriculum's streamlined approach helps nursing students to integrate concepts, apply information, and use clinical reasoning

while minimizing content overload. Further, the model facilitates the transition from sage-on-the-stage teaching to engaging students in the learning process by doing meaningful, collaborative activities in lecture and the lab. Other benefits of conceptual learning in nursing programs –

- Concentrates on problems
- Fosters systematic observations
- Develops an understanding of relationships
- Focuses on nursing actions and interdisciplinary efforts
- Challenges students to think like a nurse

New to This Edition

- **Learning Outcomes** define measurable goals at the start of each chapter and align with end-of-chapter NCLEX-style questions and the test bank.
- **Concept of** ... explains the chapter's theory that underpins the skill.
- **Review Questions** feature NCLEX-style questions that assess chapter-opening learning outcomes, answers, and rationales and serve not only as a self-review, but also as preparation for the licensing exam.
- **Enhanced eText**, available via *MyLab Nursing Concepts*, offers a rich and engaging learning experience with interactive activities and exercises. Note: Access requires an adoption of *MyLab Nursing Concepts*.
- **Instructor's Resource Manual** facilitates active learning in the classroom, lab, and clinical environment with class-tested interactive hands-on and cognitive exercises to help students apply concepts and exemplars.
- **Test Bank** offers test items written in NCLEX-like language.
- **Image Library** provides all the text's illustrations and photos to enhance your PowerPoint presentations and other materials.
- **New and Restructured Skills** 277 major skills with nearly 250 additional assessment, teaching, or care skills embedded in them. For example, *Skill 2.5 Hair: Caring for* includes the embedded skills of *Assessing and Treating Head Lice* and *Nits Infestation*.

More Changes for this Edition

- Integrates developmental ages across the lifespan throughout skills instead of having separate areas for different ages.
- Expands newborn, infant, and child procedural steps in the skills.
- Offers more photos and figures to improve learning through visual examples.

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- Identifies common advanced skills students may have opportunities to observe or assist with following safety note perimeters – ex. “Paracentesis: Assisting” provides information about this procedure.
- Broadens teaching context to include the patient in the home environment after discharge.

New Skills

The following skills are new to the third edition:

- Colostomy: Irrigating, Skill 4.19
- Fall Prevention: Assessing and Managing, Skill 15.2
- Suicide: Caring for Suicidal Patient, Skill 15.4

Revised and Restructured Skills

The presentation of the following skills was re-envisioned for the third edition:

- Blood Transfusion: Administering, Skill 12.2
- Body Mass Index (BMI): Assessing, Skill 10.1
- Capillary Blood Specimen for Glucose: Measuring, Skill 8.4
- Cardiac Compressions, External: Performing, Skill 11.22
- Closed Wound Drains: Maintaining, Skill 16.3
- Ear Medication: Administering, Skill 2.17
- Feeding, Continuous, Nasointestinal/Jejunostomy with a Small-Bore Tube: Administering, Skill 10.6
- Implanted Vascular Access Devices: Managing, Skill 5.5
- Infusion Flow Rate Using Controller or IV Pump, Skill 5.7
- Intracranial Pressure: Monitoring and Caring for, Skill 7.2
- Nasogastric Tube: Inserting, Skill 10.11
- Newborn: Assessing, Skill 14.23
- Oxygen Delivery Systems: Using, Skill 11.8
- Range-of-Motion Exercises: Assisting, Skill 9.2
- Suctioning, Oropharyngeal and Nasopharyngeal: Newborn, Infant, Child, Adult, Skill 11.14
- Venipuncture: Initiating, Skill 5.15

Organization and Structure of *Clinical Nursing Skills, Third Edition*

Clinical Nursing Skills' chapters, listed alphabetically, support concepts in volumes 1 and 2. Within each chapter, associated skills appear in subgroups. Subgroups reflect the sequence of thinking, such as assessment skills appearing before intervention skills in the chapters. As an example, the path for finding the skill about using a nasal cannula for supplemental oxygen therapy is:

- Concept—Oxygenation, Chapter 11
- Subgroup—Supplemental Oxygen Therapy
- Skill—Oxygen Delivery Systems: Using, Skill 11.8
- VARIATIONS—Nasal Cannula/Simple Face Mask/Partial Rebreather Mask, etc.

Skill Organization

- **Delegation or Assignment** offers guidelines when it is appropriate to delegate or assign skills to unlicensed assistive personnel (UAP).
- **Equipment** lists the apparatus required to perform the skill.
- **Preparation** includes safety, age, and cultural information for working with various patients.
- **Procedure** provides step-by-step best practice with rationales.
- **Photos and illustrations** depict critical steps visually.
- **Documentation** demonstrates what data to capture post-execution.
- **Variation Skills** present alternative methods for performing select skills.
- **Embedded Skills** (as appropriate) provide useful skills to enhance learning (such as USING A DOPPLER ULTRASOUND DEVICE in Skill 1.6, Pulse: Apical and Peripheral, Obtaining).

Chapter Organization

For the Third Edition, as shown in the Chapter at a Glance listed at the beginning of each chapter, each main section has a list of skills.

Chapter at a Glance	
Maintaining Blood Volume	
SKILL 12.1 Blood Products: Administering	SKILL 12.9 ECG, 12-Lead: Recording
SKILL 12.2 Blood Transfusion: Administering	SKILL 12.10 ECG, Leads: Applying
SKILL 12.3 Direct Pressure: Applying	SKILL 12.11 ECG, Strip: Interpreting
SKILL 12.4 Pressure Dressing: Applying	SKILL 12.12 Pacemaker, Insertion: Assisting
	SKILL 12.13 Pacemaker, Permanent: Teaching
	SKILL 12.14 Pacemaker, Temporary: Maintaining
	SKILL 12.15 Telemetry: Applying
	SKILL 12.16 Arterial Line: Applying
Antiembolism Devices	
SKILL 12.5 Antiembolism Stockings: Applying	
SKILL 12.6 Pneumatic Compression Device: Applying	
SKILL 12.7 Sequential Compression Devices: Applying	

New! Each chapter contains **The Concept of ...**, which explains the chapter's theoretical concept that underpins the skill, and a dedicated list of Learning Outcomes. The outcomes are reinforced by end-of-chapter review questions.

The Concept of Perfusion

Perfusion is the immersion of body cells in a fluid. Tissue perfusion refers to the movement of solutes such as oxygen, nutrients, and electrolytes in the blood through the vascular system to capillary networks. Tissue cells are bathed in solutes so they can readily cross cell membranes. Waste products of cellular metabolic activity pass into the interstitial fluid from the cells and are carried away from the cells. When tissue perfusion is diminished or absent, cells do not receive adequate oxygen, nutrients, or electrolytes. This may be manifested by a decrease in blood pressure, restlessness, confusion, cool extremities, pallor or cyanosis of distal extremities, faint peripheral pulses, slowed capillary refill, edema, or life-threatening conditions.

- ### Learning Outcomes
- | | |
|--|--|
| <p>12.1 Give examples of priority safety considerations when preparing and administering a unit of blood to a patient.</p> <p>12.2 Support the benefits of applying sequential compression devices (SCDs) to promote circulation in the lower legs of an adult patient.</p> <p>12.3 Summarize priority nursing actions if SCDs are being used on a patient, and the patient complains of numbness and tingling in one leg.</p> <p>12.4 Explain proper placement of skin electrodes on the patient being monitored on telemetry to avoid artifacts on the monitor screen.</p> | <p>12.5 Differentiate the causes for different waves and intervals, the P wave, the PR interval, the QRS wave, the T wave, and the QT interval when interpreting an electrocardiogram (ECG) pattern.</p> <p>12.6 Examine the arterial insertion site for signs and symptoms of bleeding, infection, or inflammation.</p> <p>12.7 Explain why a transcutaneous pacemaker would be applied to a patient with a life-threatening dysrhythmia.</p> <p>12.8 Explain what a pacemaker spike indicates in an ECG monitor pattern.</p> |
|--|--|

Skill Organization

SKILL 12.7 Sequential Compression Devices: Applying

Sequential compression devices (SCDs) operate differently from pneumatic compression devices. SCDs use many inflatable compartments to compress the leg in a graduated sequential fashion. The compartment closest to the foot inflates first and the compartment closest to the thigh inflates last. The amount of pressure also differs in each compartment. The highest pressure is in the first compartment and the lowest in the last one. This creates a "milking" action to empty deeper veins of the lower leg to promote optimal blood flow.

Equipment

- Single-use tape measure (to prevent cross-infection)
- SCDs, including disposable sleeves, air pump, and tubing

Preparation

- Review healthcare provider's orders and the patient's nursing plan of care.
- Gather equipment and supplies.

Procedure

1. Introduce self and verify the patient's identity using two identifiers. Explain to the patient what you are going to do, why it is necessary, and the procedure for applying the sequential compression device. **Rationale:** *The patient's participation and comfort will be increased by understanding the reasons for applying the SCD.*
2. Perform hand hygiene and observe other appropriate infection control procedures.

Delegation or Assignment

The UAP often removes and reapplies SCDs when performing assigned or delegated hygiene care. The nurse should check that the UAP knows the correct application process for SCDs. Remind the UAP that the patient should not have SCDs removed for long periods of time because the purpose of the SCDs is to promote circulation. Note that state laws for UAPs vary, so this task might be assigned to the UAP or delegated.

Equipment provides a list of tools required to execute the skill.

Preparation includes safety, age, and cultural information for working with various clients.


Procedure provides step-by-step best practice with rationales.

Photos and illustrations depict crucial steps visually.

Delegation or Assignment offers guidelines, when appropriate, to delegate or assign skills to unlicensed assistive personnel.

SKILL 12.7 Sequential Compression Devices: Applying (continued)

3. Provide for patient privacy and drape the patient appropriately. Assess legs for skin integrity and neurovascular status.
4. Prepare the patient. Position bed at correct height for procedure.
 - Place the patient in a dorsal recumbent or semi-Fowler position.
 - Measure the patient's legs as recommended by the manufacturer if a thigh-length sleeve is required. **Rationale:** *Foot and knee-length sleeves come in just one size; the thigh circumference determines the size needed for a thigh-length sleeve.*
5. Apply the sequential compression sleeves.
 - Place a sleeve under each leg with the opening at the knee.
 - Wrap the sleeve securely around the leg, securing the Velcro tabs. Allow two fingers to fit between the leg and sleeve. **Rationale:** *This amount of space ensures that the sleeve does not impair circulation when inflated. Ensure that there is no overlapping or increases in the SCD. Rationale:* *This prevents skin breakdown.*



② Slip two fingers under wrap to ensure that it is not too tight.

Structures and Features

The Concepts are set up consistently throughout the program. This allows students to anticipate the learning they will experience. Special features recur in each chapter as well, which students can use for learning and review. The basic structure of each chapter is shown below with visuals and annotations describing the content.

Concepts Related to ...

Enhanced for the Third Edition, the Concepts Related to feature links to more concepts, relationships, and nursing implications.

Concepts Related to Perfusion		
CONCEPT	RELATIONSHIP TO PERFUSION	NURSING IMPLICATIONS
Cognition	Thought processing or mental status is affected if blood volume is decreased.	<ul style="list-style-type: none"> Monitor oxygen saturation, vital signs, and orientation status Rule out physical reasons cognition may change
Comfort	Tissues not adequately oxygenated manifest pain.	<ul style="list-style-type: none"> Monitor pain and for signs of local and systemic hypoxia Implement oxygen therapy as ordered Monitor oxygen saturations and vital signs
Fluids and Electrolytes	Excess extracellular fluid volume causes lung congestion and impaired gas exchange.	<ul style="list-style-type: none"> Monitor fluid intake and output, vital signs, and oxygen saturation Implement oxygen therapy as ordered Administer medications as ordered
Intracranial Regulation	Blood flow volume to brain can change intracranial pressure (ICP).	<ul style="list-style-type: none"> Monitor vital signs, pupils, sensorium, and assess for motor or sensory neuro deficits
Tissue Integrity	Wound healing delayed without adequate perfusion to tissue.	<ul style="list-style-type: none"> Oxygen is needed for cell metabolism; hyperbaric oxygen therapy can be effective

Safety Note! and Icon ... Distinguishes skills that nursing students may observe or assist with only with faculty permission and while under direct supervision of faculty or another RN.

Safety Note! *During scheduled clinical time, nursing students may have a learning opportunity to observe or assist with this skill only with faculty permission and with direct supervision from faculty or another RN.*

Safety Considerations ... Identifies crucial safety information.

Safety Considerations

In addition to the usual blood components such as platelets and cryoprecipitate, modified blood products are becoming more popular. Washed, irradiated, or leukocyte-removed blood is being used for patients at risk because of multiple transfusions or a weakened immune system. Testing for cytomegalovirus and matching RBC or human leukocyte antigens is also done to ensure safe transfusions.

When infusing a blood product that has undergone leukocyte reduction, remember that it must be filtered again through a standard blood administration set in order to trap cellular debris that may have accumulated since the original filtration.

Patient Teaching ... Features teaching plans for patients and tips to assist patients in self-care.

Patient Teaching

Wearing Antiembolism Stockings at Home

- Ensure the patient or caregiver knows how to apply antiembolism stockings.
- Reinforce the importance and the rationales for no wrinkles and no rolling down of the stockings.
- Reinforce the importance of removing the stockings daily and inspecting the skin on the legs.
- Include instructions about:
 - Laundrying the stockings (air dry because putting them in a dryer can affect their elasticity.)
 - Needing two pairs of stockings to allow one pair to be worn while the other is being laundryed.
 - Replacing the stockings when they lose their elasticity.
- Reinforce knowledge about slipperiness of stockings if worn without slippers or shoes.
 - If the patient is ambulatory, emphasize the need for footwear to prevent falling.

Lifespan Considerations ... Presents age-related content to alert learners to differences in caring for patients.

Lifespan Considerations

OLDER ADULTS

- Because the elastic is quite strong in antiembolism stockings, older adults may need assistance putting on the stockings. Patients with arthritis may need to have another person put the stockings on for them.
- Many older adults have circulation problems and wear antiembolism stockings. It is important to check for wrinkles in the stockings and to see if the stocking has rolled down or twisted. If so, correct it immediately. **Rationale:** *The stockings must be evenly distributed over the limb to promote—rather than hinder—circulation.*
- Stockings should be removed at least once a day (check facility policy) so that a thorough assessment can be made of the legs and feet. **Rationale:** *Redness and skin breakdown on the heels can occur quickly and go undetected if not thoroughly assessed on a regular basis.*
- Provide information about the importance of wearing the elastic stockings, how to wear them correctly, and how to take care of them.

Caution! ... Highlights key details for high-risk situations when performing the skill.

CAUTION! Dextrose solution (which causes lysis of RBCs), Ringer's solution, medications and other additives, and hyperalimentation solutions are incompatible with blood or blood components.

EVIDENCE-BASED PRACTICE

Recommend Bed Rest for DVT?

Prolonged immobilization has been associated with DVT in critically ill patients. However, the value and safety of mobilizing patients with acute DVT has been a concern, largely because of the potential for venous thromboembolism (dislodging of the clot into the bloodstream) and life-threatening pulmonary embolism (PE).

A number of studies have shown that patients with acute DVT who use compression stockings and begin ambulating early after initiation of anticoagulant therapy experience several benefits from this approach. Benefits include reduced pain level, more rapid reduction in edema, increased strength maintenance, and improved flexibility. Early ambulation in these patients, with careful monitoring for any evidence of PE, resulted in no increase in incidence of PE. Conversely, bed rest and immobilization did not result in any reduction in incidence of PE. Therefore, the current recommendation of the American College of Chest Physicians is ambulation with compression as tolerated, after starting anticoagulation, in patients with acute DVT.

Source: Data from Christakou, A. (2015). *Effectiveness of early mobilization in hospitalized patients with deep venous thrombosis*. Retrieved from <http://www.hospitalchronicles.gr/index.php/hchr/article/view/553>.

Evidence-Based Practice ... Provides suggestions for best practice from available, current evidence.

EXPECTED OUTCOME	UNEXPECTED OUTCOME	POSSIBLE INTERVENTIONS
General Assessment Height and weight are obtained and recorded.	Patient's weight varies more than expected from one day to the next.	<ul style="list-style-type: none"> ■ Verify time of day weights were measured. ■ Verify if same scale was used for both weights. ■ Verify equipment's reliability. ■ Verify what clothing or linen was on the patient when weighed on both days. ■ Verify I&O record for sources of fluid loss or gain. ■ Verify MAR for medications that alter fluid balance (e.g., diuretics).
Vital Signs Temperature is within normal range.	Fever develops.	<ul style="list-style-type: none"> ■ Verify possible sources of infection and take preventive measures. ■ Notify healthcare provider as needed. ■ Implement cooling methods if temperature is dangerously high, such as tepid sponge bath, cool oral fluids, ice packs, or antipyretic drugs as ordered. ■ Assess all vital signs.
Temperature is within normal range.	Temperature remains elevated because of bacterial-produced pyrogens.	<ul style="list-style-type: none"> ■ Request order to obtain culture of possible sources of infection. ■ Give antipyretics and other drugs as ordered. ■ Decrease room temperature and remove excess covers. ■ Give tepid sponge bath.
	Temperature remains subnormal.	<ul style="list-style-type: none"> ■ Assess for blood clots; extreme low temperature can cause vasoconstriction. ■ Implement measures to promote vasodilation (application of warmth). ■ If extremity is ischemic, monitor that heat source does not exceed body temperature.
Pulse is palpated without difficulty.	Apical, femoral, and carotid pulses are absent.	<ul style="list-style-type: none"> ■ Assess all vital signs and status of the patient. ■ Immediately call for the rapid response team. ■ Initiate CPR immediately. ■ Use Doppler device to assess for presence of pulse.
	Peripheral pulse is absent.	<ul style="list-style-type: none"> ■ Assess for other signs and symptoms of circulatory impairment.
Respiratory rate, rhythm, and depth are within normal limits.	Apnea (absence of breathing) occurs, may be intermittent.	<ul style="list-style-type: none"> ■ Assess patient for pulse. ■ Begin rescue breathing at the rate of 12 per minute for an adult or 20 per minute for a child.
Labored, difficult, or noisy respirations are assessed.	Kussmaul respirations occur (deep and gasping breaths—more than 20 breaths/min).	<ul style="list-style-type: none"> ■ Implement orders for diabetic ketoacidosis, renal failure, or septic shock.

Critical Thinking Options for Unexpected Outcomes ... Demonstrates how evaluation can lead to further interventions for unexpected outcomes.

New! Review Questions with answers and rationales feature NCLEX-style questions that relate to chapter-opening learning outcomes. They serve not only as a self-review, but also as preparation for the licensing exam. Answers and rationales for the review questions can be found in Appendix A or in the Pearson MyLab and eText.

REVIEW Questions

1. A client receiving a unit of packed red blood cells begins to vomit 15 minutes into the transfusion. What should the nurse do first?
 1. Call for help.
 2. Stop the transfusion.
 3. Provide an emesis basin.
 4. Increase infusing normal saline.
2. The nurse assigns the UAP to complete morning care for a client with a sequential compression device. What information should the nurse instruct the UAP to report to the nurse?
 1. Presence of pulses in the client's feet
 2. Condition of the skin under the devices
 3. Amount of time the devices were turned off
 4. Sensation and movement of the client's feet
3. A new graduate is using an automated external defibrillator (AED) for a client who was discovered without a pulse. For which reason should the charge nurse intervene?
 1. Resuming CPR after discharging the AED
 2. Loudly stating "Clear" before discharging the AED
 3. Stopping compressions for the AED to analyze the client's rhythm
 4. Placing electrode pads below the right clavicle and above the left nipple
4. The nurse evaluates the ability of the UAP to complete a 12-lead electrocardiogram for a client. Which lead placement should the nurse correct before the measurement is recorded?
 1. Green lead placed on the client's left leg
 2. White lead placed on the client's right wrist
 3. V2 placed at the fourth intercostal space, left sternal border
 4. V6 placed at the fifth intercostal space, left midclavicular line
5. A client is prescribed 3-lead telemetry to monitor atrial fibrillation. Which lead approach should the nurse use to obtain the best assessment of this client's atrial functioning?
 1. Lead I
 2. Lead II
 3. Lead III
 4. Lead aVL
6. The nurse notes the following when analyzing a client's cardiac rhythm strip: atrial rate 60; ventricular rate 42; QRS width 0.10 seconds. Which diagnostic test should the nurse anticipate to determine the best treatment for this client's rhythm?
 1. Digoxin level
 2. T3 and T4 levels
 3. Arterial blood gases
 4. Serum electrolyte levels
7. The nurse visits the home of a client with a newly inserted permanent pacemaker. Which observation indicates that the client would benefit from additional teaching about the device?
 1. Medical alert bracelet on the right wrist
 2. Telephone transmission device installed
 3. Pacemaker information card in the wallet
 4. Cell phone in shirt pocket over the pacemaker
8. A new graduate reports that a client's arterial blood pressure monitor reading is 20 mmHg higher than the measurement from the previous shift. What should the nurse assess first to determine the reason for the change in measurement?
 1. Calibration process
 2. Pressure bag setting
 3. Arterial site dressing
 4. Angle of the head of the bed

Resources

Instructor Resources

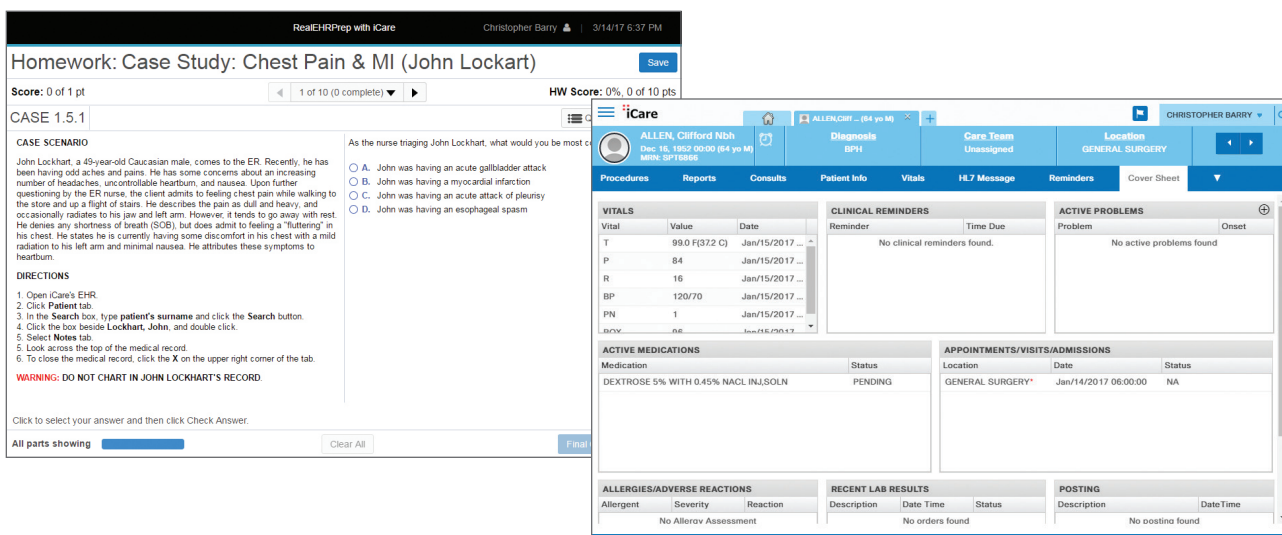
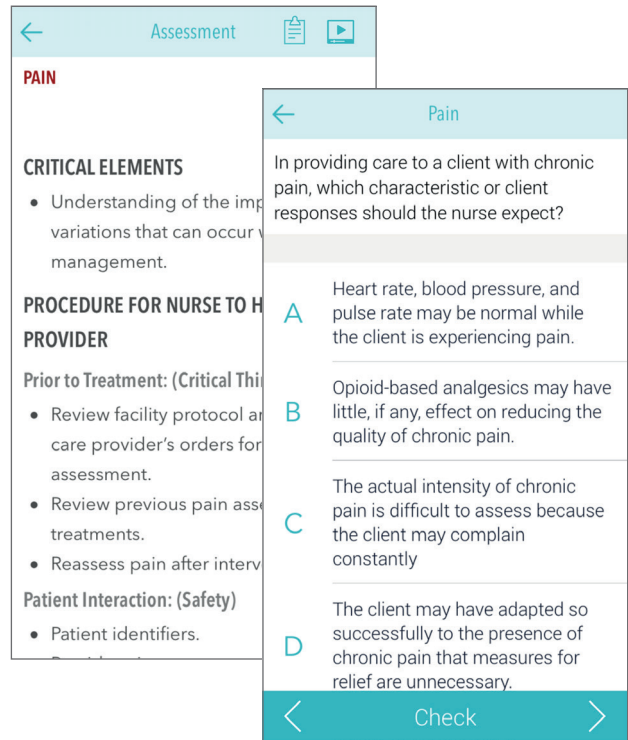
- **New! Instructor's Resource Manual** facilitates active learning in the classroom, lab, and clinical environment with class-tested interactive hands-on and cognitive exercises to help students apply concepts and exemplars.
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- **New! Image Library** provides all the text's illustrations and photos to enhance your PowerPoint presentations and other materials.
- **Skills Checklists** deliver editable check-offs for each skill to assess students' competency, which can be used as is or can be tailored to meet local requirements.

Student Resources

- **New! Enhanced eText**, available via *MyLab Nursing Concepts*, offers a rich and engaging learning experience with interactive activities and exercises. Note: Access requires an adoption of *MyLab Nursing Concepts*.
- **RealEHRprep with iCare**, Developed as a partnership between iCare and Pearson Education, RealEHRprep with iCare provides access to a real electronic health record system developed by healthcare information technology, and documentation activities created by education experts. Providing an environment that mirrors the point-of-care, students can document assessments, plan care, administer medications, communicate with other healthcare providers, and more.

Access to RealEHRprep with iCare may be packaged with Pearson materials or purchased as a standalone item.

- **Skills Hub**, The Skills Hub app meets students where they are - on their smartphones and tablets - by providing procedural steps, skills videos, assessment, and progress tracking in one mobile application. Access to Skills Hub may be packaged with Pearson materials or purchased as a standalone item.



Acknowledgments

Foremost, my thanks to Pearson Education, Inc. for their continued support of concept-based nursing education and for the privilege of being one among so many involved in the production of this third edition of Volume 3 *Clinical Nursing Skills*. Much appreciation goes to Julie Alexander, Publisher, for her continued support and advocacy for concept-based learning; Lisa Rahn, Nursing Portfolio Manager/Editor, for her leadership, decision-making ability, and consistent encouragement; Rachel Bedard, Development Editor, for guidance through the development process and for being a great partner; Bianca Sepulveda, Content Producer in

Nursing, for her organizational skills and many contributions to this edition and its eText version; Addy McCulloch and Laura Horowitz, Development Editors, for their availability to respond to questions and offer suggestions from a different perspective; and Mary Siener (and team) for the innovative cover, color scheme, and interior design of this edition. A special thanks goes to my husband for supporting me to do what I enjoy doing. Thank you, Pearson folks, for promoting a culture of professionalism and team effort during this fabulous adventure.

Barbara Callahan

Reviewers

Pearson thanks faculty who participated in pre-revision and manuscript reviews. We appreciate your thoughtful feedback, insights, and recommendations.

Stephanie Bailey, BA, RN, MHS
Nursing Instructor
British Columbia Institute of Technology
Burnaby, BC, Canada

Eleisa Bennett, RN, MSN
Instructor of Associate Degree Nursing
James Sprunt Community College
Kenansville, NC

Wendy I. Buchanan, RN, ADN, BS, BSN, MSN-E
Instructor of Nursing
Southwestern Community College
Sylva, NC

Marlena Bushway, PhD, MSNEd, RN, CNE
Professor of Nursing
New Mexico Junior College
Hobbs, NM

Kathleen Campbell, MSN, BSN
Instructor of Nursing
Hudson Valley Community College
Troy, NY

Darlene Clark, MS, RN
Professor of Nursing
The Pennsylvania State University
University Park, PA

Diane Cohen, MSN, RN
Professor of Nursing
MassBay Community College
Framingham, MA

Ann Marie Cote, MSN, RN, CEN
Professor of Nursing
Plymouth State University
Plymouth, NH

Ann Crawford, RN, PhD, CNS, CEN, CPEN
Professor, College of Nursing
University of Mary Hardin-Baylor
Belton, TX

Christy Dean, DNP, MSN, FNP-BC, CNE
Instructor of Nursing
University of Louisiana at Lafayette
Lafayette, LA

Michelle De Lima, DNP, APRN, CNOR, CNE
Associate Professor of Nursing
Delgado Community College
New Orleans, LA

James R. Fell, MSN, MBA, RN
Assistant Professor of Nursing
The Breen School of Nursing,
Ursuline University
Pepper Pike, OH

Charlene Beach Gagliardi, RN, MSN
Assistant Professor
Mount Saint Mary's University
Los Angeles, CA

Cathryn Jackson, MSN, RN
Instructor of Nursing and Associate Director of Undergraduate Programs
University of British Columbia
Vancouver, BC Canada

Carolyn Jones, BSN, MAEd, MSN
Professor of Nursing
Craven Community College
New Bern, NC

Christine Kleckner, MA, MAN, RN
Instructor of Nursing
Minneapolis Community and Technical College
Minneapolis, MN

Lynn Lowery, RN, ADN, BSN, MSN
Professor of Nursing
Delgado Community College
New Orleans, LA

Lauro Manolo, Jr., MSN
Professor of Nursing
Allan Hancock College
Santa Maria, CA

Christy McDonald Lenahan, DNP, MSN, FNP-BC, CNE
Assistant Professor of Nursing
University of Louisiana Lafayette
Lafayette, LA

Ellen Manieri, MN, MEd, RN, CMSRN
Professor of Nursing
Delgado Community College, Charity School of Nursing
New Orleans, LA

Janice Martin, MSN, BSN
Professor of Nursing
Southern Union State Community College
Opelika, AL

Amy Mersiovsky, DNP, RN, BC
Assistant Professor of Nursing
Scott and White College of Nursing,
University of Mary Hardin-Baylor
Belton, TX

xii Reviewers

Juleann H. Miller, PhD, RN, CNE
Professor of Nursing
St. Ambrose University
Davenport, IA

Linda Mollino, MSN, RN
Director of Career and Technical
Education (CTE) Programs
Oregon Coast Community College
Newport, OR

Michelle Natrop, MSN, BSN
Instructor of Nursing
Normandale Community College
Bloomington, MN

Karen Neighbors, RN
Professor of Nursing
Trinity Valley Community College
Athens, TX

Denise Owens, MS, BSN, CCRN
Instructor of Nursing
University of Maryland
Baltimore, MD

Allison Peters, AA, ADN, BSN, MSN, DNP
Professor of Nursing
University of Florida
Gainesville, FL

Katherine Poser, RN, BScN, MNEd
Professor of Nursing

St. Lawrence College School of
Baccalaureate Nursing
Kingston, ON

Margaret Prydun, PhD, RN, CNE
Professor of Nursing
University of Mary Hardin-Baylor
Belton, TX

Susan M. Randol, MSN, RN, CNE
Master Instructor of Nursing
University of Louisiana at Lafayette
Lafayette, LA

Marisue Rayno, EdD, RN
Professor of Nursing
Luzerne County CC
Nanticoke, PA

Lori-Ann D. Sarmiento, MSN, RN
Associate Professor of Nursing
Guilford Technical Community College
Jamestown, NC

Lisa S. Smith, DNP, MSN, RN
Instructor of Associate Degree Nursing
Sampson Community College
Clinton, NC

Tetsuya Umabayashi, DNP, RN
Director of Vocational Nursing Program
Tarrant County College—Trinity River East
Fort Worth, TX

Patricia Vasquez, MSN, RN
Professor of Nursing
Trinity Valley Community College
Athens, TX

Amanda Veersart, PhD, RN, CNE
Assistant Professor/Program Director
Texas Tech University
Lubbock, TX

Molly H. Wells, BSN, RN-BC, CEN
Instructor of Associate Degree Nursing
Beaufort County Community College
Washington, NC

Teri Wisdorf, RN
Professor of Nursing
Century College
White Bear Lake, MN

Lisa Zerby, MN, RN, CNOR
Adjunct Nursing Faculty
Shoreline Community College
Shoreline, WA and
Renton Technical College
Renton, WA

Megan Zerillo, MSN, RN
Professor of Nursing
University of Alabama
Birmingham, AL

Technical Reviewers

Pearson gratefully thanks those who checked the accuracy and currency of the nursing skills content during the production process. We appreciate you sharing your expertise and for your careful attention to detail.

Amanda Aird, RN, BScN
Instructor of Nursing
St. Lawrence College School of Baccalaureate Nursing
Kingston, ON

Stephanie Bailey, BA, RN, MHS
Nursing Instructor
British Columbia Institute of Technology
Burnaby, BC, Canada

Eleisa Bennett, RN, MSN
Instructor of Associate Degree Nursing

James Sprunt Community College
Kenansville, NC

Sherrilyn Coffman, PhD, RN, COI
Professor of Nursing
Nevada State College
Henderson, NV

Ann Crawford, RN, PhD, CNS, CEN, CPEN
Professor, College of Nursing
University of Mary Hardin-Baylor
Belton, TX

Lynn Perkins, PhD, MSN, RN
Instructor of Nursing
Minneapolis Community and Technical College
Minneapolis, MN

Katherine Poser, RN, BScN, MNEd
Professor of Nursing
St. Lawrence College School of Baccalaureate Nursing
Kingston, ON

SKILLS List by Key Word**Items in black are major skills. Items in red are minor skills embedded within a major skill.*

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🔴 Nursing students may observe or assist with these skills only with faculty permission and while under direct supervision of faculty or another RN.

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Chapter 1

Assessment

Chapter at a Glance

General Assessment

- SKILL 1.1 **Appearance and Mental Status:** Assessing
- SKILL 1.2 **Height:** Newborn, Infant, Child, Adult, Measuring
- SKILL 1.3 **Newborn's or Infant's Head, Chest, and Abdomen:** Measuring
- SKILL 1.4 **Weight:** Newborn, Infant, Child, Adult, Measuring

Vital Signs

- SKILL 1.5 **Blood Pressure:** Newborn, Infant, Child, Adult, Obtaining
- SKILL 1.6 **Pulse, Apical and Peripheral:** Obtaining
- SKILL 1.7 **Pulse Oximeter:** Using
- SKILL 1.8 **Respirations:** Newborn, Infant, Child, Adult, Obtaining
- SKILL 1.9 **Temperature:** Newborn, Infant, Child, Adult, Obtaining

Physical Assessment

- SKILL 1.10 **Abdomen:** Assessing
- SKILL 1.11 **Anus:** Assessing

- SKILL 1.12 **Breasts and Axillae:** Assessing
- SKILL 1.13 **Ears: Hearing Acuity,** Assessing
- SKILL 1.14 **Eyes: Visual Acuity,** Assessing
- SKILL 1.15 **Genitals and Inguinal Area:** Assessing
- SKILL 1.16 **Hair:** Assessing
- SKILL 1.17 **Heart and Central Vessels:** Assessing
- SKILL 1.18 **Mouth and Oropharynx:** Assessing
- SKILL 1.19 **Musculoskeletal System:** Assessing
- SKILL 1.20 **Nails:** Assessing
- SKILL 1.21 **Neck:** Assessing
- SKILL 1.22 **Neurologic Status:** Assessing
- SKILL 1.23 **Nose and Sinuses:** Assessing
- SKILL 1.24 **Peripheral Vascular System:** Assessing
- SKILL 1.25 **Skin:** Assessing
- SKILL 1.26 **Skull and Face:** Assessing
- SKILL 1.27 **Thorax and Lungs:** Assessing

» The Concept of Assessment

Assessment provides nurses with information about the psychological, cognitive, and emotional well-being of patients that they can use to analyze the data critically, interpret it, and make clinical judgments to implement interventions for the best patient outcomes. Assessment includes many nursing skills and actions. It is the ability to observe and pay attention to significant signs that are seen, heard, smelled, and sensed by touch. Nurses use the techniques of palpation, auscultation, and percussion to perform physical assessment examinations. Nurses can measure and monitor temperatures, pulses, respirations,

blood pressure readings, oxygen saturation, and pain. They can record and report data about the patient's history and current state of health, illness, home medications, cultural and spiritual beliefs, and acute and chronic conditions. Assessment tools can be scales and indexes (e.g., the Braden Scale to assess for risk of pressure injury, the Glasgow Coma Scale to assess consciousness, or a pain scale). Other tools such as the stethoscope, pulse oximeter, tape measure, thermometer, sphygmomanometer, and Doppler ultrasound (DUS) help nurses obtain assessment data.

Learning Outcomes

- 1.1 Summarize the role of observation when performing a general assessment.
- 1.2 Differentiate between normal and abnormal temperatures over the lifespan.
- 1.3 Support the reasoning of using a pulse oximeter for the patient with a respiratory problem.
- 1.4 Explain the examination procedures when doing a physical assessment using a head-to-toe framework.

2 Chapter 1 Assessment

- 1.5 Give examples of maneuvers used to test muscle strength throughout the body.
- 1.6 Explain lifespan considerations when performing a neurologic assessment on the older adult.

- 1.7 Differentiate between normal and abnormal breath sounds.
- 1.8 Demonstrate peripheral pulse assessment of an extremity.

The following feature links some, but not all, of the concepts related to assessment. They are presented in alphabetical order.

Concepts Related to Assessment

CONCEPT	RELATIONSHIP TO ASSESSMENT	NURSING IMPLICATIONS
Caring Interventions	Individualize patient care to best meet needs of patient	<ul style="list-style-type: none">■ Provide competent and compassionate nursing care to all patients■ Build awareness of self-care
Clinical Decision Making	Utilize assessment data to make clinical judgments about patient and set priorities of care	<ul style="list-style-type: none">■ Provide data to analyze, interpret, and implement nursing interventions to meet patient needs■ Clarify priority order of care to provide a variety of patients
Health, Wellness, and Illness	Build self-awareness of health, wellness, and illness status	<ul style="list-style-type: none">■ Provide support and encouragement to help patient change level of health, wellness, and illness
Safety	Support recognition of safety and quality care for patients and others	<ul style="list-style-type: none">■ Provide data to ensure correction of unsafe conditions for patient and others in maintaining a safe environment■ Include assessment techniques for patient and nurse safety
Skin Integrity	Observe any skin breakdown and monitor surgical wounds	<ul style="list-style-type: none">■ Provide data to recognize skin integrity alterations■ Monitor and evaluate healing progression resulting from nursing interventions

Health assessment, which is the collection and interpretation of data regarding the patient's previous and current health status, is one of the most important professional responsibilities of the registered nurse. Vigilance in performing relevant assessment techniques, determining the meaning of the findings, and taking appropriate action based on the evaluation of the data are central aspects of effective nursing care and cannot be delegated to those without the requisite skills and knowledge.

A holistic approach to assessment focuses on all aspects of the patient's mind and body to identify concerns that need to be addressed, including psychological, social, cultural, and spiritual health. Nurses gather subjective data from talking with the patient and or family and objective data from examining the patient. Experienced nurses may also use intuitive skills to notice significant cues about the patient.

Nurses can perform a comprehensive physical assessment of each individual body system. In practice, however, the generalist nurse performs a screening assessment of all systems (sometimes referred to as a head-to-toe assessment) when first encountering the patient and then more detailed focused assessments of particular systems as indicated by the patient's condition. Independent clinical judgment drives the selection of those components for which an assessment is indicated. **Box 1-1** >> presents the

order generally followed in performing a *head-to-toe assessment*. Advance practice nurses such as nurse practitioners may perform much more in-depth assessments of specific systems.

The traditional vital signs are body temperature, pulse, respirations, and blood pressure. Some healthcare facilities refer to pain as a fifth vital sign. Remembering that pain is an individual experience for patients relative to their medical history and current health status, nurses individualize their interventions for each patient. In addition, the effectiveness of respirations and circulation is commonly measured noninvasively through pulse oximetry (see Skill 1.7) at the same time as other vital signs.

All these signs, when looked at both individually and collectively, enable nurses to monitor the functions of the body. Vital signs can reflect changes that otherwise might not be observed. Monitoring a patient's vital signs should not be an automatic or routine procedure; it should be a thoughtful scientific assessment. Vital signs should be evaluated with reference to the patient's present and prior health status and compared to accepted standards (**Box 1-2** >>). If findings appear inconsistent with those anticipated, they should immediately be rechecked. Some of the vital signs that are confirmed to vary from expected values may require nursing interventions, and a few represent medical emergencies.

Box 1–1

Head-to-Toe Framework

GENERAL SURVEY INCLUDING VITAL SIGNS

Areas below are assessed and include a determination of current complaints and inspection. Palpation, percussion, and auscultation are used if indicated.

- Head
 - Hair and face
 - Eyes and vision
 - Ears and hearing
 - Nose
 - Mouth and oropharynx
- Neck
 - Muscles
 - Lymph nodes
 - Trachea
 - Thyroid gland
 - Carotid arteries
 - Neck veins
- Upper extremities
 - Skin and nails
 - Muscle strength and tone
 - Joint range of motion
- Brachial and radial pulses
- Sensation
- Chest and back
 - Skin
 - Thorax shape and size
 - Lungs
 - Heart
 - Spinal column
 - Breasts and axillae
- Abdomen
 - Skin
 - Abdominal sounds
 - Femoral pulses
- External genitals
- Anus
- Lower extremities
 - Skin and toenails
 - Gait and balance; muscle strength and tone
 - Sensation
 - Joint range of motion
 - Popliteal, posterior tibial, and dorsalis pedis pulses

Box 1–2

Times to Assess Vital Signs

- On admission to a healthcare facility to obtain baseline data
- When a patient has a change in health status or reports symptoms such as chest pain or feeling hot or faint
- Before and after surgery or an invasive procedure
- Before and/or after the administration of a medication that could affect the respiratory or cardiovascular systems; for example, before giving a digitalis preparation
- Before and after any nursing intervention that could affect the vital signs (e.g., ambulating a patient who has been on bedrest)

» General Assessment

Expected Outcomes

1. Assessment data of the patient's appearance reveal expected normal findings.
2. Height and weight are obtained and recorded.
3. Patient's weight shows expected losses, gains, or stabilization.

SKILL 1.1 Appearance and Mental Status: Assessing

This skill provides an overall initial impression or review of well-being by observing a patient for acute distress, general physical appearance, body structure, mobility, behavior, nonverbal communication, and body measurements. Measurements can be compared to standard expected measurements for age and gender across the lifespan.

Delegation or Assignment

The initial general survey assessment is completed by the nurse and not delegated or assigned to unlicensed assistive person-

nel (UAP). However, signs and symptoms of problems may be observed during usual care and may be recorded by individuals other than the nurse. Abnormal findings must be validated and interpreted by the nurse.

Unlicensed Assistive Personnel (UAP) are unlicensed healthcare workers trained to perform certain tasks delegated or assigned by nurses to help provide patient care as determined by facility policy. Nurses assess and evaluate the UAP's ability to complete a skill safely and accurately. The nurse remains responsible for the assessment, evaluation, and interpretation of abnormal findings and the determination

(continued on next page)

SKILL 1.1 Appearance and Mental Status: Assessing *(continued)*

of appropriate responses. There are many job titles for those considered a UAP, such as Patient Care Attendants, Home Health Aides, Certified Nursing Assistants, Medication Technicians, and Resident Assistants. Licensed Practical Nurses (LPN) and Licensed Vocational Nurses (LVN) are not UAPs. They are licensed nurses who work under a Registered Nurse (RN) and are regulated by state Boards of Nursing.

Equipment

- No equipment is required.

Preparation

- Observation of children’s behavior can provide important data for the general survey, including physical development, neuromuscular function, and social and interactional skills.
- Safety for newborns, infants, and children includes having an adult attending the child on an examination table or bed to avoid falls during the assessment.

- It may be helpful to have parents hold older infants and very young children for part of the assessment.
- Allow extra time for older patients to answer questions.
- Adapt questioning techniques as appropriate for older patients with hearing or visual limitations.

Procedure

1. Prior to performing the procedure, introduce self and verify the patient’s identity using two identifiers. Explain to the patient and parent (if appropriate) what you are going to do, why it is necessary, and how the patient can participate. Discuss how the results will be used in planning further care or treatments.
2. Perform hand hygiene and observe appropriate infection control procedures.
3. Provide for patient privacy.
4. Complete a general survey.

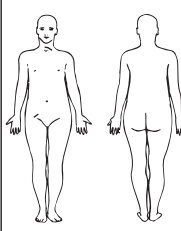
ASSESSMENT	NORMAL FINDINGS	DEVIATIONS FROM NORMAL
5. Observe body build, height, and weight in relation to the patient’s age, lifestyle, and health.	Proportionate, varies with lifestyle	Excessively thin or obese
6. Observe patient’s posture and gait, standing, sitting, and walking.	Relaxed, erect posture; coordinated movement	Tense, slouched, bent posture; uncoordinated movement; tremors, unbalanced gait
7. Observe patient’s overall hygiene and grooming.	Clean, neat	Dirty, unkempt
8. Note body and breath odor in relation to activity level.	No body odor or minor body odor relative to work or exercise; no breath odor	Foul body odor; ammonia odor; acetone breath odor; foul breath
9. Observe for signs of distress in posture or facial expression.	No apparent distress	Bending over because of abdominal pain, wincing, frowning, or labored breathing
10. Note obvious signs of health or illness (e.g., in skin color or breathing).	Well developed, well nourished, intact skin, easy breathing	Pallor (paleness), weakness, lesions, cough
11. Assess the patient’s attitude (frame of mind).	Cooperative, able to follow instructions	Negative, hostile, withdrawn, anxious
12. Note the patient’s affect/mood; assess the appropriateness of the patient’s responses.	Appropriate to situation	Inappropriate to situation, sudden mood changes, paranoia
13. Listen for speech quantity (amount and pace) and quality (loudness, clarity, inflection).	Understandable, moderate pace; clear tone and inflection	Rapid or slow pace; overly loud or soft
14. Listen for relevance and organization of thoughts.	Logical sequence, relevant answers, has sense of reality	Illogical sequence, flight of ideas, confusion, generalizations, vague
15. When procedure is completed, perform hand hygiene and leave patient safe and comfortable. Complete documentation using forms, checklists, or electronic dropdown lists supplemented by nurse’s notes or additional comments as appropriate ①.		

SKILL 1.1 Appearance and Mental Status: Assessing (continued)

ADMISSION DATA	Date <u>4-16-19</u> Time <u>3:15p.m.</u> Primary Language <u>English</u>		
	Arrived Via: <input checked="" type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher <input checked="" type="checkbox"/> Ambulatory		
	From: <input type="checkbox"/> Admitting <input type="checkbox"/> ER <input checked="" type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other		
	Admitting M.D. <u>R. Katz</u> Time Notified <u>5 p.m.</u>		
ALLERGIES & REACTIONS	ORIENTATION TO UNIT YES NO YES NO Arm Band Correct <input checked="" type="checkbox"/> <input type="checkbox"/> Visiting Hours <input checked="" type="checkbox"/> <input type="checkbox"/> Allergy Band <input checked="" type="checkbox"/> <input type="checkbox"/> Smoking Policy <input checked="" type="checkbox"/> <input type="checkbox"/> Telephone <input checked="" type="checkbox"/> <input type="checkbox"/> TV, Lights, Bed Controls, <input checked="" type="checkbox"/> <input type="checkbox"/> Electrical Policy <input checked="" type="checkbox"/> <input type="checkbox"/> Call Lights, Side Rails <input checked="" type="checkbox"/> <input type="checkbox"/> Educational Mat'l (TV Brochure) <input checked="" type="checkbox"/> <input type="checkbox"/> Nurses Station <input checked="" type="checkbox"/> <input type="checkbox"/>		
	Family M.D. <u>R. Katz</u>		
	Weight <u>125 lb.</u> Height <u>5ft. 2in.</u> BP:R <u>—</u> L <u>122/80</u>		
	Temp. <u>103F</u> Pulse <u>92, weak</u> Resp <u>8, shallow</u>		
MEDICATIONS	Source Providing Information <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Other _____		
	Unable to Obtain History <input type="checkbox"/>		
	Reason for Admission (Onset, Duration, Pt.'s Perception) <u>"Chest cold" X2 weeks S.O.B on exertion. "Lung pain, fever," "Dr. says I have pneumonia."</u>		
	Drugs <u>Penicillin</u> Food/Other <u>None known</u> Signs & Symptoms <u>rash, nausea</u> Blood Reaction <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Dyes/Shellfish <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
PSYCHOSOCIAL HISTORY	Recent Stress <u>None</u>		
	Coping Mechanism <u>Not assessed because of fatigue</u>		
	Support System <u>Husband, coworkers, friends</u>		
	Calm: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Anxious: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>Facial muscles tense; trembling</u> Religion <u>Catholic, Would want Last Rites</u> Tobacco Use: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Alcohol Use: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Drug Use: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
NEUROLOGICAL	Oriented: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time <input type="checkbox"/> Confused <input type="checkbox"/> Sedated <input type="checkbox"/> Alert <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Lethargic <input type="checkbox"/> Comatose Pupils: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive <input type="checkbox"/> Sluggish <input type="checkbox"/> Other <u>3mm.</u>		
	Extremity Strength: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal		
	Speech: <input checked="" type="checkbox"/> Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Other _____		
	Normal ROM of Extremities <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Contractures <input type="checkbox"/> Joint Swelling <input checked="" type="checkbox"/> Pain <input type="checkbox"/> Other <u>related to fatigue when coughing</u>		
RESPIRATORY	Pattern: <input type="checkbox"/> Even <input type="checkbox"/> Uneven <input checked="" type="checkbox"/> Shallow <input checked="" type="checkbox"/> Dyspnea <input checked="" type="checkbox"/> Other <u>diminished breath sounds (see NN)</u>		
	Breathing Sounds: <input type="checkbox"/> Clear <input checked="" type="checkbox"/> Other <u>inspiratory crackles</u>		
	Secretions: <input type="checkbox"/> None <input checked="" type="checkbox"/> Other <u>pink, thick sputum</u>		
	Cough: <input type="checkbox"/> None <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive		
CARDIOVASCULAR	Pulses: Apical Rate <u>92-W</u> <input checked="" type="checkbox"/> Reg. <input type="checkbox"/> Irregular <input type="checkbox"/> Pacemaker S = Strong W = Weak A = Absent D = Doppler Radial R <u>92</u> L <u>—</u> Pedal R <u>—</u> L <u>—</u> Edema: <input checked="" type="checkbox"/> Absent <input type="checkbox"/> Present Site _____ Perfusion: <input type="checkbox"/> Warm <input type="checkbox"/> Dry <input checked="" type="checkbox"/> Diaphoretic <input type="checkbox"/> Cool (Hot)		
	Oral Mucosa <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other <u>pale and dry</u>		
	Bowel Sounds: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other <u>Abd. soft</u>		
	Wt. Change: <input type="checkbox"/> <input checked="" type="checkbox"/> N/V Stool Frequency/Character <u>1/day; soft</u> Last B/M <u>4-15-19</u> <input type="checkbox"/> Ostomy (type) _____ Equip. <u>None</u>		
MEDICAL HISTORY	<input checked="" type="checkbox"/> No Major Problems <input type="checkbox"/> Gastro _____ <input type="checkbox"/> Cardiac <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> Hyper/Hypotension <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures _____ <input type="checkbox"/> Cancer <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> Respiratory <input checked="" type="checkbox"/> Other <u>childbirth-2003</u>		
	Surgery/Procedures Date <u>Appendectomy 1999</u> <u>Partial thyroidectomy 2005</u>		
	Disposition of Meds: <input checked="" type="checkbox"/> Home <input type="checkbox"/> Pharmacy <input type="checkbox"/> Safe *At Bedside		
	Special Assistive Devices: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Contacts <input type="checkbox"/> Venous <input type="checkbox"/> Dentures <input type="checkbox"/> Braces <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Access <input type="checkbox"/> Partial <input type="checkbox"/> Cane/Crutches <input type="checkbox"/> Prosthesis <input type="checkbox"/> Device <input type="checkbox"/> Upper <input type="checkbox"/> Walker <input type="checkbox"/> Glasses <input type="checkbox"/> Epidural Catheter <input type="checkbox"/> Lower <input type="checkbox"/> Other <u>None</u>		
VALUABLES	Patient informed Hospital not responsible for personal belongings.		
	Valuables Disposition: <input type="checkbox"/> Patient <input type="checkbox"/> Safe <input type="checkbox"/> Given to _____		
	Patient/SO Signature <u>None</u>		
MUSCULO-SKELETAL	Need Assist with: <input type="checkbox"/> Ambulating <input type="checkbox"/> Elimination <input type="checkbox"/> Meals <input checked="" type="checkbox"/> Hygiene <input type="checkbox"/> Dressing <u>while fatigued</u>		
	Amanda Aquilini [F age 37] #4637651 DOB 11-02-82		

NURSING ADMINISTRATION ASSESSMENT

SKILL 1.1 Appearance and Mental Status: Assessing (continued)

NUTRITION	<p>General Appearance: <input checked="" type="checkbox"/> Well Nourished <input type="checkbox"/> Emaciated <input type="checkbox"/> Other _____</p> <p>Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input checked="" type="checkbox"/> Poor -x2 Diet <u>Liquid</u> Meal Pattern <u>3/day</u> <u>days</u> <input checked="" type="checkbox"/> Feeds Self <input type="checkbox"/> Assist <input type="checkbox"/> Total Feed</p>	<p>1. What do you know about your present illness? <u>"Dr. says I have pneumonia." "I will have an I.V."</u></p> <p>2. What information do you want or need about your illness? <u>"How long do I have to stay here?"</u></p> <p>3. Would you like family/SO involved in your care? <u>Husband, Michael</u></p> <p>4. How long do you expect to be in the hospital? <u>"1-2 days"</u></p> <p>5. What concerns do you have about leaving the hospital? <u>"How long will I feel so tired all the time?"</u></p>																																										
SKIN ASSESSMENT	<p>Color: <input type="checkbox"/> Normal <input type="checkbox"/> Flushed <input checked="" type="checkbox"/> Pale <input type="checkbox"/> Dusky <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundiced <input checked="" type="checkbox"/> Other <u>Cheeks flushed, hot</u></p> <p>General Description <u>Surgical scars:</u> <u>RLQ abdomen; anterior neck</u></p>  <p>Note Cultures Obtained _____</p> <p style="text-align:center;">PRESSURE SORE™ AT RISK SCREENING CRITERIA</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>OVERALL SKIN CONDITION</th> <th>BOWEL AND BLADDER CONTROL</th> <th>REHABILITATIVE STATE</th> </tr> <tr> <th>Grade</th> <th>Grade</th> <th>Grade</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 0 Turgor (elasticity adequate, skin warm and moist)</td> <td><input checked="" type="checkbox"/> 0 Always able to ask for bedpan</td> <td><input type="checkbox"/> 0 Fully ambulatory</td> </tr> <tr> <td><input checked="" type="checkbox"/> 1 Poor turgor, skin cold & dry</td> <td><input type="checkbox"/> 1 Incontinence of urine</td> <td><input checked="" type="checkbox"/> 1 Ambulated with assistance</td> </tr> <tr> <td><input type="checkbox"/> 2 Areas mottled, red or denuded</td> <td><input type="checkbox"/> 2 Incontinence of feces</td> <td><input type="checkbox"/> 2 Chair to bed ambulation only</td> </tr> <tr> <td><input type="checkbox"/> 3 Existing skin ulcer/lesions</td> <td><input type="checkbox"/> 3 Totally incontinent Confined to bed</td> <td><input type="checkbox"/> 3 Confined to bed</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> 4 Immobile in bed</td> </tr> </tbody> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>NUTRITIONAL STATE</th> <th>MENTAL STATE</th> <th>CHRONIC DISEASE STATUS (i.e. COPD, ASCVD, Peripheral Vascular Disease, Diabetes, or Renal Disease, Cancer, Motor or Sensory Deficits, Elderly, Other)</th> </tr> <tr> <th>Grade</th> <th>Grade</th> <th>Grade</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 0 Eats all</td> <td><input checked="" type="checkbox"/> 0 Alert and clear</td> <td><input checked="" type="checkbox"/> 0 Absent</td> </tr> <tr> <td><input checked="" type="checkbox"/> 1 Eats very little</td> <td><input type="checkbox"/> 1 Confused</td> <td><input type="checkbox"/> 1 One Present</td> </tr> <tr> <td><input type="checkbox"/> 2 Refuses food often</td> <td><input type="checkbox"/> 2 Disoriented/senile</td> <td><input type="checkbox"/> 2 Two Present</td> </tr> <tr> <td><input type="checkbox"/> 3 Tube feeding</td> <td><input type="checkbox"/> 3 Stuporous</td> <td><input type="checkbox"/> 3 Three or more Present</td> </tr> <tr> <td><input type="checkbox"/> 4 Intravenous feeding</td> <td><input type="checkbox"/> 4 Unconscious</td> <td></td> </tr> </tbody> </table> <p>TOTAL <u>3</u> Refer to Skin Care Protocol</p>	OVERALL SKIN CONDITION	BOWEL AND BLADDER CONTROL	REHABILITATIVE STATE	Grade	Grade	Grade	<input type="checkbox"/> 0 Turgor (elasticity adequate, skin warm and moist)	<input checked="" type="checkbox"/> 0 Always able to ask for bedpan	<input type="checkbox"/> 0 Fully ambulatory	<input checked="" type="checkbox"/> 1 Poor turgor, skin cold & dry	<input type="checkbox"/> 1 Incontinence of urine	<input checked="" type="checkbox"/> 1 Ambulated with assistance	<input type="checkbox"/> 2 Areas mottled, red or denuded	<input type="checkbox"/> 2 Incontinence of feces	<input type="checkbox"/> 2 Chair to bed ambulation only	<input type="checkbox"/> 3 Existing skin ulcer/lesions	<input type="checkbox"/> 3 Totally incontinent Confined to bed	<input type="checkbox"/> 3 Confined to bed			<input type="checkbox"/> 4 Immobile in bed	NUTRITIONAL STATE	MENTAL STATE	CHRONIC DISEASE STATUS (i.e. COPD, ASCVD, Peripheral Vascular Disease, Diabetes, or Renal Disease, Cancer, Motor or Sensory Deficits, Elderly, Other)	Grade	Grade	Grade	<input type="checkbox"/> 0 Eats all	<input checked="" type="checkbox"/> 0 Alert and clear	<input checked="" type="checkbox"/> 0 Absent	<input checked="" type="checkbox"/> 1 Eats very little	<input type="checkbox"/> 1 Confused	<input type="checkbox"/> 1 One Present	<input type="checkbox"/> 2 Refuses food often	<input type="checkbox"/> 2 Disoriented/senile	<input type="checkbox"/> 2 Two Present	<input type="checkbox"/> 3 Tube feeding	<input type="checkbox"/> 3 Stuporous	<input type="checkbox"/> 3 Three or more Present	<input type="checkbox"/> 4 Intravenous feeding	<input type="checkbox"/> 4 Unconscious		<p style="text-align:center;">CHECK APPROPRIATE BOX</p> <p>Will patient need post discharge assistance with ADLs/physical functioning? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Does patient have family capable of and willing to provide assistance post discharge? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No family</p> <p>Is assistance needed beyond that which family can provide? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Previous admission in the last six months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Patient lives with <u>Husband and 1 child</u></p> <p>Planned discharge to <u>Home</u></p> <p>Comments: <u>Fatigue and anxiety may have interfered with learning. Re-teach anything covered at admission, later.</u></p> <p>Social Services Notified <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p style="text-align:center;">NARRATIVE NOTES</p> <p><u>S--c/o sharp chest pain when coughing and dyspnea on exertion. States unable to carry out regular daily exercise for past week. Coughing relieved "if I sit up and sit still." Nausea associated with coughing. Having occasional "chills." Occasionally becomes frightened, stating, "I can't breathe." Well groomed but "too tired to put on make-up." Assesses own supports as "good" (eg, relationship z husband). Is "worried" about daughter. States husband will be out of town until tomorrow. Left 13-year-old daughter with neighbor. Concerned too about her work (is attorney). "I'll never get caught up." Had water at noon--no food today.</u></p> <p><u>O--Chest expansion < 3cm, no nasal flaring or use of accessory muscles. Breath sounds and insp. crackles in @ upper and lower chest. Capillary refill 5 seconds.</u></p>
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FALLS SCREENING	<p>If one or more of the following are checked institute fall precautions/plan of care <input type="checkbox"/> History of Falls <input type="checkbox"/> Unsteady Gait <input type="checkbox"/> Confusion/Disorientation <input type="checkbox"/> Dizziness</p> <p>If two or more of the following are checked institute fall precautions/plan of care <input type="checkbox"/> Age over 80 <input type="checkbox"/> Utilizes cane, walker, w/c <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Impaired vision <input type="checkbox"/> Urgency/frequency in elimination <input type="checkbox"/> Multiple Diagnoses <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Medication/Sedative /Diuretic etc. <input type="checkbox"/> Inability to understand or follow directions</p>																																											
	<p>NURSE SIGNATURE/TITLE DATE TIME <u>Mary Medina, RN</u> <u>4-16-19</u> <u>3:30pm</u></p> <p>NURSE SIGNATURE/TITLE DATE TIME</p>																																											

NURSING ADMINISTRATION ASSESSMENT