Nursing 102 Care of Adults
Clinical Preparation Week
Cardiovascular: Anticoagulation

** Due Friday, February 7th by 0830 **

Your Class Prep Assignment has multiple parts. Please make sure you complete ALL the required assignments to receive full credit and be prepared for your lab.

1. Complete the following module in EdPuzzle:
https://edpuzzle.com/assignments/678566d9e2a7ace926e69b14/watch

2. Watch these videos and answer the questions on the next page:
https://youtu.be/74oq1p_tziE?si=uqHAm5S4M1zPoiZI
https://youtu.be/Cnx2_uQFOEg?si=xaj59vt8koeRUve4

3. Complete ATI Templates for the following 3 anticoagulant medications (Bring these to the lab):
   a. **Heparin sodium (concentrate on subq route) DONE**
   b. **Enoxaparin (Lovenox) subq DONE**
   c. **Warfarin (Coumadin) PO. DONE**

*Of note, these medications will **ALWAYS** be by memory on clinical day 1 and day 2 Additional medication templates that you will more than likely administer this semester you may decide to fill out a med template for (*not required for CP grade*): Xarelto, Eliquis, Arixta

4. Review your Heparin/Lovenox Administration Procedure 2025 and SQ Injection Administration Sites (will be on E360 1 week prior to the semester under "Clinical Prep")
5. Anticoagulation Questions:

a. What lab is used to monitor Heparin therapy? PTT

b. What lab is used to monitor Warfarin (Coumadin) therapy? INR

c. What dietary considerations on Warfarin do you need to educate your patients on? Vitamin K

d. Name (2) side effects of anticoagulants? Brusing, bleeding

e. What gauge needle do you use to administer a SQ injection? 25g

f. Name (3) safe considerations/education needed for anticoagulants? ie.; no drinking alcohol

Using soft bristle toothbrush, no flossing, no shaving with razor

**Be prepared to discuss all these documents throughout the lab*

Nursing 102 Care of Adults

Clinical Preparation Week

Integumentary: Pressure Injuries

** Due Friday, February 7th by 0830 to Mrs. Wingate's "Clinical Prep Integ Dropbox". **

1.) Complete the following lesson in ATI Engage Medical Surgical RN:

- *Alterations in Tisue Integrity > "Pressure Injuries" and answer the questions within the lesson. (No need to print anything)*

2.) Then read the client profile and answer the questions below:

Client Information: Name: Robert Johnson
Age: 72
Gender: Male
Weight: 230 lbs
Height: 5'7"
Primary Diagnosis: Post-stroke hemiparesis (left-sided)
Secondary Diagnosis: Type 2 Diabetes Mellitus, Hypertension
Medical History: Obesity, peripheral neuropathy, chronic kidney disease (Stage 2)
Social History: Retired construction worker, widowed, lives alone, limited family support, receives home health visits twice weekly.

Clinical Presentation: Robert presents with a pressure injury on his sacral region identified during a routine home health visit. He has limited mobility

due to left-sided weakness and primarily uses a wheelchair for mobility. He reports occasional incontinence and uses absorbent pads but has limited ability to reposition himself.

Wound Assessment:

- *Location: Sacral region, Stage 3 Pressure Injury (full-thickness tissue loss with visible adipose tissue)*
- *Size: 5 cm x 6.5 cm, depth 1.2 cm*
- *Exudate: Moderate amount, yellow and thick, pain: 6/10, worse with dressing changes*
- *Edges: Rolled edges noted, faint, musty odor*
- *Surrounding skin: Erythematous, no crepitus*

Braden Scale Assessment:

1.) Fill out a completed Braden Scale Assessment on Robert (Circle or highlight the values you select and total at bottom):

BRADEN SCALE – For Predicting Pressure Sore Risk

SEVERE RISK: Total score ≤ 9 **HIGH RISK**: Total score 10-12
MODERATE RISK: Total score 13-14 **MILD RISK**: Total score 15-18

RISK FACTOR	SCORE/DESCRIPTION				DATE OF ASSESS ➡ 1	2	3	4
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. COMPLETELY LIMITED** – Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, **OR** limited ability to feel pain over most of body surface.	**2. VERY LIMITED** – Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. SLIGHTLY LIMITED** – Responds to verbal commands but cannot always communicate discomfort or need to be turned, **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. **NO IMPAIRMENT** – Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE Degree to which skin is exposed to moisture	1. **CONSTANTLY MOIST**– Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. **OFTEN MOIST** – Skin is often but not always moist. Linen must be changed at least once a shift.	3. **OCCASIONALLY MOIST** – Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. **RARELY MOIST** – Skin is usually dry; linen only requires changing at routine intervals.				
ACTIVITY Degree of physical activity	1. **BEDFAST** – Confined to bed.	2. **CHAIRFAST** – Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. **WALKS OCCASIONALLY** – Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. **WALKS FREQUENTLY**– Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY Ability to change and control body position	1. **COMPLETELY IMMOBILE** – Does not make even slight changes in body or extremity position without assistance.	2. **VERY LIMITED** – Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. **SLIGHTLY LIMITED** – Makes frequent though slight changes in body or extremity position independently.	4. **NO LIMITATIONS** – Makes major and frequent changes in position without assistance.				
NUTRITION Usual food intake pattern [1]NPO: Nothing by mouth. [2]IV: Intravenously. [3]TPN: Total parenteral nutrition.	**1. VERY POOR** – Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, **OR** is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. PROBABLY INADEQUATE** – Rarely eats a complete meal and generally eats only about ¼ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. ADEQUATE** – Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will usually take a supplement if offered, **OR** is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	4. **EXCELLENT** – Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION AND SHEAR	1. **PROBLEM**- Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	2. **POTENTIAL PROBLEM**– Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. **NO APPARENT PROBLEM** – Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.					
TOTAL SCORE	**Total score of 12 or less represents HIGH RISK**							

Sensory Perception: 4

Moisture: 2

Activity: 2

Nutrition:3

Friction and sheer: 1

Total: 12

2.) Identify 3 risk factors for skin breakdown Robert has?
Limited mobility due to left sided weakness, occasional incontinence, primarily uses a wheelchair for mobility

3.) Write a nurse's note on the skin assessment with an intervention you would implement as well as a re-assessment:

Time	**Relevant Assessments** Indicate pertinent assessment findings.	**Time**	**Multidisciplinary Team Intervention** What interventions were done in response to your abnormal assessments?	**Time**	**Reassessment/Evaluation** What was your patient's response to the intervention?
0900	Sacral region, Stage 3 Pressure Injury, Size: 5 cm x 6.5 cm, depth 1.2 cm, Exudate: Moderate amount, yellow and thick, pain: 6/10, worse with dressing changes, Edges: Rolled edges noted, faint, musty odor, warm to touch	0900	Change the dressing, and reposition onto right side	1100	Assess wound, reposition onto left side

4.) Identify 3 Pressure Injury Prevention Strategies you would implement for Robert knowing his Braden score:

a. Reposition Q2hrs
b. Waffle cushion for wheelchair

c. Urinating more frequently to prevent incontinence, or making sure to stay dry by changing self as soon as he feels he is wet