

**Nursing 102 Care of Adults
Clinical Preparation Week- 2025**

Neurosensory: Stroke

**** Due Wednesday, February 5th by 0830 to Dr. Baich's DropBox ****

1. Log on to ATI
 - a. Learn Tab → Engage Adult Medical Surgical RN → Alterations in Neurologic Function → Review the “Stroke” lesson → Watch the “Stroke” Podcast
2. Complete the following:
 - a. After reviewing the stroke lesson:
 - i. What does BE FAST stand for? Expand upon each letter:

- B: Balance – does the person have a sudden loss of balance? _____
 E: Eyes – Has the person lost vision in one or both eyes? _____
 F: Face – Does the persons face look uneven? _____
 A: Arms – is one arm weak or numb? _____
 S: Speech – slurred speech, if the person is having trouble speaking or seem confused _____
 T: Time – time to act, call emergency services immediately _____
- ii. What is the treatment for stroke?

Hemorrhagic	Ischemic
-Surgery such as thrombectomy to remove the clot occluding the blood flow. -STAT MRI/CT scan -Control blood pressure when it is over 180/105 -Do not admin any anticoagulants -Decompressive hemicraniectomy is performed to relieve ICP from swelling of the brain. -Rehab, PT, OT, Speech Therapy	-Restore blood flow by dissolving or removing clots and preventing new clots from forming. -Administration of alteplase < 3 hrs of the onset symptoms. Aspirin may be prescribed within 48hr of manifestations

- iii. Have the NIH Stroke Scale available (will be posted in the clinical prep lesson on edvance360). Watch the following video and complete the NIH Stroke Scale: <https://www.youtube.com/watch?v=Yca-VJiHufU>.

- | | |
|---|--|
| 1. 1a: Level of Consciousness: <u> 2 </u> | 8. Motor Leg: <u> Right- 0 Left: 2 </u> |
| 2. 1b: LOC Questions: <u> 2 </u> | 9. Limb Ataxia: <u> 1 </u> |
| 3. 1c: LOC Commands: <u> 0 </u> | 10. Sensory: <u> 2 </u> |
| 4. Best Gaze: <u> 1 </u> | 11. Best Language: <u> 0 </u> |
| 5. Visual: <u> 1 </u> | 12. Dysarthria: <u> 0 </u> |
| 6. Facial Palsy: <u> 1 </u> | 13. Extinction and Inattention: <u> 0 </u> |
| 7. Motor Arm: <u> Right- 0 Left- 2 </u> | 14. Total Score: <u> 14 </u> |

- b. After watching the Podcast:
 - i. What is the role of the rehab nurse when working with a stroke patient?

A rehab nurse provides client education, reinforce what patients have practiced without PT/OT and communicate this information to the family. They also make sure the clients pain is well-managed so they can actively participate in therapy

- ii. What is the role of OT when working with a stroke patient?
An occupational therapist sets up adaptive equipment to assist clients with their daily activities, They help develop strategies for adapting to tasks bathing, dressing, and feeding themselves.

- iii. Why is a speech language pathologist (SLP) important when a patient is recovering from a stroke?
They are important for helping the patient with communication and relearning how to swallow.

Nursing 102 Care of Adults Clinical Preparation Week

Gastrointestinal: Nasogastric Tubes

**** Due Wednesday, February 5th by 0830 to Dr. Baich's DropBox ****

Class Preparation Directions:

On ATI, open the Nasogastric Tube Skills Modules 3.0.

1. Complete the module:
 - a. Essentials of nasogastric intubation
 - b. Performing nasogastric intubation
 - i. Watch videos:
 1. Inserting a nasogastric tube
 2. Care and maintenance of a nasogastric tube
 - c. Gastric decompression
 - i. Watch video:
 1. Gastric decompression
 - d. Gastric compression
 - e. Gastric lavage
 - f. Removing a nasogastric tube
 - i. Watch video:

1. Removing a nasogastric tube
 - g. Evidence-based practice
 - i. Nasogastric intubation
 - h. Key considerations
 - i. General considerations
 - ii. Clinical judgment considerations
 - i. Documentation
 - j. Activities
 - i. Practice challenge 1-3
2. Take the posttest and download the report. (You must earn at least 80% on the test. Retake the test until this is achieved.) Submit report to Dr. Baich's dropbox.

Nursing 102 Care of Adults Clinical Preparation Week

Endocrine: Diabetes

**** Due Thursday, February 6th by 0830 ****

1. Complete the following modules in EdPuzzle:
 - *What is Diabetes? Type 1 Diabetes Education*
 - *Understanding Type 2 Diabetes*

<https://edpuzzle.com/assignments/67631c62df2f6a07e327f6fa/watch>

You must achieve 80% to receive class prep credit

2. View the following video on insulin administration
➤ <https://youtu.be/C0coWZbO-E?si=63VDPwHl0x2RPUm6>
3. Come to 2/6/25 Insulin Lab prepared with the following documents:
 - Completed INSULIN ATI Template
 - Insulin Lab- Insulin Skills Checklist
 - Insulin Lab- Insulin Guidelines Chart
 - Insulin Administration Sites

- Hyperglycemia Physician Order Set
- Hypoglycemia Treatment

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

NOTE - All documents will be checked at the start of the lab. Failure to provide all documents will result in ZERO for class prep regardless of whether you successfully completed the Edpuzzle activity.

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)

b. Enoxaparin (Lovenox) subq

c. Warfarin (Coumadin) PO.

*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?
 - b. What lab is used to monitor Warfarin (Coumadin) therapy?
 - c. What dietary considerations on Warfarin do you need to educate your patients on?
 - d. Name (2) side effects of anticoagulants?
 - e. What gauge needle do you use to administer a SQ injection?
 - f. Name (3) safe considerations/education needed for anticoagulants? ie.; no drinking alcohol

****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:
 - o *Alterations in Tissue 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, warm to touch, 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					DATE OF ASSESS →			
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				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.				
FRICION 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							

2.) Identify 3 risk factors for skin breakdown Robert has?

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?

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

- a. _____
- b. _____
- c. _____