**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, sudden loss of balance_____
E: __eyes, sudden vision changes like blurred vision.._____
F: __facial drooping, weakness or asymmetry of face_____
A: __arm weakness, numbness or weakness in one arm_____
S: ___speech disturbance, slurring of speech_____
T: ___time to call 911, activate stroke protocol if 1 of 3 manifestations are present_____

ii. What is the treatment for stroke?

| Hemorrhagic | Ischemic |
|---|---|
| Surgery may be needed. Thrombectomy of the cerebral artery to remove the clot. Decompressive hemicraniectomy is preformed to relieve ICP from swelling in brain. Can also insert drain in the ventricles to remove fluid and decrease ICP. Coils or clips can treat ruptured cerebral aneurysms. | Admin of alteplase within 3 hours of the onset to restore cerebral blood flow. Should be closely monitored for any complications. Aspirin can also be given within 48 hours 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: ___2___
2. 1b: LOC Questions: ___2___
3. 1c: LOC Commands: __0___
4. Best Gaze: ___1____
5. Visual: ____1____
6. Facial Palsy: ____1____
7. Motor Arm: ____right-0 left-2____
8. Motor Leg: _right-0 left-2_____
9. Limb Ataxia: ___1_____
10. Sensory: ____2_____
11. Best Language: _____0_____
12. Dysarthria: _____0_____
13. Extinction and Inattention: _____0____
14. Total Score: _____14_____

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

To get the client close to living the way they did before their incident. Also to educate the client and communicate with the family. Help with pain management too.

ii. What is the role of OT when working with a stroke patient?

To work with clients and figure out the kinds of adaptive equipment that they might need for ADL's and help plan how the client will adapt.

iii. Why is a speech language pathologist (SLP) important when a patient is recovering from a stroke?
They help to focus on voice, motor speech, and fluency. They also focus on swallowing too. This helps ensure the client will be able to speak, eat, and drink with little to no difficulty or come up with a solution if there is difficulty.

**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?

   Measure the PTT lab value

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

   Measure INR lab value

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

   Avoid alcohol and grapefruit and cranberry juices. Some leafy greens can affect the effectiveness of the medication as well as foods high in vitamin K.

d. Name (2) side effects of anticoagulants?

   Bleeding and bruising are two side effects.

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

   25-30 gauge

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

   Be careful not to fall or hit your head. The client is at risk for bleeding very easily.

   Do not stop this medication abruptly.

   Use a soft toothbrush to avoid gum bleeding.

**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, 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

**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<br>[1]NPO: Nothing by mouth.<br>[2]IV: Intravenously.<br>[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** | | | | | | | |

(I couldn't figure out a way to write on the form, so I typed my results below)
Sensory Perception- 3 Moisture- 3 Activity- 2 Nutrition- 3 Friction and Shear- 1
Total Score- 12, High Risk

**2.)** Identify 3 risk factors for skin breakdown Robert has?
Robert occasionally has incontinence which can leave the skin wet and soiled allowing a risk for breakdown. Robert has limited ability for movement because of left sided weakness which stops him from easily getting up and moving around whenever he would like. And lastly, Robert has limited ability to reposition himself which makes it hard for him to be able to move off certain areas of skin to avoid skin breakdown.

**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? |
|---|---|---|---|---|---|
| 0930 | Pain reported at a 6/10 during assessment of a stage 3 sacral wound. Thick and yellow exudate. Edges are rolled with a musty odor. Surrounding Skin erythematous and warm to touch. | 0940 | Administered pain medication as ordered for PRN pain greater than a 5 | 1005 | Reports pain at a 3/10. Sitting up in bed watching television. |
| | | | | | |

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

a. _Turns every two hours with use of wedges for support____
b. ____Ensure linens are not soiled every time I enter the room, and change linens as needed as well as daily_____
c. ___Encourage a healthy eating diet to help with wound healing and diabetes_____