

Meet Mrs. Howard on South 5 in the Student Room at 0630 on Tuesday morning.

South 5 Clinical Prep Assignment:

*****Additional Meds for First Clinical
Week 2 Only:***

1. enoxaparin (Lovenox) 1 mg/kg SQ daily
2. insulin lispro (Humalog) 4 units SQ for blood sugar 200-250 mg/dL
3. 70% insulin aspart protamine/30% insulin aspart (NovoLog mix 70/30) 15 units SQ AC breakfast
4. insulin glargine (Lantus) 30 units SQ HS
5. Pneumococcal polysaccharide vaccine (PPV) (Pneumovax 23) 0.5 ml IM one time

Medication Workup:

Write up each medication your patient has received between 0700-1300 on Tuesday. The medications are to be written up, completely on the Medication Worksheets provided with your clinical packet.

Disease Process Form:

Bring Disease Process assignment based on the primary disorder affecting your patient. This is due Thursday at the time of nursing intervention.

Nursing Diagnoses:

Determine one nursing diagnoses for one of the patients you care for on Tuesday. Refer to guidelines for nursing diagnoses.

South 5 Clinical: Important Numbers

Mrs. Howard's Cell 806-543-3807

Med Room 86176

Student Room 54392

Central Supply 54321

Soiled Linen 12345

Suggested Daily Schedule for South 5

- 630 On unit. Meet in student room with Mrs. Howard to get nurse assignment. Locate TPCN. Introduce yourself and let the nurse know that you will be doing assessments, AM care, charting, and passing meds. Bring paperwork to Mrs. Howard to check.
- 645 Report – Nurses on South 5 do a bedside report. Try to listen to report with TPCN. (You may have to ask the TPCN if you can make a copy of the Kardex before report.) The TPCN will give you an individual report and a copy of the Kardex. ***MAKE SURE** you do not take any patient identifying information home with you. Discard any identifying info in the confidential bin before leaving the unit.
- 700 **You may NEVER give medications without a licensed nurse present.** Mrs. Howard will pass meds with each student on one patient during the week. Other meds may be given with the nurse **ONLY after** ensuring you understand why you are giving the medication. If you are passing meds with Mrs. Howard and you have a 0730, 0800 med, please let me know ASAP. Check vitals and record in the electronic medical record (EMR). (Needs to be in the computer ASAP.) Report vitals for each of your patients to your TPCN. Vitals and physical assessments are done q 4 hrs. unless...
- Your patient is on an IV vasoactive drip such as **Cordarone, Dobutrex, Natreacor, Nitroglycerin, and Dopamine**. These medications require vitals signs to be taken and documented in every hour. **BE SURE** to let your TPCN and instructor know if vitals are abnormal.
 - Your patient is within the 24 hr time frame after being transferred from SICU (q 2 hrs vital signs for the first 24 hrs after transfer). Once again – Notify your TPCN and Instructor of changes in the vitals of your patient.
 - Your patient returns from a surgical procedure. If this is the case, post-op vitals will be done. (q 15 min x 4, q 30 min x 4, q hr x 2, q 2hrs x 2)

O2 sats are checked every 4 hours with vital signs and PRN. Each nurse is assigned a tympanic thermometer and pulse ox readers are on the vitals machines. You may borrow them but you **MUST** return them promptly. **DO NOT** allow fellow students to use equipment you have borrowed from your TPCN. When you take them, you are responsible for them. Please return equipment after you use them each time.

Perform your physical assessment. Do not put it off. Early physical assessment establishes our baseline of how the patient was doing first thing in the morning. You may have to wake your patient. **Get in the habit of charting at the bedside right after you do your assessment.**

Since you have been through IM 2 Skills, you should feel comfortable with the majority of procedures. Therefore you can do skills with your licensed nurse present. If I am

available, I would love to go with you and let your nurse have a break. **If you still feel uncomfortable with a skill, please come get me to do it with you. I will have more time to spend with you than your nurse. This way we can make you feel comfortable.**

Be sure to write your name on pt's communication board in room.

800 Breakfast is usually served around 0730-0800. Most of the patients are to be up in the chair for meals. Use time while patients eat to get all needed supplies for the day.

Check chart for new doctor's orders. Your nurse may want to assist you with charting in the EMR at this time. Do not hesitate to ask your TPCN or instructor for assistance with charting. It can be challenging at times. Sometimes an experienced nurse can better put your thoughts into words.

830 Begin bath/shower. Remember – **All surgical patients are to take showers. Not bed baths.** This allows better washing away of bacteria from the incision sites. Patients are only to receive bed baths if there are specific orders for bedrest. NOTE: Do NOT leave patient room while patient is in the shower. If the patient is wearing oxygen be sure you have adequate extension tubing or a portable tank so they can wear it in the shower. The nurse/student should assist pt to and from the bathroom.

The patients are taken off telemetry when they go to the shower (or off the unit for tests). Please let the Monitor Tech know when you are going to take the pt off telemetry by calling or stopping by their area. (This number is also posted in the room). **Remove batteries first and then the leads. To put it back on put on leads first then put back in the batteries.**

The EKG pads are changed daily – usually done at shower time. You can find these on the CS carts.

You are to teach your patient about wound care. Each incision is washed with a separate soapy washcloth and rinsed thoroughly with warm water. You can use antibacterial soap (Dial) or Hibiclens liquid surgical soap. Each incision is then painted with a separate betadine swab after the shower. (Be aware of Betadine allergy. If allergic to betadine, paint with alcohol swabs.)

NOTICE: It is expected that **YOU** will bathe your assigned pt. (Not the nurse, nurse aide, etc.) The nurse or nurse aide may offer to assist you and that is fine. However, you need to be in the room taking responsibility for your patient's care. If you need assistance with ambulation, supplies, etc. ask one of your classmates, staff, or Mrs. Wolfe to help. If the patient is able to do their own bath or the spouse wants to assist, be sure you stay in the room so you will be there if they need help. Be sure to teach proper cleaning technique before they enter the shower. If a patient refuses a shower or bath or requests to put it off until later be sure you let your TPCN know **right away**. Encourage patients to shower by explaining how important it is to keep the skin clean and decrease the risk of infection.

1000 Continue with AM care/treatments and whenever possible, offer help to other students and staff. (This really helps promote improved relationships between staff and students.)

Answer call lights when possible. Check to see if your classmates need help. Nursing is a profession involving a lot of teamwork.

- 1100 Begin vitals and Accudatas. (Noon vitals can be done after 1100 and must be posted by 1200.) Finish up AM care. **Perform your second assessment and chart in the EMR.** This must be complete before leaving the unit for lunch.

Lunchtime for patients is around 1130-1200. Please help your patients up to the chair and to get their side table ready for lunch before you take your break.

- 1145 Be sure to inform TPCN when you leave for lunch. We normally will go down to lunch together. If your fellow students need assistance to get caught up, please help them instead of sitting around waiting for lunch. You have 30-45 minutes for lunch.
- 1230 Finish any tasks/procedures you have left for your patient. Clean patient's room and leave clean and orderly. Be sure your patient has fresh water, Kleenex, etc. During this time if we are caught up and have extra time we will look for procedures we can do. Remember...our first priority is the patients we are assigned. There will be lots of opportunities for procedures on S5. We have to make sure our patient's needs are met first.
- 1315 Finish your charting in the EMR and be sure your nurse checks it. Empty urine from Foley bag and record on EMR. (All patients are on strict I&O as this is considered a critical care floor. It is vital that we keep an accurate record) Remember: Normal urine output is > 30 ml/hr. If it is noon, and you notice that your patient has an output less than 150 ml total, let your TPCN and instructor know ASAP.
- 1330 Give report to TPCN. **Do not leave the unit until cleared by instructor.** Report to post-clinical conference in designated room.

Additional notes: **Be prepared for medication administration.** You need to be able to explain each medication to your patient as you open the med packages at the bedside.

Ex: "Mr. Jones, I have an aspirin for you. It is 325 mg. You are taking it once a day to help prevent blood clots."

You are to notify instructor of meds due at 0730 or 0800. Be sure you have the vital signs available when preparing to give meds. Vitals help us make decisions on whether or not to give certain medications. After medications are given, you will notify the nurse of any meds you were unable to give.

Be ready to show calculations for IVPBs.

Let your nurses know if there are procedures you are really interested in doing. They will help find opportunities for you.

This is a wonderful place to work and learn!!