LVNRN Patient Care Assessment Performance

Student Name: _____ Instructor: _____

***The critical elements are denoted with a (*) and bolded and color changed. These elements should be completed within each area to complete this check-off successfully.**

Check-off Met: (✓) for Met; (X) for Unmet

Caring and Communication _____
Standard Precautions _____
Drain Assessment _____
Fluid Management _____
Pain/Comfort _____
Safety _____

Neurological Assessment ____
Respiratory Assessment _____
Cardiac Assessment _____
Skin Assessment ____
Drain Assessment ____
Abdominal Assessment ____
Peripheral Vascular Assessment ____

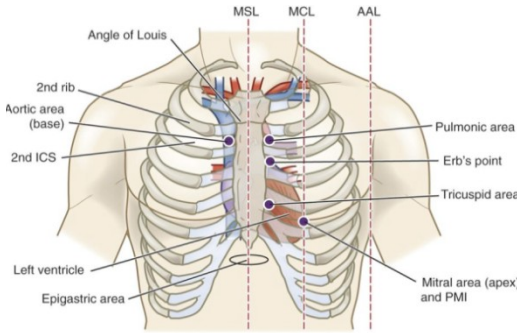
Learning Outcomes:

1. Safety/Quality: Integrate nursing care using evidence-based practice to promote safety and quality for patients, self, and others.
2. Clinical Judgment: Integrate use of current evidence-based practice and clinical competence when making clinical decisions in the provision of patient-centered care.
3. Patient-Centered Care: Integrate nursing care for patients from diverse backgrounds based on patient age, culture, values, and educational needs.
4. Professionalism: Integrate knowledge, skills, and attitudes required of the professional nurse, embracing lifelong learning to improve the quality of healthcare.
5. Communication/Collaboration: Communicate and collaborate effectively with patients, family, and members of the interdisciplinary team in various healthcare settings.

Comments:

***Address every area.**

Caring & Communication	Standard Precautions	Fluid Management	Pain/Comfort
1. **Introduce self. *** 2. **Explain purpose of interaction. *** 3. **Examples:** Focus communication towards patient-oriented interest. – "Do you have any pets?" – "Have you always lived in Lubbock?" Relate in a manner that respects the values, dignity & culture of others. –Keeping the patient covered when possible. –Inform and ask permission before lifting up/pulling down gown.	1. **Wash hands. *** **-Before, after and PRN during interaction. *** 2. **Clean stethoscope prior to touching patient with it. *** 3. **Use appropriate standard precautions. *** **Examples:** -Don appropriate isolation attire (if applicable). -Dispose of contaminated material appropriately (if applicable) such as drain fluid/needles/dressings. -Don gloves when appropriate.	1. **Assess hydration status. *** **Examples**: -Check skin turgor -Check mucous membranes -Check urine output 2. **Assess IV access. *** **Examples**: -Palpate surrounding tissue for swelling, redness, leaking or temperature change. 3. **Verify the type of IV solutions & accuracy of flow rate. *** -Look at what is infusing on your patient and then check against physician orders.	1. **Assess pain or comfort level. *** **Examples:** -Assess level of pain on scale of 0-10 and characteristics of pain, i.e. location, duration, exacerbating factors. 2. **-Provide interventions to aid in pain or comfort management. *** **Examples:** -Reposition patient -Administer pain meds --Adjust room lighting/temperature -Turn on care channel 2. **Reassess pain or comfort level after interventions. *** **Examples:** "Does that feel better?" "How is your pain now?"
Safety			
1. **Identify the patient with two identifiers. *** 2. **Verify allergies. *** 3. **Ensure the bed is in low position as appropriate *** 4. **Ensure side rails are up as appropriate for the patient. *** 5. **Ensure BVM and suction is setup (if patient is ventilated).*** 6. **Ensure call light is in reach and instructs for use when needed. *** 7. **If restraints are present, they are secure and safely applied. *** 8. **Check the bed brake before leaving the patient's room. ***			



9. **Apply non-skid socks prior to ambulation (if applicable).**			

Neurological Assessment	Respiratory Assessment	Cardiac Assessment	Skin Assessment
1. Assess level of consciousness.*	**1. Assess oxygen saturation and need for intervention.***	**1. Inspect chest.***	**1. Inspect at-risk areas for breakdown.***
a) Eye opening*	**Examples:**	**2. Auscultate heart sounds in 4 locations for at least 2 complete cycles at each location.* (LUB/DUB)**	-Such as coccyx, heels, elbows, back of head, under equipment, etc.
b) Verbal response *	-Raise HOB	**3. Auscultate and counts apical pulse for one full minute.***	**2. Assess for use of skin preservation appliances.***
c) Orientation*	-Increase or apply oxygen	**4. Place stethoscope against skin.***	**Examples:**
d) Response to pain	-Instruct to take deep breaths		-Boots to protect heels
2. Assess motor function.*	-Identify need for suctioning or breathing treatment.		-Pillows to elevate extremities
a) Hand grasp*	**2. Auscultate anterior and demonstrate posterior lung fields.***		-Special cushion used for heels/legs
b) Toe wiggle*	**3. Place stethoscope to skin.***		-Special rotation bed
c) Flexion and extension bilaterally in upper and lower extremities.			
d) Assess for arm/leg drift			
e) Assess gait			
3. Assess sensation.*			
a) Pain			
b) Temperature			
c) Touch			
d) Pressure			
4. Assess pupillary response.			
Drain Assessment	**Abdominal Assessment**		**Peripheral Vascular Assessment**

3. **Verify the locations and types of drainage devices.*** **Examples:** -Indwelling catheter inserted in the urethra and into the bladder -Biliary drain in RUQ draining bile -Jackson-Pratt drain in left upper back draining blood 4. **Assess drain fluid.*** -Such as color/odor/consistency 5. **Assess drain insertion site.*** 6. **Position drain correctly.*** **Examples:** -Below the patient -Secured to the bed -Off of the floor	1. **Inspect the abdomen.*** 2. **Auscultate the abdomen in the epigastric region and all four quadrants.*** 3. **Place stethoscope against skin.*** 4. **Perform light palpation over epigastric region and all four quadrants.*** 5. Investigate when last bowel movement was. 6. Pause tube feeding to reposition the patient (if applicable).		1. **Assess six P's in bilateral extremities:** **-Pain *** **-Pallor (Color) *** **-Pulses *** **-Paresthesia (Sensation) *** **-Paralysis (Movement)*** **-Poikilothermia (Temperature)*** 2. Use a Doppler to check peripheral pulses if needed. 3. Assess for swelling. 4. Assess for muscle atrophy. 5. Assess skin for hair loss, thickening or shiny skin. 6. Identify ulcers that are arterial/venous in nature.

***~~You must pick two priority-focused assessments and provide the rationale for each choice~~.**