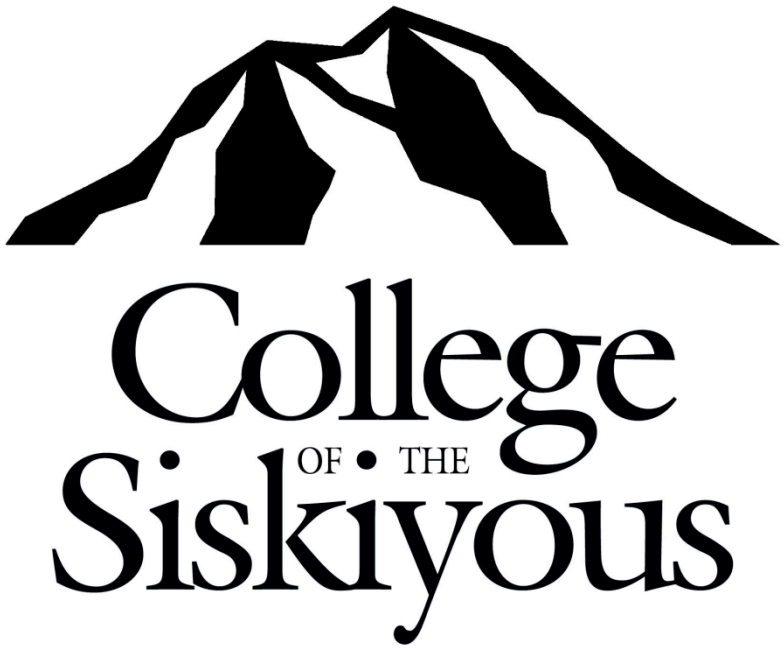
College of the Siskiyous
Vocational Nursing Program
Nursing 0951




# *Skills and Charting Book*
## *2017-2018*

**COLLEGE OF THE SISKIYOUS**
**VOCATIONAL NURSING**
**SKILLS & CHARTING BOOK 2016**

Welcome to the College of the Siskiyous' Vocational Nursing Program. We know you have worked hard to get here and are excited about the journey ahead. **ALL NURSING PROGRAMS ARE VERY DEMANDING OF YOUR TIME, ENERGY AND COMMITMENT, AND EVEN FINANCIAL RESOURCES.** Susan deWit states that "Success in nursing school depends on getting organized, using time efficiently, keeping your sense of humor, and incorporating activities into your schedule that will help reduce stress and maintain sanity." By taking a look at what you need to do now; you can plan completion of skills accordingly.

**SKILLS CHECK OFFS:**
You may not believe this, but you are luckier than many nursing students entering programs in the United States because you have a **SKILLS LAB**. Here you will be presented skills, be given demonstrations, and be expected to demonstrate competency of well over 87 skills by the end of Nursing 0951. You also have access to a supervised practice lab where you can develop competency and efficiency in the performance of many of these skills. The number of hours you spend in practice will vary depending on the amount of time you need in order to successfully pass the testing session. It is up to each individual student to put in the practice time in the Nursing Skills Practice Lab and at home in order to become proficient at these skills. An instructor will be present to supervise your practice and answer any questions.
It is also required that you team up with classmates as your practice partners and peer evaluators. A certain number of skills will be signed off by your partner **after three successful practices**. Have your partner check the skill as you perform it and correct your mistakes. Then you do the same for your partner. Next, have your partner score you while you perform the skill and finally, after three passes, have your partner sign the skill off as passed. ***It is recommended that all partner check offs are to be completed in NURS 0851.*** Your lab grade will not include those skills signed off by your peer. Once those skills are passed, you will be expected to perform them correctly during actual patient assignments. Do not practice any skills until you have viewed the skill video online or have been given a demonstration by an instructor.

This book has been set up to show you **EXACTLY** WHAT YOU NEED TO KNOW AND DO IN ORDER TO PASS THE SKILL. Before you test on any skill, you must practice and then test with your partner. In order to pass any skill you must perform every critical element which is designated by an asterisk (*), and you must also achieve at least a 75% score (sometimes it is slightly higher than 75%) on that skill. **Skills may be retaken no more than three times in order to pass. If not passed by the 3rd attempt removal from the program may occur. Discussion with the Director and other faculty will be required. The initial test score is entered into your grade.**

The first thing you need to know is that you have to memorize universal steps and incorporate them into each of the skills you will demonstrate. The following steps will always be considered critical elements:

**A** = Check the order in the chart, gather equipment, and wash your hands.
**B** = Check the patient's identification and explain the procedure to the patient. Check for allergies.
**C** = Arrange supplies/Prepare bedside table (clean with alcohol, lay paper towels down)/Provide privacy/Lock brakes/Raise bed/Lower the rail.
**D** = Move the client closer to you.
**E** = Don gloves following aseptic techniques and follow universal precautions.
Never come in direct or indirect contact with body secretions.
Never re-cap a used needle.
Anticipate protecting your mucous membranes from exposure to secretions.
Never allow your uniform to come into contact with body secretions.
**X** = Raise rails without contamination/Lower bed/Remove gloves/Wash hands.
**Y** = Make patient comfortable, place call bell, restore unit, wash hands again, dispose of equipment.
**Z** = Record and document the procedure/Report as needed—your charge nurse needs to know what you've done and how your patient responded to the procedure.

**TESTING**

**1. SLELCTING STUDENTS FOR TESTING**

A. Student teams may volunteer to go first.
B. Student teams may be assigned a certain order to be tested and are expected to be prepared at that date and time.
C. Student teams may be randomly drawn and dates and times assigned.

**2. GENERAL RULES DURING TESTING**

A. If you are not prepared to test when it is your turn, you will receive a zero score for that skill.
B. You are expected to work with a lab partner who will be your patient during a skills check off.
C. No other students are allowed to observe. If students are found observing during testing they will receive a zero for that skill.
D. Before the testing begins the student will be allowed to ask any clarifying questions and inspect the equipment. Once the testing begins the instructor shall not answer questions or intercede in your test, unless safety violations occur that would injure the volunteer patient or damage equipment.
E. Most tests are timed. If a student exceeds the allowable time they will receive a zero for that skill and will be given points up to when the timer goes off.
F. The testing will begin at the assigned time whether the student is ready or not. It is the student's responsibility to be ready with all needed supplies. It is essential all students adhere to the times due to the limited number of hours for demonstration and test.
G. The examination will end either verbally or by conduct indicating the examination has been completed, or when time is up.

**3. SCORING OF THE PERFORMANCE**

A. Points will be deducted for each step omitted, performed incorrectly, or performed out of sequence (**if sequence is relevant to patient safety**).

B. Steps designated by an asterisk (*) must be performed or the test is stopped at that time. The student does not pass that particular skill but points are given up to that asterisk point.
C. All skills which are not passed must be repeated and passed in the next NURS 99 class. The original score will be used to determine the lab grade.
D. **At the end of the first four (4) weeks, in order to advance to the hospital setting, the student must have completed and passed all required skills, have maintained at least 75% cumulative average on skills, completed required partner check offs, and successfully completed all charting requirements.**
E. At the end of the semester, in order to receive a passing clinical grade you will be expected to have passed and completed all required skills and have maintained at least a 75% cumulative skills average. You will also be expected to successfully complete at least 75% of NUR 0951 clinical objectives in order to receive a passing clinical grade.

**WAIVING OF LAB SKILLS**

During the first week of Nursing 0851 skills lab, the instructor will talk with students on an individual basis to determine approval of lab skills to be waived. The student must show CNA certification, or proof of learning of these skills and have worked as a CNA for one year within the last five years to be eligible for waiving of skills.

**DRESS CODE FOR LABS**

Hair off collar, required blue scrub top and pants, white socks, white shoes with closed toe and full back. No dangling earrings, small studs only, one hole on each ear. No other piercings. Tattoos must be covered. One ring only. Name tag must be worn. Uniforms include stethoscope, pen, scissors,pen light, calculator. **No gum chewing** or eating in the lab.

**NOTIFICATION OF LAB ABSENCE**

If you are going to be late or absent you are expected to call your instructor before the start of class. **DO NOT send the message via another student.**

**PROCEDURES FOR LOANING EQUIPMENT FROM LAB**

1. Request permission from instructor.
2. Instructor to confirm equipment in working order.
3. Log out in black book.
4. On return, instructor to confirm equipment in working order.
5. Log in black book.
6. Instructor and student signatures required.

**LAB CLEAN UP PROCEDURE AND STUDENT RESPONSIBILITIES**

1. Cleans equipment as appropriate.
2. Returns equipment and supplies to original condition. (Examples: rewraps practice trays so they are ready for the next student).
3. Disposes of trash.
4. Maintains neat and clean work area utilizing infection control principles.
5. Returns equipment and supplies to storage.

# CHARTING

As with everything new, you have to start with the simple and slowly progress to the more complex. Charting is no exception!

You have learned medical terminology, but you may not have had any practical experiences with its use up until now. You will be expected to use correct medical terms at all times. You will also be expected to use correct medical abbreviations as you learn them.

You will also be learning to use Nursing Diagnoses during this program. NANDA stands for North American Nursing Diagnosis Association. This organization identifies nursing diagnoses which are used by nurses to provide continuity and standardized terminology in all patient care activities. NANDA International states, "Nursing diagnoses communicate the professional judgments that nurses make every day to our patients, colleagues, members of other disciplines and the public. Nursing diagnoses define what we know - they are our words" **(http://www.nanda.org/AboutUs.aspx**). You will be guided through the process of learning this charting method, both verbally and through the use of interactive clinical plans (ICPs), clinical plans (CPs), and NANDA statements.

Your charting will be graded, but the grade will be based on meeting the charting criteria listed at the end of each skill, using the correct format, (i,e., date, time, signature), including a NANDA, using medical terms, and abbreviations, and turning the assignment in on time. In other words, if you attempt to meet the 5 criteria described above, you will more than likely receive at least a 75%, which is a passing score.

For those of you who take a little more time to process what you want to write, you can "pre-write" a charting assignment prior to the day it is due. It can be used as a guideline on the day the actual charting assignment is due. Look at sample charting in your skills text for ideas - either as part of your "pre-write" or as guidelines for your actual graded assignment. If you are comfortable without using the "pre-write" then don't do these practice assignments.

The charting assignment is due at the same time the skill is performed and checked off. All graphics charting must be completed at the end of each skill, as would normally be done when caring for patients. Narrative charting and NANDA charting should be completed **before testing** so it can be graded during your test.

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# OBJECTIVE CRITERIA FOR GRADING NURSES' NOTES

Your charting is expected to reflect a level significantly beyond the nurses' aid ability as you move through this program. Your assessments, observations, and documentation must reflect "professionalism" and "technical ability".

From now until graduation your charting will be evaluated almost daily. The following criteria provide guidelines for the daily evaluations. If, after being instructed to improve in an area, a student consistently fails to improve or to follow through, or requires repeated reminders, the student shall receive an unsatisfactory grade.

Know and apply the following guidelines and you will be able to successfully meet the charting objectives.

1. Record legibly.

2. If you make a mistake, line through the word, write "error" and initial. Eg: ~~John Richards~~ Sally Townsend…… (Mercy uses this format, Fairchild does not use the word "error".

3. Properly record information pertaining to the patient which will assure safety for the patient, hospital, or health worker.

4. Describe the exact time, effect, and reaction of the patient to therapy or treatment rendered.

5. Describe the character and amount of drainage, vomitus, stools, urine, or hemorrhage (bleeding) from the body.

6. Describe the type, onset, location, and duration of pain.

7. Note the time, visit, examination, and reaction of the patient to the visit of physician or other health worker.

8. Describe the patient's condition - usual, unusual, or changed.

9. Adapt to requirements of different health facility requirements.

10. Use clear, concise terms which plainly describe a situation pertaining to the patient and will be quickly understood.

11. Record facts, <u>do not include opinions or feelings.</u>

**Nurses Service Organization always looks to provide you, a nursing professional, with important tips to help you avoid malpractice. Below is an example to save for you files.**

# DO'S AND DON'TS OF DOCUMENTATION

**These tips will help you improve your charting.**

*Not only can good documentation help you defend yourself in a malpractice lawsuit, it can also keep you out of court in the first place. You have to make sure it's complete, correct, and timely. If it's not, it could be used against you in a lawsuit. The documentation "do's" and "don'ts" included in this article can help. They're excerpted from the Nurses Service Organization's 1-day seminar "Avoiding Nursing Malpractice."*

## DO'S…

- Check that you have the correct chart before you begin writing.
- Make sure your documentation reflects the nursing process and your professional capabilities.
- Write legibly
- Chart the time you gave a medication, the administered route, and the patient's response.
- Record each phone call to a physician, including the exact time, message, and response.
- Chart a patient's refusal to allow treatment or take medication. Be sure to report this to your manager and the patient's physician.
- Chart patient care at the time you provide it. If you remember an important point after you've completed your documentation, chart the information with a notation that it's a "late entry." Include the date and time of the late entry.

## DON'TS…

- Don't chart a symptom, such as "c/o pain," without also charting what you did about it.
- Don't alter a patient's record. **This is a criminal offense.** Do not use white out or obliterate. Place a single line through the mistake only.
- Don't use shorthand or abbreviations that aren't widely accepted.
- Don't write imprecise descriptions, such as "bed soaked" or "a large amount."
- Don't give excuses, such as "medication not given because not available".
- Don't chart what someone else said, heard, felt, or smelled unless the information is critical. In that case, use quotations and attribute the remarks appropriately.
- Don't chart care ahead of time. Something may happen and you may be unable to actually give that care you've charted. **Charting care that you haven't done is considered fraud**

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Vocational Nursing 51
Commonly Used Abbreviations

**Please review and ensure you are familiar with abbreviations!**

| **ABBREVIATION** | **TERM** |
|---|---|
| ā | before |
| abd | abdomen |
| ac | before meals (ante cibum) |
| ADL | activities of daily living |
| ad lib | as desired (ad libitum) |
| adm | admitted or admission |
| AFB | acid-fast bacillus |
| AKA | above the knee amputation |
| A.M. a.m. | morning (ante meridiem) |
| amb | ambulatory |
| amt | amount |
| approx. ~ | approximately |
| ASHD | arteriosclerotic heart disease |
| ax | axillary |
| BE | barium enema (x-ray) |
| bid | twice daily (bis in die) |
| BM | bowel movement |
| BP B/P | blood pressure |
| BRP | bathroom privileges |
| BUN | blood urea nitrogen |
| c | with |
| C&S | culture and sensitivity |
| CA | cancer, carcinoma |
| CAT | computerized axial tomography |
| cath | catheter, catheterized |
| CBC | complete blood count |
| c/o | complains of |
| COPD | chronic obstructive pulmonary disease |
| CVA | cerebral vascular accident |
| D5W | 5% dextrose in water |
| DNR | do not resuscitate |
| DOA | dead on arrival |
| Dr. | doctor |
| Drsg | dressing |
| DTs | delirium tremens |
| Dx | diagnosis |
| EENT | eye, ear, nose and throat |
| EKG ECG | electrocardiogram |
| FBS | fasting blood sugar |

| ABBREVIATION | TERM |
|---|---|
| Fe | iron |
| FHT | fetal heart tones |
| GB | gallbladder |
| GC | gonorrhea |
| GI | gastrointestinal |
| GP | general practitioner |
| Gm/gm | gram |
| gr | grain |
| gtt | drop (guttae) |
| H h | hypodermic |
| h hr | hour (hora) |
| H & H | hemoglobin & hematocrit |
| $H_2O$ | water |
| $H_2O_2$ | hydrogen peroxide |
| Hgb Hb | hemoglobin |
| HCl | hydrochloric acid |
| Hct HCT | hematocrit |
| Hg | mercury |
| HOB | head of bed |
| h.s. HS | at bedtime (hora somni) |
| ID | intradermal |
| I & D | incision & drainage |
| IM | intramuscular |
| I & O | intake and output |
| IV | intravenous |
| IVP | intravenous pyelogram |
| K+ | potassium |
| Kg | kilogram |
| Lab lab | laboratory |
| lb | pound |
| LLL | left lower lobe (lung) |
| LMP | last menstrual period |
| LLQ | left lower quadrant |
| LP | lumbar puncture |
| Lt. | left |
| mEq | milliequivalent |
| Mg++ | magnesium |
| mg mgm | milligram |
| MI | myocardial infarction |
| ml mL | milliliter |
| MRx1 | may repeat x 1 |
| N & V | nausea and vomiting |
| Na+ | sodium |

| ABBREVIATION | TERM |
|---|---|
| NB | newborn |
| neg. - | negative |
| no. # | number |
| noc | night, nocturnal |
| NPO | nothing by mouth (per ora) |
| NS | normal saline |
| $O_2$ | oxygen |
| OB | obstetrics |
| OOB | out of bed |
| O.S. o.s. | left eye (oculus sinister) |
| O.U. o.u. | both eyes |
| P | pulse |
| p | after |
| PAR | postanesthesia recovery |
| pc | after meals (post cibum) |
| per | by or through |
| PERLA | pupils equal reactive to light, accommodation |
| pH | hydrogen ion concentration |
| PID | pelvic inflammatory disease |
| PKU | phenylketonuria |
| P.M. p.m. | afternoon (post meridiem) |
| PO | by mouth (per os) |
| post-op | postoperative (ly) |
| pre-op | preoperative(ly) |
| prep | preparation |
| prn PRN | whenever necessary (pro re nata) |
| pt | patient |
| P.T. | physical therapy |
| PT | protime |
| q | every (quaque) |
| qh | every hour (quaque hora) |
| q2h., q3h., etc | every two hours, three hours, etc. |
| qid QID | four times a day (quater in die) |
| q.s. | quantity sufficient |
| R | rectal, respiration |
| RBC | red blood cell/count |
| RLQ | right lower quadrant |
| ROM | range of motion |
| Rx | prescription/take |
| s | without (sine) |
| Sp.gr. | specific gravity |
| SSE | soap suds enema |
| stat | at once, immediately (statim) |

| ABBREVIATION | TERM |
|---|---|
| Sx | symptoms |
| T | temperature |
| T & A | tonsillectomy & adenoidectomy |
| tab | tablet |
| TB | tuberculosis |
| tid TID | three time a day (ter in die) |
| TPR | temperature, pulse, respirations |
| Trach | tracheostomy |
| TUR | transurethral resection |
| UA | urinalysis |
| ung | ointment |
| VDRL | flocculation test for venereal disease |
| VO | Research Lab test |
| VS | verbal order |
| WBC | vital signs |
| WNL | white blood count, white blood cell |
| Wt | within normal limits |
| | weight |

## COMMONLY USED SYMBOLS

| | | | |
|---|---|---|---|
| = | equal to | ♂ | male |
| ↑ | increased | ° | degree |
| ↓ | decreased | # | number, fraction |
| ♀ | female | | |

**Review medical terminology and abbreviations as needed. They will be used throughout discussions, lectures and tests.**

**UNACCEPTABLE ABBREVIATIONS AND SYMBOLS**
(Per The Joint Commissions and Mercy Medical Center)

| | |
|---|---|
| Zero after decimal | Use whole number (3mg) |
| Decimal without preceding zero | Use (0.5mg) |
| AU | Use each ear |
| DC | Use discontinued/discharged |
| ug | Use mcg |
| @ | Use at |
| OD or o.d. | Use right eye |
| TIW or tiw | Use three times a week |
| q.d. or QD | Use daily |
| qn | Use nightly |
| qhs | Use hs |
| q.o.d. or QOD | Use every other day |
| SC or Sub q | Use subcut/subcutaneous |
| U or u | Use unit |
| IU | Use units or international unit |
| cc | Use ml |
| MS | Use morphine sulfate |
| $MSO_4$ or $MgSO_4$ | Use magnesium sulfate |
| x3d | Use for 3 days |
| ss | Use sliding scale |
| ½ | Can use quotes “1/2” |
| > or < | Use greater/lesser than |
| Use of slash mark / | Use per |
| Apothecary units | Use metric units |
| Abbreviations for drug names | Write drug names in full |