

Course Outline

COURSE: AH 71 **DIVISION:** 40 **ALSO LISTED AS:**

TERM EFFECTIVE: Spring 2021 **CURRICULUM APPROVAL DATE** 06/09/2020

SHORT TITLE: LVN - 1

LONG TITLE: Licensed Vocational Nursing - 1

<u>Units</u>	<u>Number of Weeks</u>	<u>Type</u>	<u>Contact Hours/Week</u>	<u>Total Contact Hours</u>
8.5	18	Lecture:	6.5	117
		Lab:	6	108
		Other:	0	0
		Total:	12.5	225

COURSE DESCRIPTION:

Course is designed to provide a basic introduction to patient care within the role of the Licensed Vocational Nurse (LVN). Emphasizes nursing fundamentals including principles and skills necessary for safe, effective care. Content includes introduction to health care and nursing, effective communication, client rights and needs, ethics, legal and cultural considerations, asepsis, personal care & hygiene, safety, pain & comfort, medication administration and wound care. Prerequisites: Acceptance to the Gavilan LVN program, separate application required.

PREREQUISITES:

COREQUISITES:

CREDIT STATUS: D - Credit - Degree Applicable

GRADING MODES

L - Standard Letter Grade

REPEATABILITY: N - Course may not be repeated

SCHEDULE TYPES:

- 02 - Lecture and/or discussion
- 03 - Lecture/Laboratory
- 04 - Laboratory/Studio/Activity
- 04B - Laboratory - LEH 0.75

STUDENT LEARNING OUTCOMES:

By the end of this course, a student should:

1. Provide high quality, safe, compassionate, patient-centered nursing care utilizing the nursing process and evidence-based practices.
2. Function as a professional and competent nurse generalist by providing care in a variety of healthcare settings to diverse patient populations while assimilating all ethical and legal principles within the LVN scope of practice.
3. Demonstrate teamwork and collegiality by utilizing effective communication and maintaining collaborative relationships with members of the healthcare team for the purpose of providing and improving patient care.
4. Incorporate critical thinking principles using reasoning and adaptability to make sound clinical judgments necessary for the provision of quality patient care and continuous quality improvement.
5. Employ technology including electronic medical records (EMR's), to effectively communicate, manage information and patient care, prevent errors, and support decision-making.

CONTENT, STUDENT PERFORMANCE OBJECTIVES, OUT-OF-CLASS ASSIGNMENTS

Curriculum Approval Date 06/09/2020

7.5 hours

Identify the components of the health care system.

Describe the complex factors involved in the delivery of patient care.

Identify the participants in the health care system.

Define practical and vocational nursing.

Describe the purpose, role, and responsibilities of the practical and the vocational nurse.

Summarize safety precautions to help prevent falls.

Discuss nursing interventions that promote a restraint-free environment.

Discuss safety concerns in the health care environment.

Cite the steps to be taken during a fire.

Explain the difference between medical and surgical asepsis.

7.5 hours

explain how each element of the chain of infection contributes to infection.

List five major classifications of pathogens.

Identify the body's normal defenses against infections.

Discuss nursing interventions used to interrupt the chain of infection.

Describe the signs and symptoms of a localized infection and those of a systemic infection.

Discuss the events in the inflammatory response.

Discuss standard precautions.

State the principles and rationale for the use of appropriate body mechanics.

Discuss considerations related to mobility for older adults.

Discuss the complications of immobility and the interventions to prevent them.

Demonstrate the use of assistive devices for proper positioning.

7.5 hours

Discuss the therapeutic hospital room environment.

Describe personal hygienic practices.

Discuss variations of the bath procedure determined by a patient's condition and physician's orders.

Describe the procedure for a bed bath.

Identify nursing interventions for the prevention and treatment of a pressure ulcer/injury.

Discuss heat and cold therapy and related procedures.

Describe the procedures for oral hygiene, shaving, hair care, nail care, and eye, ear, and nose care.

Outline the procedure for a back rub.

Summarize the procedure for perineal care for a male patient and a female patient.

Discuss the procedures for skin care.

Describe the procedure for making an unoccupied bed and an occupied bed.

Discuss assisting a patient in the use of the bedpan, the urinal, and the bedside commode.

7.5 hours

Discuss the importance of accurate assessment of vital signs.

Identify the guidelines for vital signs measurement.

Accurately assess oral, rectal, axillary, and tympanic temperatures.

List the various sites for pulse measurement.

Accurately assess an apical pulse, a radial pulse, and a pulse deficit.

Describe the procedure for determining the respiratory rate.

Accurately assess blood pressure.

State the normal limits of each vital sign

7.5 hours

State important legal aspects of chart ownership, access, confidentiality, and patient care documentation.

Determine when the use of Situation, Background, Assessment, and Recommendation is beneficial.

Describe the basic guidelines for charting.

Demonstrate the use of the most common equivalents of metric and apothecary measurement systems.

Explain how decreased hepatic and renal functioning affects medication absorption and excretion.

Discuss the principles of drug action and interactions.

Discuss factors that affect a patient's response to medications.

Identify the nurse's responsibilities regarding medication administration.

List the six "rights" of medication administration.

Discuss the use of the Joint Commission's abbreviations to prevent medication errors.

Explain the importance of accurately transcribing medication orders.

Define controlled substances.

Describe the correct techniques for the administration of vaginal and rectal medications.

7.5 hours

Discuss the management of the patient with an indwelling catheter or urinary diversion:

Explain the procedure for vaginal irrigation (douche).

Explain nursing interventions for the patient with nasogastric intubation.

Discuss gastric and intestinal suction.

Describe the procedure for nasogastric tube removal.

Identify the procedures for promoting bowel elimination:

Administering an enema

Inserting a rectal tube

Removing a fecal impaction

Discuss the need for and nursing care necessary to maintain an ostomy.

7.5 hours

Discuss nursing interventions and related procedures for the patient receiving oxygen therapy.

Identify safety precautions necessary when oxygen therapy is in use.

Differentiate the various types of oxygen therapy delivery devices.

Discuss transtracheal oxygen delivery.

Describe the process of suctioning a patient with a tracheostomy.

Describe the process of providing tracheostomy care.

Differentiate and describe oropharyngeal, nasopharyngeal, and nasotracheal and endotracheal suctioning.

7.5 hours

Discuss frequently noted signs and symptoms of disease conditions.

List the cardinal signs of inflammation and infection.

Describe the nursing responsibilities when assisting a physician with the physical examination.

List equipment and supplies necessary for the physical assessment.

Explain the necessary skills for the physical assessment.

List the basic essentials for a patient's health history.

Discuss the sequence of steps when performing a nursing assessment.

Discuss normal and abnormal assessment findings in the head-to-toe assessment.

Describe documentation of the physical examination/ nursing assessment.

3 hours – Midterm Exam

7.5 hours

Discuss the role of nutrition in wound healing.

Identify common complications of wound healing.

Differentiate the stages of wound healing.

Discuss the factors that impair wound healing and the interventions for each type of wound.

Explain the procedure for applying dry dressings and wet-to-dry dressings.

Describe dehiscence and evisceration and the nursing care they involve.

Identify the procedure for removing sutures and staples.

Discuss care of the patient with a wound drainage system: Jackson Pratt, Hemovac, or T-tube drainage.

Identify the procedure for performing sterile wound irrigation.

Identify the nursing interventions for the patient with vacuum-assisted closure of a wound.

Describe the purposes of bandages and binders and the precautions taken when applying them.

7.5 hours

Discuss the preferred sites for subcutaneous and intramuscular injections in adults.

Discuss the steps to correctly prepare medications for insertion into a gastric tube.

Prepare injections from an ampule and a vial.

7.5 hours

Discuss the risks of fluid volume deficits with the elderly and obese patients.

Describe the cause and effect of deficits and excesses of sodium, potassium, chloride, calcium, magnesium, phosphorus, and bicarbonate.

Differentiate among the roles of the buffers, the lungs, and the kidneys in maintaining acid-base balance.

Summarize the nurse's responsibilities for the patient receiving intravenous therapy and related procedures.

Discuss complications of intravenous therapy.

Describe the complications of blood transfusion therapy.

7.5 hours

List the functions and food sources of protein, carbohydrates, and fats.

Discuss key vitamins and minerals, their role in health, and their food sources.

Identify the effects of common medications on nutritional status.

Identify standard hospital diets and modifications for texture, consistency, and meal frequency.

List medical and surgical conditions that require a high-kilocalorie and high-protein diet, and suggest ways to increase kilocalories and protein in the diet.

Define obesity and list components of an effective weight management program.

Describe dietary management of type 1 and type 2 diabetes mellitus.

Identify medical and surgical conditions necessitating modifications in sodium, potassium, protein, or fluid intake, and describe the dietary adjustments necessary in these conditions.

Define enteral nutrition and parenteral nutrition, and list medical and surgical conditions in which nutritional support is often indicated.

7.5 hours

Identify subjective and objective data in pain assessment.

Discuss the concept of pain assessment as the fifth vital sign and the use of the pain scale.

Discuss the synergistic impact of fatigue, sleep disturbance, and depression on the perception of pain.

Discuss pain mechanisms affected by each analgesic group.

List several methods for pain control.

List six signs and symptoms of sleep deprivation.

Describe how herbs differ from pharmaceuticals.

Describe safe and unsafe herbal therapies.

Explain the scope of practice of chiropractic therapy.

Explain the difference between acupuncture and acupressure.

Explain the use of essential oils in aromatherapy.

Discuss the therapeutic results of yoga, t'ai chi, and energy field therapies.

Describe the purpose and principles of biofeedback.

Discuss the risks and benefits of marijuana used as complementary or alternative medicine.

7.5 hours

Describe the necessary documentation of the patient's condition before, during, and after a laboratory or diagnostic test.

Describe the role of the nurse in procedures for specimen collection.

State appropriate labeling for a collected specimen.

List the proper steps for obtaining urine specimens.

Discuss the procedure for obtaining stool specimens.

State the correct procedures for collecting a sputum specimen.

Identify the procedure for performing electrocardiography.

7.5 hours

Discuss the concepts of verbal and nonverbal communication.

Discuss the impact of nonverbal communication.

Use various therapeutic communication techniques.

Discuss potential barriers to communication.

Recognize trust as the foundation for all effective interaction.

Apply therapeutic communication techniques to patients with special communication needs.

Compare and contrast nursing negligence and malpractice.

Discuss the legal relationship that exists between the nurse and the patient.

Explain the importance of maintaining standards of care.

Give examples of ways the nursing profession is regulated.

Give examples of legal issues in health care.

Discuss federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule and its impact on the health care system.

Differentiate between a legal duty and an ethical duty.

Explain advance directives.

Summarize how culture affects an individual's beliefs, morals, and values.

Identify how values affect decision making.

7.5 hours

Discuss the nurse's responsibilities in performing an admission.

Describe how the nurse prepares a patient for transfer to another unit or facility.

Discuss discharge planning.

Explain how the nurse prepares a patient for discharge.

Identify the nurse's role when a patient chooses to leave the hospital against medical advice.

Explain how personal cultural beliefs and practices affect nurse-patient and nurse-nurse relationships.

Identify and discuss cultural variables that potentially influence health behaviors.

Discuss cultural and religious influences as they relate to the older adult.

Discuss the use of the nursing process in the care of culturally diverse patients

3 hours – Final Exam

Lab content:

Nursing skills lab and clinical practice

21.6 Hours

Demonstrate correct methods for the application of safety reminder devices and nursing interventions.

Demonstrate the correct use of a fire extinguisher.

Demonstrate the proper procedure for handwashing and gel hand hygiene.

Demonstrate technique for gowning and gloving.

Demonstrates principles of surgical asepsis by opening a sterile pack and maintaining a sterile field.

Demonstrate placement of the patient in various positions, such as Fowler's, supine (dorsal), Sims, side-lying, prone, dorsal recumbent, and lithotomy positions.

Demonstrate correct neurovascular assessment.

Demonstrate range-of-motion exercises and explain their purpose.

Verbalize complications caused by inactivity.

Demonstrate appropriate body mechanic techniques for turning, moving, and lifting patients.

Demonstrate passive range of motion.

21.6 Hours

Demonstrate perineal care and a complete bed bath.

Demonstrate appropriate interventions for the prevention and treatment of a pressure ulcer/injury.

Demonstrate correct use of heat and cold therapy.

Demonstrate correct technique for denture care, oral hygiene, shaving, hair care, nail care, and eye, ear, and nose care.

Demonstrate the procedure for giving a back rub.

Demonstrate making an unoccupied bed and an occupied bed.

Demonstrate the correct use of a fracture pan, a bedpan, a urinal, and a bedside commode.

21.6 Hours

Verbalize the factors that affect vital signs readings.

Accurately assess the height and weight measurements.

Discuss optimal frequency of vital signs measurement.

Demonstrate an accurate measurement of temperature, pulse (radial & apical), respirations, blood pressure, and pulse oximetry reading.

Verbalize the correct rationale for each step of the vital signs procedures.

Verbalize normal vital sign parameters.

Accurately record and report vital signs measurements

21.6 Hours

Correctly convert units of measurement within and between the metric, apothecary, and household measurement systems.

Solve dosage calculation problems accurately.

Demonstrate the methods of calculating pediatric dosages.

Demonstrate correct pyxis access.

Administer an oral medication using the 6 rights of medication administration.

Demonstrate the procedures for irrigating the eye, the ear, and the nose.

21.6 Hours

Demonstrate the correct technique for insertion and discontinuance of the following:

Male catheter

Female catheter

Nasogastric tube

Urinary catheter irrigation

Enema

Rectal tube

Demonstrates the correct setup and management of nasogastric and gastric suction.

Verbalizes the protective equipment needed and the correct steps to remove a fecal impaction.

Correctly demonstrates the application of an ostomy appliance and emptying of the appliance.

21.6 Hours

Demonstrate correct application and use of:

Face mask, venture mask

Nasal cannula

Partial or Non-rebreather mask

Tracheostomy mask

Demonstrates tracheostomy care and suctioning.

Verbalizes safety precautions necessary with a patient using oxygen.

Demonstrate an accurate measurement of temperature, pulse (radial & apical), respirations, blood pressure and pulse oximetry reading.

Accurately record and report vital signs measurements.

Accurately draws up and administers heparin and insulin injections.

Administers oral and parenteral medications using the 6 rights of medication administration.

21.6 Hours

Assemble the equipment and supplies necessary for the head to toe assessment.

Demonstrate and document a head to toe assessment.

Perform and document a health history

Demonstrate:

Inspection

Palpation

Percussion

Auscultation

Olfaction

Orientation to the hospital.

Demonstrate perineal care, bed bath, making occupied and unoccupied beds.

Demonstrate appropriate body mechanic techniques for turning, moving, and lifting patients.

Demonstrate an accurate measurement and documentation of temperature, pulse (radial & apical), respirations, blood pressure, and pulse oximetry reading.

Demonstrates competency with fingerstick glucose testing.

Demonstrate and document a head to toe assessment.

21.6 Hours

Demonstrates opening a sterile pack and maintaining a sterile field.

Demonstrates application of a dry sterile dressing, and a wet to dry dressing.

Demonstrates the correct technique for irrigating a wound.

Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag.

Locates and reviews the nursing care plan on the EHR for the assigned patients prior to the change of shift report.

Attends change of shift report and clarifies questions regarding care needs with the primary nurse and clinical instructor.

Maintains an appropriate nurse-client relationship utilizing therapeutic communication techniques. Will be evaluated when the instructor observes interactions and/or interviews the client.

Maintains cultural sensitivity as demonstrated when the instructor observes interactions and/or interviews client.

Obtains vital signs (T-P-R-B/P, SaO₂, pain) with accuracy.

Review medication profile and completes medication worksheet (indicating drug classification, drug action, the reason the patient is taking the medication, and the things that should be monitored on the assigned patient) on all medications on the patient's eMAR.

Gives oral medications with instructor adhering to the 6 rights of medication administration.

Obtains fingerstick glucose reading on assigned patient and documents on EHR.

Completes and documents a head-to-toe patient assessment and care given on EHR.

Performs shift assessment noting cardiac and lung sounds, mobility limitations and risks for falls, Braden scale, and age related changes and documents findings on EHR.

Provides thorough bedside care, hygiene, comfort measures using good body mechanics, and documents such care on EHR.

Adheres to confidentiality/HIPAA requirements at all times.

Give primary nurse end of shift report.

Provide nursing care and document the care for a patient with an ostomy.

Insert urinary catheter using aseptic technique.

Provide nursing care, including perineal care for a patient with an indwelling urinary catheter and document on the EHR.

Measure and document on the EHR a post-void residual (PVR) with catheterization or a bladder scan.

Irrigate a catheter and document on the patient's EHR.

Remove an indwelling catheter and document on the patient's EHR.
Demonstrates opening a sterile pack and maintaining a sterile field.
Demonstrates application of a dry sterile dressing, and a wet to dry dressing.
Demonstrates correct technique for irrigating a wound.
Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag.

21.6 Hours

Demonstrate the correct location for subcutaneous and intramuscular injections.
Draw up and administer a subcutaneous injection and an intramuscular injection with correct technique from an ampule and a vial.
Demonstrate giving a medication through a gastric tube.
Locates and reviews the nursing care plan on the EHR for the assigned patients prior to change of shift report.
Attends change of shift report and clarifies questions regarding care needs with the primary nurse and clinical instructor.
Maintains an appropriate nurse-client relationship utilizing therapeutic communication techniques. Will be evaluated when instructor observes interactions and/or interviews client.
Maintains cultural sensitivity as demonstrated when instructor observes interactions and/or interviews client.
Obtains vital signs (T-P-R-B/P, SaO₂, pain) with accuracy.
Review medication profile and completes medication worksheet (indicating drug classification, drug action, reason the patient is taking the medication, and the things that should be monitored on the assigned patient) on all medications on the patient's eMAR.
Gives oral medications with instructor adhering to the 6 rights of medication administration.
Obtains fingerstick glucose reading on assigned patient and documents on EHR.
Administers insulin and heparin injections with an instructor.
Completes and documents a head-to-toe patient assessment and care given on EHR.
Performs shift assessment noting cardiac and lung sounds, mobility limitations and risks for falls, Braden scale, and age related changes and documents findings on EHR.
Provides thorough bedside care, hygiene, comfort measures using good body mechanics and documents such care on EHR.
Adheres to confidentiality/HIPAA requirements at all times.
Give primary nurse end of shift report.
Provide nursing care and document the care for a patient with an ostomy.
Insert urinary catheter using aseptic technique.
Provide nursing care, including perineal care for a patient with an indwelling urinary catheter and document on the EHR.
Measure and document on the EHR a post-void residual (PVR) with catheterization or a bladder scan.
Irrigate a catheter and document on the patient's EHR.
Remove an indwelling catheter and document on the patient's EHR.
Demonstrates application of a dry sterile dressing, and a wet to dry dressing.
Demonstrates the correct technique for irrigating a wound.
Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag

21.6 Hours

Monitors and documents the client's fluid balance via intake & output and weight.
Assess and document an IV site
Calculate an IV flow rate with accuracy.
Verbalize signs and symptoms of a blood transfusion reaction.
Locates and reviews the nursing care plan on the EHR for the assigned patients prior to change of shift report.

Attends change of shift report and clarifies questions regarding care needs with the primary nurse and clinical instructor.

Maintains an appropriate nurse-client relationship utilizing therapeutic communication techniques. Will be evaluated when instructor observes interactions and/or interviews client.

Maintains cultural sensitivity as demonstrated when instructor observes interactions and/or interviews client.

Obtains vital signs (T-P-R-B/P, SaO₂, pain) with accuracy.

Review medication profile and completes medication worksheet (indicating drug classification, drug action, reason the patient is taking the medication, and the things that should be monitored on the assigned patient) on all medications on the patient's eMAR.

Gives oral medications with instructor adhering to the 6 rights of medication administration.

Obtains fingerstick glucose reading on assigned patient and documents on EHR.

Administers insulin and heparin injections with an instructor.

Completes and documents a head-to-toe patient assessment and care given on EHR.

Performs shift assessment noting cardiac and lung sounds, mobility limitations and risks for falls, Braden scale, and age related changes and documents findings on EHR.

Provides thorough bedside care, hygiene, comfort measures using good body mechanics and documents such care on EHR.

Adheres to confidentiality/HIPAA requirements at all times.

Give primary nurse end of shift report.

Provide nursing care and document the care for a patient with an ostomy.

Insert urinary catheter using aseptic technique.

Provide nursing care, including perineal care for a patient with an indwelling urinary catheter and document on the EHR.

Measure and document on the EHR a post-void residual (PVR) with catheterization or a bladder scan.

Irrigate a catheter and document on the patient's EHR.

Remove an indwelling catheter and document on the patient's EHR.

Demonstrates application of a dry sterile dressing, and a wet to dry dressing.

Demonstrates correct technique for irrigating a wound.

Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag.

Monitor, assess and document an IV site.

Calculate an IV flow rate with accuracy.

21.6 Hours

Measure, insert and check placement of a nasogastric tube. Document on patient's EHR.

Check for placement, and residual and give a bolus enteral feeding or a continuous enteral feeding. Document on patient's EHR.

Locates and reviews the nursing care plan on the EHR for the assigned patients prior to change of shift report.

Attends change of shift report and clarifies questions regarding care needs with the primary nurse and clinical instructor.

Maintains an appropriate nurse-client relationship utilizing therapeutic communication techniques. Will be evaluated when instructor observes interactions and/or interviews client.

Maintains cultural sensitivity as demonstrated when instructor observes interactions and/or interviews client.

Obtains vital signs (T-P-R-B/P, SaO₂, pain) with accuracy.

Review medication profile and completes medication worksheet (indicating drug classification, drug action, reason the patient is taking the medication, and the things that should be monitored on the assigned patient) on all medications on the patient's eMAR.

Gives oral medications with instructor adhering to the 6 rights of medication administration.

Obtains fingerstick glucose reading on assigned patient and documents on EHR.

Administers insulin and heparin injections with an instructor.

Completes and documents a head-to-toe patient assessment and care given on EHR.

Performs shift assessment noting cardiac and lung sounds, mobility limitations and risks for falls, Braden scale, and age related changes and documents findings on EHR.

Provides thorough bedside care, hygiene, comfort measures using good body mechanics and documents such care on EHR.

Adheres to confidentiality/HIPAA requirements at all times.

Give primary nurse end of shift report.

Provide nursing care and document the care for a patient with an ostomy.

Insert urinary catheter using aseptic technique.

Provide nursing care, including perineal care for a patient with an indwelling urinary catheter and document on the EHR.

Measure and document on the EHR a post-void residual (PVR) with catheterization or a bladder scan.

Irrigate a catheter and document on the patient's EHR.

Remove an indwelling catheter and document on the patient's EHR.

Demonstrates application of a dry sterile dressing, and a wet to dry dressing.

Demonstrates correct technique for irrigating a wound.

Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag.

Monitor, assess and document an IV site.

Calculate an IV flow rate with accuracy.

Measure, insert and check placement of a nasogastric tube. Document on patient's EHR.

Check for placement, and residual and give a bolus enteral feeding or a continuous enteral feeding. Document on patient's EHR.

21.6 Hours

Demonstrate the correct location for subcutaneous and intramuscular injections.

Draw up and administer a subcutaneous injection and an intramuscular injection with correct technique from an ampule and a vial.

Demonstrate giving a medication through a gastric tube.

Locates and reviews the nursing care plan on the EHR for the assigned patients prior to change of shift report.

Attends change of shift report and clarifies questions regarding care needs with the primary nurse and clinical instructor.

Maintains an appropriate nurse-client relationship utilizing therapeutic communication techniques. Will be evaluated when instructor observes interactions and/or interviews client.

Maintains cultural sensitivity as demonstrated when instructor observes interactions and/or interviews client.

Obtains vital signs (T-P-R-B/P, SaO₂, pain) with accuracy.

Review medication profile and completes medication worksheet (indicating drug classification, drug action, reason the patient is taking the medication, and the things that should be monitored on the assigned patient) on all medications on the patient's eMAR.

Gives oral medications with instructor adhering to the 6 rights of medication administration.

Obtains fingerstick glucose reading on assigned patient and documents on EHR.

Administers insulin and heparin injections with an instructor.

Completes and documents a head-to-toe patient assessment and care given on EHR.

Performs shift assessment noting cardiac and lung sounds, mobility limitations and risks for falls, Braden scale, and age related changes and documents findings on EHR.

Provides thorough bedside care, hygiene, comfort measures using good body mechanics and documents such care on EHR.

Adheres to confidentiality/HIPAA requirements at all times.

Give primary nurse end of shift report.

Provide nursing care and document the care for a patient with an ostomy.

Insert urinary catheter using aseptic technique.

Provide nursing care, including perineal care for a patient with an indwelling urinary catheter and document on the EHR.

Measure and document on the EHR a post-void residual (PVR) with catheterization or a bladder scan.

Irrigate a catheter and document on the patient's EHR.

Remove an indwelling catheter and document on the patient's EHR.

Demonstrates application of a dry sterile dressing, and a wet to dry dressing.

Demonstrates correct technique for irrigating a wound.

Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag.

Monitor, assess and document an IV site.

Calculate an IV flow rate with accuracy.

Measure, insert and check placement of a nasogastric tube. Document on patient's EHR.

Check for placement, and residual and give a bolus enteral feeding or a continuous enteral feeding.

Document on patient's EHR.

Assess and document the patient's pain.

Provide interventions (pharmacologic and non-pharmacologic) for pain relief and document.

Assess the patient for the current use of complementary and alternative therapies.

21.6 Hours

Additional skills practice of the following skills:

Medication administration

Catheter insertion

Nasogastric tube insertion

Tracheostomy care

Suctioning

Fingerstick glucose testing

Wound care

Tube feedings

Oxygen therapy

Infection control & PPE

Vital signs

Obtains, labels and packages appropriately: stool, urine, and sputum specimens.

Correctly applies leads for an EKG.

Locates and reviews the nursing care plan on the EHR for the assigned patients prior to change of shift report.

Attends change of shift report and clarifies questions regarding care needs with the primary nurse and clinical instructor.

Maintains an appropriate nurse-client relationship utilizing therapeutic communication techniques. Will be evaluated when instructor observes interactions and/or interviews client.

Maintains cultural sensitivity as demonstrated when instructor observes interactions and/or interviews client.

Obtains vital signs (T-P-R-B/P, SaO₂, pain) with accuracy.

Review medication profile and completes medication worksheet (indicating drug classification, drug action, reason the patient is taking the medication, and the things that should be monitored on the assigned patient) on all medications on the patient's eMAR.

Gives oral medications with instructor adhering to the 6 rights of medication administration.

Obtains fingerstick glucose reading on assigned patient and documents on EHR.

Administers insulin and heparin injections with an instructor.

Completes and documents a head-to-toe patient assessment and care given on EHR.

Performs shift assessment noting cardiac and lung sounds, mobility limitations and risks for falls, Braden scale, and age related changes and documents findings on EHR.

Provides thorough bedside care, hygiene, comfort measures using good body mechanics and documents such care on EHR.

Adheres to confidentiality/HIPAA requirements at all times.

Give primary nurse end of shift report.

Provide nursing care and document the care for a patient with an ostomy.

Insert urinary catheter using aseptic technique.

Provide nursing care, including perineal care for a patient with an indwelling urinary catheter and document on the EHR.

Measure and document on the EHR a post-void residual (PVR) with catheterization or a bladder scan.

Irrigate a catheter and document on the patient's EHR.

Remove an indwelling catheter and document on the patient's EHR.

Demonstrates application of a dry sterile dressing, and a wet to dry dressing.

Demonstrates correct technique for irrigating a wound.

Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag.

Monitor, assess and document an IV site.

Calculate an IV flow rate with accuracy.

Measure, insert and check placement of a nasogastric tube. Document on patient's EHR.

Check for placement, and residual and give a bolus enteral feeding or a continuous enteral feeding.
Document on patient's EHR.
Assess and document the patient's pain.
Provide interventions for pain relief and document.
Assess the patient for the current use of complementary and alternative therapies.
Obtains, labels and packages stool, urine or sputum specimens.

21.6 Hours

Skills practice & testing of random skills:

Medication administration

Catheter insertion

Nasogastric tube insertion

Tracheostomy care

Suctioning

Fingerstick glucose testing

Wound care

Tube feedings

Oxygen therapy

Infection control & PPE

Vital signs

Specimen Collection

Locates and reviews the nursing care plan on the EHR for the assigned patients prior to change of shift report.

Attends change of shift report and clarifies questions regarding care needs with the primary nurse and clinical instructor.

Maintains an appropriate nurse-client relationship utilizing therapeutic communication techniques. Will be evaluated when instructor observes interactions and/or interviews client.

Maintains cultural sensitivity as demonstrated when instructor observes interactions and/or interviews client.

Obtains vital signs (T-P-R-B/P, SaO₂, pain) with accuracy.

Review medication profile and completes medication worksheet (indicating drug classification, drug action, reason the patient is taking the medication, and the things that should be monitored on the assigned patient) on all medications on the patient's eMAR.

Gives oral medications with instructor adhering to the 6 rights of medication administration.

Obtains fingerstick glucose reading on assigned patient and documents on EHR.

Administers insulin and heparin injections with an instructor.

Completes and documents a head-to-toe patient assessment and care given on EHR.

Performs shift assessment noting cardiac and lung sounds, mobility limitations and risks for falls, Braden scale, and age related changes and documents findings on EHR.

Provides thorough bedside care, hygiene, comfort measures using good body mechanics and documents such care on EHR.

Adheres to confidentiality/HIPAA requirements at all times.

Give primary nurse end of shift report.

Provide nursing care and document the care for a patient with an ostomy.

Insert urinary catheter using aseptic technique.

Provide nursing care, including perineal care for a patient with an indwelling urinary catheter and document on the EHR.

Measure and document on the EHR a post-void residual (PVR) with catheterization or a bladder scan.

Irrigate a catheter and document on the patient's EHR.

Remove an indwelling catheter and document on the patient's EHR.

Demonstrates application of a dry sterile dressing, and a wet to dry dressing.

Demonstrates correct technique for irrigating a wound.
Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag.
Monitor, assess, and document an IV site.
Calculate an IV flow rate with accuracy.
Measure, insert and check the placement of a nasogastric tube. Document on patient's EHR.
Check for placement, and residual and give a bolus enteral feeding or a continuous enteral feeding.
Document on patient's EHR.
Assess and document the patient's pain.
Provide interventions for pain relief and document.
Assess the patient for current use of complementary and alternative therapies.
Obtains, labels and packages stool, urine or sputum specimens.

21.6 Hours

Skills practice & testing of random skills:

Medication administration

Catheter insertion

Nasogastric tube insertion

Tracheostomy care

Suctioning

Fingerstick glucose testing

Wound care

Tube feedings

Oxygen therapy

Infection control & PPE

Vital signs

Specimen Collection

Locates and reviews the nursing care plan on the EHR for the assigned patients prior to change of shift report.

Attends change of shift report and clarifies questions regarding care needs with the primary nurse and clinical instructor.

Maintains an appropriate nurse-client relationship utilizing therapeutic communication techniques. Will be evaluated when instructor observes interactions and/or interviews client.

Maintains cultural sensitivity as demonstrated when instructor observes interactions and/or interviews client.

Obtains vital signs (T-P-R-B/P, SaO₂, pain) with accuracy.

Review medication profile and completes medication worksheet (indicating drug classification, drug action, reason the patient is taking the medication, and the things that should be monitored on the assigned patient) on all medications on the patient's eMAR.

Gives oral medications with instructor adhering to the 6 rights of medication administration.

Obtains fingerstick glucose reading on assigned patient and documents on EHR.

Administers insulin and heparin injections with an instructor.

Completes and documents a head-to-toe patient assessment and care given on EHR.

Performs shift assessment noting cardiac and lung sounds, mobility limitations and risks for falls, Braden scale, and age related changes and documents findings on EHR.

Provides thorough bedside care, hygiene, comfort measures using good body mechanics and documents such care on EHR.

Adheres to confidentiality/HIPAA requirements at all times.

Give primary nurse end of shift report.

Provide nursing care and document the care for a patient with an ostomy.

Insert urinary catheter using aseptic technique.

Provide nursing care, including perineal care for a patient with an indwelling urinary catheter and document on the EHR.

Measure and document on the EHR a post-void residual (PVR) with catheterization or a bladder scan.

Irrigate a catheter and document on the patient's EHR.

Remove an indwelling catheter and document on the patient's EHR.

Demonstrates application of a dry sterile dressing, and a wet to dry dressing.

Demonstrates correct technique for irrigating a wound.

Demonstrates accurately emptying a Jackson-Pratt, hemovac, and a T-tube drainage bag.

Monitor, assess and document an IV site.

Calculate an IV flow rate with accuracy.

Measure, insert and check the placement of a nasogastric tube. Document on patient's EHR.

Check for placement, and residual and give a bolus enteral feeding or a continuous enteral feeding.

Document on patient's EHR.

Assess and document the patient's pain.

Provide interventions for pain relief and document.

Assess the patient for current use of complementary and alternative therapies.

Obtains, labels and packages stool, urine, or sputum specimens.

METHODS OF INSTRUCTION

Lecture, skills lab and hospital clinical.

OUT OF CLASS ASSIGNMENTS

Required Outside Hours: 234

Assignment Description: Students will be required to do weekly clinical assignments outside of class hours.

METHODS OF EVALUATION

Writing assignments

Percent of total grade: 10.00 %

Skill demonstrations

Percent of total grade: 10.00 %

Objective examinations

Percent of total grade: 60.00 %

Problem-solving assignments

Percent of total grade: 10.00 %

Other methods of evaluation

Percent of total grade: 10.00 %

REPRESENTATIVE TEXTBOOKS:

Cooper & Gosnell. Foundations and Adult Health Nursing. St. Louis, MO: Elsevier,2020.

Nursing fundamentals and skills lab manual for LVN nursing students. Teaches bedmaking, personal care, vital signs and the basics of patient care, adult medical surgical nursing, pediatric, obstetrics and psychiatric nursing.

ISBN: 9780323484374

Reading Level of Text, Grade: 12

Recommended Representative Textbooks

Turner. The Nurse, The Math, The Meds. St. Louis, MO: Elsevier,2020.

Math and dosage calculations for nursing students.

ISBN: 978-0323479509

Reading Level of Text, Grade: 12

Workman & LaCharity. Understanding Pharmacology: Essentials for Medication Safety. St. Louis, MO: Elsevier,2020.

Basic pharmacology text for LVN students.

ISBN: 978-1455739769

Reading Level of Text, Grade: 12

ARTICULATION and CERTIFICATE INFORMATION

Associate Degree:

CSU GE:

IGETC:

CSU TRANSFER:

Transferable CSU, effective 202130

UC TRANSFER:

Transferable UC, effective 202130

SUPPLEMENTAL DATA:

Basic Skills: N

Classification: Y

Noncredit Category: Y

Cooperative Education: N

Program Status: 1 Program Applicable

Special Class Status: N

CAN:

CAN Sequence:

CSU Crosswalk Course Department:

CSU Crosswalk Course Number:

Prior to College Level: Y

Non Credit Enhanced Funding: N

Funding Agency Code: Y

In-Service: N

Occupational Course: C

Maximum Hours:

Minimum Hours:

Course Control Number: CCC000617960

Sports/Physical Education Course: N

Taxonomy of Program: 123020