PROBLEM BASED MODULES FOR NURSING EDUCATION

CALIFORNIA STATE UNIVERSITY, SACRAMENTO SCHOOL OF NURSING

A Project

Presented to the faculty of the Department of Nursing

California State University, Sacramento

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in

Nursing

by

Laurie Susan Trent

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PROBLEM BASED EDUCATION MODULES FOR
CALIFORNIA STATE UNIVERSITY, SACRAMENTO SCHOOL OF NURSING

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Laurie Susan Trent

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Alexa C. Curtis                        Date

Department of Nursing
Abstract

of

PROBLEM BASED EDUCATION MODULES FOR
CALIFORNIA STATE UNIVERSITY, SACRAMENTO SCHOOL OF NURSING

by

Laurie Susan Trent

Current trends in healthcare related to renewed focus on quality and safety are leading to dramatic changes in nursing education. Although first published in 1984, the work of nursing theorist Patricia Benner clearly describes the manner in which nurses develop and progress from one skill level to the next (Benner, 2001). This aligns with current evidence based practice (EBP) in nursing education. Knowledge of theory is not enough. Learning technical nursing skills in isolation is not enough. Benner posited that nurses learn by exposure to the environment in which they will practice. To that end, and in light of current EBP in education, this project creates new skills lab curriculum for first semester nursing education at California State University, Sacramento.

_______________________, Committee Chair
Debra Brady

_______________
Date
ACKNOWLEDGEMENTS

I would like to acknowledge and extend my heartfelt gratitude to Debra Brady DNP RN CNS for her example of professionalism in nursing education, and invaluable assistance with this project.

I would also like to thank my family for their patience and support.
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Problem Statement

Purpose

The purpose of this project is the development of curriculum materials and content for use in a California State University, Sacramento (CSUS) first semester undergraduate nursing course. Nine new case study modules were created to facilitate the integration of curriculum content taught in theory to skills, knowledge, and dispositions for use in the clinical setting. Quality and Safety Education for Nurses (QSEN) competencies were integrated into the curriculum materials for this project. Tables detailing the module content as it relates to QSEN competencies were created for inclusion in the course materials and syllabus.

Current Trends in Nursing Education

The gap between the worlds of nursing education and nurses in practice has been highlighted over the past four decades. Efforts to bridge this gap have met with varying degrees of success. The Quality and Safety Education for Nurses (QSEN) initiative, generously funded by the Robert Wood Johnson Foundation, was founded to fill this need (Cronenwett et al., 2007). The overall goal of QSEN is to prepare future nurses with the knowledge, skills, and attitudes necessary to continuously improve the quality and safety of care delivery in health care systems (Sullivan, 2010).
Theoretical Framework

First semester CSUS undergraduate nursing students will benefit from the development of the new course materials developed for this project because the modules are presented in a situational learning context. The curriculum has been designed as a series of problem based learning (PBL) experiences. Dr. Patricia Benner introduced the concept that expert nurses develop skills and understanding of patient care over time through a sound educational base as well as a multitude of experiences. Benner applied the Dreyfus Model of Skill Acquisition to nursing, illustrated by Figure 1. The five levels of proficiency described by Dreyfus include: novice, advanced beginner, competent, proficient, and expert. The following is a summary of Benner’s descriptions of these levels of nursing development (Benner, 2001).

Figure 1. Benner’s Novice to Expert concept
The novice nurse has no practical experience and must base what he/she does on principles and rules. Benner (2001) states that: “nursing students enter a new clinical area as novices; they have little understanding of the contextual meaning of the recently learned textbook terms.” (p. 21). She goes on to say that any nurse entering a setting with a new patient population will be dealing with the same issues. The advanced beginner has dealt with enough real patient care experiences to recognize recurring components of the situation. They are also learning to discriminate between normal and abnormal situations and establish priorities as to what’s important. Benner describes the competent nurse as one who has been in the same setting or working with the same population for 2 to 3 years (p. 22). The competent nurse is better at projecting into the future and developing plans based on “conscious, abstract, analytic contemplation of the problem”. This promotes efficiency and organization. Although the competent nurse has a sense of mastery and is able to cope with a number of variables, she/he still “lacks the speed and flexibility of the proficient nurse” (p. 27). The proficient nurse perceives situations as wholes rather than aspects. The proficient nurse knows from experience what to expect in given situations and how to modify plans. Rather than having to analyze and calculate a plan, the plan simply “presents itself.” That is, due to a vast body of experience, the nurse is able to zero in on the problem with very little thought. Benner states that the proficient nurse uses “maxims” in practice (p.29). These are nuances of a situation and Benner notes that to nurses at any of the other levels of skill acquisition these maxims appear unintelligible because of their ambiguity. The expert has an intuitive grasp of
situations based on extensive experience. Rules, guidelines, and maxims are no longer necessary for dealing with familiar situations although the expert refers back to analytic methods when faced with new situations. The expert is able to zero in on the problem at hand. Performance becomes fluid, flexible, and highly proficient. The expert has a difficult time explaining what they know and how they know it because it has become internalized (Benner, 2001, p. 32).

First semester nursing students are by definition, novices (p. 21). According to the Dreyfus Model of Skill Acquisition, the novice student nurse must be given entry to situations such as those that they will encounter in practice to allow them to gain the experience necessary for skill development (Benner, 2001, p. 20). Case study and situational learning provide students opportunities to experience situations that are similar to those they will encounter in practice, without potential harm to patients. The situational learning experiences written for this project give students the experiences and confidence they need to move quickly through the novice stage toward the expert level of nursing practice. Andrews and Jones (1996) found the teaching strategy of PBL in nursing education to be an effective method to bridge the gap between theory and practice in nursing education.

CSUS nursing faculty will benefit directly from the materials produced for this project. The nursing skills lab scripts, written specifically for the CSUS School of Nursing comprise ten learning modules. One script had been in existence and was used as a template for the nine new scripts written for this project. The series of ten modules is to
be presented in the form of an unfolding case study that spans the semester. Tables
detailing the module content in relation to QSEN competencies were created for inclusion
in the course materials and syllabus.

Review of the Literature

Quality and Safety Education for Nurses

The Institutes of Medicine released a series of reports (IOM, 2003) indicating that
more than 98,000 Americans were dying yearly due to medical errors. Sullivan (2010)
states that this reported data led to calls for quality and safety improvements in the
medical field. In response to those calls, the Robert G. Woods foundation funded the
creation of the organization known as Quality and Safety Education for Nurses (QSEN).
QSEN's primary goal is to address the challenge of preparing future nurses with the
knowledge, skills and attitudes (KSAs) necessary to continuously improve the quality and
safety of the health care systems in which they work (Cronenwett et al., 2007). This
project was designed with QSEN competencies as the primary guidelines and goals.

As part of a national initiative to improve quality and safety education in pre-
licensure nursing programs, 15 schools participated in a 15-month learning collaborative
sponsored by Quality and Safety Education for Nurses, funded by the Robert Wood
Johnson Foundation. The collaborative developed a set six of pre-licensure Knowledge
Skills Attitudes (KSA) competencies. These KSA’s were developed by and for nursing
educators to be incorporated into nursing curricula nationwide, including: patient-
centered care; teamwork and collaboration; evidence-based practice; quality
improvement; safety; and informatics (Cronenwett, Sherwood, & Gelmon, 2009). QSEN competencies are detailed in Table 1.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Patient-centered care</td>
<td>Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.</td>
</tr>
<tr>
<td>Teamwork and collaboration</td>
<td>Function effectively within nursing and interprofessional teams and fostering open communication, mutual respect, and shared decision making to achieve quality patient care.</td>
</tr>
<tr>
<td>Evidence Based Practice (EBP)</td>
<td>Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.</td>
</tr>
<tr>
<td>Safety</td>
<td>Minimizes risk of harm to patients and providers through both system effectiveness and individual performance.</td>
</tr>
<tr>
<td>Informatics</td>
<td>Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.</td>
</tr>
</tbody>
</table>

Table 1. QSEN's Definitions of Quality and Safety for Nursing, adapted from QSEN (2009). Definitions and prelicensure KSAs.

The development of the QSEN framework has translated to a complete shift in what can be considered as fundamentals of pre-licensure nursing education. Teaching approaches focusing on technical skills, while important, can no longer be the centerpiece of the program. Quality and safety competency, as advanced by QSEN, is now considered an essential component of nursing education. Within a quality and safety framework, novices begin to identify with professional nursing roles that reach far
beyond tasks, skills, and procedures. How to make such a fundamental change has been a challenge to nursing programs throughout the country. The new fundamentals are based on the six new core QSEN areas. Each core area contains its own set of knowledge, skills, and attitudes, and reflects a commitment to improvement in quality and safety in healthcare. For example; Patient Centered Care no longer solely encompasses listening to the patient and demonstrating respect and compassion (Preheim, Armstrong, & Barton, 2009, p. 695). Patient centered care within the QSEN framework “emphasizes recognition of the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient’s preferences, values, and needs. Demonstrating respect and compassion” (QSEN, 2009). The KSAs of patient centered care include:

- **K**—Integrate understanding of multiple dimensions of patient-centered care: patient, family, and community preferences and values; coordination and integration of care; information, communication, and education; physical comfort and emotional support; involvement of family and friends; and transition and continuity.

- **S**—Elicit patient values, preferences, and expressed needs as part of the clinical interview, implementation of care plan, and evaluation of care.

- **A**—Value seeing health care situations “through patients’ eyes.”

(QSEN, 2009)
In addition to the overall goals of quality and safety, nursing skills are now rightfully centered in the larger context of the patient’s preferences and values. Physical comfort and emotional support are one knowledge aspect of the larger competency. The concept of the “patient as full partner” includes activities such as the provision of hygiene care, oversight of nutrition, and assistance with elimination for patients. Teaching of patient centered care is no longer limited to skills associated with bathing, feeding, or Foley insertion (Preheim, Armstrong, & Barton, 2009, p. 695). Of course patient centered care is just one of the QSEN basic competencies. Each competency within the QSEN module was carefully developed to promote quality and safety in nursing. Quality and safety in nursing education represents a paradigm shift for nursing education. There is much challenge in changing the entire framework for nursing education, but the mandate to do so comes with the promise of great potential for growth and improvements for the future of nursing (Preheim, Armstrong, & Barton, 2009).

**Case Study and Problem Based Learning in Nursing Education**

In the interest of exposing nursing students to situations that are similar to clinical practice situations, there is interest in the nursing education community for developing unfolding case studies such as those prepared for this project. The National League for Nursing has partnered with Advancing Care Excellence for Seniors (ACES): Resources and Teaching Tools to Use in Prelicensure Nursing Curricula. “The four unfolding cases recently released by the NLN present students with a series of realistic encounters and simulated patients in varied health care settings. Developed by a team of simulation
experts under the leadership of Dr. Pamela Jeffries, the cases evolve over time and reveal new situations at each encounter” (King, et al., 2011, pg. 276). Azzarello & Wood (2006) describe the differences between case studies and unfolding case studies. Traditional case studies present all of the scenario data at one time, while unfolding case studies present data in stages. Unfolding case studies are written problem oriented descriptions of events or situations that more closely reflect clinical practice because “much of the problem data are not immediately available. Care must begin before all information about the situation is known and additional data become available throughout the nurse-client relationship” (Azzarello & Wood, 2006, p. 11).

“Role-play techniques can serve as an effective substitute for, and supplement to, simulation technology when teaching clinical nursing skills. They provide risk-free opportunities to practice clinical skills and develop clinical judgment” (Comer, 2005, p. 357). Comer describes observations from the introduction of role-play scenarios in an Associate Degree Nursing (ADN) program. Comer reports that ninety-six percent of the class returned favorable responses on an informal questionnaire. Students wrote of enjoying the activity and finding it a better way to learn nursing interventions. In addition, the historic rate of failure for this nursing program on the first exam had been ten of thirty students. Following the introduction of the curriculum-specific role-play scenarios, the failure rate dropped to five of thirty.

Malesela, 2009, conducted qualitative, exploratory, descriptive and contextual research design to examine how fourth-year nursing students experienced the case study
as a learning opportunity in order to make research-based recommendations. “The use of the case study as a teaching strategy is implemented from the second year and increases as the level of training increases. The choice of fourth-year BCur students as participants was appropriate because they already had two academic years of exposure to the case study as a teaching strategy. “The participants were asked to describe their experiences regarding the use of case studies as a learning opportunity” (Malesela, 2009, p. 2).

Twenty-two out of twenty-four of the fourth year students that participated described the case studies as very beneficial and effective as a teaching and learning method. Three main categories that emerged from the data analysis include case study usage increases critical thinking; case study usage increases theory-practice integration and that case study usage increases growth in presentation skills. Malesela concludes that the uses of case studies and case presentations should be increased at all levels of nursing education as a teaching method to facilitate the critical thinking of learners. Gaberson & Oermann (2010) note that case studies are effective for the student nurse in applying concepts and other types of knowledge to clinical practice, and for promoting the development of cognitive skills. With case study, students can analyze patient data, identify needs and problems, and decide on the best approaches for the situation.

Kanter (1977, 1993) defined power as the ability to mobilize resources and accomplish goals. This is an essential component of effective nursing practice. The results of a 2005 study by Siu, Spence Laschinger, and Vingilis support the applicability of Kanter's theory of structural empowerment to nursing education settings. Nursing
students were randomized into two programs; problem-based learning (PBL) or a conventional lecture learning (CLL) program. Students in the PBL program (n = 41) had significantly higher perceptions of structural and psychological empowerment than students in the CLL program (n = 67) (Siu, Spence Laschinger, and Vingilis, 2005, p. 471).

A quest to explore engaging forms of teaching and learning led faculty at Samford University to investigate a variety of teaching strategies for their nursing program. PBL was found to embody many of aspects of the mission statement for the school including most importantly active learning. A classroom was converted to a dedicated PBL laboratory, and a library was created specifically to support the use of PBL at the school. PBL content has been integrated throughout the curriculum. Evaluation of student learning is measured quantitatively through short answer, multiple choice, and essay examinations, end-of-course evaluations, and weekly PBL modules. Qualitative modes of assessment include projects, papers, Web page development, concept maps, peer evaluations, self-evaluations, and semester-long problems (Alexander, McDaniel, Baldwin, & Money, 2002).

**Overview of the Project**

Nine skills lab module faculty scripts were written for this project to assist California State University, Sacramento nursing faculty to present the skills lab content in a planned and consistent manner. Situational learning and case study experiences assist novice nurses to have the context for learning and move forward. The faculty scripts
written for this project facilitate presentation of a case study that unfolds as the semester progresses, with one fictional patient. The students are introduced to the fictional patient, “Gloria Larsen” (G.L) in a skilled nursing facility setting. The patient subsequently falls, breaking a hip which necessitates admission to the hospital. During the course of the G.L.’s hospital stay, the students learn to work through difficult clinical and psycho-social problems that are a reflection of those encountered in the clinical setting. Each module with its accompanying clinical situation is designed to be presented on successive clinical skills lab days. The case study modules were created to facilitate integration of curriculum content that is taught in theory to skills, knowledge, and dispositions for use in clinical practice by placing the student in the simulated experience as a first-hand participant in the skills lab.

The scripts for the faculty use during skills labs were written by the author. The topics for each module were discussed and chosen by the faculty mentor Deborah Brady, DNP, RN, CNS, and the writer. One script that had been written and previously introduced into the curriculum titled “Beds, Baths, and Beyond” was provided to the author as a style guide for subsequent scripts, and will continue in use as one of the ten modules in this series. The nine scripts written for this project continue with this fictional patient, and include content for the following modules:

1. Accucheck
2. Cardiovascular Assessment
The “Beds, Baths, and Beyond” script serves as an introductory module wherein the fictional patient is first presented to the students. The basic nursing activities of turning, bathing, and repositioning for comfort, and prevention of decubiti are introduced. The Accucheck script provides opportunity for students to learn when blood glucose is checked, how it is checked, what to do about it, and what factors influence blood glucose levels such as diet, stress, and medications. The cardiovascular assessment module provides experience in cardiovascular assessment, EKG, oxygen administration, vital signs monitoring, Nitroglycerin sublingual administration, and evaluation of cardiac enzyme laboratory result interpretation. The respiratory assessment scenario allows for student experience with pulse oximetry, auscultation and interpretation of breath sounds,
patient teaching of the incentive spirometer, and oxygen therapy. The script covering urinary catheterization and bowel care allows students to practice not only how to insert a Foley catheter using sterile technique and other skills; it allows students to practice therapeutic communication with the patient. The module that includes transfers, ambulation, range of motion, and musculoskeletal and neurological assessments provides for situational practice of these important aspects of nursing care. In addition, monitoring and interpretation of vital signs, as well as mental status in relation to patient fall risk is taught in this experience. The script that includes gastrointestinal assessment provides for a realistic acute care situation in which the student practices abdominal assessment, therapeutic communication, and practices the psychomotor skills of inserting a nasogastric tube and connecting it to a suction set-up for gastric decompression. A second respiratory module is included that allows for student experience with auscultation of breath sounds, interpretation of vital signs and lab values, calling a physician for orders, sputum collection, and administration of intravenous (IV) antibiotics. The integumentary assessment module provides a learning experience to practice skin assessment, interdisciplinary communication, wound care, pressure ulcer prevention techniques, and patient teaching. The discharge planning module provides opportunity for students to practice communication skills with family members, patient, and discharge planner in a realistic scenario involving patient and family psychosocial issues.

Quality and Safety Education for Nurses (QSEN) competencies were integrated into the curriculum materials for this project. Tables that detail the module content in
relation to QSEN competencies for each of the ten modules and scripts were created for this project, and are suitable for inclusion in the course materials and syllabus.

**Conclusions and Recommendations**

The intended objectives were met, in that the scripts have been approved by faculty for use in the California State University, Sacramento first semester clinical nursing skills lab, and the QSEN competencies were used as a guide for development. The tables that were designed for this project clearly show the relationship between curriculum content and QSEN goals. The effectiveness of the curriculum has yet to be evaluated with actual first semester students and CSUS nursing faculty. The limitations of this project are that the modules have not yet been tested with actual nursing students.

Problem based learning as a model for nursing education was described by Kathleen A. Badeau, MSN, RN. Self-directed learning, critical thinking and problem-solving skills, and reflection are facilitated by PBL. Small group dialogue fostered by skilled facilitators/tutors is a key concept to the success of PBL. Badeau concludes that PBL and case study learning can facilitate an “effective educational methodology allows nurses to achieve best practice outcomes based on real-life clinical problems, thus linking research evidence to nursing practice” (Badeau, 2010, p. 249). This is a fitting description for the goals of this project, and accurately describes the intended flow of teaching-learning for the modules.

Each module in this series was designed as an interactive role-play learning experience. The scenarios are intended for use in simulated patient care areas at CSUS...
with students, nursing faculty, and a life-like patient mannequin. Props such as patient care equipment, beds, linens, etc. are utilized to enhance the learning experience. Nursing students have the opportunity to step into a simulated practice environment; hear, speak, see, and do the things that nurses do in practice. Psychomotor skills, professional collaboration, and critical thinking skills are developed as students participate in the scenarios. Critical conversations that nurses have with physicians, patients, and family members are role-played, allowing students to experience and practice in a controlled learning environment.

This project was an effort to help to bridge the gap between theoretical learning to quality and safety in nursing education and practice. By being based firmly in the realms of PBL and QSEN, the curriculum brings additional evidence based nursing education to CSUS nursing. In addition, the learning modules align with Patricia Benner’s work which states that the novice nurse (or student nurse) must be placed in the clinical situation to gain the experience needed to move beyond functioning strictly by context-free rules. By placing the student in simulated clinical situations via case study and role play such as in skills labs with learning modules such as those written for this project, the student is able to develop the skills needed to move quickly through the novice stage. Research opportunities related to this project include the comparison of quantitative and qualitative measures of improvement following implementation of the new curriculum materials. Evaluation of the curriculum involves the establishment of standards, systematic data-gathering, application of the standards, and formulation of judgments about the value of
the value, quality, utility, effectiveness or significance of the curriculum (Fitzpatrick, Sanders, & Worthen, 2004).
Appendix A: Accucheck

Script: Accucheck

Patient:

Gloria Larson
DOB 3/9/1942
MR: 0090876787

Dx: 68 year old female Post-op Day Seven, Right hip ORIF.
Hx: Recent Left CVA

Simulator:
Static or MF mannequin
Wig on
Saline Lock
Name tag
Sequential Compression Devices (SCDs) on legs of manikin
Dry surgical dressing to Right lateral hip
Abductor pillow
Nasal Cannula

Props:
Accuchecck meter
Strips
Lancets
Cotton balls
Alcohol prep pads
Box of gloves

Roles:
RN
Nursing Student

Prebriefing:
Students read case history
Shift report: The Blood Glucose at bedtime (abbreviated HS for hour of sleep) was 283.
Patient has been on solumedrol to decrease inflammation of the lungs due to COPD.

Script:
RN introduces self; (Friendly open tone)
   “So glad we will be working together, I understand that Mrs. Larson’s blood glucose level has been trending upward, so we will keep an eye on that today.”

Washes hands
Enter room
Put on gloves

**Time: 0710**

RN Introduce self and student
Check patient’s ID band

RN states: (patient)
   “Good morning Mrs Larsen, how are you this morning? We’d like to check your vital signs”

Vital signs are taken & are within normal limits (WNL).

RN states: (patient)
   “Mrs Larsen, we’re going to check your blood sugar level now.”

RN asks: (student)
   “Why are we checking blood sugar at this time of day?” “That’s correct. We check it before meals and at bedtime. In addition, if the patient has signs & symptoms of hypoglycemia, we check again.”

RN guides student through the following steps:

A capillary blood sample may be taken from any site, usually finger, ear or heel. Clean the puncture site with alcohol and allow it to dry completely. Puncture the skin to provide a spontaneous flow of blood without squeezing. Wipe away the first drop of blood prior to obtaining a sample.

Follow manufacturer instructions for operation of glucose meter.

Turn meter on. Ensure the code number displayed on the glucose meter matches the code on the vial of test strips.

Obtain blood sample in approved method and apply to glucose test strip. Check that the yellow window of the test strip is completely filled with blood. After removing a test
Running Head: PROBLEM BASED MODULES FOR NURSING EDUCATION

strip, tightly cap the test strip vial to maintain a low moisture environment. Moisture in the air will damage the test strips.

**Blood glucose is 296.**

**RN asks: (student)**

“Can you think of a reason why the patient’s blood glucose would be elevated?”

**RN states: (patient)**

“Mrs Larsen, your blood glucose is high because of the medication we’re giving you to help your lungs. We’ll give you some insulin to bring it lower.”

**RN asks:**

“What else do we need to make sure we do before we leave the room?”
Discuss Putting: bed down, bedside table close, call light in reach, and finish with a “Goodbye I will be back with your medication” example.

Reference

UC Davis Medical Center Patient Care Standards, Policy ID: VII-06
Appendix B: Cardiovascular Assessment

**Script: Cardiovascular Assessment**

Patient:

**Gloria Larson**  
**DOB 3/9/1942**  
**MR: 0090876787**  

**Dx:** 68 year old female Post-op Day Five, Right hip ORIF.  
**Hx:** Recent Left CVA

**Simulator:**  
Static or MF mannequin  
Wig on  
Saline Lock  
Name tag  
SCDs on  
Dry surgical dressing to Right lateral hip  
Abductor pillow  
Nasal Cannula

**Props:**  
Specimen cup  
Box of gloves

**Roles:**  
RN  
Nursing Student

**Prebriefing:**  
Students read case history  
Shift report: NOC shift RN reports that the patient had a good night & there are no changes.

**Time: 0700**

**Script:**  
RN introduces self; (Friendly open tone)  
“So glad we will be working together, let’s go check on Mrs Larsen.”
Washes hands
Enter room
Put on gloves

RN Introduce self and student
   Check patient’s ID band

RN states: (patient)
   “Good morning Mrs Larsen, how are you this morning? We’d like to check your vital signs”
Mrs Larsen states that she’s not feeling well & in fact is having chest pain.

RN asks: (patient)
   “Are you having any shortness of breath? Can you describe the pain? Does the pain radiate to any other area of your body? Can you rate the pain on a 0-10 scale with 0 being no pain & 10 being the worst pain ever in your life? ”
Patient says that she is not having any shortness of breath, the pain feels like a tightness, aches, & it does not radiate anywhere else. She rates the pain at 5/10

RN asks (student)
   “What do you think we should do now?” “Yes, we will take a set of vital signs & call the MD to get orders.”
Vital signs: BP = 140/80 mm Hg, Heart Rate = 80/min, irregular.
Physical examination: the patient is slightly pale

RN states: (patient)
   “Mrs Larsen, Let’s put you on some extra oxygen. We will be back in just a few minutes.”
O2 is applied at 2L/minute via nasal cannula.

Call to MD. Order received for 12-lead EKG, cardiac enzymes, & Nitroglycerin sublingual tablet 0.3 mg now, dissolved under the tongue or in the buccal pouch every 5 minutes as needed, up to 3 doses in 15 minutes.

Time 0710

Washes hands
Enter room
Put on gloves

RN states (patient)
“Mrs Larsen, we have a nitroglycerine tablet for your chest pain. Is it feeling any better?”

Patient states that it is about the same & vital signs show no significant changes. 6 Rights are completed & Nitro tab is given.

RN states (student)
“Let’s get the EKG started now. Here’s a mnemonic that helps me to remember where the leads go:

<table>
<thead>
<tr>
<th>Mnemonic</th>
<th>Color of lead</th>
<th>Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>White is Right</td>
<td>White</td>
<td>Upper Right chest</td>
</tr>
<tr>
<td>Snow over the trees</td>
<td>Green</td>
<td>Lower Right chest</td>
</tr>
<tr>
<td>Smoke over fire</td>
<td>Black</td>
<td>Upper Left chest</td>
</tr>
<tr>
<td>Chocolate over the heart</td>
<td>Brown</td>
<td>Center chest (sternum)</td>
</tr>
</tbody>
</table>

EKG during the chest pain episode showed ST-segment elevation. Patient states that the chest pain is slightly better, but still not gone. A second dose of nitroglycerin is given & the chest pain resolves.

Time 0745
The patient's biomarkers returned negative for MI.

Washes hands
Enter room
Put on gloves

RN states (patient)
“Mrs Larsen, how are you feeling now? Are you having any chest pain?”

Patient denies pain at this time.

RN states (patient)
“We’d like to take another EKG.”
The follow-up EKG, taken when the pain had resolved, showed resolution of ST-segment elevation and no electrocardiographic indications of an evolving or resolving MI.

After careful assessment and evaluation of serial laboratory test, serial ECGs, physical exam findings, and other diagnostic tests, the physician determined that Mrs. Larsen had variant (Prinzmetal's or vasospastic) angina. Diltiazem was ordered to prevent coronary vasospasm and recurrent chest pain attacks.

Reference

UC Davis Medical Center Patient Care Standards, Policy ID: VI-18, Oxygen Administration
Appendix C: Respiratory Assessment, Pulse Oximetry, Incentive Spirometer

**Script: Respiratory Assessment, Pulse Oximetry, Incentive Spirometer, Oxygen Therapy**

Patient:

**Gloria Larson**  
DOB 3/9/1942  
MR: 0090876787

**Dx:** 68 year old female Post-op Day Five, Right hip ORIF.  
**Hx:** Recent Left CVA

**Simulator:**  
Static or MF mannequin  
Wig on  
Saline Lock  
Name tag  
SCDs on  
Dry surgical dressing to Right lateral hip  
Abductor pillow  
Nasal Cannula

**Props:**  
Box of gloves

**Roles:**  
RN  
Nursing Student

**Prebriefing:**  
Students read case history  
Shift report: O2 sats have been running low, so O2 on at 3L/minute. No other vital sign changes noted.

**Time:** 0700

**Script:**  
RN introduces self; (Friendly open tone)  
“So glad we will be working together today.”
Washes hands
Enter room
Put on gloves

RN Introduce self and student
   “Check patient’s ID band”

RN states: (patient)
   “Good morning, how are you this morning? Can you please tell me your name?
   Where are we? Do you know the date? Who is the president now? Do you know why
   you’re in the hospital?”

Patient is disoriented to date, president, and name of hospital, but is reoriented easily.
Knows she fell & hurt her hip.

RN states (patient)
   “We’d like to check your vital signs now. Are you having any pain?”

O2 sat is 88% on 3L/minute via nasal cannula, temp 37.8C (100.0F)

RN states: (patient)
   “We’d like to listen to your lungs now.”

Fine crackles upon auscultation.

RN asks (student)
   “What are your recommendations at this point?” “Yes, we should instruct the pt
to use her IS.”

RN asks (patient)
   “Could you please show me how you’ve been doing with your incentive
spirometer?”

Patient states that she does not like to use it, but reluctantly does, to 400cc. Coughs &
says she doesn’t like to use it because it makes her cough.

O2 sat is now 93%.

Lung sounds re-assessed, now clear to auscultation, but diminished to the bases
bilaterally.

RN states (patient)
“Mrs Larsen, it is very important that you use the incentive spirometer to exercise your lungs. This will help to prevent pneumonia. I’d like for you to do this 10 more times during the next 30 minutes. We will come back to check on you.”

RN asks: (student)
“What else do we need to make sure we do?”
Discuss reconnecting the SCD’s, Placing the abductor pillow in place between the knees, putting bed down bedside table close, call light in reach, and finish with a goodbye I will be back to check on you example.

Time 0730

Washes hands
Enter room
Put on gloves

RN states (patient)
“Mrs Larsen, how have you been doing with the incentive spirometer? We’d like to re-check your temperature now.”

Temp is now 37.2, O2 sat is now 94%

RN states (patient)
“Good job! Your temperature is back to normal now Mrs Larsen, but it is very important that you keep using the incentive spirometer often. We will get you out of bed for a walk soon & that will help too. We’d also like to have you out of bed in the chair as much as possible to help prevent pneumonia.”

Reference

UC Davis Medical Center Patient Care Standards, Policy ID: XVII-25, Attachment 7, Section XVII-25, Pulmonary Hygiene Patient Pathway

UC Davis Medical Center Patient Care Standards, Policy ID: VI-18, Oxygen Administration
Appendix D: Urinary Catheterization, Sterile Technique, Bowel Elimination

**Script: Urinary Catheterization, Sterile Technique, Bowel Elimination**

Patient:

**Gloria Larson**
**DOB 3/9/1942**
**MR: 0090876787**

**Dx:** 68 year old female Post-op Day Three, Right hip ORIF.
**Hx:** Recent Left CVA

**Simulator:**
Static or MF mannequin
Wig on
Saline Lock
Name tag
SCDs on
Dry surgical dressing to Right lateral hip
Abductor pillow

**Props:**
3 pillows
Draw sheet
Box of gloves
Front wheel walker
Bedside commode

**Roles:**
RN
Nursing Student

**Prebriefing:**
Students read case history
Shift report: The Foley Catheter was removed at 2400 (midnight) last night, post-op Day 2, per hospital policy.
The patient has been unable to void so far, but the NOC shift RN used a bedpan rather than the bedside commode.
Bladder scan at 0500 showed 150 ml of urine in bladder & pt states that she didn’t feel like she needs to void.
Running Head: PROBLEM BASED MODULES FOR NURSING EDUCATION

Day shift to follow up.

**Time: 0700**

**Script:**

RN introduces self; (Friendly open tone)
“So glad we will be working together, I understand that Mrs. Larson has had difficulty voiding. We will assess her & address that problem right away.”

RN asks: (student) “Can you think of a way to assess a patient for the need for I&O (in & out) catheter?”
“Yes, we can use a bladder scanner.”
Washes hands
Enter room
Put on gloves

RN Introduce self and student
Check patient’s ID band

RN states:
“Good morning Mrs Larsen, how are you this morning? We’d like to check your vital signs”

Vital signs are taken & are within normal limits (WNL)

RN asks: (patient)
“Can you please tell me your name? Where are we? Do you know the date? Who is the president now? Do you know why you’re in the hospital?”

Patient is disoriented to date, president, and name of hospital, but is reoriented easily.

RN states: (patient)
“Mrs Larsen, I understand that you have not voided since the catheter came out last night. Do you feel like you need to go now?”

Mrs Larsen states that she’s not sure if she needs to go or not, but she does feel constipated.

RN states: (patient)
“Let’s do a quick scan of your bladder & then we can decide.”
Ask student to pull the curtain for patient modesty, and bring bladder scanner to the bedside.

We don’t have a bladder scanner at the school, but here are pictures of what it looks like.

RN states: (patient)

“Mrs Larsen, we are going to scan your bladder to assess for the amount of urine in the bladder. It’s like an ultrasound, and it’s not painful.”

Chat with student, talk about how to turn on the device, apply a small amount of gel to the lower abdomen (just above the pubic symphysis), hold the scanner (angled at 45 degrees) & press the button to scan.

The scan shows 750 ml.

RN states: (patient)

“This shows us that you have quite a bit of urine in your bladder. Let’s get you up to the bedside commode now.”

Ask student to Set up bedside commode near bedside and Position front wheel walker within reach of nurse & patient

RN states: (Student)

“Let’s disconnect the SCD’s. Just like yesterday, we will need to assist her in moving her leg as she stands with assist, using the FWW for additional support. We will also turn off the bed alarm for now.”

Because the patient has baseline dementia & is considered a fall risk, a bed alarm is in use.

RN states: (patient)

“Alright, let’s start the transfer. Gloria, you will need to start scooting yourself toward this side of the bed, using your left leg as much as possible. We will help you with the Right”

“That was a good transfer. Gloria, do you feel steady there?”

Mrs Larsen states that she feels steady on the commode.

Explain to student that the nurse must assess if the patient is steady sitting on the commode independently or not.

Because the pt is mildly confused, she should not be left alone on the bedside commode.
If the pt is not confused or impulsive, it is nice to step away to give the patient some privacy, but don’t go far (stand just outside the door or just a few feet away from the other side of the curtain).

**Mrs Larsen sits on the commode for 5 minutes, but is unable to void.**

**RN states: (patient)**

“That’s OK Mrs Larsen, let’s get you back into bed.”

Ask student to assist lifting patient’s Right leg back into bed.

**RN states: (patient)**

“Mrs Larsen, we’re going to insert a catheter into your bladder to get that urine out. We will take the catheter right back out. It will just take a few minutes.”

**Mrs Larsen asks why we can’t just put one in & leave it in there like she had before.**

**RN states: (patient)**

“There’s a higher risk of infection with leaving a catheter in the bladder, so we will not leave one in.”

“By relieving the pressure on the bladder with the In & Out catheter, you should be able to void like usual next time.”

**RN asks: (patient)**

“Mrs Larsen, are you allergic to iodine?”

**Patient states that she is not.**

**RN states: (student)**

“We will assist Mrs Larsen to a position of comfort and visibility such as, recumbent position with knees flexed and separated to relax abdominal and perineal muscles (arms to side or across chest).”

**RN instructs student to take the following steps:**

1. Open catheterization tray (Touchless In and Out catheter kit) and create sterile field.
2. Place sterile protector under buttocks.
3. Wash hands prior to putting on sterile gloves.
4. Separate labia with thumb and forefinger to expose and visualize meatus.
5. Use forceps, cleanse meatus with a single Povidone-iodine soaked cotton ball, using a single downward stroke front to back. Repeat with remaining cotton balls to cleanse inside of labia, vault and meatus.
6. Remove the cap from the end of the bag while squeezing the tabs to hold the insertion tip in place. Insert catheter tip into the meatus and advance tubing into the urethra by pushing it through the bag. Do not pull the tubing out of the bag. Do not insert further than the flange base. Keep the urine collection bag below the level of the bladder to prevent leakage. Gentle pressure can be applied to the area of the patient’s bladder (just above symphysis pubis) to assist with emptying of urine. When the bladder is drained, pinch the tubing prior to removal.

Instruct student to empty urine into toilet (note the amount for documentation) & dispose of all supplies into biohazard (red bag) container.

RN asks: (patient)
“Mrs Larsen, does that feel better?”

Patient states that she does feel better, but still feels constipated.

**Time: 0710** Head to toe assessment. Bowel sounds: hypoactive. Abdomen distended.

Washes hands  
Enter room  
Put on gloves

RN asks: (student)  
“Is there anything in the MAR that we can give Mrs Larsen for constipation?”

RN states: (student)  
“Yes, she has been getting Colace BID, and we can give Milk of Magnesia (MOM) now. If that has not worked by early afternoon, we can give a Dulcolax suppository.”

RN states: (patient)  
“Mrs Larsen, we can give you Milk of Magnesia now. If that has not worked by early afternoon, we can give you a Dulcolax suppository.”

RN asks: (student)  
“What else do we need to make sure we do before we leave the room?”
Discuss Putting: bed down, bedside table close, call light in reach, and finish with a “goodbye I will be back with your medication” example.

**Time: 0730**
Running Head: PROBLEM BASED MODULES FOR NURSING EDUCATION

RN asks: (student)  
“Now that we have the MOM, what things will we have to do before giving the medication?”  
“That’s correct, we will do the 6 Rights”

Washes hands  
Enter room  
Put on gloves

RN asks: (patient)  
“Can you please tell me your first & last name….and your birthdate”

6 rights are completed by checking patient ID, MAR, & medication.

Medication (MOM) given.

Time: 1030 Mrs Larsen had a BM, and voided 500 ml (into the hat) in the bathroom while up with Physical Therapy.
Appendix E: Transfers, Ambulation, Musculoskeletal/Neurological Assessments

**Script: Transfers, Ambulation, Range of Motion, Musculoskeletal/Neurological Assessments**

Patient:

**Gloria Larson**  
DOB 3/9/1942  
MR: 0090876787  

**Dx:** 68 year old female Post-op Day Two, Right hip ORIF.  
**Hx:** Recent Left CVA

- Transfers, Ambulation, ROM  
- Musculoskeletal/Neuro Assessments  
- VS revisited

**Simulator:**  
Static or MF mannequin  
Wig on  
IV  
Foley catheter  
Name tag  
SCDs on  
Dry surgical dressing to Right lateral hip  
Abductor pillow  
Gait belt

**Props:**  
3 pillows  
Draw sheet  
Box of gloves  
Front wheel walker  
Bedside commode

**Roles:**  
RN  
Nursing Student

**Prebriefing:**
Students read case history
Explain roles of student is to ask questions, help with care
Orient students to room/bed

**Script:**

**RN introduces self:** (Friendly open tone)  
“So glad we will be working together, I need help assisting Mrs. Larson up to the bedside commode (BSC)”

**RN asks:**
“What should we check before getting her out of bed?”
“Let’s check the physical therapist notes”
“The PT note states that she has only minimal weakness to her Right side & that she is cleared to get out of bed with nursing”

“We will also need to check her vital signs and pain level first”

Washes hands
Enter room
Put on gloves

**RN Introduce self and student**
“Check patient’s ID band”

**RN states:** (patient)
“Mrs Larsen, we’re going to check your vital signs before we get you out of bed”

**RN asks:** (patient)
“Can you please tell me your name? Where are we? Do you know the date? Who is the president now? Do you know why you’re in the hospital?”

**Patient is disoriented to date, president, and name of hospital, but is reoriented easily.**

**RN asks:** (patient)
“Mrs Larsen, can you feel me touching your foot? Can you wiggle your toes? Can you lift this leg off the bed? Can you push against my hand with your foot?”
(Perform a brief musculoskeletal assessment)

**RN asks:** (student)
“Are these vital signs OK? What about the fact that she’s a bit confused? Do you anticipate any problems with this when she gets out of bed?”
Chat with student, talk about what you are gathering (peri care supplies, FWW, BSC, gait belt)

Explain process to patient (chatty friendly even if patients cannot return comment) of transferring to the bedside commode

RN asks: (student)
   “What side of the bed should we put the bedside commode on?”
   “That’s correct, it should be set up on her “stronger or unaffected” side. So, in this case, we will put it on the left side of her bed.”

Ask student to Set up bedside commode near bedside and Position front wheel walker within reach of nurse & patient

RN states: (student)
   “Let’s disconnect the SCD’s and move the Foley catheter bag to hang from the FWW) so it will be out of the way”
   “Do you remember why she needs to wear these devices (SCD’s) on her legs?”
   “We’ll keep the Foley bag lower than her bladder because if we don’t it could cause a urinary tract infection (UTI).”

RN states: (patient)
   “Alright, let’s start the transfer. Gloria, you will need to start scooting yourself toward this side of the bed, using your left leg as much as possible. We will help you with the Right”

RN states: (student)
   “Now that she’s sitting on the edge of the bed, we can put the gait belt on. We will have to be sure to keep IV lines out from under the patient & away from the bedside commode (BSC) pan”
   “That was a great transfer! Let’s clean her up & walk out to the hallway before we get her back to bed”

Because the pt is mildly confused, she should not be left alone on the bedside commode.
RN states: (student)

“Make sure that the peri area is clean because as you know, catheters provide an easy access for e-coli from the stool to travel right up into the sterile bladder, so excellent peri care is really important.”
“We will remove the catheter tomorrow night per hospital policy (< 48 hours, at midnight on post-op day 2)”

RN states: (patient)

“Now that we’ve had a good walk, let’s get you back into bed”
RN states: (student)

“It’s very important to keep the IV tubing and Foley catheter lines from tangling or getting caught under her body as we get her back to bed”

Ask student to assist lifting patient’s Right leg back into bed.

Position Mrs. Larson tilted with one flat pillow under her hip on the opposite side with abductor pillow between knees.
Float the heels off the end of the pillow; check arms are free of tubing, side-rails up X3.

RN asks: (student)

“What else do we need to make sure we do?”
Discuss reconnecting the SCD’s, Placing the abductor pillow in place between the knees, putting bed down bedside table close, call light in reach, and finish with a goodbye I will be back to check on you example.

DEBRIEF NOTES:

Reference

UC Davis Medical Center, Patient Care Standards, Policy ID: IX-10, C. Urethral Urinary Catheter, Foley and Straight: Insertion, Maintenance and Removal

UC Davis Medical Center Patient Care Standards, Policy ID: IV-31, Sequential Compression Sleeve/Control Unit/Management of Patient
Appendix F: Gastrointestinal Assessment, Nasogastric tube Insertion

**Script: Gastrointestinal Assessment, Nasogastric tube Insertion**

Patient:

**Gloria Larson**  
DOB 3/9/1942  
MR: 0090876787

**Dx:** 68 year old female Post-op Day 7, Right hip ORIF.  
**Hx:** Recent Left CVA

**Simulator:**  
Static or MF mannequin  
Wig on  
Saline Lock  
Name tag  
SCDs on  
Dry surgical dressing to Right lateral hip  
Abductor pillow  
Wash basin (curved emesis basin is too small)  
Non-allergenic tape  
Protective pad or towel  
Gloves  
Safety pin  
IV tape  
Sharpie marker  
Cup of water with straw  
Stethoscope  
60 cc Irrigating syringe  
Water soluble lubricant  
NG tube 16 Fr  
Suction setup to wall suction with cannister  
Box of gloves  
Soft wrist restraints

**Roles:**  
RN  
Nursing Student
Prebriefing:
Students read case history
Shift report: NOC shift reports that patient has not had a BM x4 days, complains of constipation, abdomen is distended, bowel sounds hypoactive. Pt has been given Colace, Milk of Magnesia, and Dulcolax suppository x3 in the past 24 hours with no result. 300 ml emesis at 2300, and 200 ml emesis at 0600. Zofran 4 mg IV was given at 2310, but pt reports no relief. MD was paged by NOC shift. There are new orders for NPO and abdominal X-ray (pending). IV fluids are running per order.

Time 0830

Abdominal x-ray shows that the patient has an ileus. Orders received for NG to low intermittent wall suction for gastric decompression.

RN introduces self; (Friendly open tone)
“So glad we will be working together, I understand that Mrs. Larsen has an ileus and we will be placing an NG tube to wall suction to decompress her stomach. It is unpleasant having it put in, but it will help her stomach to feel better. Let’s get the supplies we need for it.”

“Because Mrs Larsen has some baseline dementia, we will have a set of soft wrist restraints ready, just in case we need them to use temporarily while we are placing the NG.”

RN states (patient)
“Mrs Larsen, we are going to put a tube in your nose. It will go into your stomach, and it will help you to feel a lot better. It will probably be in for a couple of days.”

Guide the student through the following steps to place the NG.

PROCEDURE:
1. If possible, explain the procedure to the patient
2. Position the patient in a sitting in high-Fowler’s position.
3. Place a protective pad/towel on the patient’s chest as well as provide the patient with a basin to minimize contact with aspirated gastric contents.
4. Using the NG tube as a measuring device determine the length of the NG tube to be passed by measuring the length from
   a. nose to earlobe
   b. earlobe to xiphoid process
5. Add the measurements together and mark this total distance with a permanent marker.
6. Inspect both of the patient’s nostrils for patency. Have the patient blow nose if able.
7. Place the distal end of the tube into the basin on the patient’s lap.
8. Lubricate the first 6 inches of the NG tube liberally with a water soluble lubricant. Choose the largest patent nostril and begin to pass the NG tube through the nostril to the nasopharynx; direct the tube through the nostril aiming down and back.
9. With the patient's neck in a neutral position, gently direct the tube tip posteriorly into his nostril, keeping it parallel with the nasal septum and the superior surface of the hard palate. Allowing the tip to seek its own passage, advance it to the nasopharynx, which is 2 to 3 inches (5 to 7.5 cm) in. (You'll know it's there when insertion gets easier)
10. When the tube enters the nasopharynx, flex the patient's neck slightly. If he's able, have him drink water through a straw so his swallowing can help pass the tube. As he swallows, continue to pass the tube gently but firmly to the mark you established earlier for gastric placement. If you encounter resistance, rotate the tube slightly, but don't force it. If it stops advancing, withdraw it slightly and try again.

   **Caution:** If the patient begins coughing or suddenly can't speak, the tube may have entered his trachea. Remove the tube, make him comfortable, and try again.
11. When the mark on the tube reaches the entrance to the patient's nostril, confirm tube tip position using nonradiographic means, such as visualizing the aspirate.
12. Verify NG tube placement in the stomach by two of the following:
   a. Chest X-ray
   b. Aspirating gastric contents with the irrigation syringe
   c. While listening over the epigastrium with a stethoscope quickly instill a 30cc air bolus with the irrigation syringe. Air entering the stomach will produce a “whooshing” sound.
   d. Ask the patient to hum or talk. Coughing, cyanosis or choking may indicate that the NG tube has passed through the larynx.
   e. Place the open end of the NG tube in a cup of water. Persistent bubbling may indicate that the NG tube has passed through the larynx.
   f. Once the NG reaches the stomach, the distal end of the tube will often spontaneously start draining stomach content or bile into the basin.

   - If unable to positively confirm that the NG tube has been placed is in the stomach the tube must be removed immediately and re-attempted.
   - Once confirmed for placement, secure the NG tube by placing one end of tape on from the bridge to the tip of the nose and the other end wrapped around the tube itself. If possible the nose should be clean and prepped prior to securing with tincture of benzoin.
Connect the NG tube to low intermittent wall suction. If a Salem sump tube is utilized it important to remember that the blue pigtail must be kept at the level of the fluid in the patient’s stomach. This will prevent gastric contents from leaking back through vent lumen.

To deter the NG tube from dangling and possible dislodgment:
   a) Curve and tape the tube to the patient’s cheek to prevent unnecessary tugging on the nostrils. Attach the tube to the patient’s gown.
   b) Wrap a small piece of tape around the tube near the connection creating a tab.
   c) Pin the tape tab to the patient’s gown with the safety pin.

13. Wash your hands- Document the date, time, tube type, length of tube extending from the patient's nose, how he tolerated the procedure, and how you confirmed tip location.

Reference

Appendix G: Respiratory Assessment, Sepsis, Pneumonia

Script: Respiratory Assessment, Sepsis, Pneumonia

Patient:

Gloria Larson
DOB 3/9/1942
MR: 0090876787

Dx: 68 year old female Post-op Day Five, Right hip ORIF.
Hx: Recent Left CVA

Simulator:
Static or MF mannequin
Wig on
Saline Lock
Name tag
SCDs on
Dry surgical dressing to Right lateral hip
Abductor pillow
Nasal Cannula
IV: primary & piggyback bags, primary & secondary tubings

Props:
Specimen cup
Box of gloves

Roles:
RN
Nursing Student

Prebriefing:
Students read case history
Shift report: NOC shift RN thinks she may have “something brewing” Productive cough, low-grade temp at 0400 was 99.7 (37.5), RR was 22 at 0400.

MD just placed order for chest X-ray (CXR), complete blood count (CBC), basic metabolic panel (BMP), blood cultures (BC), urine for analysis & culture (UA/CS), and sputum sample for culture & sensitivity.
Time: 0700

Script:
RN introduces self; (Friendly open tone)

“So glad we will be working together, I understand that Mrs. Larson has had a bit of a low-grade temp and a cough. There are also new orders for chest X-ray (CXR) and sputum sample for culture & sensitivity. We will assess her & address those issues right away.”

Chat with student talk about what you are gathering and for the sputum collection (specimen cup & lab label).

RN states:
 “We will call radiology to ensure they received the order for the CXR”

Radiology is called & order is confirmed. They will be up to take the portable CXR within the next hour.

Washes hands
Enter room
Put on gloves

RN Introduce self and student
 Check patient’s ID band

RN asks: (patient)
 “Can you please tell me your name? Where are we? Do you know the date? Who is the president now? Do you know why you’re in the hospital?”

Patient is disoriented to all but name. This is a change from her baseline.

RN asks (student)
 “What do you think could be causing a change in her mental status?”
Discuss with student that the RN will reorient as much as possible with a reassuring tone so as not to upset the patient.

RN states: (patient)
 “We’d like to check your vital signs now”
Vital signs are taken & temp is now 37.6, O2 sat is 86%, RR 24, HR 94, BP 95/58

RN states: (patient)
 “We’d like to listen to your lungs now.”
Fine crackles upon auscultation.

“Could you please show me how you’ve been doing with your incentive spirometer?”

Patient states that she does not like to use it, but reluctantly does, to 400cc. Coughs & says she doesn’t like to use it because it makes her cough.

O2 sat is now 90%.

Lung sounds re-assessed, now clear to auscultation but diminished to the bases bilaterally.

RN states: (patient)

“Mrs Larsen, you appear to be developing pneumonia. Your doctor has ordered a chest X-ray and a sputum sample to be sent to the lab. In addition, you had a low-grade fever and your lungs sounds indicate that you could be getting pneumonia. The incentive spirometer will really help you to prevent this from getting worse. You will need to use this at least ten times every hour.”

RN states: (patient)

“Mrs Larsen, we need to put this nasal cannula on you to give you extra oxygen.”

Nasal cannula is applied & O2 started at 2L/minute.

RN asks: (patient)

“Mrs Larsen, could you please try to cough up some sputum for the sample? It needs to be from as deep down as possible, not saliva.”

Lab label is compared to patient ID bracelet & pt is asked to state her name & date of birth (DOB). Patient produces an adequate specimen. Lab label is applied to specimen cup with date, time & initials written on label by RN. Lid is secured, placed in biohazard bag.

Washes hands
Put on gloves

A colleague has drawn & sent blood cultures, complete blood count, and basic metabolic panel.

RN states: (patient)
“Mrs Larsen, we also need a urine specimen. It needs to be a “clean-catch”. We will help you with this next time you get up to the bedside commode.”

RN asks: (student)

“What else do we need to make sure we do before we leave the room?”

Discuss Putting: bed down, bedside table close, call light in reach, and finish with a “Goodbye I will check on you soon” example.

All lab specimens are sent & documented.

Time: 0830

Lab results:
Chemistry: Na 135, K 4.5, Cl 109 CO2 24 BUN 24, Creat 0.8, Bl Glucose 169, Ca 8
Hematology: WBC 8.4, Hgb 12.5, Hct 38.2, RBC 3.9, Platelets 334
Blood cultures: in process
CXR: Ground glass appearance to bilateral lower lobes, indicating possible infiltrates (fluid).

New orders received:
- Bolus 500 ml Normal Saline IV now.
- Start IV Fluids-Normal Saline @ 100 ml/hour.
- Vancomycin: 1 Gm IV every 12 hours.
- Albuterol 3 mg (0.1%) and Ipatropium 0.5 mg (0.017%) Nebulized every 6 hours PRN shortness of breath.

Time: 0840

RN asks: (student)

“Now that we have the Bolus and IV fluid orders, what things will we have to do before giving any IV medication or fluid?”

“That’s correct, we check our IV tubing & labels to ensure that they are not expired.”

Washes hands
Enter room
Put on gloves
Check patient’s ID band

All tubing is found to be within date, so it may be used.

RN states: (patient)

“Mrs Larsen, we have some IV fluid & an IV fluid bolus for you.”
RN asks: (student)
    “Now that we have the IV fluids & the bolus in hand, what things will we have to
do before giving the bolus?”
    “That’s correct, we will do the 6 Rights”

RN asks: (patient)
    “Can you please tell me your first & last name….and your birthdate”
6 Rights are completed by checking patient ID, MAR, & medication. Normal Saline
bolus & IV fluids are started.

RN asks:
    “What else do we need to make sure we do before we leave the room?”
    Discuss Putting: bed down, bedside table close, call light in reach, and finish with
a “Goodbye I will be back to check on you soon” example.

Reference

UC Davis Medical Center Patient Care Standards, Policy ID: XVII-25, Attachment 4,
Section XVII-25, *Evidence-based Clinical Practice Guidelines for Pneumonia*

UC Davis Medical Center Patient Care Standards, Policy ID: VI-18, *Oxygen
Administration*
Appendix H: Integumentary Assessment, Positioning, Pressure Ulcers

Script: Integumentary Assessment, Positioning, Pressure Ulcers

Gloria Larson
DOB 3/9/1942
MR: 0090876787

Dx: 68 year old female Post-op Day 12, Right hip ORIF.
Hx: Recent Left CVA

Simulator:
Static or MF mannequin
Wig on
Saline Lock
Name tag
SCDs on
Right lateral hip incision with Steri-Strips

Props:
Box of gloves

Roles:
RN
Nursing Student

Prebriefing:
Students read case history
Shift report: Patient had a good night, no changes.

Script:
RN introduces self; (Friendly open tone)
“So glad we will be working together, let’s go get some vital signs and do an assessment.”

RN Introduce self and student
Check patient’s ID band

RN states:
“Good morning Mrs Larsen, how are you this morning? We’d like to check your vital signs”

**Vital signs are taken & are within normal limits (WNL)**

**RN states: (patient)**

“Mrs Larsen, we’re going to check your surgical site & your skin in general.”

**RN asks: (student)**

“What should we be careful of as we turn her?”

“That’s right. She had hip surgery recently, so that area is still tender. We will use the draw sheet to carefully turn her & minimize the time she is laying on the operative (Left) side.”

**During the skin check, Mrs Larsen is found to have a Stage 1 pressure ulcer to her sacrum, and a small skin tear to the right buttock.**

**RN asks: (student)**

“See this area of skin that’s reddened here at the sacrum? You need to check if it blanches, like this.”

“Since it does not blanch (turn white & then pink again) and the skin is intact, this is a most likely a Stage 1 pressure ulcer.”

**RN asks: (student)**

“See this skin tear here?” “This is caused by friction and shear as the patient was moved around in the bed.”

**RN states: (patient)**

“Mrs Larsen, we’re going to call the doctor an order for a wound care nurse consult. In the meantime, we will position you turned a bit to your side.”

**Wound care RN completes the consult & makes the following recommendations:**

- Turn Q 2 hours
- First Step Select Bed
- Dri-Flow pads only (no pink pads)
- Apply Cavilon No-Stick Barrier to sacral wound BID & PRN soiling
- Apply Mepilex Border dressing to skin tear
- Keep all skin areas clean & dry
RN states: (student)

“The MD has written the order for the specialty bed.” “Why do you think they want to put her on a different bed & why do they want special pads?”

Chat with student talk about what you are gathering: Dri-Flow pads, Cavilon No-Stick Barrier, and Mepilex Border dressing.

Specialty bed has been delivered.

Washes hands
Enter room
Put on gloves

RN Introduce self and student
Check patient’s ID band

RN states: (patient)

“Mrs Larsen, we’re going to put you on a different bed to help keep your skin in good condition.”

Direct student to assist in moving the new bed into place next to the regular bed & assist with sliding the patient onto the new bed with only the Dri-Flow pad under her

RN states: (patient)

“Mrs Larsen, we’re going to put some medication and a dressing on your bottom to keep your skin intact.”

Direct student to assist in applying the Cavilon & Steri-Strips to the appropriate areas & position the patient in a semi-Fowler’s position with the head of bed (HOB) no more than 30 degrees, tilted to the side with pillows behind her & between her legs, heels off the bed. Make sure she’s comfortable.

RN states: (patient)

“Mrs Larsen, we will be turning you every two hours & asking you to be out of bed walking or in the chair as much as possible.”

RN asks: (student)

“What else do we need to make sure we do before we leave the room?”

Discuss Putting: bed down, bedside table close, call light in reach, and finish with a “Goodbye I will check on you soon” example.
Reference

UC Davis Medical Center, All Inpatient Care Areas, Patient Care Standards, Policy ID: IV-03, *Ordering Specialty Beds, Low Air Loss Mattresses, Bariatric Beds and Bariatric Equipment*

UC Davis Medical Center, Patient Care Standards, Policy ID: XII-02, *Patient at Risk for Developing or Those With Pressure Ulcer*
Appendix I: Discharge Planning

Script: Discharge Planning

Patient:

Gloria Larson
DOB 3/9/1942
MR: 0090876787

Dx: 68 year old female Post-op Day 15, Right hip ORIF.
Hx: Recent  Left CVA

Simulator:
Static or MF mannequin
Wig on
Saline Lock
Name tag
SCDs on

Props:
Box of gloves

Roles:
RN
Nursing Student
Discharge planner
Patient
Patient’s daughter, Pamela Bassett

Prebriefing:
Students read case history
Shift report: Patient is doing well. MD has ordered a discharge planning consult for today. Patient’s daughter is to be in at 10 am for apt with D/C planner.

Time 1000, Setting: patient room

RN states
“Good morning everyone, let’s all introduce ourselves.”
Introductions are made.
D/C planner states
   “We’re here to discuss the plan for when you’re ready to leave the hospital Mrs Larsen. Have you and your daughter discussed whether you’ll be going back to where you’ll be going back to where you were living before you came to the hospital or some other arrangements?”

Patient states
   “I’d like to go home.”

Daughter Pamela states
   “Mom don’t you remember, you’re all moved out of your house. You live at Manor Oaks now.”

Patient states
   “Well then can’t I come live with you?”

Daughter Pamela states
   “Mom, we’ve talked about this before, I don’t have an extra room at all. And I’m at work so much I wouldn’t be home enough to take care of you.”

Patient asks
   “Can a nurse come to help me at your house then?”

D/C planner states
   “That is an option if you have a room she could stay in, but it could be a difficult option. I’m not sure if it would be the best choice since you have fallen before. I think the care home could be a better place since there are nurses there to help you 24 hours a day. A home health nurse would only be there for an hour on week-days day to help.”

RN states
   “That is true. If you only have help for an hour a day on week-days, and Pamela is gone most of the time at work, you could have a very difficult time there Gloria.”

Daughter Pamela states
   “Mom, I’d love for you to stay with me, but I just don’t think it would be best. I can still bring ‘Mom, I’d love for you to stay with me, but I just don’t think it would be best. I can still come visit you every day after work, and I can bring you to my house for dinner on most Sundays like we did before. It was working out well at Manor Oaks. I know you’ve made some friends there, right.”

Patient states
“Well yes, I think that will be alright then.”

D/C planner states
“Alright then, I will make the arrangements for today. We can have you taken there by ambulance.”

Patient & daughter both thank D/C planner

RN states
“I’ll let you both know what time the ambulance transport will be here to take you to Manor Oaks.”

Reference
UC Davis Medical Center, Hospital Policies and Procedures, Policy ID: 3328, *Ambulance Transportation*
Appendix J: Beds Baths and Beyond

Note: This is the script that had previously been introduced into the nursing curriculum at CSUS, and was provided to the author for use as an example for the other nine scripts.

**Script of Day 1 Beds Baths and Beyond**

Patient:

**Gloria Larson**
DOB 3/9/1942
MR: 0090876787

**Dx:** 68 year old female with recent Left CVA

**Simulator:**
Static or MF mannequin
Wig on
IV
Foley catheter
Red mark on coccyx
Brown “feces moulage”
Name tag
SCDs on

**Props:**
Infection control gowns, gloves, mask
3 pillows
Bath basin
4 Wash cloths/ 1 towel
Draw sheet
Chucks
Bath products
Box of gloves

**Roles:**
RN
Nursing Student

**Prebriefing:**
Students read case history
Explain roles of student is to ask questions, help with care
Orient students to room/bed

**Script:**

**RN introduces self:** (Friendly open tone)

“So glad we will be working together, I need help cleaning and repositioning Mrs. Larson”

Chat with student talk about what you are gathering and how to put on isolation equipment
Gathers bath supplies
Washes hands
Put on isolation gown, mask, gloves
Enter room

**RN Introduce self and student**

“ID patient’s band”

Explain process to patient (chatty friendly even if patients can not return comment)

Ask student to position bed higher to avoid bending

Remove pillows
Turn patient to side bend pt knee, and support at shoulder and knee.

Clean patient

**RN states:**

“How does her skin look to you, I think there is some redness, she has several pressure points”

Discuss what you will do for care and the option of a wound care nurse consult.

Demonstrate peri care and catheter care

**RN states:**

Catheters provide an easy access for ecoli from the stool to travel right up into the steril bladder, so excellent peri care is really important. Foley catheters are the number one cause of hospital acquired infections. She really needs a StatLock device to hold the catheter. I will bring one of these in next time. It helps prevent infection by securing the catheter to the leg.”

Change gloves
Apply level 3a cream and Zinc second level 3b cream to patient
Change pad and draw sheet and check bed for any objects under skin.

RN states
“IT is important to make sure there are not small objects in the linen that could cause pressure, and that the sheets are smooth so they do not cause skin wrinkles or discomfort. I always place a draw sheet so that I can easily and safely move a patient up in bed. “

RN states:
“What other areas do you think we should check for pressure points?”
Discuss Assessing back, neck, heals, elbows for breakdown

RN asks:
“Why do you think she needs to wear these devices on her legs. “
Discuss importance of preventing clots in the leg (DVT) that can travel (embolize) to the lungs to cause pulmonary emboli that are often fatal, or will require intubation and major oxygen support. They are preventable if we pay attention to what the patient needs to have added to the treatment plan.”

Position Mrs. Larson on opposite side with pillows at back, between knees
Float the heals off the end of the pillow, check arms are free of tubing, siderails

RN asks:
“What else do we need to make sure we are do?”
Discuss Putting bed down bedside table close, call light in reach, and finish with a goodby I will be back to check on you example.

DEBRIEF NOTES:
# Appendix K: Module to QSEN table, color

*Note:* This table may be re-formatted into landscape page orientation when used as a component of syllabi or for other uses.

<table>
<thead>
<tr>
<th>Module</th>
<th>QSEN area</th>
<th>QSEN Knowledge</th>
<th>QSEN Skills</th>
<th>QSEN Attitudes</th>
</tr>
</thead>
</table>
| Bed Bath & Beyond:  
  • Bathing  
  • Incontinence care  
  • Positioning  
  • Infection control | Quality Improvement (QI) | Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patients and families  
  
  Give examples of the tension between professional autonomy and system functioning | Use tools (such as flow charts, cause-effect diagrams) to make processes of care explicit  
  
  Participate in a root cause analysis of a sentinel event | Value own and others’ contributions to outcomes of care in local care settings |
| Bed Bath & Beyond:  
  • Bathing  
  • Incontinence care  
  • Positioning  
  • Infection control | Patient-centered Care | Integrate understanding of multiple dimensions of patient centered care:  
  ◦ patient/family/community preferences, values  
  ◦ coordination and integration of care  
  ◦ information, communication, and education  
  ◦ physical comfort and emotional support | Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care  
  
  Communicate patient values, preferences | Value seeing health care situations "through patients’ eyes"  
  
  Respect and encourage individual expression of patient values, preferences and expressed needs  
  
  Value the patient’s expertise with own health and... |
<table>
<thead>
<tr>
<th>Transfers</th>
<th>Ambulation</th>
<th>ROM</th>
<th>Musculoskeletal /Neuro Assessments</th>
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<tbody>
<tr>
<td>Transfers</td>
<td>Ambulation</td>
<td>ROM</td>
<td>Musculoskeletal/Neuro Assessments</td>
</tr>
<tr>
<td>• Transfers</td>
<td>• Ambulation</td>
<td>• ROM</td>
<td>• Musculoskeletal/Neuro Assessments</td>
</tr>
<tr>
<td>Patient-centered Care</td>
<td>Patient-centered Care</td>
<td>Patient-centered Care</td>
<td>Patient-centered Care</td>
</tr>
<tr>
<td>Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort.</td>
<td>Assess presence and extent of pain and suffering</td>
<td>Assess levels of physical and emotional comfort</td>
<td>Recognize personally held values and beliefs about the management of pain or suffering</td>
</tr>
<tr>
<td>Elicit expectations of patient &amp; family for relief of pain,</td>
<td>Recognize that patient</td>
<td>Appreciate the role of the nurse in relief of all types and sources of pain or suffering</td>
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</table>
discomfort, or suffering
Initiate effective treatments to relieve pain and suffering in light of patient values, preferences and expressed needs

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</tr>
<tr>
<td>Transfers</td>
<td>Ambulation</td>
<td>ROM</td>
<td>Musculoskeletal/Neuro Assessments</td>
</tr>
<tr>
<td>Safety</td>
<td>Examine human factors and other basic safety design principles as well as commonly used unsafe practices (such as, work-arounds and dangerous abbreviations)</td>
<td>Demonstrate effective use of technology and standardized practices that support safety and quality</td>
<td>Value the contributions of standardization/reliability to safety</td>
</tr>
<tr>
<td></td>
<td>Describe the benefits and limitations of selected safety-enhancing technologies (such as, barcodes, Computer Provider Order Entry, medication pumps, and automatic alerts/alarms)</td>
<td>Demonstrate effective use of strategies to reduce risk of harm to self or others</td>
<td>Appreciate the cognitive and physical limits of human performance</td>
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<tr>
<td></td>
<td>Discuss effective strategies to</td>
<td>Use appropriate strategies to reduce reliance on memory (such as, forcing functions, checklists)</td>
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</tbody>
</table>
## PROBLEM BASED MODULES FOR NURSING EDUCATION

### Reduce Reliance on Memory

<table>
<thead>
<tr>
<th>Module</th>
<th>Component</th>
<th>Evidence-Based Practice (EBP)</th>
<th>Quality Improvement (QI)</th>
<th>Informational Technologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary Catheterization</td>
<td>Explain the role of evidence in determining best clinical practice</td>
<td>Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice</td>
<td>Identify essential information that must be available in a common electronic health record</td>
<td>Navigate the electronic health record</td>
</tr>
<tr>
<td>I &amp; O, Sterile Technique, Bowel Elimination</td>
<td>Participate in structuring the work environment to facilitate integration of new evidence into standards of practice</td>
<td>Seek information about outcomes of care for populations served in care setting</td>
<td>Value the need for continuous improvement in clinical practice based on new knowledge</td>
<td>Value technologies that support clinical decision-making,</td>
</tr>
</tbody>
</table>
| • **Respiratory Assessment**  
| • **Sepsis** | Safety | Database to support patient care  
| | | Contrast benefits and limitations of different communication technologies and their impact on safety and quality  
| | | Document and plan patient care in an electronic health record  
| | | Employ communication technologies to coordinate care for patients  
| | | Error prevention, and care coordination  
| | | Protect confidentiality of protected health information in electronic health records  
| • **Respiratory Assessment**  
| • **Pulse Oximetry**  
| • **Incentive Spirometer**  
| • **Oxygen Therapy** | Evidence-based Practice (EBP) | Discriminate between valid and invalid reasons for modifying evidence-based clinical practice based on clinical expertise or patient/family  
| | | Consult with clinical experts before deciding to deviate from evidence-based protocols  
<p>| | | Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best |</p>
<table>
<thead>
<tr>
<th>• Respiratory Assessment</th>
<th>preferences</th>
<th>practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pulse Oximetry</td>
<td>Patient-centered Care</td>
<td>Explore ethical and legal implications of patient-centered care</td>
</tr>
<tr>
<td>• Incentive Spirometer</td>
<td></td>
<td>Describe the limits and boundaries of therapeutic patient-centered care</td>
</tr>
<tr>
<td>• Oxygen Therapy</td>
<td></td>
<td>Recognize the boundaries of therapeutic relationships</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>• Accuchecks Informati cs</th>
<th>Informati cs</th>
<th>Explained why information and technology skills are essential for safe patient care</th>
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<tbody>
<tr>
<td></td>
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<td>Seek education about how information is managed in care settings before providing care</td>
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<tr>
<td></td>
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<td>Apply technology and information management tools to support safe processes of care</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>• Accuchecks Quality Improve ment (QI)</th>
<th>Quality Improve ment (QI)</th>
<th>Describe strategies for learning about the outcomes of care in the setting in which one is</th>
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<tbody>
<tr>
<td></td>
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<td>Seek information about outcomes of care for</td>
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<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Appreciate that continuous quality improvement is an essential part</th>
</tr>
</thead>
</table>
### Integumentary Assessment
- **Engaged in Clinical Practice**
  - Describe own strengths, limitations, and values in functioning as a member of a team
  - Demonstrate awareness of own strengths and limitations as a team member
  - Initiate plan for self-development as a team member
  - Act with integrity, consistency and respect for differing views
- **Seek Information about Quality Improvement Projects in the Care Setting**
  - Acknowledge own potential to contribute to effective team functioning
  - Appreciate importance of intra- and inter-professional collaboration

### Positioning
- **Patient-centered Care**
  - Integrate understanding of multiple dimensions of patient centered care:
    - Patient/family/community preferences, values
    - Coordination and
  - Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and
  - Value seeing healthcare situations "through patients’ eyes"
  - Respect and encourage individual expression of patient values,
| Cardiovascular Assessment | Teamwork and Collaboration | Describe examples of the impact of team functioning on safety and quality of care. Explain how authority gradients. | Follow communication practices that minimize risks associated with handoffs among providers and across transitions in care. | Appreciate the risks associated with handoffs among providers and across transitions in care. | integration of care ◦information, communication, and education ◦physical comfort and emotional support ◦involvement of family and friends ◦transition and continuity. 
Describe how diverse cultural, ethnic and social backgrounds function as sources of patient, family, and community values.

evaluation of care ◦Communicate patient values, preferences and expressed needs to other members of health care team ◦Provide patient-centered care with sensitivity and respect for the diversity of human experience.

preferences and expressed needs ◦Value the patient's expertise with own health and symptoms ◦Seek learning opportunities with patients who represent all aspects of human diversity ◦Recognize personally held attitudes about working with patients from different ethnic, cultural and social backgrounds ◦Willingly support patient-centered care for individuals and groups whose values differ from own. |
<table>
<thead>
<tr>
<th>Cardiovascular Assessment</th>
<th>Safety</th>
<th>Delineate general categories of errors and hazards in care</th>
<th>Communicate observations or concerns related to hazards and errors to patients, families and the health care team</th>
<th>Value own role in preventing errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal Assessment</td>
<td>Patient-centered</td>
<td>Demonstrate comprehensive</td>
<td>Assess presence and</td>
<td>Recognize personally held</td>
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</table>
### NG Insertion

**Care**
- Understanding of the concepts of pain and suffering, including physiologic models of pain and comfort.
- Assess levels of physical and emotional comfort.
- Elicit expectations of patient & family for relief of pain, discomfort, or suffering.
- Initiate effective treatments to relieve pain and suffering in light of patient values, preferences and expressed needs.
- Values and beliefs about the management of pain or suffering.
- Appreciate the role of the nurse in relief of all types and sources of pain or suffering.
- Recognize that patient expectations influence outcomes in management of pain or suffering.

### Gastrointestinal Assessment

**Evidence-based Practice (EBP)**
- Differentiate clinical opinion from research and evidence summaries.
- Describe reliable sources for locating evidence reports and clinical practice guidelines.
- Read original research and evidence reports related to area of practice.
- Locate evidence reports related to clinical.
- Appreciate the importance of regularly reading relevant professional journals.
<table>
<thead>
<tr>
<th>Discharge Planning</th>
<th>Patient-centered Care</th>
<th>Examine how the safety, quality and cost effectiveness of health care can be improved through the active involvement of patients and families. Examine common barriers to active involvement of patients in their own health care processes. Describe strategies to empower patients or families in all aspects of the health care process.</th>
<th>Remove barriers to presence of families and other designated surrogates based on patient preferences. Assess level of patient's decisional conflict and provide access to resources. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management.</th>
<th>Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. Respect patient preferences for degree of active engagement in care process. Respect patient's right to access to personal health records.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Planning</td>
<td>Teamwork and Collaboration</td>
<td>Describe scopes of practice and roles of health care team members. Describe strategies for identifying and managing overlaps in team member roles and</td>
<td>Function competently within own scope of practice as a member of the health care team. Assume role.</td>
<td>Value the perspectives and expertise of all health team members. Respect the centrality of the patient/family as core members of</td>
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<tr>
<td>accountabilities</td>
<td>of team member or leader based on the situation</td>
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<tr>
<td>Recognize contributions of other individuals and groups in helping patient/family achieve health goals</td>
<td>Initiate requests for help when appropriate to situation</td>
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<tr>
<td>Clarify roles and accountabilities under conditions of potential overlap in team member functioning</td>
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<tr>
<td>Integrate the contributions of others who play a role in helping patient/family achieve health goals</td>
<td>Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities</td>
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</table>
Appendix L: Module to QSEN table, standard

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<th>QSEN area</th>
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<th>QSEN Attitudes</th>
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<td>Bed Bath &amp; Beyond:</td>
<td>Quality</td>
<td>Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patients and families Give examples of the tension between professional autonomy and system functioning</td>
<td>Use tools (such as flow charts, cause-effect diagrams) to make processes of care explicit Participate in a root cause analysis of a sentinel event</td>
<td>Value own and others' contributions to outcomes of care in local care settings</td>
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<tr>
<td>• Bathing</td>
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<tr>
<td>• Incontinence care</td>
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<td>• Positioning</td>
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<tr>
<td>• Infection control</td>
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<tr>
<td>Bed Bath &amp; Beyond:</td>
<td>Patient-</td>
<td>Integrate understanding of multiple dimensions of patient centered care: patient/family/community preferences, values coordination and integration of care information, communication, and education physical comfort and emotional support involvement of family and friends transition and continuity Describe how diverse cultural, ethnic and social backgrounds function as sources of patient, family, and community values</td>
<td>Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care Communicate patient values, preferences and expressed needs to other members of health care team Provide patient-centered care with sensitivity and respect for the diversity of human experience</td>
<td>Value seeing health care situations &quot;through patients' eyes&quot; Respect and encourage individual expression of patient values, preferences and expressed needs Value the patient's expertise with own health and symptoms Seek learning opportunities with patients who represent all aspects of human diversity Recognize personally held attitudes about working with patients from different ethnic, cultural and social backgrounds Willingly support patient-centered care for individuals</td>
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<tr>
<td>• Bathing</td>
<td>centered Care</td>
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<td>Activity</td>
<td>Patient-centered Care</td>
<td>Safety</td>
<td>and groups whose values differ from own</td>
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<td>Transfers</td>
<td>Demonstrates comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort.</td>
<td>Examines human factors and other basic safety design principles as well as commonly used unsafe practices (such as, work-arounds and dangerous abbreviations) Describe the benefits and limitations of selected safety-enhancing technologies (such as, barcodes, Computer Provider Order Entry, medication pumps, and automatic alerts/alarms) Discuss effective strategies to reduce reliance on memory</td>
<td>Assesses presence and extent of pain and suffering Assess levels of physical and emotional comfort Elicits expectations of patient &amp; family for relief of pain, discomfort, or suffering Initiates effective treatments to relieve pain and suffering in light of patient values, preferences and expressed needs</td>
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<td>Ambulation</td>
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- Transfers
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<tr>
<th>• Urinary Catheterization</th>
<th>Evidence-based Practice (EBP)</th>
<th>Explain the role of evidence in determining best clinical practice. Describe how the strength and relevance of available evidence influences the choice of interventions in provision of patient-centered care.</th>
<th>Participate in structuring the work environment to facilitate integration of new evidence into standards of practice. Question rationale for routine approaches to care that result in less-than-desired outcomes or adverse events.</th>
<th>Value the need for continuous improvement in clinical practice based on new knowledge.</th>
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<td>• Urinary Catheterization</td>
<td>Quality Improvement (QI)</td>
<td>Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice.</td>
<td>Seek information about outcomes of care for populations served in care setting. Seek information about quality improvement projects in the care setting.</td>
<td>Appreciate that continuous quality improvement is an essential part of the daily work of all health professionals.</td>
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<td>• Respiratory Assessment</td>
<td>Safety</td>
<td>Delineate general categories of errors and hazards in care. Describe factors that create a culture of</td>
<td>Communicate observations or concerns related to hazards and errors to.</td>
<td>Value own role in preventing errors.</td>
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<td>Safety (such as, open communication strategies and organizational error reporting systems)</td>
<td>Patients, families and the health care team</td>
<td>Use organizational error reporting systems for near miss and error reporting</td>
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| **Respiratory Assessment**  
*Pulse Oximetry*  
**Incentive Spirometer**  
**Oxygen Therapy** | Evidence-based Practice (EBP) | Discriminate between valid and invalid reasons for modifying evidence-based clinical practice based on clinical expertise or patient/family preferences | Consult with clinical experts before deciding to deviate from evidence-based protocols Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best practices |
| **Respiratory Assessment**  
*Pulse Oximetry*  
**Incentive Spirometer**  
**Oxygen Therapy** | Patient-centered Care | Explore ethical and legal implications of patient-centered care  
Describe the limits and boundaries of therapeutic patient-centered care | Recognize the boundaries of therapeutic relationships Facilitate informed patient consent for care Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care Appreciate shared decision-making with empowered patients and families, even when conflicts occur |
| **Accuchecks** | Informatics | Explain why information and technology skills are essential for safe patient care | Seek education about how information is managed in care settings before providing care Apply technology and information management tools to support safe processes of care Appreciate the necessity for all health professionals to seek lifelong, continuous learning of information technology skills |
| **Accuchecks** | Quality Improvement (QI) | Describe strategies for learning about the outcomes of care in | Seek information about outcomes of care for Appreciate that continuous quality improvement is an |
### Integumentary Assessment
- **Assessment**
- **Positioning**
- **Pressure Ulcers**

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<th>Demonstrate awareness of own strengths and limitations as a team member Initiate plan for self-development as a team member Act with integrity, consistency and respect for differing views</th>
<th>Acknowledge own potential to contribute to effective team functioning Appreciate importance of intra-and inter-professional collaboration</th>
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| Integumentary Assessment | Positioning | Pressure Ulcers | Patient-centered Care | Integrate understanding of multiple dimensions of patient centered care:  
\- patient/family/community preferences, values  
\- coordination and integration of care  
\- information, communication, and education  
\- physical comfort and emotional support  
\- involvement of family and friends  
\- transition and continuity  
Describe how diverse cultural, ethnic and social backgrounds function as sources of patient, family, and | Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care  
Communicate patient values, preferences and expressed needs to other members of health care team  
Provide patient-centered care with sensitivity and respect for the diversity of human experience | Value seeing health care situations "through patients' eyes" Respect and encourage individual expression of patient values, preferences and expressed needs  
Value the patient’s expertise with own health and symptoms  
Seek learning opportunities with patients who represent all aspects of human diversity  
Recognize personally held attitudes about working with patients from different ethnic, cultural and social backgrounds | Value seeing health care situations "through patients' eyes" Respect and encourage individual expression of patient values, preferences and expressed needs  
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| Cardiovascular Assessment | Teamwork and Collaboration | Describe examples of the impact of team functioning on safety and quality of care. Explain how authority gradients influence teamwork and patient safety. | Follow communication practices that minimize risks associated with handoffs among providers and across transitions in care. Assert own position/perspective in discussions about patient care. Choose communication styles that diminish the risks associated with authority gradients among team members. | Appreciate the risks associated with handoffs among providers and across transitions in care. |
| Cardiovascular Assessment | Safety | Delineate general categories of errors and hazards in care. Describe factors that create a culture of safety (such as, open communication strategies and organizational error reporting systems). | Communicate observations or concerns related to hazards and errors to patients, families and the health care team. Use organizational error reporting systems for near miss and error reporting. | Value own role in preventing errors. |

- **Gastrointestinal Assessment**

  | Patient-centered | Demonstrate comprehensive | Assess presence and extent of | Recognize personally held values and |
### NG Insertion

- Care
- Understanding of the concepts of pain and suffering, including physiologic models of pain and comfort.
- Pain and suffering
- Assess levels of physical and emotional comfort
- Elicit expectations of patient & family for relief of pain, discomfort, or suffering
- Initiate effective treatments to relieve pain and suffering in light of patient values, preferences and expressed needs
- Beliefs about the management of pain or suffering
- Appreciate the role of the nurse in relief of all types and sources of pain or suffering
- Recognize that patient expectations influence outcomes in management of pain or suffering

### Gastrointestinal Assessment

- Evidence-based Practice (EBP)
- Differentiate clinical opinion from research and evidence summaries
- Describe reliable sources for locating evidence reports and clinical practice guidelines
- Read original research and evidence reports related to area of practice
- Locate evidence reports related to clinical practice topics and guidelines
- Appreciate the importance of regularly reading relevant professional journals

### Discharge Planning

- Patient-centered Care
- Examine how the safety, quality and cost effectiveness of health care can be improved through the active involvement of patients and families
- Examine common barriers to active involvement of patients in their own health care processes
- Describe strategies to empower patients or families in all aspects of the health care process
- Remove barriers to presence of families and other designated surrogates based on patient preferences
- Assess level of patient’s decisional conflict and provide access to resources
- Engage patients or designated surrogates in active
- Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care
- Respect patient preferences for degree of active engagement in care process
- Respect patient’s right to access to personal health records
| **Discharge Planning** | Teamwork and Collaboration | Describe scopes of practice and roles of health care team members. Describe strategies for identifying and managing overlaps in team member roles and accountabilities. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | Function competently within own scope of practice as a member of the health care team. Assume role of team member or leader based on the situation. Initiate requests for help when appropriate to situation. Clarify roles and accountabilities under conditions of potential overlap in team member functioning. Integrate the contributions of others who play a role in helping patient/family achieve health goals. | Value the perspectives and expertise of all health team members. Respect the centrality of the patient/family as core members of any health care team. Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities. |
References


Resource Library:

http://findarticles.com/p/articles/mi_hb3317/is_5_23/ai_n28947081/?tag=content;col1


Running Head: PROBLEM BASED MODULES FOR NURSING EDUCATION

King, E., Cline, D., Mengel, A., McLaughlin, B., Rizzolo, M., Tagliareni, E., (2011), Headlines from the NLN. Nursing Education Perspectives, Jul/Aug2011, Vol. 32 Issue 4, p276-277, 2p; DOI: 10.5480/1536-5026-32.4.76


Quality and Safety Education for Nurses, retrieved from:
http://www.qsen.org/ksas_prelicensure.php#safety


Running Head: PROBLEM BASED MODULES FOR NURSING EDUCATION

UC Davis Medical Center, Hospital Policies and Procedures, Policy ID: 3328, Ambulance Transportation

UC Davis Medical Center, Patient Care Standards, Policy ID: IV-03, Ordering Specialty Beds, Low Air Loss Mattresses, Bariatric Beds and Bariatric Equipment

UC Davis Medical Center, Patient Care Standards, Policy ID: IV-31, Sequential Compression Sleeve/Control Unit/Management of Patient

UC Davis Medical Center, Patient Care Standards, Policy ID: VI-18, Oxygen Administration

UC Davis Medical Center, Patient Care Standards, Policy ID: VII-06

UC Davis Medical Center, Patient Care Standards, Policy ID: IX-10, C. Urethral Urinary Catheter, Foley and Straight: Insertion, Maintenance and Removal

UC Davis Medical Center, Patient Care Standards, Policy ID: IX-10, III C.

UC Davis Medical Center, Patient Care Standards, Policy ID: XII-02, Patient at Risk for Developing or Those With Pressure Ulcer

UC Davis Medical Center, Patient Care Standards, Policy ID: XVII-25, Attachment 4, Section XVII-25, Evidence-based Clinical Practice Guidelines for Pneumonia

UC Davis Medical Center, Patient Care Standards, Policy ID: XVII-25, Attachment 7, Section XVII-25, Pulmonary Hygiene Patient Pathway