Example of Documentation for DTRs and Clonus:

Patient evaluated for deep tendon reflexes and clonus in lower extremities.

Hyper-reflex:	4+ DTRs in right leg with 3 beats clonus. 4+ DTRs in left leg with 3 beats clonus
Normo-reflex:	2+ DTRs in right leg with 0 beats clonus 2+ DTRs in left leg with 0 beats clonus
Hypo-reflex:	1+ DTRs in right leg with 0 beats clonus 1+ DTRs in left leg with 0 beats clonus

Q 3 (OB)

DEEP TENDON REFLEXES (DTRs) AND CLONUS

Hello. My name is _____. This is the **Deep Tendon Reflexes and Clonus** Station. This is your client who was diagnosed with Pregnancy-Induced Hypertension during the last weeks of her pregnancy. She is now 8 hours postpartum and resting in bed. You are to check the DTRs in her lower extremities and evaluate for clonus. Your patient is here. You will demonstrate and document one of the following: (faculty will choose).
Assume that the reflexes and clonus are the same for both legs and feet.

1. Abnormal hyper-reflexes (4+ reflexes, and 3 beats clonus)
2. Normal reflexes (2+ reflexes, and 0 beats clonus)
3. Abnormal hypo-reflexes (1+ reflexes, and 0 beats clonus)

You have washed your hands and explained the procedure to your client. You have 10 minutes to complete this station. What time does your watch say?

START TIME _____. Please tell us when you have completed all the critical elements for this station.
END TIME _____

1. **Identifies** client, (**comparing** written name and number to name band)

2. Supports a flexed lower extremity above popliteal fossa and locates patellar tendon

3. Briskly taps the patellar tendon with reflex hammer to elicit the reflex response

4. Describes the result of the assigned reflex response
   hyper-reflex: exaggerated kick of the leg;
   normo-reflex: brisk kick of the leg;
   hypo-reflex: depressed kick of the leg

5. Dorsiflexes the foot and releases to elicit the clonus response

6. Describes the result of the assigned clonus response
   hyper-reflex: 3 beats of the foot;
   normo-reflex: 0 beats of the foot;
   hypo-reflex: 0 beats of the foot

7. Repeats the procedure on the other leg and foot

8. Documents the findings on the client's chart

9. "Have you completed all the critical elements for this station? (? Asked)

10. Met time limit

Q 3 (Pedi)

Pediatric Fluid Volume Status Assessment

Hello, my name is _____. This is the Pediatric Fluid Volume Status Assessment Station. This is your 8-month-old client who has a history of vomiting and diarrhea for two days. Here are the narrative nurse's notes where you will chart your assessment of his hydration status. You have already washed your hands, greeted your client & family, and explained what you are going to do. You have 10 minutes to complete this station. What time does your watch say?

START TIME _____ Please tell me when you have completed all the critical elements for this station.

END TIME _____

1. **Identifies** client (**comparing** written name and number to name band).
2. Verbalizes would determine amount of weight lost.
3. Verbalizes would take heart rate & blood pressure.
4. Demonstrates & verbalizes palpation of anterior fontanel.
5. Demonstrates & verbalizes evaluation of mucous membranes and presence or absence of tears.
6. Demonstrates & verbalizes capillary refill time.
7. Demonstrates & verbalizes evaluation of pedal pulse.
8. Verbalizes would evaluate behavior of child (level of irritability to lethargy), utilizing parent's judgment.
9. Raises crib rail, if present, and then tests left & right sides for security.
10. Does **not l**eave bedside with crib rail down
11. Records data related to each of the above assessment findings.
12. "Have you completed all the critical elements for this station?" (? Asked)
13. Met time limit.

Q 3 (Pedi)

Pediatric Fluid Volume Status Assessment

Examples of Acceptable Narrative Nurse's Notes

1. "Parent's report infant has lost about 2 pounds in the last week. Heart rate is slightly increased for age & activity level; blood pressure is slightly decreased. AF is soft and depressed. CFT is approximately 4 seconds. Mouth seems dry and few tears despite increased irritability during exam. Mom states 'more irritable today than yesterday'. Pedal pulses slightly decreased.

OR

2. Heart rate, blood pressure, and weight unchanged in last 24 hours. AF remains depressed and CFT about 4 seconds. Pulses are thready, mouth is dry and child is very irritable, crying without tears.

ACCEPTABLE DOCUMENTATION **must** include data on the assessment of **each parameter:**

1) weight	2) heart rate	3) blood pressure
4) AF	5) CFT	6) mucous membranes
7) tears	8) pedal pulse	9) behavior

Examples of UNACCEPTABLE Narrative Nurse's Notes

1. "No findings of fluid volume deficit. Everything normal."

2. "Dehydration assessment done, child moderately dehydrated."

Q 3 (OB/PEDI)

NEONATAL APICAL PULSE

Hello, my name is _____. This is the **Neonatal Apical Pulse** Station. A baby girl was delivered an hour ago. At birth her Apgar scores were 9/9. She cried lustily and was pink, except for some acrocyanosis. Using a stethoscope, demonstrate assessment of heart rate, and document:

1) A normal neonatal apical pulse rate
2) 2 signs that could indicate a need for further assessment

You have 5 minutes to complete this station. What time does your watch say?

START TIME _____ Please tell me when you have completed all the critical elements for this station.
END TIME _____

1. Lowers crib rail, if present, protecting client.

2. **Identifies** client, (**compares** written name & number to wrist/ankle band).

3. Wipes stethoscope head & tubing with alcohol.

4. Places stethoscope at PMI (mid-clavicle, nipple line).

5. Counts rate using stethoscope for 1 full minute.

6. Leaves client in supine position, covered with blanket

7. Raises crib rail, if present, and then tests left & right sides for security.

8. Documents apical pulse rate within 110-160 bpm

9. Documents 4 signs that could indicate a need for further assessment
   1) generalized cyanosis 3) heart rate <110 bpm
   2) murmur 4) heart rate >160 beats bpm

10. Does **not** leave bedside with crib rail down

11. "Have you completed all the critical elements for this station?" (? Asked)

12. Met time limit

Q3 (OB/PEDI)

NEONATAL BULB SUCTIONING

Hello, my name is _____. This is the **Neonatal Bulb Suctioning** Station. A new mother on the postpartum unit calls you because she says her baby is choking. Frothy mucus is observed coming from the neonate's mouth, and the face color is cyanotic. Using the bulb syringe provided, demonstrate how you would bulb suction this neonate. You have 5 minutes to complete this station. What time does your watch say?

START TIME _____ Please tell me when you have completed all the critical elements for this station.

END TIME _____

1. Lowers crib rail, if present, protecting client.
2. Positions neonate for suctioning (side-lying or football-hold with head down, turned to the side).
3. Compresses bulb syringe before inserting syringe.
4. Suctions the mouth before the nose putting the tip of bulb into the lower bucal pocket.
5. Releases the bulb compression gradually while aspirating secretions.
6. Leaves client in supine position, covered with blanket.
7. Raises crib rail, if present, and then tests left & right sides for security
8. Does not leave bedside with crib rail down.
9. "Have you completed all the critical elements for this station?" (?Asked).
10. Met time limit

Q3 (OB/PEDI)

NEONATAL RESPIRATIONS

Hello, my name is _____. This is the **Neonatal Respiration** Station. Baby girl Jones was just delivered and has been placed in her crib. Her Apgar scores were 9/9. She cried lustily at the time of birth. This is the documentation sheet. You are to demonstrate the assessment of the respiratory rate and document the following:

1) **A normal respiratory rate**
2) **5 signs that identify respiratory distress**

You have 5 minutes to complete this station. What time does your watch say?

START TIME ____ Please tell me when you have completed all the critical elements for this station.
END TIME _____

1. Lowers crib rail, if present, protecting client.

2. **Identifies** client (**compares** written name and number to name band).

3. Observes the client for signs of respiratory distress and explains 5 signs of respiratory distress.
    1) grunting
    2) nasal flaring
    3) seesaw breathing
    4) intercostal retractions
    5) substernal retractions

4. Counts rate visually, tactually or with stethoscope for 1 full minute.

5. Leaves client in supine position, covered with blanket.

6. Raises crib rail, if present, and then tests left & right sides for security.

7. Documents respiratory rate within 30-60 respirations per minute.

8. Documents 5 possible signs of respiratory distress

9. Does not leave bedside with crib rail down.

10. "Have you completed all the critical elements for this station?" (? Asked)

11. Met time limit.

Q3 (OB/PEDI)

NEONATAL APICAL PULSE

STUDENT _____

DATE _____

Client name _____

Medical record number _____

1. Normal neonatal apical pulse rate _____

2. 4 signs that could indicate a need for further assessment

1) _____ 3)_____

2) _____ 4)_____

Q3 (OB/PEDI)

NEONATAL RESPIRATIONS

STUDENT _____

Client Name _____

Medical Record Number _____

1. Normal respiratory rate _____

2. 5 signs of respiratory distress:

   1)_____

   2)_____

   3)_____

   4)_____

   5)_____

5/14

Q3 (Pedi)

NEUROVASCULAR ASSESSMENT

Hello, my name is _____. This is the **Neurovascular Assessment** Station. This is your client who has a limb device as part of his medical treatment. Here are your narrative nurse's notes where you will chart your neurovascular assessment of the site. You have already washed your hands, greeted your client, and explained what you are going to do. You have 10 minutes to complete this station. What time does your watch say?

START TIME _____ Please tell me when you have completed all the critical elements for this station.

END TIME _____

1. **Identifies** client (**comparing** written name and number to name band)

2. Identifies the location and type of medical device(s)

3. Demonstrates & verbalizes palpation bilaterally for presence or absence of pulses distal to site

4. Checks capillary refill time distal to the site bilaterally.

5. Demonstrates & verbalizes assessment for temperature and color of extremities bilaterally distal to the site.

6. Elicits client's response to tactile stimuli to distal portion of the extremities bilaterally

7. Asks client to move distal portion of extremities bilaterally or elicit movement by stimulation.

8. Records data related to the site location, device type, and each of the above assessment findings, bilaterally.

9. "Have you completed all the critical elements for this station?" (? Asked)

10. Met time limit.

5/14

NEUROVASCULAR ASSESSMENT

Documentation includes:

data on the assessment of each parameter, bilaterally **:**

1. type of device
2. site (location) of device
3. distal pulses
4. distal CFT or CRT
5. distal temperature
6. distal sensation
7. distal movement
8. distal color

Examples of Acceptable Narrative Nurse Notes:

1. " Device (splint, ace wrap, cast, etc.) at _____ (RLE, LLE, RUE, LUE). Lower extremities pale pink and cool bilaterally. Left pedal pulse not palpable, popliteal pulses equal bilaterally. Capillary refill less than 3 seconds bilaterally. Sensation diminished in left foot compared to right. Client able to move lower extremities bilaterally upon command."

OR

2. " Device (splint, ace wrap, cast, etc.) at ____ (RLE, LLE, RUE,LUE). Toes pink and warm bilaterally and move bilaterally without difficulty with CRT < 3 seconds bilaterally. Pedal pulses palpable bilaterally. Sensation present bilaterally."

Examples of **Unacceptable Narrative** Nurse Notes

1. "No findings of neurovascular deficits. Everything normal."

2. "Neurovascular assessment done, right leg cooler than left leg."

Q3 (OB)

Uterine Assessment Documentation

Date_____

Student Name _____

Client Name _____Medical Number_____

Assessment:

Two Abnormal findings

1._____

2._____

Q 3 (OB)

PERFORMING UTERINE ASSESSMENT

Hello, my name is _____. This is the station for **Performing Uterine Assessment.** You are assigned to the Postpartum Unit, and are caring for a postpartum patient who delivered her baby 12 hours ago. She has had an uneventful recovery thus far. Your patient is here. You will assess her uterus, and locate her uterine fundus at the umbilicus. You will document your assessment and two (2) abnormal findings. You have already washed your hands, provided for patient privacy, and explained the procedure to the patient. You have 10 minutes to complete this station. What time does your watch say?

START TIME_____. Please tell us when you have completed all of the critical elements for this station.
END TIME _____

1. **Identifies** patient, (**comparing** written name and number to name band).
2. Explains to the patient what will be done; lowers head of bed to flat position and places patient in supine position
3. Ensures that patient is comfortable lying on back
4. Dons gloves.
5. Places one hand over symphysis to guard the uterus.
6. Palpate abdomen for uterine fundus with other hand steady pressure
7. Verbalizes that uterus should feel firm and be located at the level of the umbilicus
8. Demonstrates uterine massage for a non-firm uterus (cupped hand or fingertips) while examining vaginal lochia flow for excessive bleeding and clots.
9. Covers patient and returns bed to previous position
10. Documents assessment and two (2) abnormal findings:
    1. Uterus located above the level of the umbilicus and deviated from midline
    2. Uterus boggy
11. "Have you completed all the critical elements for this station?" (? Asked)
12. Met time limit.

5/14