**STEP 3 SKILL : 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 their 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 leave 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.

**STEP 3 Pediatric Fluid Volume Status Assessment Example**

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.

**STEP 3 SKILL: NEONATAL BULB SUCTIONING and FOLLOWUP ASSESSMENT**

Hello, my name is \_\_\_\_\_\_\_\_\_. This is the Neonatal bulb suctioning and assessment station.

A new mother on the postpartum unit calls you because she says her baby is making gurgling sounds. Frothy mucus is observed coming from the neonate's mouth. Using the bulb syringe provided, demonstrate how you would bulb suction this neonate. After suctioning neonate's mouth and nose, assess apical pulse and respirations. You have 15 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. Identifies client, (compares written name & number to wrist/ankle band).
4. Holds the tip of the bulb between middle finger and forefinger with the bulb touching the palm of the hand and uses thumb to push out the air. Puts the tip of bulb into the lower bucal pocket and releases the bulb compression gradually while aspirating secretions. Removes the syringe and squeezes the bulb forcefully to expel the mucus on a blanket and wipes the syringe.
5. Squeezes the air out of the bulb of the syringe to create a vacuum as above. Gently inserts the rubber tip just a bit into one nostril. Slowly releases the bulb to suction out mucus. Removes the syringe and squeezes the bulb forcefully to expel the mucus into a tissue. Wipes the syringe and repeat the process for the other nostril.
6. Wipes stethoscope head & tubing with alcohol.
7. Places stethoscope at PMI (mid-clavicle, nipple line).
8. Counts heart rate using stethoscope for 1 full minute.
9. 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
10. Counts rate visually, tactually or with stethoscope for 1 full minute.
11. Does not leave bedside with crib rail down.
12. Documents suctioning and subsequent assessment.
13. "Have you completed all the critical elements for this station?" (? Asked)
14. Met time limit.

**STEP 3 SKILL: NEUROVASCULAR ASSESSMENT**

Hello, my name is \_\_\_\_\_\_\_\_\_\_. This is the Neurovascular Assessment Station. This is your client who has a limb device as part of their 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.

NEUROVASCULAR ASSESSMENT documentation example

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."

**STEP 3 SKILL Deep Tendon Reflexes and Clonus**

Hello. My name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This is the Deep Tendon Reflexes and Clonus Station. This is your client who was diagnosed with preeclampsia 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. You have already washed your hands, greeted your client, and explained what you are going to do. 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?

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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

**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