NURSING 234 Syllabus

Spring 2017

Carroll University Nursing Program

This manual serves as a guide to the Nursing 234 course.

Nursing Program Mission
The Carroll University nursing program builds on Carroll University’s mission of providing a superior educational opportunity to our students, one grounded in the liberal arts tradition and focused on career preparation and lifelong learning. Nursing practice is built on nursing knowledge, theory, and research. Nursing practice derives knowledge from a wide array of other fields and disciplines, adapting and applying this knowledge as appropriate to professional practice. The mission of the Carroll University nursing program is to prepare nurses for professional practice in a variety of settings, preparing them to take on characteristics that will allow them to function in the generalist professional nursing role.

Nursing Program Vision
Be a leader of Baccalaureate Nursing education among liberal arts Universities in Wisconsin.

Course Description
This course, in association with Nursing 233, is focused on the application and integration of the nursing process to promote physical wellness. Simulated and actual client-care experiences provide an opportunity for student development and practice in the roles of professional nursing that assist the individual to regain or maintain an optimal health state. Therapeutic interventions related to fundamental needs across the life span are addressed and a basic skill level is expected as an outcome of the course.

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Course Objectives

Ties to The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008) noted in parentheses.

At the conclusion of the course, the student will:
1. Apply concepts from the arts and sciences when examining the impact of all elements of the environment on an individual's functioning (Essential I.1,2,3)

2. Demonstrate self-direction in time and task management to prepare for and effectively participate in clinical skills labs and to deliver safe, quality, patient-centered care in the clinical setting.(Essential VIII.2)

3. Implement communication strategies that promote and support the development of effective inter/intra-professional teams and therapeutic relationships. (Essentials I.4; VI.2, 3; and IX.4, 21)

4. Approach clients and families in an empathetic manner. (Essentials II.4; and IX.2,9)

5. Use the language of the nursing discipline to report and document patient data in an accurate, concise, pertinent, and timely manner (Essential VI.2, 6)

6. Integrate knowledge gained from liberal studies, nursing theory, client history, clinical findings, and pathophysiological concepts to plan and deliver patient care that is evidence-based and reflective of inter-professional and patient perspectives. (Essentials I.1, 2, 3, 7; II.7, 8; III.1,6; VII.1, 2, 3; IX.1, 3, 6, 7, 8, 11)

7. Develop and implement patient plans of care which are consistent with the Carroll University Criteria for Care Planning. (Essentials III.4; IV.6; VII.3; IX.3, 6, 7, 8, 9, 11,19)

8. Demonstrate an organized ability to perform selected psychomotor skills in a safe, efficient and compassionate manner in the long-term care environment. (Essentials II.8; and IX.12,16)

9. Demonstrate an entry-level ability to evaluate the credibility of evidence. (Essentials III.4; and IX.11)

10. Consistently demonstrate respect for the uniqueness of individuals in the clinical setting. (Essential VIII.3)

11. Implement patient care that appeals to the values held by the client.(Essentials I.5 and IX.5)

12. Demonstrate awareness of complex organizational systems and a basic understanding of organizational structure, mission, vision, philosophy and values. (Essential II.3,4)

13. Begin to apply leadership concepts, skills and decision making in the provision and delegation of quality patient care (Essentials II.1; VI.5, 6; and IX.14)

14. Identify and begin to assume the legal/ethical responsibilities and accountabilities of the professional nurse in the nursing laboratory and clinical setting. (Essentials IV.8; VI.1,6; VIII 1, 2, 3,10,12; and IX.12)

15. Demonstrate clinical practice that reflects a beginning understanding of the roles and relationships of and among members of the multi-disciplinary team.(Essentials IV.8; VI.1,6; VIII 1, 2, 3,10,12; and IX.12)

16. Uphold the Carroll University Standards of Professional Conduct in the clinical setting (Essentials VIII.4; and VIII.1, 2, 3, 10,13)

17. Understand the dynamic nature of small group behavior and applies leadership concepts and skills including communication, team-building, negotiation and conflict management in the development and delivery of a community teaching project.(Essentials II.1; VI.3,5).
Kathy Sampson, BSN, RN, MSN, CCRN
Senior Instructional Faculty
Office: Voorhees B6
Office Phone: 262-650-4934
Cell Phone: 262-366-4574
ksampson@carrollu.edu
Office Hours: Mondays 1100-1400; most Wednesdays 1100-1300 by appt

Candy Lindorfer, BSN, RN, MSN
Adjunct Clinical Faculty
Office: Voorhees B6
Cell Phone: 262-894-6621
clindorf@carrollu.edu
Office Hours: Thursday 1200 to 1300 and by appt

Ashley Maas, BSN, RN, MSN in progress
Adjunct Clinical Faculty
Office: VOB6
Cell Phone: 262-370-4609
amaas@pio.carrollu.edu
Office Hours: Tuesday 1200 to 1300 and by appt

Josie Rukamp, BSN, RN, MSN in progress
Adjunct Clinical Faculty
Office: Voorhees B6
Cell Phone: 920-360-2107
jrukamp@carrollu.edu
Office Hours: XXX and by appt

Jim Mikolajczak BSN, RN, MSN
Clinical Assistant Professor
Office: Henke Nursing Center 08
Cell Phone: 414-614-9835
Campus Phone: 262-650-4929
jmikolaj@carrollu.edu
Office Hours: Wednesday 0900-1300 and by appt

Karla Kwapił, BSN, RN, MSN, M.Ed
Clinical Assistant Professor
Office: Voorhees B4
Cell Phone: 920-988-0737
kkwapil@carrollu.edu
Office Hours: TBA and by appt

Cindy Vanderloop, BSN, RN, MSN
Adjunct Clinical Faculty
Office: Voorhees B6
Cell Phone:
cvanderl@carrollu.edu
Office Hours: TBA and by appt

Carroll University Nursing
Adjunct Clinical Faculty
Office: Voorhees B6
Cell Phone: 262-622-2983
kkorn@carrollu.edu
Office Hours: TBA and by appt
Clinical site Locations

Linden Grove-Waukesha
425 University Ave
Waukesha, WI 53188
262-524-6400

Linden Grove-Mukwonago
837 County Rd NN East
Mukwonago, WI
262-363-6830

Lake Country Health Center
2195 N. Summit Village Way
Oconomowoc, WI 53066
262-567-4662

New site -TBA

United Community Center [UCC]
1028 S 9th St,
Milwaukee, WI 53204
414-384-3100

All Clinical sites will hold clinical for 6 hours. Attendance is mandatory. Sick calls to your instructor need to be placed as soon as possible before the start of your clinical. Options for making up your clinical hours will be left up to your clinical instructor.

Snacks are up to each student to provide on their own. There is not a refrigerator on site for our use.

Students must abide by HIPPA policies for each facility. No cell phones are allowed in facilities.

Students will not take orders from physicians, pass medications, or work outside their scope of practice.

Be advised there are no lockers for student use. Carroll University and/or Hospital are not responsible for lost or stolen items.

Parking is limited at all facilities. Your instructor will direct you to appropriate parking areas for each site.

Refer to Nursing 234 LMS website for specific site information.
**NRS 234 – Course Expectations**

**Statement on Academic Integrity:**

The Carroll University Academic Integrity Policy is located in your student handbook. Familiarize yourself with the academic integrity policy. If a student violates this policy in any way, a sanction of failure on the assignment/assessment or failure in the course will result. If you have questions about appropriate citations in your writing, please ask.

**Accommodation for Disabilities:**

Students with documented disabilities who may need accommodations, or any student considering obtaining documentation, should make an appointment with the Carroll University disabilities coordinator in the Walter Young Center, no later than the first week of class. Walter Young Center may be reached by calling 262-524-7335.

**A. Course Overview:**

This course fits the conceptual framework and assists the student to acquire the expected program outcomes as follows:

- Liberal education for baccalaureate generalist nursing practice.
- Liberal education concepts must be applied to the planning and choice of interventions for patients and their families. Knowledge of the natural world and of the scientific method, understanding of human behavior and culture are foundations of clinical practice. The course requires that the student appropriately apply knowledge from these and other disciplines to the understanding and application of patient care.

**B. QSEN: The Quality and Safety Education for Nursing**

The overall goal for the Quality and Safety Education for Nurses (QSEN) project is to meet the challenge of preparing future nurses who will have the knowledge, skills and attitudes (KSAs) necessary to continuously improve the quality and safety of the healthcare systems within which they work.

1. **Safety**
   
   The student will:
   
   • Minimize risk of harm to patients and providers through both system effectiveness and individual performance.

2. **Patient-Centered Care:**
   
   The student will:
   
   • 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.

3. **Evidence based practice**
   
   The student will:
   
   • Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

4. **Quality Improvement (QI)**
   
   Students will:
   
   • 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.

5. **Information technology**
   
   Students will:
   
   • Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.

6. **Teamwork and Collaboration**
   
   Students will:
   
   • Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.
**Required Texts:**

See Requirements for Nursing 233

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**Assessment of Student Performance:**

**A. Direct patient care:**

Supervised clinical practice will provide opportunities to plan, implement, and evaluate nursing care for the long term care client. The sophomore level student will manage nursing care for one client gathering history and physical assessment data to create a patient-centered plan of care. Clinical proficiency includes reading and interpreting the chart, demonstrating understanding of the patients' medical history, and demonstrating competency in the timing and accomplishment of focused physical assessment at a level consistent with the student's level of progress in the Carroll University Nursing Program. Students will demonstrate an ability to correlate patient data to the effect the data have (or should have) on nursing care decision making. The conclusion of the clinical day includes a post conference discussion to facilitate professional sharing of clinical experiences.

**B. Assignments:**

1. **System-focused Patient History and Physical Assessment Competency:**

In order to progress from NRS234 skills lab to the clinical setting, all students must demonstrate competency in system-focused patient history taking and physical assessment. Failure to successfully complete this requirement prior to the start of clinical practicum in the long-term care environment will result in the implementation of a learning contract- and student will not be allowed to progress to the clinical setting. The student’s exclusion from practice in the clinical setting will conclude in unsuccessful (U) completion of NRS 234.

Students are required to pair with another classmate and schedule competency testing on sign-up sheets found in the nursing lab. See your course calendar for the absolute due date. All students are required to demonstrate competency of one randomly selected physiological system. Students are encouraged to review the Focused-Assessment criteria for competency in preparation for the testing.

2. **Clinical Assignments: Minimal satisfactory requirements to progress in the course:**

   A. 3 of 5 weekly written **self-assessment reflections** will evidence critical thinking.
   
   B. 3 of 5 weekly written **client assessments** will evidence critical thinking and assessment documentation at the sophomore level.
   
   C. **Weekly care plans** (identified as a psychosocial problem and a physiological problem IPOC) must receive a satisfactory score (78%).
   
   D. Satisfactory demonstration of **bedside focused assessments** of assigned resident: Cardiovascular/Respiratory, Neurological/Musculoskeletal, and GI/GU.
   
   E. **Lab Practice Log:** 2 hours of lab practice per week with evidence of 10 hours at midterm evaluation and additional 10 hours at final clinical evaluation.
   
   F. **The Nursing Process Paper:** is comprehensive evidence regarding student progress toward meeting course objectives. The Nursing Process Paper serves as the culmination of the semester’s work in the clinical setting; The NPP is basis for discussion and evidence of a student’s ability to understand the Nursing Process. A satisfactory score is evidence a student can demonstrate the Nursing Process proficiently. And unsatisfactory score may result in unsuccessful completion of the course. The final score of the completed NPP will be distributed in the assignment grade of NRS233.
   
   G. **Group Teaching Project:** Group process will be analyzed as students prepare an age appropriate teaching project for the preschool/elementary school-age students. Evidence of group process, incorporation of learning theories, and evidence of learning will be evaluated; Points will be distributed in the assignment grade of NRS233.
The weekly clinical assignments are due before the start of the student’s clinical day every week. The grade will be S or U based on the student’s ability to demonstrate critical thinking, analysis, and general knowledge throughout the assignment. If a student receives unsatisfactory grades on their written work they need to meet with the faculty and design and implement a learning contract for success in the course. Weekly observation of student, reflection of decision making, physical assessments, and care plans will determine student’s progress in the course.

**Written Assignments:** All written work is to be **Word Processed using Microsoft Word** and must evidence student’s ability to follow both verbal and written instructions. Students can acquire Microsoft Word through the university ITS. Points will be deducted for failure to follow directions. Written work must reflect the level of professionalism expected of a sophomore college student. Points will be deducted for errors including but not limited to spelling, syntactical, and inappropriate use of abbreviations. It is an expectation that students edit their own work. **All written work will be submitted in accurate APA format,** failure to do so will result in a deduction of points. Refer to Carroll University Academic Integrity Policy; plagiarism can result in failure of the course.

**C. Laboratory Modules:**

Laboratory days are designed to simulate clinical decision making and nursing skills. Laboratory days typically include four modules, allowing for hands on practice of nursing skills. Students are expected to be prepared by watching ATI assigned videos prior to lab and to be engaged in all learning activities. Simulation experiences are a large component of laboratory learning modules.

1. **ATI:** [atitesting.com](http://atitesting.com)

Assessment Technologies Institute (ATI) is a tool for you. ATI can assist you in increasing your nursing knowledge and in your skill development. ATI skills modules will be assigned for several of the lab competencies. This will include a pretest, videos, reading and ATI coursework, and a post test. Any skills modules that are assigned related to an ATI review must be reviewed before coming to the associated lab. **The pretest on ATI must be completed, printed, and brought to lab that day.** The student will not be eligible for lab participation points for that day without the completed pretest. For any **ATI skills modules associated with a skills check off the post-test must be completed, printed, and brought to the instructor/peer mentor in order to be eligible to check off. You must receive a 90% or better on your post-test in order to check off the NRS234 required skills.** See your syllabus calendar for these assignments and due dates.

2. **Skills competency:**

**Skill Practice Procedure:**

- All students are expected to log a total of 20 hours of practice time in the lab per semester. At least Two hours per week are to be documented to equal ten hours before fall break/ midterm and ten additional hours [at 2 hours per week minimum] between midterm and EXPO. If students do not complete the 20 total hours, they are not eligible to take the final competency EXPO and will be unsuccessful in NRS234. Practice begins the first week of lab. BSN practice sessions, which begin with clinical weeks, will count toward hours of practice.

- Log sheets will be kept in the student’s personal competency binder. Jill Switalski, lab manager, a BSN lab assistant, or Peer Mentor-Evaluator [PME] must initial that you were in lab practicing during the time you are signed in. Please extend professional courtesy and do not interrupt a testing session to have the log signed. Student workers and Administrative assistant [RayAnn] are not eligible to sign your log.

- Misrepresentation of practice hours is a violation of the Carroll University Academic Integrity Policy. Violations of the Carroll University Academic Integrity Policy will result in a sanction as listed in the policy including the possibility of failing NRS234.

- You are not allowed to practice in the lab if there is a class in session in the lab.
3. Skill Check off Procedure:

1. Make an appointment for skill check-off with an evaluator in the lab. The signup sheet is on the table in the lab. Be sure to sign up well in advance and allow for need to remediate the skill evaluation as needed. **Bring the Skill Check Off form and the post-test to your appointment.**

2. All skills in NRS234 are related to an ATI skills module. **You must take the post test, print it, and bring it to your check off in order to be eligible to be evaluated.** You must earn a 90% or better on your post-test in order to be eligible to check off. It is the student’s responsibility to maintain a binder of evidence of all post tests and skill check off forms.

3. Skill check-off is NOT practice time. Come prepared to test. The evaluator will not direct you. If you are unprepared the PME has been instructed to ask you to remediate. Be professional and do not take offense to the evaluation. If you are unprepared now, you will not be successful at EXPO.

4. If you do not show up at the time of your scheduled appointment, there is no guarantee that the evaluator will be able to complete the competency check off. You may need to reschedule.

5. **Professionalism counts:** If you are a ‘no show’ for 2 sessions, you are at risk for being unsuccessful in NRS234.

4. Skill Remediation Procedure:

- If you are unsuccessful in a skill competency check off, you need to practice and reschedule the skill check off.
- Schedule the retest no sooner than 24 hours from your first attempt. You must sign up for a retest appointment.
- If you fail a second time, you will need to make an appointment with your clinical instructor and develop a learning contract plan for success in NRS234.

D. Mid and Final Semester Evaluation:

Students will complete a written self-evaluation at midterm based on the course objectives. Individual conferences will be conducted to discuss student achievement of course objectives at midterm and end of semester with your clinical faculty. Learning contracts will be initiated by clinical faculty for any students unsuccessful at midterm. Follow course calendar to plan for appointments.

E. End of semester Skills EXPO performance:

At the end of the semester, students will demonstrate skill safety and competency at EXPO. Students will be provided with a list of potential skills to be evaluated. Skill demonstration is scenario based and may include more than one skill or procedure. This evaluation is based on QSEN and the standard of safety in practice. Students will have 30 minutes to complete assigned nursing interventions. The 20 hours of lab practice time and skill competency check-offs during the semester are designed to facilitate student success at skill expo.

**Success at skill EXPO is a Course Benchmark.** If a student is unsuccessful at their first attempt, they will remediate on the Tuesday following EXPO week in the nursing skill laboratory. Time is to be arranged by course instructor. Two faculty evaluators will observe the student’s second skill EXPO scenario. If a student is unsuccessful in their second skill EXPO demonstration they will be unsuccessful in the course.

F. Medication Calculation and Abbreviation Proficiency:
Medication calculations and abbreviation competency is a benchmark for NRS234. Students in all clinical practicum courses across the Carroll University Nursing Program are required to demonstrate competency in medication calculations. Opportunities for developing competency in medication calculation are provided through The Student Mentor-Evaluator Program (PMEs), Nursing Math tutors in the Learning Commons, and required Math Calculation Workbook. It is an expectation that all students are self-directed in promoting their learning and, if necessary, students will engage in every opportunity provided to insure their success in meeting this Course Benchmark. The benchmark for the sophomore level is medication calculations and abbreviation competency with a passing score of 90% correct. In the event a student is unsuccessful at the first testing, there is one opportunity for remediation and retesting to meet the benchmark. Failure to achieve this benchmark on the second attempt will result in course failure. [See Nursing Department policy on Medication Math Mania and Abbreviations Policy and Procedures. See course calendar for the dates for math competency remediation).

Student Expectations

Faculty Policies:

1. Attendance is mandatory for all clinical and laboratory sessions.
   - Students who do not attend lab or clinical orientation can be academically withdrawn from the course by the Chair of the Undergraduate Nursing Program.
   - Absence(s) must be approved prior to a missed session. Absence(s) may result in the forfeit of an alternative experience, an extra project (and/or presentation), and/or a make-up clinical day at the students expense (time and financial).
   - Lab is held Tuesdays or Thursdays from 0700 am until 1150 am, in the Henke Nursing Center. Clinical and EXPO take place at 0600-1150.
   - One unexcused absence or lab dismissal automatically will result in a clinical learning contract.
   - A second unexcused absence or lab dismissal will result in failure of the course.
   - Absence for more than two clinical/lab experiences may result in failure of the course.

2. Students are expected to apply the concepts learned through concurrent corollary didactic course.

3. All required course textbooks are essential to be successful in the course.

4. Cell phones are not permitted in lab or at clinical. Students found using their cell phone during their clinical or lab times may be asked to leave and/or will be graded as unsuccessful for the day.

5. Professional behavior is expected at all times. Students displaying unprofessional behavior will be dismissed for the clinical day with an unsatisfactory evaluation.

6. Students will be held accountable for being on time and meeting all designated deadlines. Appropriate assignment of additional work will be given to compensate for learning lost through delayed student responses.

7. Students must prepare and be knowledgeable about the lab modules and assigned client care, medications, treatments, and pathophysiology prior to providing care. Students who are unprepared will be asked to leave the clinical setting.

Late assignments:

Submission of all required student work by due date is an expectation of this course. Extensions will be granted only in extenuating circumstances and must be negotiated with instructor prior to due date. Inability to communicate clearly, and in a timely fashion regarding anticipated difficulty meeting deadlines is evidence that the student lacks the attitude and skill necessary to think critically and to assume professional accountability as required by course objectives. Failure to follow directions on any given assignment will result in a deduction of points; a minimum of a 10% deduction. Students will have one attempt to successfully complete written assignments. No assignments may be corrected or
redone for points. Late completion of online and ATI modules will result in 0 points; however are required to still be completed. Student will be unsuccessful in NRS233 and/or NRS 234 if assignments are not completed.

**Unsuccessful Student Progress:**

Students who are unsuccessful at mid-term (or any other point in semester per faculty determination) will be required to collaborate with faculty to develop a student learning contract as a means to plan learning strategies that can promote and support student success. Learning activities, objectives, explicit measures and due dates will be identified and documented on the student learning contract. Students must successfully complete their learning contract in order to successfully complete the course. **Documentation** of learning contract requirements is the student’s responsibility to maintain and present upon faculty request. Learning contract documentation is to be recorded on a log, which the student is responsible to obtain signatures from BSN, tutor, etc., to evidence tasks were completed.

**Dress**

1. Students are expected to wear their clinical uniform to all scheduled lab, EXPO, and clinical days. Uniform is not required for BSN practice sessions or PME skill check offs.
2. Uniform is clean, pressed, and lint free. Shoes are made of solid material [no mesh] and are clean and white.
3. Only white shirts may be worn under the uniform.
4. Uniform pants may not touch the floor.
5. Cover all tattoos.
6. Remove all facial rings/studs. You may wear one pair of small earrings.
7. Keep finger nails short and clean. No fake nails. Nail polish is to be clear or pale pink only.
8. Hair is to be neat and pulled back and out of your face; use hair bands, bobby pins and hairspray to prevent falling hair.
9. Engagement and/or wedding ring only.
10. Remove bracelets and arm bands; these are an infection control hazard!
11. Watches with a second hand are recommended.
12. Pocket size hand sanitizer is recommended at clinical sites.

**Lab Etiquette:**

The nursing lab is a sophisticated lab which provides all Carroll University Nursing students along with other Health Science students’ opportunities for skill development in their profession through teaching, demonstration, practice, simulation and testing. Carroll University strives to maintain lab equipment that is the most current, technologically advanced and similar to equipment utilized by our clinical rotation sites.

1. No Food or Drinking in the practice or computer labs.
2. All equipment is to be picked up and properly stored after you are done using it.
3. Used sharps must be placed in an appropriate sharps container.
4. Garbage is to be thrown out.
5. Dirty laundry is to be placed in the appropriate dirty laundry container.
6. Mannequins are to be treated with respect and care.
7. All computers and electrical equipment must be turned off when you are done using it.
8. Otoscopes and ophthalmoscopes must be turned off and put away when you are done using them.
9. Wash hands prior to touching any equipment and/or mannequin.
10. If you are unsure on how to use equipment – ASK.
11. If there is any equipment malfunction or breakage, notify the lab coordinator or a BSN immediately.
12. Quiet is to be observed when a demonstration or teaching session is occurring.
13. Do not enter the lab when a class is in session. – Classes are posted outside the lab door.
14. During practice times, respect fellow students.
15. If you do not comply with the above or you behavior is disruptive, you will be asked to leave the lab. If you are therefore unable to fulfill your requirements for your course, you are in danger of failing the course.

16. The lab should be left in the same or better condition than when you began using it for the day.

Scenarios/Simulations:
Scenarios/Simulations are opportunities for you the student to demonstrate high quality, professional patient care. This involves talking to your mannequin or patient-student as if they are your real patient. This does not involve ignoring the patient. There may also be times when you need to verbalize steps, pertinent negatives, assessments, etc to your evaluator. You will have needed to practice in the lab prior to these simulation experiences.

Carroll University Nursing Program Standards of Professional Conduct of the Student:

Professional Conduct of the Student:
The student:
1. Attendance – Attends all required classroom, clinical, nursing program, and university activities.
2. Attentiveness – Demonstrates alertness, attentiveness, and active participation in all required classroom, clinical, nursing program and university activities.
3. Authority – Demonstrates respect for all those placed in authority.
4. Communication – Demonstrates effective communication in all written, verbal, and nonverbal communication with patients, families, professional colleagues, faculty, administrators, and peers.
5. Cooperation – Demonstrates the ability to effectively collaborate with others, giving and accepting freely the exchange of information and constructive criticism.
6. Demeanor – Demonstrates a positive, open attitude towards peers, teachers, and others during the course of study; maintains a professional and respectful manner in interpersonal relations; functions in a supportive, constructive, and responsive manner, in all situations.
7. Ethics – Conducts self in compliance with the ANA Code of Ethics.
8. Inquisitiveness – Demonstrates the spirit of inquiry.
9. Judgment – Engages in decision-making that reflects the integration of personal, professional and academic conduct.
10. Maturity – Functions as a responsible, ethical, law-abiding adult.
11. Personal Appearance – Demonstrates personal hygiene and dress that reflects the standards expected of a professional nurse.
12. Professional Role – Conducts self as a professional role model in compliance with ANA Standards of Practice and the Wisconsin State Board of Nursing Rules and Regulations.
13. Responsibility – Demonstrates accountability for knowing, following, and meeting expectations in classroom, laboratory, and clinical settings; nursing school performance is the primary commitment.
15. Timeliness – Demonstrates accountability in meeting professional and academic deadlines; arrives and is prepared to participate at the start of scheduled course, laboratory, and clinical times.

Professional Accountability:
Certain nursing courses within the Carroll University Nursing Program require additional classroom time outside of the scheduled hours. It is the responsibility of the student to work with the Nursing Faculty if there is a scheduling conflict with other courses. *Do not assume* you can skip another course for a nursing course.

**Email etiquette:**

As the Carroll University environment is considered a professional setting, any email correspondence between you and the professor must be written in a professional manner. More specifically, your emails should be: composed clearly and articulately; use formal, professional language; include relevant subject heading and what class you are in (e.g., Question about Project for NRS 320); and use proper spelling, grammar, and punctuation *Emails that do not meet these standards may not receive a response.*

In general, email will be answered during standard business hours: 9am-5pm Monday through Friday. *Do not assume* that emails sent outside of those hours, or on weekends, will be returned until the resumption of standard business hours.

**Safety in clinical practice statement and plan:**

Safety in practice is basic to the delivery of nursing care. Therefore, to pass this course a student must consistently demonstrate safe practice. *If in the professional opinion of the professor, a student's performance in the clinical area is unsafe or indicates poor judgment, the student will not pass the course, regardless of the level of achievement in other areas being evaluated.*

The nursing professors of Carroll University recognize that student learning in the clinical setting is a dynamic process that requires commitment on the part of students and instructors. At all levels of clinical practice from novice to expert, professional nursing practice reflects developing analytical and problem-solving skills; application of antecedent and developing nursing knowledge; and increasing opportunities for practice. Concurrently, we recognize that the concept of non-malfeasance, "the duty to do no harm," is an ethical standard integral to professional nursing practice. In keeping with our commitment to support and promote professional nursing practice we have developed the following policy for response to nursing-student failure to protect patient safety in the clinical setting:

**First offense:**

If a student demonstrates unsafe practice in the clinical setting, she or he may have one or more of the following consequences upon the discretion of the clinical instructor:

1. The student may be instructed to leave the clinical setting immediately and to schedule a meeting with the professor to develop a specific plan for evidencing course outcomes. The student will not be allowed to return to clinical until the plan is established, documented and agreed upon by both the professor and the student. Primarily, the plan will entail skills remediation in the nursing lab on campus. Time missed from clinical must be made-up per program policy.

2. The student may be instructed to write a professional journal reflecting on the unsafe practice cited. The journal should demonstrate critical thinking, accurate self-assessment and corrective actions to be taken by the student that will prevent future unsafe nursing practice.

3. The student may be required to conduct a review of the literature (ROL) on a topic of the professor's choice. The student will then demonstrate increased nursing knowledge through a written paper. The paper should evidence synthesis of nursing knowledge acquired through their ROL and integration of professional nursing ethics including non-malfeasance.
4. If the student denies the citation of unsafe practice, and presents a supporting argument, at the discretion of the level clinical coordinator, the student may be offered one opportunity to be observed in the clinical setting by a second Carroll University professor. After observation, this professor will formally document her or his observations and make professional recommendations regarding the student's progression in the nursing curriculum. Recommendation that the student be dismissed from the nursing program is one possible outcome.

5. If as a result of unsafe student-nursing practice any patient is emotionally or physically harmed to a degree that the patient requires increased observation, related medical treatment and/or the patient experiences temporary or permanent disability, the student will be dismissed from the nursing program. If as a result of unsafe student-nursing practice any patient experiences injury that is temporary, permanent or fatal, the student may be dismissed from the nursing program.

Second offense:

If a student demonstrates unsafe practice in the clinical setting for a second time in any given semester, any of the consequences of a first offense may be imposed for a second offense, and at the discretion of the professor, the student may not be allowed to return to clinical and will not pass the course.

Modifications to the syllabus:

The instructor and the University reserve the right to modify, amend, or change the syllabus (schedule, course requirements, grading policy, etc.) as the curriculum and/or program require(s).

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<td>31</td>
</tr>
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<td>32</td>
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<td>33</td>
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<td>Clinical Assignments:</td>
<td></td>
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<td>-Weekly Client IPOC Rubric</td>
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<tr>
<td>-Nursing Process Paper [NPP]</td>
<td>40</td>
</tr>
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<td>46</td>
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<td>58-65</td>
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<td>Lab Week 1</td>
<td>66</td>
</tr>
<tr>
<td>Lab Week 2</td>
<td>71</td>
</tr>
<tr>
<td>Lab Week 3</td>
<td>81</td>
</tr>
<tr>
<td>Lab Week 4</td>
<td>82</td>
</tr>
</tbody>
</table>
NRS234 Skills Practice Log

2- hours minimum required per week.

**Required:** Evidence of 10 hours minimum at midterm evaluation & 10 hours minimum between midterm and final evaluation.

Present log to clinical instructor at Midterm and Final Evaluations

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time In</th>
<th>Time Out</th>
<th>Skills Practiced</th>
<th>Peer/Mentor Lab Assistant Signature</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
NRS 234 ATI Skill Check Offs

Each skill is 30 minute check off.

*Student is responsible to bring all post tests to skill lab check offs with 78% or better score. PME or BSN will return check off to student. It is the student’s responsibility to maintain a binder of all skill checked off.*

**Week #4: all BSN check offs =**

--- Focused Assessments: Successful completion by all NRS234 students with a partner [check off only with BSN]

**In lab class week #4:**

--- #1 ATI Skills Competency Check-off with BSNs during lab:

--- Ambulation with gait belt, walker, crutches, cane; and transferring with a gait belt AND bathing- complete bed bath

--- **Begin PME check offs**

--- #2 ATI Skills Competency Check-off with Peer Mentor in lab:

--- Medication Administration part 1: injections (subcut, IM, ID), Mixing medications using one syringe (insulin)

--- **Lab skill due**

--- #3 ATI Skills Competency Check-off with Peer Mentor in lab:

--- Medication Administration part 2: rectal, oral ophthalmic and otic gtts, transdermal patch, nasal spray.

--- **Lab skill due**

--- #4 ATI Skills Competency Check-off with Peer/Mentor in lab:

--- Wound Care. Dry dressing change with wound cleansing. Obtaining a wound specimen

--- **AND** Oxygen administration- nasal cannula, simple face mask, NRB mask; Oral and nasal Suctioning AND

--- **Lab skill due**

--- #5 ATI Skills Competency Check-off with Peer/Mentor in lab:

--- Blood Glucose Testing; Administering IV medication using IV push; Discontinuing IV

--- **Lab skill due**

--- #6 ATI Skills Competency Check-off, with Peer/Mentor in lab:

--- Sterile gloving; Urinary catheter insertion; use of bedpan and urinal; clean catch urine specimen; indwelling catheter care, Urine specimen collection from Foley catheter
Carroll University Nursing Program  
NRS 234 Student Contract

Read and initial each of the following. Then sign and date below:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand that my primary job is nursing student.</td>
<td></td>
</tr>
<tr>
<td>I have read the course syllabus and I understand that it is my responsibility to follow the information provided in the course syllabus; including all assignment rubrics.</td>
<td></td>
</tr>
<tr>
<td>I understand that the course objectives set the standards in this course and that I am responsible for reviewing the objectives and monitoring my own learning.</td>
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</tr>
<tr>
<td>I understand that I am responsible to develop the ability to assess my own work, using the objectives provided for the course.</td>
<td></td>
</tr>
<tr>
<td>I understand that I will be documenting patient care according to criteria provided in class and in the clinical agency, on my assigned patients.</td>
<td></td>
</tr>
<tr>
<td>I understand that I am to use the lab time to practice and improve my abilities in nursing care skills.</td>
<td></td>
</tr>
<tr>
<td>I understand this course requires continued practice of the skills that are presented; it is my responsibility to schedule practice time in the lab per course requirements. I understand that it is my responsibility to be well-practiced and thus fully prepared to demonstrate competency of clinical skills prior to attempting to do so before an evaluator in the clinical lab.</td>
<td></td>
</tr>
<tr>
<td>I understand that, if at any time, I am unsure of my abilities to achieve the objectives for this course, I may request an assessment from my faculty instructor.</td>
<td></td>
</tr>
<tr>
<td>I understand that the work of the course requires consistent classroom attendance and active clinical participation.</td>
<td></td>
</tr>
<tr>
<td>I understand that the grades I receive on exams and learning activities in the classroom, clinical lab and clinical practicum are my responsibility.</td>
<td></td>
</tr>
<tr>
<td>I understand that for the final clinical grade the professor will consider all of my clinical work and match my work as a whole against the criteria provided in clinical evaluation forms which are driven by the course objectives.</td>
<td></td>
</tr>
<tr>
<td>I understand that I am held to professional standards of behavior. Therefore, I understand that unprofessional conduct on my part, which is recognized by patients, families, agency staff and/or faculty, will result in consequences up to and including dismissal from the nursing program. This includes the use of personal electronic devices during class time, clinical time, or laboratory time, unless directed by faculty.</td>
<td></td>
</tr>
<tr>
<td>I understand publishing, duplicating, and disseminating course materials on websites is considered academic dishonesty.</td>
<td></td>
</tr>
</tbody>
</table>

Student signature: ___________________________ Date: __________
Carroll University

N234 Foundations of Nursing-Practicum

Mid-term Student Self-Assessment of Progression toward Achievement of NRS234 Course Objectives

Complete the following self-assessment of your progress toward meeting the following course objectives and submit on the due date per course the calendar. Your mid-term self-assessment will be reviewed by NRS234 faculty. Your ability to accurately self-assess your performance and to document evidence to support your assertions will be graded as an S or U. Faculty are looking for evidence that your critical thinking skills are developing at a level expected of a foundational level nursing student at mid-term. If you receive a U on this assignment, you will be required to redo it.

Date________________  Student_______________________________
Instructor______________________ Agency__________________________

Use the KEY below to rate your progress toward achieving course objectives, then document evidence to support your conclusions. Since the majority of NRS234 clinical time has been spent on campus so far this semester, you are reminded that the clinical laboratory provides a simulated clinical setting. Consider your interactions with faculty, staff and peers (the health care team), and your engagement in the presented patient scenarios, simulations, case-studies etc. when evaluating your progress.

KEY:
S= “Satisfactory” course progress. Student has met this course objective
PM= Student has “partially met” this course objective and is progressing satisfactorily at mid-term
U= Unsatisfactory course. Student has demonstrated no or very little progress toward achieving this course objective.
N/O= No opportunity

Critical Thinking: QSEN= Safety

1. Applies concepts from the arts and sciences when examining the impact of all elements of the environment on an individual’s functioning

2. Demonstrates self-direction in time and task management to prepare for and effectively participate in clinical skills labs and to deliver safe, quality, patient-centered care in the clinical setting

Communication: QSEN= Patient-Centered Care & Informatics

3. Implements communication strategies that promote and support the development of effective inter/intra-professional teams and therapeutic relationships.

4. Approaches clients and families in an empathetic manner.
5. Uses the language of the nursing discipline to report and document patient data in an accurate, concise, pertinent, and timely manner.

6. Integrates knowledge gained from liberal studies, nursing theory, client history, clinical findings, and pathophysiological concepts to plan and deliver patient care that is evidence-based and reflective of inter-professional and patient perspectives.

7. Develops and implements patient plans of care which are consistent with the *Carroll University Criteria for Care Planning* (use grid below).

**Nursing Process per *Carroll University Nursing Criteria for Care Planning*:**

<table>
<thead>
<tr>
<th>Performance Objectives</th>
<th>S</th>
<th>P/M</th>
<th>U</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment:</strong> demonstrates a systematic assessment of pertinent objective and subjective behaviors as evidenced by (AEB):</td>
<td></td>
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<tr>
<td>1. Student collection and documentation of patient data in that reflect effective skill levels of patient interviewing and physical examination skills for foundations level of study. Patient data is accurate and demonstrates an appropriate level of completeness</td>
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<tr>
<td>2. Student accurately and completely documents weekly assessments and nurse’s notes in clear, nursing language</td>
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<tr>
<td>3. Student selects, clusters and documents patient data effectively. Data cluster provides evidence to support area of focus for nursing intervention</td>
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<tr>
<td><strong>Analysis/Diagnosis:</strong> uses the collected assessment data to provide an accurate list of patient problems. The student differentiates nursing diagnosis from other clinical/collaborative problems. When the problem is diagnosed as a nursing problem, the student states it in NANDA format AEB and follows guidelines:</td>
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<tr>
<td>1. Student formulates nursing diagnoses that reflect patient problems and etiology of problems</td>
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<tr>
<td>2. Student shows judgment in prioritizing patient problems</td>
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<tr>
<td>3. Student demonstrates critical thinking in identifying problem etiology (causative factors)</td>
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<tr>
<td>4. Nursing diagnoses reflect NANDA format</td>
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<tr>
<td>5. <strong>Nursing diagnoses are documented in one of the following formats:</strong></td>
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<tr>
<td>Two-part diagnosis for RISK problems (problem r/t etiology):</td>
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<tr>
<td>Three-part diagnosis for ACTUAL problems (problem r/t etiology AEB signs &amp; symptoms):</td>
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<tr>
<td><strong>Planning/Setting Goals or Outcomes:</strong> devises statements of the intended, or realistically expected goal/outcomes to resolve the patient’s problems AEB:</td>
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</tbody>
</table>
1. Student develops broad, overriding goal statements that directly reflect the *problem component* of nursing diagnoses.

2. The goal statement must:
   - Begin with, "The patient will…"
   - Be realistic
   - Be time-oriented
   - End with, “as evidenced by…” which is followed by a list of specific desired outcomes

3. Student identifies desired outcomes that reflect specific, observable & measurable client responses that can be used to evaluate goal achievement.

**Interventions**: designs individualized activities to solve the identified problems. *Nursing interventions are written in a comprehensive fashion that demonstrates an appropriate amount of planning AEB*:

1. The student develops a minimum of 10 nursing interventions supported by rationale for each nursing diagnosis.
2. Student develops nursing interventions that are specific to patient (realistic for patient in the context of his or her psycho/social, physiological and external environments).
3. Student develops nursing interventions that are explicit: What, *exactly* is to be done?
   - By whom will it be done?
   - When will it be done?
   - How often will it be done?
   - How far…? (i.e. ambulation) etc.

**Rationale**: exhibits knowledge of the scientific principles underlying nursing actions by citing rationale for each of the planned interventions AEB:

1. Student supports each nursing intervention with rationale found in professional nursing literature (scholarly sources only: nursing textbooks, nursing journals, etc.)
2. Student demonstrates spirit of professional inquiry through documentation of interventions and rationales gathered from multiple scholarly sources.

**Evaluation**: analyzes the effectiveness of nursing interventions through evaluation of goal achievement within the prescribed time frame AEB:

1. Evaluation statements consist of two parts: a conclusion and supporting data.
2. Student documents conclusion that identifies if the patient goal was “met,” “partially met,” or “not met.”
3. The student provides evidence to support her/his conclusion regarding goal achievement by documenting client responses.
e. Demonstrates an organized ability to perform selected psychomotor skills in a safe, efficient and compassionate manner in the long-term care environment.

**Research: QSEN=Evidenced Based Practice**

f. Demonstrates an entry-level ability to evaluate the credibility of evidence.

**Valuing/Culture: QSEN=Patient-Centered care**

g. Consistently demonstrates respect for the uniqueness of individuals in the clinical setting.

h. Implements patient care that appeals to the values held by the client.

**Leadership: QSEN= Quality Improvement**

i. Demonstrate awareness of complex organizational systems and a basic understanding of organizational structure, mission, vision, philosophy and values.

j. Begin to apply leadership concepts, skills and decision making in the provision and delegation of quality patient care

k. Recognizes his or her own strengths/limitations and seeks assistance from the appropriate persons when indicated

   1. Is self-directed in reporting client data to a designated health team member before leaving the clinical area

l. Identifies Quality Improvement initiative in the professional setting.
Professional Socialization: QSEN=Teamwork and Collaboration

m. Identifies and begin to assume the legal/ethical responsibilities and accountabilities of the professional nurse in the nursing laboratory and clinical setting.

n. Demonstrates clinical practice that reflects a beginning understanding of the roles and relationships of and among members of the multi-disciplinary team.

o. Demonstrates an understanding of the dynamic nature of small group behavior and applies leadership concepts and skills including communication, team-building, negotiation and conflict management in the development and delivery of a community teaching project.

p. Upholds the Carroll University Standards of Professional Conduct in the clinical setting:

Carroll University Nursing Program Standards of Professional Conduct

<table>
<thead>
<tr>
<th>Performance Objectives</th>
<th>The student meets the following:</th>
<th>S</th>
<th>PM</th>
<th>U</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attendance</td>
<td>Attends all scheduled clinical, laboratory and classroom sessions.</td>
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<tr>
<td>2. Attentiveness</td>
<td>Demonstrates alertness, attentiveness, and active participation in all required classroom, clinical, nursing program and university activities.</td>
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<tr>
<td>3. Authority</td>
<td>Demonstrates respect for all those placed in authority.</td>
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<tr>
<td>4. Communication</td>
<td>Demonstrates effective communication in all written, verbal, and nonverbal communication with patients, families, professional colleagues, faculty, administrators, and peers.</td>
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<tr>
<td>5. Cooperation</td>
<td>Demonstrates the ability to effectively collaborate with others, giving and accepting freely the exchange of information and constructive criticism.</td>
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<tr>
<td>6. Demeanor</td>
<td>Demonstrates a positive, open attitude towards peers, teachers, and others during the course of study; maintains a professional and respectful manner in interpersonal relations; functions in a supportive, constructive, and responsive manner, in all situations.</td>
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</table>
7. **Ethics** – Conducts self in compliance with the ANA Code of Ethics.

8. **Inquisitiveness** – Demonstrates the spirit of inquiry.

9. **Judgment** – Engages in decision-making that reflects the integration of personal, professional and academic conduct.

10. **Timeliness** – Demonstrates accountability in meeting professional and academic deadlines; arrives and is prepared to participate at the start of scheduled course, laboratory, and clinical times.

11. **Moral Standards** – Respects the rights and privacy of other individuals and does not violate the laws of our society.

12. **Personal Appearance** – Demonstrates personal hygiene and dress that reflects the standards expected of a professional nurse.

13. **Professional Role** – Conducts self as a professional role model in compliance with ANA Standards of Practice and the Wisconsin State Board of Nursing Rules and Regulations.

14. **Responsibility** – Demonstrates accountability for knowing, following, and meeting expectations in classroom, laboratory, and clinical settings; nursing school performance is the primary commitment.

15. **Safety** – Demonstrates and maintains safety in practice during the delivery of nursing care.

Summary comments:

Student Signature: __________________________________________

Faculty Signature:____________________________________________

*Bring your completed copy to your Midterm Clinical evaluation*
Carroll University Nursing Program
NRS234 Clinical Practicum: Student Evaluation by Faculty at
Mid-clinical Practicum And Final Practicum

Student: _________________________   Clinical Site: ____________________________  
Clinical Faculty________________________ Semester:___________________________

KEY:
S= “Satisfactory” course progress. Student has met this course objective
PM= Student has “partially met” this course objective and is progressing satisfactorily at mid-term
U=Unsatisfactory course. Student has demonstrated no or very little progress toward achieving this course objective.
N/O=No opportunity

CRITICAL THINKING: QSEN=Safety, Patient-Centered Care & Evidence-Based Practice [EBP]
Course Objectives 1, 2, & 6

<table>
<thead>
<tr>
<th>Performance Objectives- The student:</th>
<th>S</th>
<th>PM</th>
<th>U</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Applies concepts from the arts and sciences when examining the impact of all elements of the environment on an individual’s functioning</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Demonstrates self-direction in time and task management to prepare for and effectively participate in clinical skills labs and to deliver safe, quality, patient-centered care in the clinical setting.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6. Integrates knowledge gained from liberal studies, nursing theory, client history, clinical findings, and pathophysiological concepts to plan and deliver patient care that is evidence-based and reflective of inter-professional and patient perspectives</td>
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</tbody>
</table>

COMMUNICATION QSEN=Safety, Patient-Centered Care & Informatics
Course Objectives: 3, 4, & 5

<table>
<thead>
<tr>
<th>Performance Objectives- The student:</th>
<th>S</th>
<th>PM</th>
<th>U</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implements communication strategies that promote and support the development of effective inter/intra-professional teams and therapeutic relationships.</td>
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<tr>
<td>2. Approaches clients and families in an empathetic manner.</td>
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</tbody>
</table>
3. Uses the language of the nursing discipline to report and document patient data in an accurate, concise, pertinent, and timely manner

**NURSING PROCESS: QSEN=Patient-Centered Care & Safety**
Successful demonstration of each component of the nursing process must be evident to be successful in the course.

Course Objectives: 7 & 8

<table>
<thead>
<tr>
<th>Performance Objectives- The student:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develops and implements patient plans of care which are consistent with the Carroll University Criteria for Care Planning (below)</strong></td>
</tr>
<tr>
<td><strong>Assessment:</strong> demonstrates systematic assessment of pertinent objective and subjective behaviors through the collection of a health history and the accomplishment of a physical examination as evidenced by (AEB):</td>
</tr>
<tr>
<td>4. Student collection and documentation of patient data that reflects the level of effectiveness in patient interviewing and physical examination skills for the foundations level of study. Patient data is accurate and demonstrates an appropriate level of completeness</td>
</tr>
<tr>
<td>5. Student accurately and completely documents weekly assessments and nurse’s notes in clear, nursing language</td>
</tr>
<tr>
<td>6. Student selects, clusters and documents patient data effectively. Data cluster provides evidence to support area of focus for nursing intervention</td>
</tr>
<tr>
<td><strong>Analysis/Diagnosis:</strong> uses the collected assessment data to provide an accurate list of patient problems. The student will differentiate nursing diagnosis from other clinical/collaborative problems. When the problem is diagnosed as a nursing problem, the student will state it in NANDA format AEB:</td>
</tr>
<tr>
<td>7. Student formulates nursing diagnoses that reflect patient problems and etiology of problems</td>
</tr>
<tr>
<td>8. Student shows judgment in prioritizing patient problems</td>
</tr>
<tr>
<td>9. Student demonstrates critical thinking in identifying problem etiology (causative factors)</td>
</tr>
</tbody>
</table>
10. Nursing diagnoses reflect NANDA format

11. Nursing diagnoses are documented in one of the following formats:
   - Two-part diagnosis for RISK problems (problem r/t etiology)
   - Three-part diagnosis for ACTUAL problems (problem r/t etiology AEB signs & symptoms)

| Planning/Setting Goals or Outcomes; devises statements of the intended, or realistically expected, intended goal/outcomes to resolve the patient’s problems AEB: |

| 12. Student develops broad, overriding goal statements that directly reflect the problem component of the nursing diagnoses |

<table>
<thead>
<tr>
<th>13. The goal statement must:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begin with, &quot;The patient will…&quot;</td>
</tr>
<tr>
<td>Be realistic</td>
</tr>
<tr>
<td>Be time-oriented</td>
</tr>
<tr>
<td>End with, &quot;as evidenced by…&quot; which is followed by a list of specific desired outcomes</td>
</tr>
</tbody>
</table>

| 14. Student identifies desired outcomes that reflect specific, observable & measurable client responses that can be used to evaluate goal achievement |

| 15. The student develops a minimum of 5 nursing interventions supported by rationale for each nursing diagnosis |

| 16. Student develops nursing interventions that are specific to the patient (realistic for patient in the context of his or her psycho/social, physiological and external environments) |

| 17. Student develops nursing interventions that are explicit: What, exactly is to be done? By whom will it be done? When will it be done? How often will it be done? How far…? (i.e. ambulation), etc. |
**Rationale:** exhibits knowledge of the scientific principles underlying nursing actions by documenting rationale for each of the planned interventions AEB:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>18.</td>
<td>Student supports each nursing intervention with rationale found in professional nursing literature (scholarly sources only: nursing textbooks, nursing journals, research, etc.)</td>
</tr>
<tr>
<td>19.</td>
<td>Student demonstrates spirit of professional inquiry through documentation of interventions and rationales gathered from multiple peer reviewed, scholarly sources</td>
</tr>
<tr>
<td>20.</td>
<td>Cites sources for all written nursing intervention rationales in APA format</td>
</tr>
</tbody>
</table>

**Evaluation:** Analyzes the effectiveness of nursing interventions through evaluation of goal achievement within the prescribed time frame AEB:

<table>
<thead>
<tr>
<th></th>
<th>PM</th>
<th>U</th>
<th>N/O</th>
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<tbody>
<tr>
<td>21.</td>
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<td>22.</td>
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<td>23.</td>
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<td>24.</td>
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</table>

**RESEARCH: QSEN=EBP**

Course Objective: 9

**Performance Objectives** - The student:

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<thead>
<tr>
<th></th>
<th>S</th>
<th>PM</th>
<th>U</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.</td>
<td>Demonstrates an entry-level ability to evaluate the credibility of evidence</td>
<td></td>
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</tbody>
</table>

**VALUING/CULTURE: QSEN=Patient-Centered Care**

Course Objectives: 10 & 11

**Performance Objectives** - The student:

<table>
<thead>
<tr>
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<th>U</th>
<th>N/O</th>
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<tbody>
<tr>
<td>26.</td>
<td>Consistently demonstrates respect for the uniqueness of individuals in the clinical setting</td>
<td></td>
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<tr>
<td>27.</td>
<td>Implements patient care that appeals to the values held by the client</td>
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</tbody>
</table>

**LEADERSHIP: QSEN=Quality Improvement & Safety**

Course Objectives: 12, 13 & 17

**Performance Objectives** - The student:
### Performance Objectives - The student:

<table>
<thead>
<tr>
<th></th>
<th>SPM</th>
<th>N/I</th>
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<th>N/O</th>
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<tbody>
<tr>
<td>30.</td>
<td>Identifies and begins to assume the legal/ethical responsibilities and accountabilities of the professional nurse in the nursing laboratory and clinical setting:</td>
<td></td>
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<tr>
<td>31.</td>
<td>100% Attendance for all clinical and laboratory activities</td>
<td></td>
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<tr>
<td>32.</td>
<td>Uses the time spent in clinical laboratory to meet the clinical objectives</td>
<td></td>
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<tr>
<td>33.</td>
<td>Demonstrates evidence of study and preparation to apply the concepts learned through past &amp; concurrent attendance in the corollary didactic course (NRS100, NRS230, NRS233, NRS236).</td>
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<tr>
<td>34.</td>
<td>Consistently meets all designated deadlines</td>
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<tr>
<td>35.</td>
<td>Evidences preparation and knowledge about the assigned client care, medications, treatments, and pathophysiology prior to providing care. Successfully completes Written Assignment #1- <em>Defining Medical Diagnoses</em></td>
<td></td>
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<tr>
<td>36.</td>
<td>All written work is processed (as directed) evidences student’s ability to follow both verbal and written instructions</td>
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<tr>
<td>37.</td>
<td>Written work reflects the level of professionalism expected of a sophomore nursing student. Prior to submission, student edits own written work for accuracy of spelling, syntax, and accurate and appropriate use of abbreviations.</td>
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<tr>
<td>38.</td>
<td>Submits an APA reference page for all written work where appropriate.</td>
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<tr>
<td>39.</td>
<td>Completes and submits documentation of minimum required hours of skills practice time completed in clinical laboratory on campus 10 hours at midterm/10 additional by final evaluation</td>
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<tr>
<td>40.</td>
<td>Writes weekly reflections and self-assessments of clinical performance which demonstrates critical thinking as defined by grading criteria using the rubric as a guide.</td>
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<tr>
<td>41.</td>
<td><strong>Course Benchmark</strong> - Demonstrates sophomore level skills competency of all clinical skills identified in course calendar in the clinical laboratory (sophomore level coordinator to document in student’s <em>Master Skills List</em>).</td>
<td></td>
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<tr>
<td>42.</td>
<td><strong>Course Benchmark</strong> - Skills EXPO: student successfully completes all skills simulations in Skills EXPO</td>
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</tbody>
</table>

**PROFESSIONAL SOCIALIZATION: QSEN=Teamwork and Collaboration, EBP, Patient-Centered Care**

Course Objectives: 14, 15 &16
43. Demonstrates clinical practice that reflects a beginning understanding of the roles and relationships of and among members of the multi-disciplinary team

* Student brings Master Skills List to Final Clinical Evaluation: Yes______ No_______

<table>
<thead>
<tr>
<th>Performance Objectives- The student:</th>
<th>S</th>
<th>PM</th>
<th>U</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>44. Upholds the Carroll University Standards of Professional Conduct in the clinical setting AEB:</td>
<td></td>
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<tr>
<td>Standards of Professional Conduct:</td>
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<tr>
<td>A. <strong>Attendance</strong> – Attends all required classroom, clinical, nursing program, and university activities.</td>
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<tr>
<td>B. <strong>Attentiveness</strong> – Demonstrates alertness, attentiveness, and active participation in all required classroom, clinical, nursing program and university activities.</td>
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<td>C. <strong>Authority</strong> – Demonstrates respect for all those placed in authority</td>
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<tr>
<td>D. <strong>Communication</strong> – Demonstrates effective communication in all written, verbal, and nonverbal communication with patients, families, professional colleagues, faculty, administrators, and peers.</td>
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<td>E. <strong>Cooperation</strong> – Demonstrates the ability to effectively collaborate with others, giving and accepting freely the exchange of information and constructive criticism.</td>
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<tr>
<td>F. <strong>Demeanor</strong> – Demonstrates a positive, open attitude towards peers, teachers, and others during the course of study; maintains a professional and respectful manner in interpersonal relations; functions in a supportive, constructive, and responsive manner, in all situations.</td>
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<tr>
<td>G. <strong>Ethics</strong> – Conducts self in compliance with the ANA Code of Ethics.</td>
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<tr>
<td>H. <strong>Inquisitiveness</strong> – Demonstrates the spirit of inquiry.</td>
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<tr>
<td>I. <strong>Judgment</strong> – Engages in decision-making that reflects the integration of personal, professional and academic conduct.</td>
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<tr>
<td>J. <strong>Maturity</strong> – Functions as a responsible, ethical, law-abiding adult.</td>
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<tr>
<td>K. <strong>Personal Appearance</strong> – Demonstrates personal hygiene and dress that reflects the standards expected of a professional nurse.</td>
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<tr>
<td>L. <strong>Professional Role</strong> – Conducts self as a professional role model in compliance with ANA Standards of Practice and the Wisconsin State Board of Nursing Rules and Regulations.</td>
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<tr>
<td>M. <strong>Responsibility</strong> – Demonstrates accountability for knowing, following, and meeting expectations in classroom, laboratory, and clinical settings; nursing school performance is the primary commitment.</td>
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<tr>
<td>N. <strong>Safety</strong> – Demonstrates and maintains safety in practice during the delivery of nursing care.</td>
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<tr>
<td>O. <strong>Timeliness</strong> – Demonstrates accountability in meeting professional and academic deadlines; arrives and is prepared to participate at the start of scheduled course, laboratory, and clinical times.</td>
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</tbody>
</table>

Faculty Comments:
**Midterm** or **Final Evaluation** [circle]:  Satisfactory_____  Unsatisfactory_____

Student Signature: ____________________________________________  Date:_________________________

Clinical Faculty Signature: ___________________________________
Weekly Clinical Grading Expectations:
NRS234 is a Satisfactory (S) or Unsatisfactory (U) course. Each student assignment is graded as an “S” or “U” according to the grading rubrics. A learning contract will be initiated upon the second “U” in any assignment or lab/performance. No exceptions. See student handbook for procedures related to a learning contract. Late assignments will be considered a “U” or be deducted 10% per day late. Any 3 unsatisfactory grades in an assignment and/or lab/clinical performance will result in a U for the course.

Examples of two “U” in the course:

1. Weekly clinical performance was marginal
2. Written work (reflection, care plan, client assessment & main assignment) add up to <78% for the week
3. Unprofessional behavior or no participation in lab

Weekly Clinical Reflection Topics: Evidence of Critical Thinking

- **Week 1:** Use rubric to demonstrate critical thinking, evidence of goal setting, and your efforts to meet the course objectives. Weekly expectation to incorporate EBP and scholarly resources into your reflections.
  
  - Identify your goal, based on course objectives, and identify ability to meet/ partially meet/not meet your goal.
  - How did the day go? Was it as you expected? What did you do to prep and how did that plan go or how did you have to change things to make it work?
  - Was it easy or hard to do physical assessments and vitals; why and why not? What will you change in your professional practice to make next week even better?
  - Did you do anything at clinical that impacted the quality of life for your client? What did you think about, and why, that could make it better for your client at the Long Term care facility?
  - Support your evidence with EBP [scholarly sources].

- **Week 2:** Elaborate on week 1. Add a Quality Improvement [QI] topic. Students are responsible to identify what Quality Improvement means in nursing and identify an idea based on observations from clinical week 1.
  “What did the student observe which could be improved for the quality of care and safe practice”
  2) The student will identify a Quality Improvement idea/topic which could improve Quality care or safety at their clinical setting.

- **Week 3:** Elaborate again on previous week topics and add scholarly evidence to support QI ideas. Using EBP, identify an actual practice change which is related to the QI topic you identified in week 2. What does the literature say about the topic you identified in Week 2? How you will change your practice or could change something at the facility to create Quality Improvement for clients and nurses.

- **Week 4 & 5, if needed:** Use rubric to demonstrate critical thinking, evidence of goal setting, and your efforts to meet the course objectives. Expectations include incorporating EBP and scholarly sources into your reflections.
**Weekly Clinical Reflection Grading Rubric:** See Calendar for weekly topic of Reflection

<table>
<thead>
<tr>
<th>Description of work</th>
<th>Resulting Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Written content is:</strong></td>
<td><strong>S=greater than 2.5 points of 4</strong></td>
</tr>
<tr>
<td>• 500 word minimum; 2 pages [0.25]</td>
<td>Satisfactory total score is 2.5 points or greater</td>
</tr>
<tr>
<td>• Is insightful and represents deep thought into <strong>nursing process</strong> [0.5]</td>
<td></td>
</tr>
<tr>
<td>• Reflects experience and feelings [0.5]</td>
<td></td>
</tr>
<tr>
<td>• Enhances self-exploration [0.25]</td>
<td></td>
</tr>
<tr>
<td>• Acknowledges identifying and meeting clinical course objectives [0.5]</td>
<td></td>
</tr>
<tr>
<td>• Make <strong>interdisciplinary connections</strong> [0.5]</td>
<td></td>
</tr>
<tr>
<td>• Answers <strong>weekly inquiries</strong> as directed [0.5]</td>
<td></td>
</tr>
<tr>
<td>• <strong>Formatted with APA.</strong> Written professionally with few grammar or spelling mistakes [0.5]</td>
<td></td>
</tr>
<tr>
<td>• Appropriate peer-reviewed reference included in <strong>APA format.</strong> [0.5]</td>
<td></td>
</tr>
<tr>
<td><strong>Points are subtracted for Written Content that is:</strong></td>
<td><strong>Unsatisfactory score is less than 2.5</strong></td>
</tr>
<tr>
<td>• Written poorly, with numerous mistakes or is unprofessional [-0.5]</td>
<td></td>
</tr>
<tr>
<td>• Is superficial and depicts events rather than nursing processes and experiences [-0.5]</td>
<td></td>
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<tr>
<td>• Provides no learning to self or meeting course objective [-0.5]</td>
<td></td>
</tr>
<tr>
<td>• Inappropriate APA or reference [-0.5]</td>
<td></td>
</tr>
<tr>
<td><strong>Written Content is:</strong></td>
<td><strong>(0) U</strong></td>
</tr>
<tr>
<td>• Not completed</td>
<td></td>
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<tr>
<td>• Not completed on time</td>
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</tbody>
</table>

Upload weekly assigned Clinical Reflections to ‘Courseworks’
### Weekly Clinical Performance Grading Criteria:

Name______________________________

<table>
<thead>
<tr>
<th>SCALE/LABEL</th>
<th>STANDARD PROCEDURE</th>
<th>Patient Care: PERFORMANCE QUALITY</th>
<th>ASSISTANCE REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPERVISED S</td>
<td>Safe Accurate</td>
<td>Efficient, coordinated, confident. Expedient use of time.</td>
<td>With occasional physical or verbal direction. Makes most care decisions based on current knowledge and practice.</td>
</tr>
<tr>
<td>ASSISTED U</td>
<td>Mostly safe and accurate</td>
<td>Partial demonstration of skills. Inefficient or uncoordinated. Delayed time expenditure. Unsafe in delivery of care- (3 occurrences=fail)</td>
<td>Frequent verbal and/or physical direction. Decisions not based on current knowledge and practice.</td>
</tr>
<tr>
<td>MARGINAL U</td>
<td>Questionable safe and questionable accurate</td>
<td>Unskilled and inefficient. Considerable and prolonged time expenditure. Unsafe in delivery of care- (3 occurrences=fail)</td>
<td>Continuous verbal and/or physical direction. Decisions not based on current knowledge and practice.</td>
</tr>
</tbody>
</table>

### Clinical Failing Behaviors

<table>
<thead>
<tr>
<th>Performance and decisions are unsafe. (Skill interventions unsafe, bed in high position, side rails down, call light out of reach)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments are inaccurate and not focused</td>
</tr>
<tr>
<td>Unable to correlate/discuss patient interventions and diagnostics</td>
</tr>
<tr>
<td>Technical skills and nursing interventions are unsafe</td>
</tr>
<tr>
<td>Breeches patient confidentiality</td>
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<tr>
<td>Student unable to function independently</td>
</tr>
<tr>
<td>Does not communicate significant patient events to health care team and/or instructor</td>
</tr>
<tr>
<td>10. Does not provide evidence of EBP in providing safe, effective patient care</td>
</tr>
<tr>
<td>12. Other</td>
</tr>
</tbody>
</table>

Give examples
Weekly Focused Client Assessment

Student will document a client assessment weekly. Upload assessment and Rubric to LMS. Follow rubric to complete a successful weekly client assessment.

Date: ___________________           Patient Initials: ___ _______       Age: ______

Vital Signs: _______T   _______P   _______R   _______BP
Pain Assessment: (use OLDCART, describe any non-verbal indicators)

Musculoskeletal and Safety: (Include: gait; use of assistive devices, transfer ability; detailed ROM and strength; MORSE scale, memory, recognize potential effects of medications, sensation/perception, etc.)

Focused-Respiratory Assessment: (Include: Inspection, palpation, percussion, auscultation: anterior/posterior)

Focused-Cardiovascular Assessment: (Include: Inspection, palpation, percussion, auscultation: central and peripheral vascular: anterior/posterior)

Integumentary Assessment: (Include: Braden scale, temperature, color, intact or breakdown areas, etc)

GI/GU/Nutrition: (Inspect, auscultation, percussion, palpation; diet, appetite)

Neurological (sensory, cognition, MMSE, orientation, LOC, speech, etc)

Psycho/social (Roles/Relationship, Value/Belief/Family considerations)

Sleep/rest

Other data: (Ears, nose throat; lymph nodes, hair, lab values, therapy, etc.)

Satisfactory______     Unsatisfactory______
### Weekly Client Assessment Rubric

<table>
<thead>
<tr>
<th>Category</th>
<th>Not addressed-0</th>
<th>Partially met-1-2 points</th>
<th>Complete-3</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Assessment</td>
<td></td>
<td></td>
<td></td>
<td>OLDCART completed</td>
</tr>
<tr>
<td>Musculoskeletal/Safety</td>
<td></td>
<td></td>
<td></td>
<td>Includes ROM &amp; strength, mobility ability, Refer to &amp; include MORSE scale, MMSE</td>
</tr>
<tr>
<td>Focused-Respiratory</td>
<td></td>
<td></td>
<td></td>
<td>inspection, percussion, palpation, auscultation</td>
</tr>
<tr>
<td>Focused-Cardiovascular</td>
<td></td>
<td></td>
<td></td>
<td>inspection, percussion, palpation, auscultation</td>
</tr>
<tr>
<td>Integumentary</td>
<td></td>
<td></td>
<td></td>
<td>Any breakdown, pressure areas, Refer to &amp; include Braden scale</td>
</tr>
<tr>
<td>GU/GI/ Nutrition</td>
<td></td>
<td></td>
<td></td>
<td>Inspection, auscultation, percussion, palpation</td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
<td>sensory/cognition/MMSE, orientation, LOC, speech</td>
</tr>
<tr>
<td>Psycho/social</td>
<td></td>
<td></td>
<td></td>
<td>Roles/Relationship, Value/Belief/Family considerations</td>
</tr>
<tr>
<td>Sleep/rest</td>
<td></td>
<td></td>
<td></td>
<td>Pattern, signs/symptoms of good/poor sleep</td>
</tr>
<tr>
<td>Other assessment data</td>
<td></td>
<td></td>
<td></td>
<td>labs, treatments, therapy,</td>
</tr>
<tr>
<td><strong>Point total</strong></td>
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satisfactory [more than 23 points] ______ unsatisfactory [less than 23 points]_______

Additional Faculty Comments:
Assignment Instruction  
NRS234 Clinical Assignment #1  

Medical Diagnoses: Defining and Making Clinical Connections  

Directions: On the day of your clinical orientation to the long-term care environment you will have the opportunity to meet your assigned resident. Over the course of five weeks, you will be challenged to provide safe, quality patient-centered care and this will require your awareness and understanding of the pathophysiological processes identified by your resident’s medical diagnoses. To this endeavor, on the day of orientation, you will review your client’s chart and gather a list of his or her medical diagnoses. Review this list with your clinical professor to ensure accuracy and to eliminate potential duplication. Document the medical diagnoses clearly and concisely- do not include ICD-9 coding language (used for Medicare billing).

Next, using a pathophysiology text or library references gain understanding of each diagnosis. You may use scholarly sources, including the pathophysiology and medical surgical nursing texts that can be found in the nursing lab or in the library. You may not cite popular publications or web sites as these are information sources for lay people, not professionals. Further, you may not rely on your medical dictionary for this assignment.

Using Microsoft Word, document each medical diagnosis and the related definition in the appropriate columns in a grid as outlined below. Be sure to write the definitions in your own words and to cite sources appropriately using APA format. In the third column, document clinical signs and symptoms associated with each medical diagnosis.

Upload your completed assignment in APA format (includes APA cover page and reference list) to Courseworks the following week, before beginning of your clinical practicum. It is a course expectation that understanding of your resident’s medical problems is reflected each week in clinical practice. This knowledge must inform your patient history taking, physical assessments and the planning and delivery of care.

<table>
<thead>
<tr>
<th>Medical Diagnosis: (define and or describe in detail the pathophysiology; all info requires use of APA format &amp; required for each entry)</th>
<th>Mechanism of Disease</th>
<th>Associated signs and symptoms (be specific: what lab value ranges/numbers are associated with the identified disease, i.e: hypertension, diabetes. Separate APA citation/reference required for each entry)</th>
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</table>
Written Assignment #2- Safety-focused Care Plan-in class assignment

Successful application of the nursing process is an expectation of NRS234 and NRS233. In this assignment you are required to develop a nursing care plan with a focus on SAFETY. Based on N233 classroom scenario, your small group will format a care plan using the Care Plan form posted on LMS. You must document a data cluster to support your diagnosis, develop and document a nursing diagnosis, an overriding goal statement with measurable outcomes, and one intervention by each team member, which is supported with rationale cited from scholarly sources. Nursing texts will be allowed, but you must cite primary sources only. For example, you may not cite research studies cited in your nursing text unless you retrieve the article yourself through a literature search. Citations of nursing research from nursing texts as a secondary source will not be accepted. Use the Criteria for Weekly Care Planning (found on LMS) to evaluate your work during the planning process and prior to submission.

A typed, complete care plan is to be submitted by one group member on LMS ‘Courseworks’.

Be sure all members names are included on the document

Your N233 professor will provide written and verbal feedback related to your group’s plan as appropriate.

1. Incorporate the safety assessment tool (on LMS) with your care plan.

2. Incorporate the MORSE scale (on LMS) with your care plan.

3. As with all written work in nursing, ensure APA formatting for this assignment. Upload to ‘Courseworks’

Written Assignment #3- Skin-focused Care Plan-due week 2 of clinical

Successful application of the nursing process is an expectation of NRS234 and NRS233. In this assignment you are required to develop a nursing care plan with a focus on SKIN integrity for your assigned resident in the NRS234 clinical. Format your care plan using the Care Plan form posted on LMS. You must document a data cluster to support your diagnosis, develop and document a nursing diagnosis, an overriding goal statement with measurable patient outcomes, and a minimum of 5 interventions supported with rationale cited from scholarly sources. Nursing texts will be allowed, but you must cite primary sources only. For example, you may not cite research studies cited in your nursing text unless you retrieve the article yourself through a literature search. Citations of nursing research from nursing texts as a secondary source will not be accepted. Use the Criteria for Weekly Care Planning (found on LMS) to evaluate your work during the planning process and prior to submission. Your clinical professor will provide written and verbal feedback related to your [IPOC] plan as appropriate.
1. Incorporate the Braden scale (on LMS) with written care plan.

2. As with all written assignments in nursing, ensure APA formatting. Upload to ‘Courseworks’

**Written Assignment #4- Nutrition-focused Care Plan --due week 3 of clinical**

Successful application of the nursing process is an expectation of NRS234 and NRS233. In this assignment you are required to develop a nursing care plan with a focus on Nutrition for your assigned resident in the NRS234 clinical. Format your care plan using the Care Plan form posted on LMS. You must document a data cluster to support your diagnosis, develop and document a nursing diagnosis, an overriding goal statement with measureable patient outcomes, and a **minimum of 5 interventions supported with rationale** cited from scholarly sources. Nursing texts will be allowed, but you must cite primary sources only. For example, you may not cite research studies cited in your nursing text unless you retrieve the article yourself through a literature search. Citations of nursing research from nursing texts as a secondary source will not be accepted. Use the **Criteria for Weekly Care Planning** (found on LMS) to evaluate your work during the planning process and prior to submission. Your clinical professor will provide written and verbal feedback related to your plan as appropriate.

1. Submit your completed Nutrition Assessment (on LMS) with written care plan.

2. Diagnoses may only be: [Risk or actual] **Imbalanced Nutrition: Less than body requirements or more than body requirements.** [do not use hypovolemia, fluid deficits, GI problems, etc]

2. As with all written assignments in nursing, ensure APA formatting. Upload to ‘Courseworks’

**Written Assignment #5- Psychosocial-focused Care Plan--due week 4 of clinical**

Successful application of the nursing process is an expectation of NRS234 and NRS233. In this assignment you are required to develop a nursing care plan with a focus on an identified psychosocial problem for your assigned resident in the NRS234 clinical. Format your care plan using the Care Plan form posted on LMS. You must document a data cluster to support your diagnosis, develop and document a nursing diagnosis, an overriding goal statement with measureable patient outcomes, and a **minimum of 5 interventions supported with rationale** cited from scholarly sources. Nursing texts will be allowed, but you must cite primary sources only. For example, you may not cite research studies cited in your nursing text unless you retrieve the article yourself through a literature search. Citations of nursing research from nursing texts as a secondary source will not be accepted. Use the **Criteria for Weekly Care Planning** (found on LMS) to evaluate your work during the planning process and prior to submission. Your clinical professor will provide written and verbal feedback related to your plan as appropriate. Upload to ‘Courseworks’

*Student must demonstrate 78% for satisfactory completion or remediate if unsatisfactory*

*Student must use at least 3 scholarly sources for the 5 rationales and list in APA format.*
You may not use: Risk for unstable blood sugar, Latex allergy (risk or actual), Risk for impaired liver function, or chronic confusion, or impaired memory.

** (Do not use a diagnosis related to memory and confusion). Follow faculty instruction regarding additional limitations or permissions.

---

**Written Assignment #6- Physiological-focused Care Plan--due week 5 of clinical**

Successful application of the nursing process is an expectation of NRS234 and NRS233. In this assignment you are required to develop a nursing care plan with a focus on an identified physiological problem for your assigned resident in the NRS234 clinical. Format your care plan using the Care Plan form posted on LMS. You must document a data cluster to support your diagnosis, develop and document a nursing diagnosis, an overriding goal statement with measureable patient outcomes, and a minimum of 5 interventions supported with rationale cited from scholarly sources. Nursing texts will be allowed, but you must cite primary sources only. For example, you may not cite research studies cited in your nursing text unless you retrieve the article yourself through a literature search. Citations of nursing research from nursing texts as a secondary source will not be accepted. Use the Criteria for Weekly Care Planning (found on LMS) to evaluate your work during the planning process and prior to submission. Your clinical professor will provide written and verbal feedback related to your plan as appropriate. Upload to ‘Courseworks’

*Student must demonstrate 78% for satisfactory completion or remediate if unsatisfactory*

*Student must use at least 3 scholarly sources for the 5 rationales and list in APA format.*

You may not use: Risk for unstable blood sugar, Latex allergy (risk or actual), Risk for impaired liver function, or chronic confusion, or impaired memory.

** (Do not use a diagnosis related to memory and confusion). Follow faculty instruction regarding additional limitations or permissions.
Weekly Care Planning Grading Rubric

(Used for grading of Psycho-social and Physiological care plans)

Student Name: ______________________________________  Faculty: ____________________________

Clinical Site: ____________________________________  Clinical Date: _______  Clinical Week # _______

<table>
<thead>
<tr>
<th>Application of Nursing Process: Criteria for Care Planning</th>
<th>Points possible</th>
<th>Points earned</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment- The student:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-documents subjective &amp; objective data [cluster data] that</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>are accurate with appropriate level of completeness to</td>
<td></td>
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<tr>
<td>support nursing Dx. No pertinent data are missing.</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-uses appropriate terms and abbreviations in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>documentation of patient data</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-accurately differentiates subjective and objective data</td>
<td></td>
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</tr>
<tr>
<td>and identifies secondary data when appropriate</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-effectively clusters data, documenting only that data</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>which provides evidence to support area of focus for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nursing intervention and nursing Dx</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>5 total</strong></td>
<td></td>
<td><strong>points</strong></td>
</tr>
<tr>
<td><strong>Diagnosis- the student:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-demonstrates critical thinking in identifying patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>problem and problem etiology</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-formulates a nursing Dx using a NANDA approved diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Documents nursing Dx in one of the following formats:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Two-part Dx for RISK problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(problem r/t etiology)</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Three-part Dx for ACTUAL problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(problem r/t etiology AEB Signs &amp; Sx of the problem)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
-documents a nursing Dx that is effectively supported by data cluster (*evidence of stated problem, etiology, and signs & symptoms can be readily found in data cluster*)

<table>
<thead>
<tr>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 total points</td>
</tr>
</tbody>
</table>

**Planning and Goal statement- the student:**
- develops a broad, overriding goal statement that directly reflects the *problem component* of the nursing Dx.

| The goal statement:  
| Begins with, “The client will....” | 0.5 |
| Is realistic | 0.5 |
| Is time oriented | 0.5 |
| Ends with "AEB" [as evidenced by]... | 0.5 |
| **And** is followed by a list of specific desired outcomes which indicate goal attainment: | 0.5 |
| These desired outcomes or indicators *reflect observable* client outcomes that reflect specific, observable client responses that can be used to evaluate goal achievement | 1.5 |
| And are measureable | 0.5 |

| 5 total points |

**Interventions- the student:**
- develops 5 nursing interventions which will assist the client in attaining identified goals. The *nursing interventions* are:
  - Specific to patient *(realistic)*
  - Explicit *(indicating what exactly is to be done; by whom it is to be done; when it will be done; how often it will be done; how far...etc)*

| The *rationales*:  
| Support each related nursing intervention *(provide evidence to prove why the nursing intervention is an appropriate nursing action to manage client problem and promote goal attainment)* | 1 point each= 5 points total |
| Are presented as quotations or paraphrase from scholarly literature *(textbooks, nursing journals, published nursing/medical research or other professional sources as directed by faculty)* with accurate APA citations | 1 point each= 5 points total |

**APA:**
- accurate in-text citations
- submits an accurate APA reference page
- cover page in APA format
- spirit of inquiry [minimum 3 references]

| 4 points total |

**Evaluation- the student:**

| 1 point |
-recognizes that evaluation statements consist of two parts: a conclusion and supporting data
-formats evaluation statement as follows
"client goal met," "progressing toward goal" "client not progressing toward goal" "goal not met" AEB patient outcome/s

<table>
<thead>
<tr>
<th></th>
<th>Total possible</th>
<th>Total earned</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory _____</td>
<td>Unsatisfactory _____</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>(minimum 78%= [&gt; or = 23.5 points]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Faculty Comments:

The Nursing Process Paper: Integration of NRS233, NRS234

General Guidelines:

In order to demonstrate satisfactory progress in N234 and NRS233 you are required to complete the assignment outlined below as verification of your achievement of specific course objectives. This paper is to be submitted to your NRS233 and NRS234 professors on the dates assigned on the Integrated Course Calendar.

Format:

APA format is an expectation. The Nursing Process Paper is to be written with careful reporting, and well expressed thoughts, using appropriate grammar, syntax and spelling. Points will be deducted for errors in conventional writing. Your paper is to be word-processed using Microsoft Word. It is to be double-spaced

Appropriate sources for data collection:

Your client is and should be the primary source of data. Secondary sources including family members, friends, staff and the medical chart may also be used when appropriate. This is particularly important when data cannot be validated directly by your client or by your direct observation. You may not document assessments conducted by other health care professionals unless the data represents that which you cannot determine or validate through your own professional nursing assessment.

All secondary sources must be indicated in parentheses directly following related data. Examples of documentation of secondary sources of client data: client admitted to nursing home following a left hip fracture (chart); client has always minimized her pain experience (daughter); and, although she is confused, client appears to enjoy listening to classical music in the afternoons (staff). Refer to your NRS233 lecture notes for further clarification if necessary.
Evaluation and grading:

Assessment and feedback regarding your paper from both your NRS233 and your NRS234 professors will impact your overall grade for the Nursing Process Paper in NRS233 and your success in NRS234. A minimum passing score is 78%. It is an expectation that your Nursing Process Paper will evidence critical thinking, accurate data collection and analysis, effective problem solving and your ability to make connections between client history and clinical findings. Format your client history and physical assessment as outlined below.

The Nursing Process Paper

Part I. Collection and Documentation of the Comprehensive Nursing Health History

Use the Nursing Health History presented in Weber to guide your collection and documentation of a comprehensive history and a complete and accurate physical assessment of your assigned resident in the long-term care environment (NRS234 clinical). Both subjective and objective data is to be organized and analyzed through the application of Gordon's Functional Patterns (Weber; Jarvis). See the outline below. Both subjective and objective data is to be written economically as it would be documented in a patient’s chart.

Refrain from using introductory clauses such as, “When asked about____, the patient said, __________.” Document the data that you have collected in a clear and concise manner. Do not document what "you" the examiner did. Document your findings. Remember, you may not document assessment findings of other healthcare professionals found in the chart that are within the scope of nursing. Comprehensive data collection is an expectation. Examples of acceptable documentation will be demonstrated in NRS233 and can be reviewed in Weber and Jarvis.

Use Weber as your guide for the collection of data and present client history in the following format:

Health History by Functional Health Pattern

Client Profile

Biographical Data

Patient Initials only: ________________ DOB: ________________ Age: ___Sex: ___
Address: deferred Telephone #: deferred
Place of birth: ___________________ Ethnic Origin: ______________
Religious affiliation: ______________ Military Service (yes/no: branch/dates/war) ______________
Highest Level of Education completed: _______________ Form of Transportation used: ______________
Name of health care facility preferred for emergency care ________________

HCPOA (initials only) ________________ ____________ (yes or no) if yes, is the HCPOA activated? ______________
Agent: list relationship to client only, i.e. ‘daughter’ Living Will (yes or no) ______________________________

Height __________ Weight __________ BMI ____________
Braden Score and risk __________ Morse Scale Score and risk __________ Nutrition score and risk __________

Date of Admission: ______________

Reason for Placement in Long-term Care Environment: ______________

Comment on who is providing the history and their reliability.

Past Medical History (including medical diagnoses, accidents, injuries, and hospitalizations)

Allergies: (Include: medications, food, and environmental allergies. Include response to exposure to specific allergens. For example, Bee sting-response: SOB. (Specifically address and document whether or not pt has allergies to seafood, iodine, latex, and adhesive tape

Detailed focused assessment data is to be included for each system under appropriate Functional Pattern Include associated lab values under appropriate Functional Pattern

Developmental History:
Subjective Data:
Objective Data: Lag in expected cognitive or physical development

Health Perception-Health Management Pattern:
Subjective Data:
Client’s Perception of Health; Client’s Perception of Illness; Health Management and Habits; Compliance with Prescribed Medications and Treatments

Objective Data:
General Physical Survey.

General Physical Survey:

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Blood Pressure (position)</th>
<th>Pulse (Radial)</th>
<th>Respiratory Rate</th>
<th>Temperature (Route)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Nutritional-Metabolic Pattern

Subjective Data:
Dietary and Fluid Intake; Conditions of Skin; Condition of Hair and Nails; Metabolism

Objective Data:
Skin, Hair, and Nail Assessment; Head, Face and Neck Assessment; Mouth, Teeth, Throat, Nose, and Sinus Assessment
Lab values

Elimination Pattern

Subjective Data:
Bowel Habits; Bladder Habits

Objective Data:
Abdominal and Genitourinary Assessment.

Activity-Exercise Pattern

Subjective Data:
Activities of Daily Living; Leisure Activities; Exercise Routine; Occupational Activities

Objective Data:
Thoracic and Lung Assessment; Heart Assessment;
Peripheral Vascular Assessment; Musculoskeletal Assessment, Lab values

Sexuality-Reproduction Pattern

Subjective Data:
Male or Female

Objective Data:
Breast and Genitourinary Assessment.

Sleep-Rest Pattern

Subjective Data:
Sleep Habits; Special Problems; Sleep Aids

Objective Data:
Observe Appearance- Pale; Puffy eyes with dark circles; Observe behavior-Yawning; Dozing during the day; Irritability; Short attention span
Sensory-Perceptual Pattern

Subjective Data
Perception of Senses; Pain Assessment; Special Aids

Objective Data
Eye Assessment; Ear Assessment;
Neurological and Cranial Nerve Assessment (include evidence of each CN I-XII)

Cognitive Pattern

Subjective Data:
Ability to Understand; Ability to Communicate; Ability to Remember; Ability to Make Decisions, MMSE score

Objective Data:
Mental Status Assessment

Role-Relationship Pattern

Subjective Data:
Perception of Major Roles and Responsibilities in Family; Perception of Major Roles and Responsibilities at Work; Perception of Major Social Roles and Responsibilities

Objective Data:
Observe client interactions with family, friends, and staff. Include: Outline a family genogram for your client [Include a key identifying alive, dead, male, female] (attach as Appendix A; computer graphic)

Self-Perception-Self-Concept Pattern

Subjective Data:
Perception of Identity; Perception of Abilities and Self-Worth; Body Image

Objective Data: Document related observations

Coping-Stress Tolerance Pattern

Subjective Data:
Perception of Stress and Problems in Life; Coping Methods and Support Systems

Objective Data: Document related observations

Value-Belief Pattern

Subjective Data:
Values, Goals, and Philosophical Beliefs; Religious and Spiritual Beliefs

Objective Data:
Observe religious practices; Observe client's behavior for signs of spiritual distress; observe client and her/his environment for evidence of personal values
**Part 2 Pharmacology: Current Medications:** complete the grid; use abbreviations as appropriate

1. Record all medications prescribed for your client; add more rows as needed, **use Font size 8**
2. List each scheduled medications and any prns used regularly as ordered for your client. Include prns which have been administered daily.
3. Include the table in the NPP
4. Use APA as appropriate

<table>
<thead>
<tr>
<th>Drug Trade and generic name (1 point)</th>
<th>Class (1 point)</th>
<th><strong>Action/ Use and Indication for your client (3 points-action)</strong> (3 points-indication)</th>
<th>Prescribed dose (1 point)</th>
<th>Frequency (1 point)</th>
<th>Route (1 point)</th>
<th>Food, drug herbal interaction (3 point)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example:</strong> Trade-Tylenol Generic-acetaminophen</td>
<td>Antipyretic Non-opioid analgesic (Mosby's drug guide, 2014, p.103).</td>
<td><strong>Action:</strong> pain relief &amp; Fever reducer -indicated for arthritic pain every morning</td>
<td>650 mg</td>
<td>every 4 hours, prn</td>
<td>po</td>
<td>none</td>
</tr>
<tr>
<td><strong>Example:</strong> Aspirin</td>
<td>Antithrombolytic (Mosby's drug guide, 2014, p 62).</td>
<td><strong>Action:</strong> prevents blood clot formation, relieves pain and fever -indicated for history of previous DVT and TIA</td>
<td>180mg</td>
<td>Daily</td>
<td>po</td>
<td>Green vegetables</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Trade and Generic name [con’t] [part 2]</th>
<th>Appropriate Dose range: weight/age/ organ based [need APA] (2 points)</th>
<th>Life threatening adverse /side effects/ contraindications; list only those pertinent to your client [need APA] (3 points)</th>
<th>Nursing Considerations/ assessment prior to administration/ teaching/ labs [need APA] (5 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example:</strong> Trade-Tylenol Generic-acetaminophen</td>
<td>For adults and children 12 years of age and older, the recommended dose of acetaminophen is 650 to 1000 mg every 4 to 6 hours as needed, not to exceed 4000 mg in 24 hours (Mosby's drug guide, 2014).</td>
<td>CV: Chest pain, dyspnea, <strong>myocardial damage</strong> when large doses are ingested daily for several weeks (Mosby's drug guide, 2014). GI: <strong>Hepatic toxicity and failure</strong>, (Mosby’s drug guide, 2014). GU: Acute kidney failure, renal tubular necrosis (Mosby’s drug guide, 2014). <strong>Hematologic:</strong> Methemoglobinemia, hemolytic anemia (Mosby's drug guide, 2014). <strong>Hypersensitivity</strong> (Mosby’s drug guide, 2014).</td>
<td>- Avoid using multiple preparations containing acetaminophen. - Give drug with food if GI upset occurs. - Do not exceed recommended dose; do not take for longer than 10 days. - Discontinue drug if hypersensitivity reactions occur. - Assess for jaundice (Mosby’s drug guide, 2014).</td>
</tr>
</tbody>
</table>

**Current Treatments:** *(Examples to include: PT, OT, nutrition supplement, dressing change, TED stockings, ect.)*
Grading Rubric: submit copy of rubric with NPP upload to LMS

NURSING PROCESS PAPER (NRS233/234)

Assessment: _____ /30 points
Student collects patient data that evidences the level of skills competency in patient interviewing and physical examination expected of a 200-level student nurse (0-4pts).

Documentation reflects appropriate professional terminology and use of abbreviations (0-4pts).

Client assessment data is accurate and demonstrates an appropriate level of completeness in all physical assessments (0-20pts).

Student accurately differentiates primary (Patient) & secondary sources (CNA, RN, Family) and subjective & objective data as instructed (0-2pts).

Genogram _____/2 points
Includes key (1pt)
At minimum, includes client and parents (1 pt)

Follows all directions: ____/1 point

Student Name: ___________________
Clinical Faculty_____________________________

Assessment + genogram+ directions: ____/33
APA ____ / 8
Pharmacology ____ / 24
Total Score: _____/ 65 points

Evaluator Feedback: Assessment:

____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________

____________________________________
Pharmacology: Drug List (24 points)

Student completes the grid for all scheduled and prn medications. Emphasis on completeness, critical thinking, and nursing implications.

-1-2 points if sections are incomplete or not specific to your client [-1 for action or -1 point for indication unclear for client.]

Pharm: _____/24

*point deductions as follows:*

**Pharmacology:** -1 if Trade and Generic are not properly identified. **Abbreviations** -0.5 = if any "do not use"

**Abbreviations** -0.5 = if any "do not use"

- 1 any missing allergy data (food, drugs, environment, adhesive tape, shellfish, iodine and latex) all must be addressed

**Med List** -0.5 if indication is not specific to the client

-0.5 inappropriate life-threatening used

Evaluator Feedback: Pharmacology:

____________________________________

____________________________________

____________________________________

____________________________________

Application of APA:

**Spirit of professional inquiry** (2pt)

Use of more than 1 scholarly source to gather reference [minimum of 2 sources]

**Citations:** (2 pts)

All Sources are cited in APA format (2pt)

**Cover Page:** (1 pt)

APA cover page is accurately formatted (1pt) APA

-0.5 if running head does not line up with page number

-0.5 if cover page titles are not in top ½ of page

0 points= > 1 error

**Reference page:** (3pts)

reference page is accurate:

3 points= Perfect; 2 points= 1 error "type";

1 point= 2 errors

Evaluator Feedback APA:

____________________________________

____________________________________

____________________________________

____________________________________

Application of APA_____/8
Carroll University Nursing: Foundations of Practice
NRS233/234 Group Teaching Presentation Directions

**Purpose:** The NRS233/234 group teaching assignment provides an opportunity for students to engage in small group process. In addition, the project affords an opportunity for students to learn the role of a nurse educator in planning, implementing, and evaluating a teaching plan.

**Plan:** All NRS233/234 students will complete a group teaching project covering a faculty-approved, Age-specific topic on the established due date. NRS233/234 students are challenged to teach the children at the United Community Center [UCC] an Age-Specific topic of interest during a 20 minute presentation held at the UCC on the designated day. In addition, students will video record the presentation and upload the video to LMS per course calendar due date. Students will work in groups of 4, and all students will actively engage their audience for a maximum of 20 minutes in teaching their topic, and allow additional time for Q&A; maximum of 30 minutes is allowed from start to finish. All team members are expected to participate in the presentation. Students are responsible to obtain supplies to create a tri-fold poster, video presentation, and handout materials.

**NRS234 instructor can copy your handouts through Carroll U duplication with at least two week notice.**

All NRS233/234 students will participate in developing learning outcomes and evaluating if learning occurred. Students should assess audience knowledge after the presentation to determine if Lesson plan’s learning outcomes were met. Group teaching presentations must evidence student application of at least one Learning Theory; see K&E text Chapter 27. Group members are expected to actively engage the UCC audience. Finally, students will reflect on their teaching effectiveness through both Peer Feedback from video presentation and feedback received from UCC audience.

**Group Process:** Effective group process will require ongoing self and collaborative assessment, the implementation of professional communication strategies including negotiation and conflict management, and effective time and task management. The roles and responsibilities of each member are to be determined by the group with one specific requirement: all students are to assume the role of leader (meeting facilitator) and recorder at least one time during the project planning; you must meet a minimum of 4 times to fulfill this requirement.

**Evaluation and Grading:** All groups must compile and submit evidence of their teaching project for evaluation as outlined in the Teaching Project Criteria by the due date. Late submissions will deduct 10% of total possible points for each day late.

All presentations will be pre-recorded and uploaded to LMS for peer review one week prior to UCC presentation. The Video Producing Team must supply a peer feedback tool to collect peer review data. This tool will provide the team data, along with UCC classroom feedback, to identify barriers, strengths, and other evaluation summary of the presentation.

Each student will be assigned peer videos to view and complete the team’s provided peer feedback tool, and return the comments to that team.

It is the video producing teams’ responsibility to ensure the video is uploaded correctly to NRS234 LMS and can be retrieved and viewed at due date.

**Rules of presentation: Poster or Powerpoint slides and classroom Handouts:**

- **All posters** must reflect understanding and application of “Poster, Poster” see LMS for faculty provided resource. (See LMS for Poster-Poster reference; be sure posters are age appropriate, font is readable, references, names included, etc). Posters or copy of Powerpoint slides are to be given to faculty for grading after UCC presentation. Include age appropriate information, readable font, APA references, member names included, etc

- Powerpoints can be presented on Smart Boards in most classrooms.

- **Educational handouts** must be age appropriate with proper APA. Handouts are intended to add interaction and student engagement during presentation. Provide a copy of any handouts or learning materials to your NRS234 instructor.
N233/234: Analysis of Group Process: Group assessment: (group completes together after each meeting)-

Group Teaching Topic: ________________________________ Date: __________ Meeting start time: ________end-time: ________

Members Present: ________________________________________________________________

Members Absent: ______________________________________________ Meeting #____________________

Group Member Assuming the Leadership Role today: ____________________________

Evaluate the group leader's strengths and opportunities for growth: support your conclusions with evidence.

Analyze each group member's participation in the planning and decision making process: identify strengths and opportunities for growth. Be sure to include commentary on blocking behaviors that you observed.

Discuss how you were feeling as the group interaction was taking place.

Conflict occurs in every group always. Document the specific areas of conflict that emerged in today's meeting and your group's efforts to resolve them.
Lesson Plan

Topic: __________________________  Team members: ________________________________________________

Step 1: Planning the Lesson

Instructional Materials.

1.
2.
3.

Instructional Objectives

1.
2.

Step 2: Present Lesson

- Lesson intro- Example: Bill will introduce our topic and other Nursing students

  1.
  A.
  B.

- Learning objectives/outcomes

  Upon completion of the lesson, learner will be able to: [what are measurable outcomes]

  1.
  2.

- Planned activity, handouts, discussion, or interaction with audience during presentation

  1.
  2.

- Evaluation of student learning [how will you evaluate learning]

  1.
  2.
A team's purpose is defined by its team charter or contract. The charter will identify a team's mission, guidelines to function, objectives, time frame, and consequences of actions.

### Purpose of the team:
(Why was the team formed?)

__________________________________________________________________________________________

### Team Established Guidelines:
(Include the rules for members to have a successful team: what are responsibilities, contribution, communication, collaboration, etc., rules)

________________________________________________________________________________________________

________________________________________________________________________________________________

### Ensuring Fair Contribution and Collaboration to Accomplish the Team Goal:
(How will your team make sure all members contribute fairly? How will you address team members who are not contributing fairly?)

________________________________________________________________________________________________

________________________________________________________________________________________________

### Non-involvement behaviors and lack of team commitment:
(What are the consequences of a team member who lacks participation and does not meet established deadlines?)

________________________________________________________________________________________________

### Resolving Conflict:
(All team experience conflict. How will your team defuse and resolve conflicts?)

________________________________________________________________________________________________
NRS233/234 Teaching Project

Application of Learning Theory Report Form

Teaching Topic: ______________________

Complete as a group, typed format and include in final folder of evidence. Use as many copies of this form as necessary to provide rationale and demonstrate your application of learning theories referenced from K&E Chapter 27. One or more theories are required to be identified.

Group Members: _____________________________________________________________________________

Learning Theory: ___________________________________________________________________________

Evidence of application in teaching project presentation:

Learning Theory: ___________________________________________________________________________

Evidence of application in teaching project presentation:

Learning Theory: ___________________________________________________________________________

Evidence of application in teaching project presentation:

[add more as necessary]

Peer feedback Tool: Create a written tool that your peers will complete as they watch your video recording of the presentation. The tool is a way for your team to gather constructive criticism of what you did well, what could be improved, if you were professional in the delivery of the presentation, evaluation of your teaching effectiveness, and evidence of learning. The written feedback will be returned to you and your team will summarize the feedback in your final team evaluation of the presentation.

Final Assessment and Evaluation of teaching effectiveness: Group is responsible to evaluate their presentation in a 1-page paper or less. Team will acknowledge potential barriers to learning and evidence measures of actual learning among UCC audience participants and from peer evaluations of the recorded video presentation. Indicate in your team
evaluation evidence that shows learning occurred based on results from UCC audience feedback & peer evaluations.

**NRS233/234 Group Teaching Project Rubric**

**Rubric for Poster Presentation: Evaluation and Grading Form**

**Group Members:**

1. ___________________________  
2. ___________________________

3. ___________________________  
4. ___________________________

**Topic:** ___________________________  
Faculty evaluating: ____________________

<table>
<thead>
<tr>
<th>Before Presentation: Evidence to be uploaded to Courseworks</th>
<th>Team initials as completed</th>
<th>Faculty initials as received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval of Age specific teaching topic</td>
<td></td>
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<tr>
<td>Team Charter/contract on LMS</td>
<td></td>
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<tr>
<td>Lesson plan with learning outcomes on LMS</td>
<td></td>
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<tr>
<td>Video Presentation uploaded on LMS</td>
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<tr>
<td>Peer Feedback Tool</td>
<td></td>
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<tr>
<td>Classroom Presentations: .... <strong>UCC clinical week</strong></td>
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</tbody>
</table>

**After Presentation: Evidence to be uploaded to Courseworks**

<table>
<thead>
<tr>
<th>Documentation and evaluation of group process (Analysis of Group Process) – each individual submits once –</th>
<th></th>
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</table>

2. **Assessment and Evaluation** of student learning:

**Group is responsible to evaluate presentation in a 1-page paper or less. Indicate evidence that learning occurred** based on results from UCC audience feedback & peer evaluations -

3. Submit copy of **Feedback tool** used for peer evaluation-

4. APA formatted **reference page**-

**Point Distribution:**

**Professional Accountability:**

All deadlines met _______ (2 points)

Follows all directions : Poster, handouts and project requirements submitted _______ (2 points)

Team Charter/contract complete and submitted _______ (5 points)

Each group member demonstrates professional dress and grooming @ presentation _______ (5 points)

**Analysis of Group Process:**
Each Team member provides at least one Analysis of Group Process with assessment-documentation and evaluation that reflects understanding of small group dynamics, effective problem-solving, conflict resolution strategies, and the value of peer feedback (10 points) –

**Faculty Comments:**

### Evidence of scholarly work:

Presentation Poster, Powerpoint slides and handouts are visually appealing and professionally constructed. Posters will have evidence that students used faculty-provided resource, "Poster, Poster". Includes handouts and other teaching aids that are easy to read, have appropriate font, are age appropriate, include proper APA citations. Both poster, Powerpoint slides, and handouts are accurate, and free of spelling and grammatical errors. All members names must be on all presentation materials (handouts, posters, Powerpoint) (20 points)

- Effective incorporation and evidence of learning theories in presentation (5 points)
- Lesson Plan: detailed and specific to Age population (10 points)
- Appropriate incorporation of scholarly literature in presentation (5 points)

Final Evaluation of teaching effectiveness: acknowledges potential barriers to learning and evidences measures of actual learning among UCC audience participants and from peer evaluations. (10 points)

- APA formatting and reference page (4 points)

**Faculty Comments:**

### Evidence of professional communication:

Presentation reflects group respect for audience (2 points)

- 20-30 minutes time frame adhered: includes presentation, Q&A (5 points)
- Group members effectively engage audience throughout the presentation (10 points)
- Written peer feedback tool is thoughtfully developed and effectively distributed to peers (5 points)

**Faculty Comments:**

**Comments:**

**Final Score: ___________/100**
### Mini-Mental State Examination (MMSE): Cognitive Assessment

**Date of Examination:** _______________

**Client Initials:** _______________ **DOB**____________________ **Years of School Completed**________

Approach the client with respect and encouragement.

**Ask:** Do you have any trouble with your memory? _____yes _____no

**Ask:** May I ask you some questions about your memory? _____yes _____no

<table>
<thead>
<tr>
<th><strong>Time Orientation</strong> (5 points)</th>
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<tbody>
<tr>
<td><strong>Ask:</strong> What is the year?</td>
<td>/1</td>
</tr>
<tr>
<td>What is the season?</td>
<td>/1</td>
</tr>
<tr>
<td>What is the month of the year?</td>
<td>/1</td>
</tr>
<tr>
<td>What is the date?</td>
<td>/1</td>
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<tr>
<td>What is the day of the week?</td>
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<table>
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<tr>
<th><strong>Place Orientation</strong> (5 points)</th>
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<tbody>
<tr>
<td><strong>Ask:</strong> Where are we now? What is the state?</td>
<td>/1</td>
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<tr>
<td>What city?</td>
<td>/1</td>
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<tr>
<td>What part of the city?</td>
<td>/1</td>
</tr>
<tr>
<td>What building?</td>
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<tr>
<td>What floor of the building?</td>
<td>/1</td>
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<table>
<thead>
<tr>
<th><strong>Registration of Three Words</strong> (3 points)</th>
<th></th>
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<tbody>
<tr>
<td><strong>Say:</strong> Listen carefully. I am going to say three words. You say them back after I stop. Ready? Here they are... <strong>PONY</strong> (wait one second), <strong>QUARTER</strong> (wait one second), <strong>ORANGE</strong> (wait one second). What are those words?</td>
<td></td>
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<tr>
<td>Pony</td>
<td>/1</td>
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<tr>
<td><strong>Attention and Calculation: Serial 7’s (5 points)</strong></td>
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<tr>
<td><strong>Ask:</strong> Subtract 7 from 100 and continue to subtract 7 from each subsequent remainder until I tell you to stop. What is 100 take away 7?</td>
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<tr>
<td><strong>Say:</strong> Keep going…</td>
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<table>
<thead>
<tr>
<th><strong>Recall of Three words (5 points)</strong></th>
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<tbody>
<tr>
<td><strong>Ask:</strong> what were those three words I asked you to remember? Give one point for each correct answer.</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Pony 1</td>
</tr>
<tr>
<td>Quarter 1</td>
</tr>
<tr>
<td>Orange 1</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Naming (2 points)</strong></th>
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<tbody>
<tr>
<td><strong>Ask:</strong> What is this?</td>
</tr>
<tr>
<td>Show a pencil. 1</td>
</tr>
<tr>
<td>Show a watch [or other object]. 1</td>
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<table>
<thead>
<tr>
<th><strong>Repetition (1 point)</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Say:</strong> Now I am going to ask you to repeat what I say. Ready? No ifs, ands or buts. 1</td>
</tr>
<tr>
<td>Now, you say that.</td>
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<table>
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<tr>
<th><strong>Comprehension (3 points)</strong></th>
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<tbody>
<tr>
<td><strong>Say:</strong> Listen carefully because I am going to ask you to do something. Take this paper in your left hand (1 point), fold it in half (1 point), and put it on the floor (1 point). 3</td>
</tr>
</tbody>
</table>
### Reading (1 point)

**Say:** Please read the following and do what it says, but do not say it out loud.

- Close your eyes

### Writing (1 point)

**Say:** Please write a sentence. If the patient does not respond, say: Write about the weather.

### Drawing (1 point)

**Say:** Please copy this design.

### Total Score

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Maximum Score: 30. Individuals with normal mental status average score 27. Scores 24-30 indicate no cognitive impairment; Scores 24-23 are questionable and require further assessment. Scores less than 21, may be seen with organic disease (delirium or dementia) or affective disorders. Scores that occur with dementia and delirium: 18-23= mild cognitive impairment; 0-7 = severe cognitive impairment.

Assess level of consciousness along a continuum:

<table>
<thead>
<tr>
<th>Alert</th>
<th>Drowsy</th>
<th>Stupor</th>
<th>Coma</th>
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</thead>
<tbody>
<tr>
<td>Cooperative:</td>
<td>_____yes _____no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressed:</td>
<td>_____yes _____no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxious:</td>
<td>_____yes _____no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Vision:</td>
<td>_____yes _____no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Hearing:</td>
<td>_____yes _____no</td>
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Native Language:__________________

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Name: ________________________________

NRS234 –Foundations of Nursing Practice

Focused Assessment Competency Testing: Respiratory

Subjective:

_____ Student collects adequate data regarding history of present illness

☐ c/o: ______________________________

_____ Student uses OLDCART to ask follow-up questions

☐ Onset:
☐ Duration:
☐ Location:
☐ Character:

_____ (Student collects adequate details regarding character of sx. For example: if +productive cough, data regarding sputum is collected; if +hemoptysis, frank blood?, old blood/coffee grounds? etc.)

☐ Aggravating/alleviating factors:
☐ Rate:
☐ Treatments tried:

_____ Student collects adequate data regarding past medical history

☐ Asthma, emphysema, bronchitis, pneumonia, TB, PE (Pulmonary Emboli)?
☐ Difficulty breathing?
☐ CP with breathing?
☐ Wheezing: pt's perception of cause?
☐ SOB at rest? SOB with activity? (How much activity?)
☐ Cough?
☐ Hemoptysis?
☐ Toxin or pollution exposure?

_____ Student inquires about prescribed respiratory medications when appropriate (i.e., use of inhalers, antihistamines, singulair for asthma etc.)

_____ Student inquires about patient allergies (drug, environmental, food)

_____ Student specifically asks about allergies to shellfish, latex, and adhesive tapes

Objective:

_____ INSPECTION:
- Respiratory rate, pattern and effort
- Posture
- Inspects the chest and back
  - Skin integrity and color
  - Costal angle
  - Shape and symmetry of chest.
  - AP and lateral diameter of chest

**PALPATION:**
- anterior and/or posterior tactile fremitus?
- chest expansion

**PERCUSSION:**
- lateral and posterior back

**AUSCULTATION:**
- Lung sounds (anterior, posterior, and lateral)
- Adventitious sounds (bell of stethoscope)?

**Evaluation**

<table>
<thead>
<tr>
<th>Satisfactory (minimum passing score = 6)</th>
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</table>

**Unsatisfactory** - student is referred to Kathy Sampson to plan skills remediation and second attempt to demonstrate competency.
Focused Assessment Competency Testing: Cardiovascular/Peripheral Vascular

**Subjective:**

_____ Student collects adequate data regarding history of present illness

☐ c/o: ___________________________

_____ Student uses OLDCART to ask follow-up questions

☐ Onset:
☐ Duration:
☐ Location:
☐ Character:
☐ Aggravating/alleviating factors:
☐ Rate:
☐ Treatments tried:

_____ Student collects adequate data regarding past medical history [ask as appropriate]

☐ Precordial or retrosternal CP?

☐ Palpitations?

☐ DOE? – specify how much exertion (i.e., walking one flight of stairs, from the chair to the bathroom, or just talking)

☐ Orthopnea? How many pillows for sleep?

☐ LE ulcers?

☐ Last EKG, Last Stress Test

☐ HTN, CAD, PVD, Permanent Pace maker, Cardiac Catheterizations, DMR (direct myocardial revascularization) or CABG (coronary bypass surgery), CHF, or LE edema? Anemia? Nocturia?

_____ Student inquires about prescribed cardiovascular medications/treatments *when appropriate* (i.e., nitroglycerine SL, anti-hypertensives, cardiac medications, blood thinner, TEDs etc.)

_____ Student inquires about patient allergies always (drug, environmental, food)
Student specifically asks about allergies to shellfish, latex, and adhesive tapes

**Objective:**

- INSPECTION:
  - Skin integrity and color; hair distribution
  - Precordial heaves, lifts, or pulsations?

- PALPATION:
  - Blood Pressure
  - Precordial thrills?
  - PMI
  - Carotid pulses
  - Pulse rate and rhythm (radial)
  - Peripheral pulses- amplitude and symmetry (radial, DP/PT)
  - LE edema?
  - CRT (BUE and BLE)

- PERCUSSION deferred

- AUSCULTATION:
  - Carotid bruits?
  - Apical Pulse
  - Heart sounds (landmarks and auscultates five areas: APETM)
    - Rubs?
    - Gallops?
  - Murmurs (bell of stethoscope)?

**Evaluation**

| Student independently demonstrates competency in focused patient history taking and physical assessment (2 pts) | Student requires minimal prompting by evaluator to demonstrate competency in focused patient history taking and physical assessment (1 pts) | Student is unable to demonstrate competency in focused patient history taking and physical assessment with minimal prompting by evaluator (0 pts) |
Focused Assessment Competency Testing: Gastrointestinal/Urinary

Subjective:

_____ Student collects adequate data regarding history of present illness

☐ c/o: ______________________

_____ Student uses OLDCART to ask follow-up questions

☐ Onset:
☐ Duration:
☐ Location:
☐ Character:
☐ Aggravating/alleviating factors:
☐ Rate:
☐ Treatments tried:

_____ Student collects adequate data regarding past medical history

☐ Missing or loose teeth? Tooth pain?
☐ Dentures or partials? Do they fit properly? Gum lesions?
☐ Appetite? Food Intolerance?
☐ Dysphagia?
☐ Pain associated with eating or other abdominal or flank pain?
☐ Pyrosis [heartburn]?
☐ Nausea/Vomit? (character)
☐ LBM (date)? Frequency of BMs? Recent change?
☐ Diarrhea or Constipation?
☐ Stool characteristics?
☐ Bright red bloody or black tarry stools?
☐ Hemorrhoids or rectal bleeding?
☐ Urinary frequency?
Dysuria, polyuria, or oliguria? Nocturia (# voids per noc)?
- Hesitancy? Straining? Narrowed stream (if appropriate)?
- Urine characteristics?
- Hx of ulcer, liver or gallbladder problems, jaundice, colitis, IBS, diverticulosis?
- Hx of kidney disease, kidney stones, recurrent UTIs, or prostate problems?

_____ Student inquires about use of prescribed/OTC GI/GU medications/treatments
(i.e. special diets, antacids, stool softeners, laxatives, enema, blood thinner etc.)

_____Student inquires about patient allergies (drug, environmental, food)
_____Student specifically asks about allergies to shellfish, latex, and adhesive tapes

Objective:

_____INSPECTION:
- Lips, oral mucosa, tongue, teeth and gums
- Skin integrity and color (i.e., scars, straiae, petechiae etc.)
- Abdominal contour, symmetry, and distention
- Abdominal pulsations? Or obvious masses
- Genitalia deferred (erythema, edema, lesions, discharge)
- Anus deferred (lesions, prolapsed, hemorrhoids)

_____AUSCULTATION:
- Bowel sounds
- Vascular sounds

_____PERCUSSION:
- Abdominal wall
- Fluid Wave (if abdomen is distended)?

_____PALPATION:
- Light then deep palpation X 4 quadrants
- Rebound tenderness?
- Genitalia deferred

Evaluation

| Student independently demonstrates competency in focused patient history taking and physical assessment (2 pts) | Student requires minimal prompting by evaluator to demonstrate competency in focused patient history taking and physical assessment (1 pts) | Student is unable to demonstrate competency in focused patient history taking and physical assessment with minimal prompting by evaluator (0 pt) |
Student conducts a patient history which is:

- systematically and well organized (1.5 pts)
- informed by patient responses (1.5 pts)

Student conducts a patient history which is:

- mostly systematic and organized (1 pt)
- mostly informed by patient responses (1 pt)

Student conducts a patient history which is:

- somewhat/not systematic or well organized (0 pt)
- somewhat/not informed by patient responses (0 pt)

Physical assessment is appropriate in its completeness given presenting patient problem (3 pts)

Physical assessment is mostly appropriate in its completeness given presenting patient problem (2 pts)

Physical assessment is lacking completeness given presenting patient problem (0 pt)

Satisfactory (minimum passing score = 6)

Unsatisfactory - student is referred to Kathy Sampson to plan skills remediation and second attempt to demonstrate competency.

Name _________________________________

Focused Assessment Competency Testing: Musculoskeletal/Neurological

Subjective:

- Student collects adequate data regarding history of present illness
  - c/o: ____________________________

- Student uses OLDCART to ask follow-up questions
  - Onset:
  - Duration:
  - Location:
  - Character:
  - Aggravating/alleviating factors:
  - Rate:
  - Treatments tried:

- Student collects adequate data regarding past medical history
  - Problems with memory (recent or remote)?
  - Disorientation? Hallucinations (visual or auditory)?
  - Nervousness, mood changes?
  - Limitations of movement?
  - Joint pain, stiffness or swelling? Worse in the morning or at the end of the day?
  - Crepitus?
  - Weakness?
  - Numbness or tingling (paresthesia)? Paralysis?
  - Tic? Tremor (at rest or intentional)?
Gait problems or other coordination problems?

Hx of seizures, blackouts, syncope, stroke, or DVT? Depression, ADHD or other mental health problems? Peripheral neuropathy?

Hx of arthritis, gout, back pain or disk disease? Other chronic pain?

____ Student inquires about use of prescribed/OTC medication/treatments (i.e. pain medication, anti-depressants, antipsychotics, stimulants, prosthetics, massage therapy etc.)

____ Student inquires about patient allergies (drug, environmental, food)

____ Student specifically asks about allergies to shellfish, latex, and adhesive tapes

**Objective:** Mental Status:

- AA&O X4?
- Confused to ___person___place___time___situation

Cranial Nerves:

- I- olfactory
- II-optic (visual acuity and confrontation)
- III, IV, VI - oculomotor, trochlear, abducens
  - √ PERLA, Cardinal positions of gaze
- V- trigeminal (mastication: temporal and masseter muscles)
- VII- facial (raise eyebrows, smile, puff out cheeks, taste)
- VIII- acoustic (ability to hear normal conversation; whisper test)
- IX, X- glossopharyngeal and vagus (uvula and soft palate rise on phonation; gag reflex)
- XI- spinal accessory (shoulder shrug against resistance)
- XII- hypoglossal ("light, tight, dynamite"; tongue midline)

Motor system/musculoskeletal:

- Joints (symmetry, deformity, erythema, edema, increased warmth?)
- ROM and strength bilaterally
- Tics? Tremor? (at rest or intentional)
- Gait
- Rhomberg Test

Sensory system:
**Evaluation**

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<tbody>
<tr>
<td><strong>Student independently demonstrates competency in focused patient history-taking and physical assessment (2 pts)</strong></td>
<td><strong>Student requires minimal prompting by evaluator in attempt to demonstrate competency in focused patient history-taking and physical assessment (1 pts)</strong></td>
<td><strong>Student is unable to demonstrate competency in focused patient history-taking and physical assessment with minimal prompting by evaluator (0 pt)</strong></td>
</tr>
<tr>
<td>Student conducts a patient history which is:</td>
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<td>Student conducts a patient history which is:</td>
</tr>
<tr>
<td>_____ systematic and well organized (1.5 pts)</td>
<td>_____ mostly systematic and organized (1 pts)</td>
<td>_____ somewhat/not systematic or well organized (0pt)</td>
</tr>
<tr>
<td>_____ informed by patient responses(1.5 pts)</td>
<td>_____ mostly informed by patient responses(1 pts)</td>
<td>_____ somewhat or not informed by patient responses (0pt)</td>
</tr>
<tr>
<td>____ Physical assessment is appropriate in its completeness given presenting patient problem (3 pts)</td>
<td>____ Physical assessment is mostly appropriate in its completeness given presenting patient problem(2pts)</td>
<td>____ Physical assessment is lacks completeness given presenting patient problem(0 pt)</td>
</tr>
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**Satisfactory** (minimum passing score = 6)

**Unsatisfactory**- student is referred to Kathy Sampson to plan skills remediation and second attempt to demonstrate competency.
Lab WEEK 1 and Orientation Day Meet in Nursing Center classroom at 0700

Part 1: Purpose: Clinical and Lab Orientation

Student Learning Outcomes:
• Understand course objective and student expectations
• Explain the CDC isolation guidelines
• Identify risks for nosocomial infections.
• Explain the rationale for standard precautions

Pre-Lab Work: **Student is responsible to be prepared for all lab activities**
• Review lab manual and come prepared with any questions
• Review all clinical requirements; you cannot participate in clinical if requirements are incomplete.
• Read & Bring signed student contract to lab orientation
• View ATI videos and read K&E chapter corresponding to topics:

**Kozier & Erb’s Fundamentals of Nursing**
K&E Ch35-Medications: pp 848-850; 862-864; 866-871; 872-893; 900-917.
K&E Ch 31-Asepsis pp. 685-690; 693-700.
Smith Ch 10- Medications for Eye and Ear Disorders pp. 266-268; 280-282

**ATI Nursing Video Skills:** [Bring ATI Pretest to LAB for listed ATI Nursing Video Skills]-
Medications 1-4 [ATI pretest due at lab all post tests are needed at PME skill check off]
-Infection Control- bring post test to lab
-Surgical Asepsis-bring post test to lab

Lab Objectives week 1:

Lesson 1: Classroom Activity: Asepsis and Infection Control:
-Explain the rationale for standard precautions
-Explain the difference between medical and surgical asepsis
-Explain the CDC isolation guidelines
-Identify risks for nosocomial infections.

Lesson Plan:
1. Review types of isolation and indications
2. Donning and removing sterile gloves.
3. Donning Personal Protective Equipment [PPE]

Lesson 2: In Lab: Medication Administration:
-Identify legal and ethical responsibilities of the nurse.
-Identify the nurse’s role in medication administration
-Identify methods to reduce med errors.
-State the “rights” to accurate medication administration & identify 3 patient checks.
-Identify sites used for intra-dermal, subcutaneous, and intramuscular injections
-Describe essential steps in safely administer topical, ophthalmic, otic, nasal, vaginal, respiratory inhalation, rectal and IV medications.
- Describe response to needlestick injury

Lesson Plan:
Station 1: Safe Medication Administration: Non-Parenteral
Skill Focus: Safe medication administration and RN responsibility. Demonstrate and practice administration of non-parenteral medications through Medication administration practice scenarios. ATI skill check off: see calendar for due date.

Station 2: Safe Medication Administration: Parenteral-Intravenous [IV] administration
Part One: IV site care
Skill Focus: Demonstration of peripheral intravenous [PIV] insertion and removal; PIV site care and dressing change; Discontinuing PIV. Discuss monitoring IV site for phlebitis and infiltration.
Part Two: IV infusion
Skill Focus: Demonstration of initiating IV infusion, changing IV bag, and priming IV tubing. Assessment of IV site for safe IV push medication administration and flushing IV cap. Discuss monitoring IV site for phlebitis and infiltration.

ATI skill check off: see calendar for due date. Students will not start IVs at sophomore level, but skill check off will evidence student can complete IV site care, dressing change, flush a capped IV[CIV]. Also will verbalize understanding of how to d/c the IV, and what are signs/symptoms and causes of IV infiltrate and phlebitis.

Station 3: Safe Medication Administration: Parenteral-Intramuscular [IM] injections:
Skill Focus: Select appropriate injection sites. Demonstrate and practice IM medication administration using Z-track method; includes syringe/needle selection, drawing up medication, land marking appropriate sites. ATI skill check off: see calendar for due date.

Station 4: Safe Medication Administration: Parenteral-Subcutaneous [SQ] and Intradermal [ID] injections, and mixing insulin
Skill Focus: Select appropriate injection sites. Demonstrate and practice SQ/ID medication administration. Draw up, mix, and administer insulin. ATI skill check off: see calendar for due date.

Handouts: Lesson 1: Infection Control

Transmission-Based Precautions
There are three types of transmission-based precautions: contact precautions (for diseases spread by direct or indirect contact), droplet precautions (for diseases spread by large particles in the air), and airborne precautions (for diseases spread by small particles in the air). Each type of precautions has some unique prevention steps that should be taken, but all have standard precautions as their foundation.

Contact Precautions
- Used for patients/residents that have an infection that can be spread by contact with the person’s skin, mucous membranes, feces, vomit, urine, wound drainage, or other body fluids, or by contact with equipment or environmental surfaces that may be contaminated by the patient/resident or by his/her secretions and excretions.
- Examples of infections/conditions that require contact precautions: Salmonella, scabies, Shigella, and pressure ulcers.
- In addition to standard precautions:
  - Wear a gown and gloves upon room entry of a patient/resident on contact precautions.
  - Use disposable single-use or patient/resident-dedicated noncritical care equipment (such as blood pressure cuffs and stethoscopes).
- For certain organisms likely to have spores (like Clostridium difficile) and some disease with ongoing transmission (like Norovirus), “special” contact precautions are needed. In addition to the measures above, perform hand hygiene using soap and water and consider use of a hypochlorite solution (e.g., bleach) for environmental cleaning.

Droplet Precautions
- Used for patients/residents that have an infection that can be spread through close respiratory or mucous membrane contact with respiratory secretions.
- Examples of infections/conditions that require droplet precautions: influenza, N. meningitidis (one of the causes of meningitis), pertussis (also known as “whooping cough”), and rhinovirus (also known as the “common cold”).
- In addition to standard precautions:
  - Wear a mask upon room entry of a patient/resident on droplet precautions.
  - A single patient/resident room is preferred. If not available, spatial separation of more than 3 feet and drawing the curtain between beds is especially important.
  - Patients/residents on droplet precautions who must be transported outside of the room should wear a mask if tolerated and follow respiratory hygiene/cough etiquette.

Airborne Precautions
- Used for patients/residents that have an infection that can be spread over long distances when suspended in the air. These disease particles are very small and require special respiratory protection and room ventilation.
- Examples of infections/conditions that require airborne precautions: chickenpox, measles, and tuberculosis.
- In addition to standard precautions:
  - Wear a mask or respirator prior to room entry, depending on the disease-specific recommendations. Most diseases will require N95 or higher respiratory protection.
  - Place patient/resident in an airborne infection isolation (AI) room – a single-person room that is equipped with special air handling and ventilation capacity.
    - If the facility does not have an AI room, place the person in a private room with the door closed until the person is transferred to another facility with an AI room.
  - When possible, non-immune healthcare workers should not care for patients/residents with vaccine preventable airborne diseases (like measles and chickenpox).

Administering Medications: Practice Guidelines

Question any medication order that is illegible or that you consider incorrect. Call the prescriber for clarification.

Be knowledgeable about the medications you administer. Know why the medication is indicated for your patient. Look up any medication that you are not familiar with.

Keep narcotics and barbiturates in a locked place—federal law governs the use of these medications.

Do not administer liquid medications that are cloudy or that have changed color.

Calculate drug doses accurately. Prudent nurses ask another nurse to double-check their calculations.

Administer only medications that you have personally prepared.

Before administering a medication, identify the client correctly using the appropriate means of identification, such as checking the identification bracelet.

Do not leave medications at the bedside.

If a patient vomits after taking oral medication, report this to the prescriber.

Have another nurse check the dosages of heparin (anticoagulant), insulin, and certain other IV medications per agency policy.

When a medication is held for any reason, document that fact along with the reason. Notify the prescriber.

If a medication error is made, notify the prescriber and the charge nurse. Complete incident report per agency policy.

10 rights of medication administration:
Right medication
Right dose
Right route
Right time
Right client
Right client education
Right documentation
Right to refuse
Right assessment
Right evaluation

Three Checks of Medication Administration:
First Check: Read MAR and compare the medication to the MAR.
Second Check: While preparing medication check the medication against the MAR.
Third Check: Check at the bedside

Forms of Medication by Route of Administration

Oral Route

Solid Forms
Caplet: Solid dosage form for oral use; shaped like a capsule and coated for ease of swallowing
Capsule: Medication encased in a gelatin shell
Tablet: Powdered medication compressed into a hard disk or cylinder
Enteric coated: Tablet that is coated so that it does not dissolve in stomach; meant for intestinal absorption

Liquid Forms
Elixir: Clear fluid containing water and alcohol; designed for oral use; usually has sweetener added
Extract: Concentrated medication form made by removing the active portion of medication from its other components
Glycerite: Solution of medication combined with glycerin for external use
Solution: Liquid preparation that may be used orally, parenterally, or externally; can also be instilled into body organ or cavity (bladder irrigation). Must be sterile for parenteral use
Suspension: Finely dissolved particles in a liquid medium; when left standing, particles settle to bottom of container; not used intravenously
Syrup: Medication dissolved in a concentrated sugar solution
Troche (lozenge): Flat, round dosage form containing medication that dissolves in mouth; not meant for ingestion

Aerosol: Aqueous medication sprayed and absorbed in the mouth and upper airway; not meant for ingestion
Sustained release: Tablet or capsule that contains small particles of medication coated with material that requires a varying amount of time to dissolve

Topical Route

Ointment (salve or cream): Semisolid, externally applied preparation; usually containing one or more medications
Liniment: Oily liquid
Lotion: Emollient liquid that can be clear solution, suspension, or emulsion
Paste: Medication preparation that is thicker than ointment; absorbed through the skin more slowly than ointment
Transdermal patch: Disk or patch embedded with a medication that is absorbed through the skin over a designated period of time

Parenteral Route

Solution: Preparation that contains water with one or more dissolved compounds. The solution must be sterile
Powder: Particles of medication that are reconstituted with water, dissolved, and administered parenterally. The solution must be sterile

Instilled into Body Cavities

Suppository: Solid dosage form mixed with gelatin and shaped in the form of a pellet for insertion into a body cavity (rectum or vagina). The suppository melts when it reaches body temperature and is then absorbed
Intraocular disk: Disk similar to a contact lens embedded with a medication that is inserted into the client's eye. The medication is absorbed over a designated period of time

Adapted from Perry and Potter Clinical Nursing Skills & Techniques, 6th edition and Kozier & Erb's Fundamentals of Nursing, 8th edition
**Lesson 3: IM injections**

**Lesson 4: Subcutaneous and intradermal injections, and mixing insulin**

### Recommended Needle and Syringe Sizes

<table>
<thead>
<tr>
<th>Type Injection</th>
<th>Use</th>
<th>Needle Length</th>
<th>Needle Gauge</th>
<th>Solution amount</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intradermal</td>
<td>TB</td>
<td>26-27 gauge</td>
<td></td>
<td>0.01-0.1 ml</td>
<td>-sites: forearm, scapular of back</td>
</tr>
<tr>
<td></td>
<td>Allergy tests</td>
<td></td>
<td></td>
<td></td>
<td>-10-15 degree insertion</td>
</tr>
<tr>
<td>Subcutaneous</td>
<td>insulin, heparin</td>
<td>3/8-5/8”</td>
<td>26-29 gauge</td>
<td>less than 1.5ml</td>
<td>-sites: abdomen, upper posterior hip, lateral upper arm and thigh</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- don’t aspirate before injection</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- use with non-irritating meds</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-45-90 degree insertion</td>
</tr>
<tr>
<td>IM</td>
<td>oils and aqueous staining (iron)</td>
<td>1-1 ½ “</td>
<td>18-27 (20-25)</td>
<td>1-3ml</td>
<td>-irritating solutions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1-2= UE</td>
<td>-sites: ventrogluteal, dorsogluteal [avoid site], deltoid, rectus femoris</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3ml=LE</td>
<td>vastus lateralis [recommended in peds]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-Z-track used for reducing leakage of medication into tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-90 degree insertion</td>
</tr>
</tbody>
</table>

Subcutaneous Injection Guidelines
for Needle Length and Gauge Selection*

<table>
<thead>
<tr>
<th>Location of Injection</th>
<th>Needle Length</th>
<th>Needle Gauge</th>
<th>Needle Angle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterolateral thigh, Upper outer arm</td>
<td>1/2” - 5/8”</td>
<td>26 - 30G</td>
<td>45° - 90°</td>
</tr>
<tr>
<td>Triceps area, Upper buttocks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen (avoid 2” radius around umbilicus)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Adapted from Fundamentals of Nursing: Human Health and Function, R. Craven, C. Hirnle, 4th ed. Lippincott Williams & Wilkins 2003

ISO Hub Color Standards for safety-engineered needles
# Intramuscular Injection Guidelines

for Needle Length and Gauge Selection

**INTRAMUSCULAR (IM)**

<table>
<thead>
<tr>
<th>Location of Injection</th>
<th>Needle Length</th>
<th>Needle Gauge</th>
<th>Needle Angle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infants &lt; 18 months</td>
<td>7/8&quot; - 1&quot;</td>
<td>25 - 27 G</td>
<td>90°</td>
</tr>
<tr>
<td>Deltoid muscle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventrogluteal site</td>
<td>7/8&quot; - 11/4&quot;</td>
<td>22 - 25 G</td>
<td>90°</td>
</tr>
<tr>
<td>Dorsogluteal site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vastus lateralis muscle</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Children (>18 months and walking to 18 years) | 1" - 1 1/2" (up to 3" for large adults) | 19 - 25 G | 90° |

| **Adult**              |               |              |             |
| > 18 years             | 19 - 25 G     | 90°          |             |

* Adapted from Fundamentals of Nursing: Human Health and Function, R. Craven, C. Himle, 4th ed. Lippincott Williams & Wilkins 2003

** Prior to administering an IM injection, refer to your procedure manual to determine the injection site utilizing body landmarks.

### ISO Hub Color Standards for safety-engineered needles

Lab WEEK 2: Meet in Nursing Center classroom at 0700

Student Learning Outcomes:

Safety and mobility in nursing care
- Explain measures to prevent falls
- Use safe practices when positioning, moving, lifting and ambulating clients

Oxygenation:
- Describe the impact of a client's level of health, age, lifestyle, and environment on tissue oxygenation
- Identify and describe clinical outcomes of hyperventilation, hypoventilation, and hypoxemia
- Identify nursing interventions that promote oxygenation

Diagnostic Testing:
- Perform GMT testing that reflects high quality, safe patient care

Pre-Lab Work: **Student is responsible to be prepared for all lab activities**
- Review all clinical requirements; you cannot participate in clinical if requirements are incomplete.
- View ATI videos and read K&E chapter corresponding to topics:

Lab Prep: View ATI videos and read K&E chapter corresponding to topics
**Student is responsible to be prepared for all lab activities**

READ: Kozier & Erb’s Fundamentals of Nursing
- K&E: ch 31 review pp. 700-710
- K&E: ch 37-Perioperative Nursing- pp. 966-968
- K&E: ch 37-pp. 970-973 [anti-emboli stockings]; pp. 946-947 [ACE wraps]
- K&E: ch 44-Activity and Exercise-pp.1134-1177
- K&E: ch 27-Teaching-p.497 [Barriers to Learning], & p. 508-514-; [Selecting Teaching Strategies; Evaluation of patient learning]
- K&E: ch 50: Oxygenation- pp. 1389-1417
- K&E: ch 34: Diagnostic Testing-GMT: pp. 815-818

ATI Nursing Video Skills: [Bring ATI Pretest to LAB for listed ATI Nursing Video Skills- all post tests due with PME check off]
- Diabetes Management-[GMT, mixing insulin: ATI pretest due at lab]
- Airway Management
  - suctioning: oral and nasal (not in-line video)- ATI pretest due at lab
  - trach care
- Oxygen Therapy- ATI pretest due at lab
  - all (except O2 tanks)
- Ambulation, transferring, ROM- ATI pretest due at lab [post test due week 4 lab]
  -view all, except transfer to a gurney.

Lesson 1: Classroom activity: Sterile Field and Gloving: Video and large group demonstration

Lesson 2: In Lab: Clinical Decision Making

Lesson Plan:
Station 1: - Diabetes Management

Station 2: **Airway Management and Oxygen Therapy**

Skill Focus: Demonstrate and apply various oxygen devices: nasal cannula, simple face mask, non-rebreather mask; Demonstrate and practice non-sterile oral and nasal suctioning with a Yankauer device or suction catheter. Demonstrate care of tracheostomy tube. *Clinical Decision-making*: Recognizing and managing the patient in respiratory distress. *ATI skill check off: see calendar for due date.*

Station 3: **Patient teaching: early mobilization**

Skill Focus: Discussion of barriers of patient education and learning with selected teaching strategies; Evaluation of patient learning. *Patient teaching skills*: Students actively participate in moving as a post-op patient in/out of bed, leg exercises. Demonstrate coughing and deep breathing exercises and incentive spirometer [IS].

Station 4: **SIM MAN: Failure to rescue**

Skill Focus: Respiratory focused assessment and interventions in respiratory distress: Avoid failure to rescue. SIMulation will allow for critical thinking to recognize and intervene early in patient distress. Students work as a team to assess, make clinical decisions, document, and give SBAR report.

Lesson 3: **In Lab: Ambulation and mobility aides**

Lesson Plan:

**Station 1: Ambulation: walker**

Skill Focus: Transfer patient to/from bed to W/C; ambulate patient with a walker and gait belt. *ATI skill check off: see calendar for due date.*

**Station 2: Ambulation: cane and crutches**

Skill Focus: Ambulate your patient with a cane and crutches using a gait belt; *per ATI nurse is on unaffected side for all ambulation, unless excessive weakness*. *ATI skill check off: see calendar for due date.*

**Station 3: Application of ACE wraps and TED stockings**

Skill Focus: Apply ACE wrap and TED stockings on your patient; understand the role of these interventions in prevention of immobility complications.
Importance of Hemoglobin A1c Test

The hemoglobin A1c test -- also called HbA1c, glycated hemoglobin test, or glycohemoglobin -- is used to determine how well your diabetes is being controlled. The A1C test gives you a picture of your average blood glucose (blood sugar) control for the past 2 to 3 months.

The amount of hemoglobin A1c will reflect the last several weeks of blood sugar levels, typically encompassing a period of 120 days.

Glucose enters your red blood cells and binds or glycates with molecules of hemoglobin. The more glucose in your blood, the more hemoglobin gets glycated. By measuring the percentage of A1C in the blood, you get an overview of your average blood glucose control for the past few months.

A1C Values

The A1C test measures your average blood glucose for the past 2 to 3 months.

Diabetes is diagnosed at an A1C of greater than or equal to 6.5%

<table>
<thead>
<tr>
<th>Result</th>
<th>A1C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>less than 5.7%</td>
</tr>
<tr>
<td>Prediabetes</td>
<td>5.7% to 6.4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>&gt;6.5%</td>
</tr>
</tbody>
</table>

Diabetes Symptoms

The following symptoms of diabetes are typical. However, some people with type 2 diabetes have symptoms so mild that they go unnoticed.

Common symptoms of diabetes:
- Urinating often
- Feeling very thirsty
- Feeling very hungry - even though you are eating
- Extreme fatigue
- Blurry vision
- Cuts/bruises that are slow to heal
- Weight loss - even though you are eating more (type 1)
- Tingling, pain, or numbness in the hands/feet (type 2)

Adapted from:
Clinical Decision Making: Hypoglycemia

Your body needs a steady supply of sugar (glucose) in order to function properly. If glucose levels become too low, as occurs with hypoglycemia, it can have these effects on your brain:
Confusion, abnormal behavior or both
Shakiness        Visual disturbances      Hunger
Seizures [though uncommon]    Sweating/diaphoresis
Loss of consciousness     Anxiety
Heart palpitations        Tingling sensation

These signs and symptoms aren't specific to hypoglycemia and there may be other causes. An intravenous blood sample to test your blood sugar level at the time of these signs and symptoms is the only way to know for sure that hypoglycemia is the cause.

Immediate initial treatment
The initial treatment depends on your symptoms. Early symptoms can usually be treated by consuming sugar, such as eating candy, drinking fruit juice or taking glucose tablets to raise your blood sugar level. If your symptoms are more severe, impairing your ability to take sugar by mouth, you may need an injection of glucagon or intravenous glucose.

Clinical Decision Making: Hyperglycemia

High blood sugar (hyperglycemia) affects people who have diabetes. Several factors can contribute to hyperglycemia in people with diabetes, including food and physical activity choices, illness, nondiabetes medications, or not taking enough glucose-lowering medication.

It's important to treat hyperglycemia, because if left untreated, hyperglycemia can become severe and lead to serious complications requiring emergency care, such as diabetic coma. In the long term, persistent hyperglycemia, even if not severe can lead to complications affecting your eyes, kidneys, nerves and heart.

Early signs and symptoms
Recognizing early symptoms of hyperglycemia can help you treat the condition promptly. Watch for:
Frequent urination    Fatigue
Increased thirst     Headache
Blurred vision

Later signs and symptoms
If hyperglycemia goes untreated, it can cause toxic acids (ketones) to build up in your blood and urine (ketoadicosis). Signs and symptoms include:
Fruity-smelling breath    Confusion
Nausea and vomiting     Coma
Shortness of breath     Abdominal pain
Dry mouth    Weakness

Slow-healing sores or frequent infections
Areas of darkened skin; in creases
Treatment

- **Get physical.** Regular exercise is often an effective way to control your blood sugar.
- **Take your medication as directed.** If you have frequent episodes of hyperglycemia, the doctor may adjust the dosage or timing of your medication.
- **Follow a diabetes eating plan.** Eat less, and avoid sugary beverages.
- **Check your blood sugar.** Monitor your blood glucose.
- **Adjust your insulin doses to control hyperglycemia.** Adjustments to your insulin program or a supplement of an extra dose of short-acting insulin. See *Standing orders* prescribed by the MD.


Station 2: Oxygenation

Oxygenation Summary [per ATI]

<table>
<thead>
<tr>
<th>Name of Device</th>
<th>Amount of Oxygen provided</th>
<th>Device setting</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room Air [RA]</td>
<td>21%</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Nasal Cannula [NC]</td>
<td>24-44%</td>
<td>1-6 Lt/min</td>
<td>Provide humidification for flow rates 4 Lt/min or greater</td>
</tr>
<tr>
<td>Simple mask</td>
<td>40-60%</td>
<td>5-8 Lt/min</td>
<td>The mask acts as the O2 reservoir. Caution with those at risk for aspiration or airway obstruction.</td>
</tr>
<tr>
<td>Venturi mask</td>
<td>24-60%</td>
<td>4-12 Lt/min</td>
<td>Uses different size adapters to achieve precise oxygen concentration. Good choice for COPD client.</td>
</tr>
<tr>
<td>Partial Rebreather mask [PRM]</td>
<td>40-70%</td>
<td>6-11 Lt/min</td>
<td>The reservoir bag has no valves or only 2-way valves. The bag is filled 2/3 full of O2. 2-way valves allow patients to exhale into reservoir bag, and inhale 1/3 of own exhaled air from the bag = &quot;rebreath&quot;</td>
</tr>
<tr>
<td>Non-rebreather mask [NRM]</td>
<td>60-80%</td>
<td>10-15 Lt/min</td>
<td>Mask and bag contain one-way valves to prevent inhaling exhaled air; they do not allow patients to rebreathe own air. Can present suffocation hazard if both valves on mask are used.</td>
</tr>
<tr>
<td>Aerosol, face tents and trach collars</td>
<td>24-100%</td>
<td>at least 10Lt /min</td>
<td>Allows for high humidification. Works well for a client not tolerating a mask.</td>
</tr>
</tbody>
</table>

All devices attempt to maintain adequate oxygen saturation at greater than or equal to 92% per pulse oximetry.

Safety:

- Post "No Smoking" signs.
- Educate clients of fire hazards when oxygen is in use.
- Wear cotton clothing; avoid synthetic or wool which can generate static electricity.

- Be sure electrical appliances are grounded, and electrical equipment in good working condition.

- Do not use flammable materials near client when O2 is in use [alcohol, acetone, etc].

Adapted from:
Patient Education: Leg Exercises

Venous return from the legs slows during surgery and may actually decrease in some surgical positions. With circulatory stasis of the legs, thrombophlebitis and emboli are potential complications of surgery. Venous return is increased by flexion and contraction of the leg muscles.

(1) To prevent thrombophlebitis, instruct the patient to exercise the legs while on bedrest. Leg exercises are easier if the patient is in a supine position with the head of the bed slightly raised to relax abdominal muscles. Leg exercise should be individualized using the following guidelines.

(a) Flex and extend the knees, pressing the backs of the knees down toward the mattress on extension.

(b) Alternately, point the toes toward the chin (dorsiflex) and toward the foot of the bed (plantar flex); then, make a circle with the toes.

(c) Raise and lower each leg, keeping the leg straight.

(d) Repeat leg exercises every 1 to 2 hours.

(2) Ambulate the patient as ordered.

(a) Provide physical support for the first attempts.

(b) Have the patient dangle the legs at the bedside before ambulation.

(c) Monitor the patient's blood pressure while he dangles.

(d) If the patient is hypotensive or experiences dizziness while dangling, do not ambulate.
Client Education:

Coughing & Deep Breathing

Be familiar with:

- Use of Incentive Spirometry
- Chest Physiotherapy: Postural Drainage, vibration and chest percussion
- Huff Coughing

Adapted from:

- Position for maximum chest expansion.
- Take a deep breath through your nose to filter, warm and to moisten the air.
- Hold your breath for a short time. Exhale (breathe out) slowly and gently through pursed lips (as if you were blowing out a candle).
- Do the above for three breaths. On the third breath, cough instead of breathing out. Coughing is done to try to bring up any mucus from your lungs. Repeat this deep breathing two more times.
  - Use huff coughing as alternative to forceful cough in COPD client: use a “huff” to exhale alternated with pursed lip exhalation
Lab WEEK 3: Meet in Nursing Center LAB at 0700

Student Learning Outcomes:

Nutrition
State the goals of enteral nutrition
Demonstrate procedure for initiating and maintaining tube feeding
Describe methods to avoid complications of tube feedings

Skin integrity and basic wound care
Describe factors affecting skin integrity
Identify clients at risk for pressure ulcers
Describe the four stages of pressure ulcer development
Identify assessment data pertinent to skin integrity, pressure sites, and wounds. BRADEN score.
Discuss measures to prevent pressure ulcer formation.
Identify and demonstrate essential steps of obtaining wound specimens, applying dressings, and irrigating a wound

Elimination:
Describe characteristics of normal and abnormal urine
Insert and remove a urinary catheter
Obtain urine specimen
Demonstrate steps to apply an external urinary device
Verbalize understanding of documentation and reporting of urinary elimination.

Lab Prep: View ATI videos and read K&E chapter corresponding to topics
**Student is responsible to be prepared for all lab activities

READ:
Kozier & Erb’s Fundamentals of Nursing
K&E: ch 36 Skin Integrity and Wound care pp. 920-946;
K&E: ch 47 Nutrition- pp. 1282-1296 [Enteral nutrition]
K&E: ch 49 Fecal Elimination- pp. 1359-1366 [bedpans and enemas]
K&E: ch 48 Urinary Elimination- pp. 1313-1336

ATI Nursing Video Skills: [Bring ATI Pretest to LAB for listed ATI Nursing Video Skills- all post tests due with PME check off]
Urinary Catheter Care- ATI pretest due at lab
- all
Wound and pressure ulcer care- ATI pretest due at lab
Enteral Nutrition-
- Insert feeding tube- ATI pretest due at lab
- Manage feeding tube
- Admin. Enteral feeding via syringe
- Admin. Enteral feeding via pump

Lesson 1: In Lab: Large group: Bed pan and urinal placement-I&O

Lesson 2: In Lab: Clinical Decision Making

Lesson Plan:
Station 1: Urinary Catheter Management

Skill Focus: Insertion, removal and maintenance of both Male and female indwelling urinary catheter [Foley] and pericare.
Station 2: Electronic Medical Record [EMR]- Computer lab

Skill Focus: Use Informatics to complete an electronic database. Simulation through EPIC electronic medical record. Completed EMR is due at end of station time today.

Station 3: Nasogastric [NG] tube care

Skill Focus: Discuss the purpose for NG tube placement. Demonstrate and practice insertion and removal of a NG tube; Demonstrate and practice percutaneous endoscopic gastrostomy [PEG] or gastric-tube [G-tube] site care; Discuss low-intermittent [LIS] GI suction; Discuss types of tube feeding [TF] nutrition and how TF is delivered through NG or PEG tubes; Discuss and demonstrate multiple types of enema administration.

Station 4: Basic Sterile Dry Dressing Change

Skill Focus: Demonstrate and practice cleansing a wound, obtain a wound specimen and application of a transparent wound barrier. Stage Pressure Ulcers; Demonstrate accurate risk for skin breakdown with use of Braden Scale.

Lab WEEK 4: Meet in Nursing Center classroom at 0700

Student Learning Outcomes:

Meeting client care needs:
- Identify safety and comfort measures that support a positive environment for the client.
- Recognize when it is appropriate to delegate hygiene skills to UAP
- Demonstrate appropriate hygiene skills
- Demonstrate interventions that prevent falls
- Demonstrate physical assessment incorporated during client hygiene [bed bath]
- Demonstrate appropriate documentation and reporting of health assessment
- Demonstrate safe practices when positioning, moving, lifting and ambulating clients

Simulation Learning Objectives

- Conduct a head-to-toe assessment on the patient integrated with bathing.
- Gather and analyze cluster data
- Use appropriate evidence-based tools to complete an overall assessment of safety and skin risks.
- Identify priority nursing concerns and Nursing Diagnosis.
- Identify and report critical physical assessment findings using SBAR
- Use SBAR techniques when communicating with other members of the health care team
- Maintain safety in the clinical environment

Lab Prep: View ATI videos and read K&E chapter corresponding to topics

**Student is responsible to be prepared for all lab activities

READ: Kozier & Erb’s Fundamentals of Nursing
K&E: Ch 33- Hygiene

ATI Nursing Video Skills: [Bring ATI Post-test to LAB for listed ATI Nursing Video Skills]  
Personal Hygiene –ATI post test due  
Ambulation, transferring, ROM-ATI post test due at lab  
-all, except transferring with lift device
and to a gurney.  

Restraints and alternatives- **ATI post-test due at lab**

**Bring to lab:**
ATI Skill check list & post test for Ambulation and transferring; ATI post test for Hygiene

**Lesson 1: In classroom: Large group:**

**Lesson Plan:**
1. Meet Millie: video and worksheet
2. Dysphasia: Nursing role is prevention of aspiration

**Lesson 2: In Lab: Clinical Decision Making**

**Lesson Plan:**
Large Group in LAB: Dysphasia interventions: Liquid thickeners

**Skill Focus:** Practice mixing liquid thickeners to desired consistency. Discuss the risks associated with dysphagia and risks of clients requiring liquid thickeners.

**Lesson 3**

**Station 1: Millie “Unfolding Case Study” Role Play: Clinical Decision Making**

**Skill Focus:** Complete a mock clinical day: Assessment and hygiene.

**Station 2: Safety, Mobility and Ambulation**

**Part 1: Skill Evaluation:** **ATI Ambulation/Mobility Check off**-

**Skill Focus:** Evaluation of ATI Ambulation/transfer/Mobility skills [student will provide ATI posttest and skill check off form]:
Crutch walking, cane, walker, transfer in & out of bed, transfer to a w/c; apply and use gait belt.

**Part 2: Restraints and alternatives + seizure precautions**

**Skill Focus:** Demonstration and Discussion: Restraints and alternatives

**Lesson 4: Large group activity**

**Part 1: Critical Thinking: Putting it All Together**

**Part 2: Hoyer Lift Demonstration and Hover transfer device**

**Skill Focus:** Safe, non-weight bearing transfers using no-lift devices

**Part 3: Positioning in Bed**

**Skill Focus:** **Positioning in Bed:** use safe techniques and pillows as positioning devices
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 24 &amp; 26</td>
<td>Orientation week&lt;br&gt;- Safe medication administration&lt;br&gt;- Implement standards of infection control</td>
<td>ATI pretests due-Medication 1-4: Diabetes Management; admin insulin; IV therapy; Read text: K&amp;E chapters, and Smith [ch 1&amp;3] &amp; view ATI videos as per syllabus [see lab plan]&lt;br&gt;- This week begins: 2 hours required lab practice time [Sunday-Saturday]- record on your lab log</td>
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<tr>
<td>Lab 1 1/31 or 2/2 0800-1150</td>
<td>- Client teaching &lt;br&gt;- Prevention of falls and safe mobility/transfer techniques &lt;br&gt;- Promotion of oxygenation &lt;br&gt;- Nursing and Diabetes management</td>
<td>ATI pretests due: Oxygenation, GMT, ambulation/transfers &lt;br&gt;Read K&amp;E chapters as per syllabus</td>
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<tr>
<td>Lab 2 2/7 &amp; 2/9 0700-1150</td>
<td>- Nursing role in enteral nutrition&lt;br&gt;- Prevention and treatment of pressure ulcers&lt;br&gt;- Nursing interventions of urinary and fecal elimination</td>
<td>ATI pretests due: Urinary Catheter Care &lt;br&gt;Wound and pressure ulcer care[Dry dressing change] &lt;br&gt;Enteral Nutrition [Insert/remove feeding tube] &lt;br&gt;Read K&amp;E chapters as per syllabus</td>
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Discuss measures to prevent pressure ulcer formation. Identify and demonstrate essential steps of obtaining wound specimens, applying dressings, and irrigating a wound.

**Elimination:**
Identify factors that commonly influence urinary and fecal elimination
Obtain urine specimen
Describe characteristics of normal and abnormal urine
Insert, irrigate and remove a urinary catheter
Demonstrate steps to apply an external urinary device and perform urinary catheterization,
Verbalize understanding of documentation and reporting of urinary elimination.

Lab 4
2/21 & 2/23
0630-1150

- Meeting client care needs in long term care setting through simulation

**ATI posttests due:**
- Hygiene;
- Ambulation; Restraints
- Skill Check off due: in lab-
- Ambulation and transferring
  [with gait belt, walker, crutches, cane] & Hygiene
- Focused Assessments due: by Friday
- Read K&E chapters & view videos as per syllabus [lab plan]

**Lab Objectives week 4: Clinical Sim Day Meeting client care needs:**
Identify safety and comfort measures that support a positive environment for the client.
Recognize when it is appropriate to delegate hygiene skills to UAP
Demonstrate appropriate hygiene skills
Demonstrate interventions that prevent falls
Demonstrate physical assessment incorporated during client hygiene [bed bath]
Demonstrate appropriate documentation and reporting of health assessment
Demonstrate safe practices when positioning, moving, lifting and ambulating clients
Simulation Learning Objectives
Conduct a head-to-toe assessment on the patient integrated with bathing.
Gather and analyze cluster data
Use appropriate evidence-based tools to complete an overall assessment of safety and skin risks.
Identify priority nursing concerns and Nursing Diagnosis.
Identify and report critical physical assessment findings using SBAR
Use SBAR techniques when communicating with other members of the health care team
Maintain safety in the clinical environment

Clinical Calendar:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Assignment due</th>
<th>Weekly Clinical Objectives: [Applied to every week]</th>
</tr>
</thead>
</table>
| Clinical Orientation 2/28 & 3/2 0700-1130 | **Clinical Orientation at your clinical site:**
**Note your day of week may change to meet clinical site needs** | Lab Informatics: EPIC EMR paper Reflection: “Fears and Feelings” | -Assume the professional roles and responsibilities of the professional nurse in the assessment, planning, delivery of safe, quality, patient-centered care in the long-term environment
-Delivers care that demonstrates valuing and respect for the uniqueness of individuals |
| Clinical 1 3/7 & 3/9 0600-1130 | 1st full clinical day
Focus: Safety and Skin [MORSE, BRADEN scale]
-Demonstrate Cardio-respiratory assessment, safe transfer | Medical Diagnosis Paper due
Skill Check off due 3/9; Parenteral Medications [IM, SQ, ID] | See above “Clinical Orientation” |
| Clinical 2 3/21 & 3/23 0600-1130 | **Clinical Focus:** Nutrition [Nutrition Assessment Tool]
-Demonstrate Cardio-respiratory assessment | **Clinical 2**
- Client Assessment from week 1
- Skin IPOC
- Self reflection from week 1 | See above “Clinical Orientation” |
| Clinical 3 | Clinical Focus: Psychosocial problem  
Demonstrate Cardio-respiratory & GI/GU assessment | Clinical 3  
Skill Check off due 3/30: Non-parentreral Medication | **Weekly Clinical Objectives:**  
See above “Clinical Orientation”  
*Midterm evaluation with clinical faculty [student brings lab log and midterm self-assessment]* |
|---|---|---|---|
| 3/28 & 3/30  
0600-1130 | | | |
| Clinical 4 [could be UCC day; then start at 0745] | Clinical 4  
Teaching Presentations  
Lifespan: Evidence of Piaget and Erickson  
Skill Check off due 4/6: Oxygenation AND Wound Care | Recognize developmental and cognitive behaviors of children. | |
| 4/4 & 4/6  
0600-1130 | | | |
| Clinical 5 | Clinical 5  
Skill Check off due 4/13: GMT AND IV site care, assessment & cap IV | **Weekly Clinical Objectives:**  
See above “Clinical Orientation” | |
| 4/11 & 4/13  
0600-1130 | | | |
| Clinical 6 | Clinical 6  
Demonstrate Neuro/musculoskeletal assessment | **Weekly Clinical Objectives:**  
See above “Clinical Orientation” | |
| 4/18 & 4/20  
0600-1130 | | | |
| EXPO | SIM Skill Evaluation | EXPO 06-1200 | -Demonstrate competency in selected psychomotor skills.  
-Demonstrate clinical judgment that evidences safe, high quality patient care |
| 4/25 & 4/27 | | | |
| EXPO remediation | | EXPO remediation | |