ASSOCIATE DEGREE NURSING

RNSG 1362
Clinical to RNSG 1309

Revised 12-2012
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Panola College  
Associate Degree Nursing Program

COURSE NAME: Clinical Nursing

COURSE NUMBER: RNSG 1362

Semester Credit Hours: 3  
Lecture Hours per week: 0  
Clinical Hours per week: 12  
Contact Hours per Semester: 192  
State Approval Code: CIP 51.3801

PRE-REQUISITES: CHEM 1405, BIOL 2401, BIOL 2402, PSYC 2301 RNSG 1205

CO-REQUISITES: RNSG 1309

Course Description: A method of instruction providing detailed education, training and work-based experience and direct patient care, generally at a clinical site. Specific detailed learning objectives are developed for each course by the faculty. On-site clinical instruction, supervision, evaluation and placement is the responsibility of the college faculty. Clinical experiences are unpaid external learning experiences.

Goals of the Course: Students will use the nursing process in providing preventive, maintenance, and restorative care for adult clients. Concepts of nursing will be applied from a professional nursing view within the framework of member of the profession, provider of patient-centered care, patient safety advocate, and member of the health care team. Students will also apply concepts of nursing, environment, person, health and education throughout the course.

Core Competencies: Students are expected to demonstrate basic competency in reading, writing, oral communication, math, and computer skills. Students are expected to be an active learning participant by assuming accountability in preparing for each class by completing required readings and/or other learning activities as listed in the syllabus. Proficiency will be measured by clinical participation, skills assessment, documentation, and interaction as a team member.

Course Requirements:
1. Regular clinical attendance within current attendance policies.
2. An average of 75% or better on course work.
3. Preparation and active participation in clinical conferences.
4. Outside individualized readings and assignments.
5. Compliance with all rules and regulations as outlined in the current Department of Nursing’s Student Handbook and the Panola College Catalog.
6. Basic Life Support cardiopulmonary resuscitation certification received through Panola College with an expiration beyond expected date of graduation.
COURSE GRADING

Each student will be evaluated in a clinical conference at the mid and endpoint of this clinical course. The evaluation will be based on observation of the student’s performance and behaviors in the clinical setting and all required written assignments.

The Associate Degree Nursing Program, in accordance with policy, uses the following numerical scale in computing final course grades:

- A = 90-100
- B = 80-89
- C = 75-79
- F = below 75

There will be no rounding of grades (See Student Handbook.)

Final grades will consist of the following:

- Clinical evaluation/observation (refer to Evaluation tool) 85%
- Teaching Project (3.5%)/Care plans (3.5%)/Holistic Assessment (8%) 15%

Concurrent enrollment in RNSG 1309 is required. Successful completion of both the theory and the clinical course is required for progression. If the student is not successful in either of the courses (RNSG 1362 or RNSG 1309), BOTH courses must be repeated for two new grades.

DOSAGE CALCULATION EXAM

A dosage calculation exam will be administered. The pass rate is 100% and the student will be given three opportunities to achieve this score. If the student does not achieve 100% by the third attempt, they will be dropped from the course with an "F" (failure).

Achievement examinations will be administered throughout the nursing program. In addition to fulfilling the academic requirements of Panola College, all students must successfully pass a comprehensive achievement examination in the final semester of the nursing program in order to be eligible to graduate. This is the capstone experience. Please refer to policy 6.7 in the Student Handbook for further information.

In preparation for these examinations and the NCLEX for licensure after graduation, students are advised to increase their exposure to similar questions they will see on NCLEX. This can be accomplished by completing periodic self-evaluation review exams as found in NCLEX Review texts. These are also available online. To access these sites, the student should utilize a Google.com or a Bing.com search, using “NCLEX questions” as the search item.

Special Needs
If any student in this class has special classroom or testing needs because of a physical, learning, or emotional condition, please contact ADA Counselor in the Administration Building, telephone 903-693-1123.

Withdrawing from a course
Withdrawing from a course is the student’s responsibility. If you do not withdraw yourself, you will receive a grade of "F" if you do not attend class.
### METHOD OF INSTRUCTION

- Observation
- Client care assignments
- Clinical conferences, pre/post
- Group discussion
- Group presentation
- Student-Teacher conferences
- Comprehensive Holistic Assessment
- Return demonstration
- Teaching Plan
- Simulation

### TEXTBOOK/REFERENCES


*Drug book of choice*

**Additional Resources:**

- Google.com
- Bing.com
- Youtube.com
- Evolve.com
- Nursingcenter.com
- [www.bon.texas.gov/](http://www.bon.texas.gov/)
# COURSE OBJECTIVES (Learning Outcomes)

## THE NURSE AS A MEMBER OF THE PROFESSION
At the end of the course, the student will be able to:

1. Follow the legal/ethical concepts that influence the practice of nursing. (Scans IBii, iii, v, ICv, IIAv, IICi) PO# 1 DEC# I a, b

2. Explain life-long learning of nursing to promote excellence in nursing practice. (Scans IBi, ICi, ii, iv, IIbiv, IIciii) PO# 2 DEC# I c, d

## THE NURSE AS A PROVIDER OF PATIENT-CENTERED CARE
At the end of the course, the student will be able to:

3. Gather information regarding patient responses to altered health status to provide basic nursing care. (Scans IAi, ii, iii, iv, IBi, ii, iii, iv, v, IIa, iii, IIbiii, IIc, ii, iii, iv, IIIe, ii) PO# 3 DEC# II a, b, c, d, e, f

4. Apply principles of patient education to teaching patients. (Scans IAi, ii, iv, v, IBii, IIbii, iii, vi, IIcii, ii, iii) PO# 4 DEC# II g

5. Explain rationale for nursing plan of care in an organized manner using current information, and other appropriate resources. (Scans IAi, v, IBi, ii, iii, v, IIa, iii, IIcii) PO# 5 DEC# II h

## THE NURSE AS A PATIENT SAFETY ADVOCATE
At the end of the course, the student will be able to:

6. Recognize and implement mandatory safety measures for patients, staff, and visitors and receive training prior to providing care as needed. (Scans IAi, IBi, v) PO# 6 DEC# III b, d, e, f

7. Implement measures to promote quality and a safe environment for patients, self, and others. (Scans IAiv, v; IBi, ii, iii, v) PO# 7 DEC# III a, b, c

## THE NURSE AS A MEMBER OF THE HEALTH CARE TEAM
At the end of the course, the student will be able to:

8. Use confidential information from the Health Care Team to provide patient-centered care. (Scans IAiv, v; ICi, ii, iii, iv, v; IIbiv, iv, v, vi) PO# 8 DEC# IV a, d

9. Describe activities that promote health care advocacy. (Scans IBi, ii, iii, iv, v) PO# 9 DEC# IV b, c

10. Explore the technological advances in nursing that have and will improve patient outcomes. (Scans IIcii, ii, iii, iv; IIdii, ii, iii) PO# 10 DEC# IV c

11. Identify within the Scope of Practice those nursing activities which can legally, ethically, and morally be delegated to non-professional personnel. (Scans IBii, v; IIaiv; IIBi, iv, vi) PO# 11 DEC# IV f, g
## CLINICAL ASSIGNMENTS (METHOD OF EVALUATION)

### THE NURSE AS A MEMBER OF THE PROFESSION:
Using critical thinking and a problem solving approach, the student will:

<table>
<thead>
<tr>
<th>1. Follow legal-ethical framework for the practice of nursing in Texas.</th>
<th>CO# 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Demonstrate professional behavior and accountability within limits of nursing knowledge.</td>
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<tr>
<td>B. Follow the Texas Nurse Practice Act.</td>
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<td>C. Follow the ANA Code of Ethics.</td>
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<td>D. Follow the faculty's instructions.</td>
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<td>E. Follow the Panola Student Handbook policies and ADN dress code.</td>
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<td>F. Follow the rules and policies of assigned agency.</td>
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<tr>
<th>2. Participate in clinical self-evaluations in a professional manner.</th>
<th>CO# 2</th>
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<tbody>
<tr>
<td>A. Document specific behaviors student has performed.</td>
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<tr>
<td>B. Use self-evaluation, reflection and feedback to modify and improve practice.</td>
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### THE NURSE AS A PROVIDER OF PATIENT-CENTERED CARE
Using critical thinking and a problem solving approach, the student will:

<table>
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<tr>
<th>3. Develop clinical reasoning skills by applying the nursing process when providing culturally-appropriate, direct-care to one adult patient.</th>
<th>CO# 3</th>
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<tbody>
<tr>
<td>A. Use various data collection methods to obtain patient and family history.</td>
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<tr>
<td>B. Perform a comprehensive holistic assessment on a nursing home client to identify health needs and monitor changes in health status. Perform partial health histories on other assigned clients.</td>
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<td>C. In collaboration with patient(s), develop three different nursing care-plans.</td>
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<td>D. Implement fundamental, individualized nursing interventions for adult patient(s).</td>
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<tr>
<td>F. Communicate changes in patient status to other providers.</td>
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<tr>
<th>4. Assess for learning needs and provide client teaching in the nursing home and hospital settings.</th>
<th>CO# 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Assess learning needs of patients and their families related to risk reduction and health promotion, maintenance, and restoration.</td>
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<tr>
<td>B. Provide informal teaching for all clients as appropriate.</td>
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</tbody>
</table>
C. Develop and present a formal teaching plan.

5. Locate and utilize resources which are optimal and cost-effective for patient care.  
   CO# 5

**THE NURSE AS A PATIENT SAFETY ADVOCATE**  
Using critical thinking and a problem solving approach, the student will:

6. Promote a safe, effective environment.
   - A. Accurately identify patient by two different methods.
   - B. Safely perform all nursing measures and procedures.
   - C. Safely calculate dosages and administer medications and treatments.
   - D. Seek supervision for entire process of medication administration from nursing instructor or preceptor.
   - E. Assess potential risk for patient harm related to accidents and implement measures to prevent risk of patient harm.
   CO# 6

7. Seek assistance if practice requires behaviors or judgments outside of individual knowledge and expertise.  
   CO# 7

**THE NURSE AS A MEMBER OF THE HEALTH CARE TEAM**  
Using critical thinking and a problem solving approach, the student will:

8. Gather data from patient chart and healthcare staff to formulate nursing plan of care.
   - A. Communicate changes in patient status and/or negative patient outcomes as a result of care provided.
   CO# 8

9. Identify the patient's right of self determination and choice.
   - A. Identify any unmet, basic patient needs and notify instructor.
   - B. Maintain confidentiality according to HIPPA guidelines.
   CO# 9

10. Use technology in the delivery of patient care.
    - A. Use electronic equipment correctly to obtain patient data.
    - B. Identify, collect, process and report patient data to instructor.
    CO# 10

11. Give examples of skills and patient-centered tasks that may legally and ethically be delegated to non-professional personnel.  
    CO# 11
Secretary of Labor’s Commission on Achieving Necessary Skills (SCANS)

SCANS Skills are grouped in two areas: (1) foundation skills and (2) workplace competencies.

1. **Foundation Skills** are defined in three areas: (a) basic skills, (b) thinking skills, and (c) personal qualities.

(a) **Basic Skills:** A worker must read, write, perform arithmetic and mathematical operations, listen, and speak effectively. These skills include:

   1. Reading: locate, understand, and interpret written information in prose and in documents such as manuals, graphs, and schedules;
   2. Writing: communicate thoughts, ideas, information, and messages in writing; and create documents such as letters, directions, manuals, reports, graphs, and flow charts;
   3. Arithmetic and Mathematical Operations: perform basic computations and approach practical problems by choosing appropriately from a variety of mathematical techniques;
   4. Listening: receive, attend to, interpret, and respond to verbal messages and other cues; and
   5. Speaking: organize ideas and communicate orally.

(b) **Thinking Skills:** A worker must think creatively, make decisions, solve problems, visualize, know how to learn, and reason effectively. These skills include:

   1. Creative Thinking: generate new ideas;
   2. Decision Making: specify goals and constraints and generate alternatives, consider risks, and evaluate and choose the best alternative;
   3. Problem Solving: recognize problems and devise and implement plan of action;
   4. Visualize (“Seeing Things in the Mind’s Eye”): organize and process symbols, pictures, graphs, objects, and other information;
   5. Knowing How to Learn: use efficient learning techniques to acquire and apply new knowledge and skills; and
   6. Reasoning: discover a rule or principle underlying the relationship between two or more objects and apply it when solving a problem.

(c) **Personal Qualities:** A worker must display responsibility, self esteem, sociability, self management, integrity, and honesty. These qualities include:

   1. Responsibility: exert a high level of effort and persevere toward goal attainment;
   2. Self Esteem: believe in one's own self worth and maintain a positive view of oneself;
   3. Sociability: demonstrate understanding, friendliness, adaptability, empathy, and politeness in group settings;
   4. Self Management: assess oneself accurately, set personal goals, monitor progress, and exhibit self control; and
   5. Integrity and Honesty: choose ethical courses of action.

2. **Workplace Competencies** are defined in five areas: (a) resources, (b) interpersonal skills, (c) information, (d) systems, and (e) technology.

(a) **Resources:** A worker must identify, organize, plan, and allocate resources effectively.

   1. Time: select goal-relevant activities, rank them, allocate time, and prepare and follow schedules.
   2. Money: Use or prepare budgets, make forecasts, keep records, and make adjustments to meet objectives.
   3. Material and Facilities: Acquire, store, allocate, and use materials or space efficiently.
   4. Human Resources: Assess skills and distribute work accordingly, evaluate performance and provide feedback.

Examples: use computer software to plan a project; prepare a budget; conduct a cost/benefits analysis; design an RFP process; write a job description; develop a staffing plan.

(b) **Interpersonal Skills:** A worker must work with others effectively.

   1. Participate as Member of a Team: contribute to group effort.
   2. Teach Others New Skills.
   3. Serve Clients/Customers: work to satisfy customers’ expectations.
   4. Exercise Leadership: communicate ideas to justify position, persuade and convince others, responsibly challenge existing procedures and policies.
   5. Negotiate: work toward agreements involving exchange of resources, resolve divergent interests.
   6. Work with Diversity: work well with men and women from diverse backgrounds.

Examples: collaborate with a group member to solve a problem, work through a group conflict situation, train a colleague, deal with a dissatisfied customer in person, select and use appropriate leadership styles, use effective delegation techniques, conduct an individual or team negotiation, demonstrate an understanding of how people from different cultural backgrounds might behave in various situations.

(c) **Information:** A worker must be able to acquire and use information.

   1. Acquire and Evaluate Information.
   2. Organize and Maintain Information.
   3. Interpret and Communicate Information.
   4. Use Computers to Process Information.
Examples: research and collect data from various sources, develop a form to collect data, develop an inventory record-keeping system, produce a report using graphics, make an oral presentation using various media, use on-line computer databases to research a report, use a computer spreadsheet to develop a budget.

(d) **Systems**: A worker must understand complex interrelationships.
   (1) Understand Systems: know how social, organizational, and technological systems work and operate effectively with them.
   (2) Monitor and Correct Performance: distinguish trends, predict impacts on system operations, diagnose deviations in systems' performance and correct malfunctions.
   (3) Improve or Design Systems: suggest modifications to existing systems and develop new or alternative systems to improve performance.
   Examples: draw and interpret an organizational chart; develop a monitoring process; choose a situation needing improvement, break it down, examine it, propose an improvement, and implement it.

(e) **Technology**: A worker must be able to work with a variety of technologies.
   (1) Select Technology: choose procedures, tools or equipment including computers and related technologies.
   (2) Apply Technologies to Task: understand overall intent and proper procedures for setup and operation of equipment.
   (3) Maintain and Troubleshoot Equipment: Prevent, identify, or solve problems with equipment, including computers and other technologies.
   Examples: read equipment descriptions and technical specifications to select equipment to meet needs, set up and assemble appropriate equipment from instructions, read and follow directions for troubleshooting and repairing equipment.
Panola College
Associate Degree Nursing

STUDENT ACKNOWLEDGEMENT

I have read the Panola College Associate Degree Nursing program syllabus for RNSG 1362 Clinical Nursing, and I understand the policies as discussed.

I will comply with the syllabus requirements as delineated. **In addition, I will comply with the current ADN Student Handbook as found on the ADN web page.** It is my understanding that this form will become part of my permanent file.

______________________________ Student Name (Printed)

______________________________ Student Signature

_________________________ Date
COMPREHENSIVE HOLISTIC NURSING ASSESSMENT
GRADING CRITERIA

1. All students must turn in a Comprehensive Holistic Nursing Assessment for their nursing home patient. The information should be pertinent and related to the most current admission or episode of care. There should be a cover page and reference page that must be typed using APA format.

2. The Comprehensive Holistic Nursing Assessment must address the four dimensions, i.e.: physical, psychological, social-cultural, and spiritual. If information within the four dimensions is not applicable for your patient, state “not applicable,” with a description of why it is not applicable. Include the completed client information sheet (CIS). Give information that is appropriate, remembering to be specific.

3. Complete a full care plan on two nursing diagnoses, 1-from the Physical dimension and a 2nd one from the psychological, social-cultural, or spiritual dimension of your patient. Each must be appropriate, specific and the highest priority problems, using the attached patient care plan format. The nursing diagnoses used in the care plan should be supported by the data from the comprehensive assessment.

4. The Comprehensive Holistic Nursing Assessment is a part of your final clinical grade. This assignment evaluates your ability to interview a client and will show your skill in assessment and to think critically.

5. The Comprehensive Holistic Nursing Assessment due date is on your calendar, but is subject to change. Consult with your clinical instructor to confirm the date your paper is due.

ASSESSMENT (60%)

   a. Holistic Nursing Assessment
   b. Medication List
   c. Client Information Sheet (CIS)

CARE PLAN (35%)

FORMAT (5%)

Cover page and reference page.
Must be typed or computer generated.
Use the patient care format provided in this syllabus
Use correct spelling and grammar.

COMMENTS:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

STUDENT NAME: ____________________________________________

INSTRUCTOR: _____________________________________________
Complete a client interview to collect data on your client in the nursing home. This should be a combination of subjective and objective data that paints a picture of who the client is. This interview data may need to be collected over several clinical days. Remember that all information collected is confidential.

**HOLISTIC NURSING ASSESSMENT**

**COMPLETE HEALTH HISTORY:** (Write a summary of medical and surgical information about your client and the dates they each occurred. Place the different information under medical or surgical, as appropriate) Some dates may be difficult to obtain. Confirmation and validation of the information must, however, be made through the use of patient’s reliable family, medical record, observation of scarring, and/or wounds.

Source and reliability of information: Patient ___ Family ___ Staff ___ Medical Record ___ Friend ___ Significant other ___

**I. Biographical Data (Be specific)**

- **Client Name** (initials only):
  - Male______ Female______
- Date of Birth: Stated____ Actual____ Age: Stated____ Actual____
- **Birthplace:** City and State________________
- Race (Culture): Caucasian___ African American ___ Hispanic ___ Asian___ Biracial ___ Middle Eastern ___ Native American___
- Ethnicity: Irish ___ German ___ Swedish ___ Slovak ___French ___ Japanese ___ Chinese ___Philipino ___ Eastern Indian ___
- Social Participation: Supportive family ___ Facility family ____ Individual friendships ___ Usually alone ___ No social desire___
- Occupation and/or year retired:
- **Marital status:** Married ___ Divorced ___ Separated ___ Widowed ___ Never married ___ Single ___

**II. Financial Data**

- **Insurance:** Medicare ___ Medicaid ___ BlueCross/ BlueShield ___ Private Pay ___ Other ___

**III. Initial Admission**

Date of initial admission: _______

- **Chief complaint:** A statement of the presenting problem and duration: (Why is the patient in the nursing home? Put in the client’s own words and place that statement in quotes).

- **History of the Presenting Problem:**
  1. Onset of the problem:
  2. Current Status of the problem:
  3. Reason for seeking help at this time:
IV. Physical Dimension (Refer to “Walking Through a Medical Record”)

A. Client’s Health History

- Medical History: List all Medical diagnoses and Dates of diagnosis (If dates are not available, state that “patient unaware”, “dates not listed in medical record”, “family unaware”, etc.

- Surgical History: List all Surgeries completed and Dates. Some surgeries may only be accounted for due to an identified scar.

- List all Medications: (details about all medications will be included on the medication list). Organize the medications into:
  
  A. Prescription:
  B. Over-the-Counter (OTC):
  C. Herbal medicine
  D. Dietary supplements
  E. Include immunizations

- Communicable Diseases: As a child (measles, mumps, etc.) or as an adult (MRSA, shingles, etc.)

- Allergies: (Food, drug, or environmental...)

- Injuries/Accidents: (Dates/outcomes) This includes falls...

- Disabilities/Handicaps: (Details) This includes visual, tactile, hearing, paralysis, etc...

- Blood Transfusions: (Dates/reactions) Have they had any?

V. Family Health History

Record specific data about chronic illness/deaths in parents, grandparents, and siblings of patient. This helps identify potential risks that the patient has.

- Parents
- Grandparents
- Great-Grandparents
- Siblings

VI. Social-Cultural Dimension

- Alcohol Use: How often? When was last drink?
- Tobacco Use: (Smoke, chew...specifics) How many per day?
- Illicit Drug Use: Last time used? Types of drugs used?
- Sexual Practice: (Discuss as sexual intimacy. Any diseases/injuries that may reduce frequency/times of intimacy)
• Travel History: Within United States or Internationally

• Work Environment: (Details) What job held the longest?

• Home Environment: (Describe both the nursing home environment as well as their environment prior to admission)
  A. Physical environment:
  
  B. Psychological environment (initiate/maintain healthy relationships?):
  
  C. Social-Cultural environment (specifics of own culture/open to other cultures?):

• Hobbies/Leisure Activities:

• Stress: (Do they have any/how do they handle stress)

• Education:

• Roles/Relationships: (mothers, daughters, friends.....)

VII. Characteristic Patterns Of Daily Living
(Be specific about what their schedule is during the day for 24 hours and how has it changed since living in the nursing home)

VIII: Spiritual Dimension

• Life Values (what is important in life):

• Beliefs about illness:
  (Dietary modifications, medications, blood products, etc.)

• Sense of transcendence (client’s ability to accept illness/level of compliance with treatment):

• Self-actualization (client’s ability to live a rewarding, enriched life):

IX: Psychological Dimension
(Discuss each with appropriateness to situation)

• Orientation: (person, place, time)

• Attention:

• Memory:
  Short term:
  Long term:

• Judgment:
• Spatial Perception: (Can the client tell distances)

• Abstract Reasoning: (Can the client explain the meaning of “every cloud has a silver lining”)

• Thought Processes & Content: (Do they connect)

• Client’s Self-report of Feelings:

• Client’s Presentation or Affect (sad, angry, anxious, flat, etc.):

X: Health Maintenance Activities

• Sleep: (Number of hours) Does the patient take sleeping medication?

• Diet:

• Exercise:

• Stress Management:

• Use of Safety Devices: (Walker, cane, wheelchair…..)

• Health Check-ups:

XI: Review Of Systems

Utilize the physical assessment book to identify what to look for with each patient and within each system (subjective and objective data)

• General: Height ___ Weight ___ (Lbs. or Kg.) BMI ___

• Vital Signs: Temperature: Oral ___ Rectal ___ Cutaneous ___ Axillary ___ (F or C)

• Heart Rate: Apical ___ Radial ___ (L or R)

• Respirations: ___ Pulse oximetry: ___

• B/P: (R/L) Lying ___ Sitting ___ Standing ___

• Body type and stature:

• Posture:

• Body movements/tremors:

• Hair growth patterns:
• Neurological: (PERLA, strength of hand grasps, strength in legs, symmetry, LOC)

• Psychological:

• Skin:

• Head:

• Eyes:

• Ears:

• Nose and Sinuses:

• Mouth:

• Throat/Neck:

• Back:

• Thorax and breath sounds:

• Breasts and axillae:

• Heart:

• Carotid pulsations:

• Abdomen:

• Groin area:

• Genitalia:
  Male: 
  Female:

• Urinary:

• Lower extremities:

• Peripheral vascular examination: (Radials, pedals, post-tibials...)

• Musculoskeletal: (Gait, able to hold self in alignment)

• Nutrition:
• Endocrine: (Thyroid or diabetes)

• Odors: Alcohol        Fruity        Bad breath        Body odor

• Nails: Cleanliness     Length        Evidence of biting   Clubbing

• Manner of dress: Cleanliness  Appropriateness

• Personal hygiene: Cleanliness  Grooming

• Speech: Clarity        Volume        Voice tone & inflection

Diagnostic Tests: X-rays, MRI, CAT, etc. (include results)

Current Lab Tests/results -----only abnormal
MEDICATIONS

List the 6 rights of medication:

List the patient identifiers:

When giving medications ALWAYS consider:

- Potential adverse reactions
- Pertinent assessments needed
- Parameters to consider
- Labs to look at
- Contraindications
- Can the medications be crushed?
- Should the medication be given with food?
- How would you give this medication through a feeding tube?
- What follow up is necessary?
- Patient education
- What if the patient refuses to take the medication?
# MEDICATION LIST

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Functional/Chem Class</th>
<th>Applicable Indication</th>
<th>Dosage</th>
<th>Route</th>
<th>Frequency</th>
<th>Possible Side Effects that Client has:</th>
<th>Nursing Consideration</th>
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CRITERIA FOR CARE PLANS

Listed below are the criteria that will be used to grade your care plan. Please BE SURE that your care plans have identified each portion of these criteria. You will receive a grade on your first and last care plan.

_____1. (4) Assessment—Contains both subjective and objective data on your patient. This data should be only data that pertains to your Nursing Diagnosis. This data should be written in the format: Subjective Data: Objective Data: Medical Dx:

_____2. (4) Client Information Sheet (including Medication Sheet) must be complete with appropriate information.

_____3. (4) Develop two Nursing Diagnosis, based on assessment data. The Nursing Diagnosis must be written in three-part format. It must address the MAIN signs and symptoms of your patient’s illness/problem (assessment data.)

_____4. (4) Prioritize NANDA in order of importance—your Nursing Diagnosis should reflect the highest priority of your client.

_____5. (4) Develop holistic, measurable, specific objectives written in the form of “By_______client will ____.” The objective (goal) must relate directly to the NANDA (label).

_____6. (4) Develop individualized interventions dealing with pharmacological, medical, psychological and social-cultural needs of the client. (addresses the R/T)

_____7. (4) Interventions must be comprehensive, specific and feasible. DO NOT copy interventions word-for-word from the book; use them to formulate ideas and put them in your own words.

_____8. (4) Specify when/how often each intervention is to be done. You must have at least three interventions per Nursing Diagnosis.

_____9. (4) Rationale will consist of direct quotes from textbooks or other appropriate reference materials. Cite each quote by listing source, year and page numbers in APA 6th edition format. Example: (Smith & Smith, 1999, p. 102). The sources used must be listed on a separate Reference page.

_____10. (4) Evaluate your objectives (NOT your interventions!). Indicate if your goal was met, not met or partially met, AND give supporting data to support your evaluation.
# NURSING CARE PLAN GUIDELINES

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Nursing Diagnosis</th>
<th>Patient Objectives (Goals)</th>
<th>Nursing Intervention (Address the R/T)</th>
<th>Rationale for Nursing Interventions</th>
<th>Evaluation (of goal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment requires: 1. Communication with the pt via the pt interview and nursing history.</td>
<td>Nursing Diagnosis * (NANDA approved) followed by “related to” phrase followed by “as evidenced by” … Contributing factors: Environmental, Sociological Psychological, Spiritual, Physiological, or any other factors involving health problems AEB: Describes the Related to (R/T) Usually Risk DX. do not have AEB</td>
<td>Must be: -NANDA* section of the nursing diagnosis. -patient centered -action oriented -mutually exclusive -realistic -measurable -behaviorally stated Need to include condition, projected time, and date for pt to achieve goal. Need one goal i.e., Ms. Doe will walk to the end of the hall &amp; back QID with the assistance of a walker by 10/12. ROMBA: (reasonable, objective, measurable ,believable, assessable)</td>
<td>Nurse Directed. Contains action verb stated clearly. Should include: -What is to be done or given. -How the behavior is to be performed. -Frequency &amp; specific time for order to be done. -Should also include: comfort measures, treatments, medications, observations, and teaching. Interventions need to address the &quot;R/T&quot; statement of nursing diagnosis; at times, interventions may need to relate to the &quot;AEB&quot; instead.</td>
<td>Give scientific rationale for each nursing intervention &amp; sources (APA format). State why nursing intervention was developed or selected. List reference &amp; page number. Create reference page.</td>
<td></td>
</tr>
<tr>
<td>2. Data: Physical Intellectual Emotional Social Spiritual (Subjective Data:) What the pt says. (Objective data:) Observable, measurable data i.e., laboratory reports, nursing observations, review of the chart</td>
<td></td>
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<td></td>
<td>Show data that supports evaluation of client objectives.</td>
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<tr>
<td>3. Medical Diagnosis:</td>
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<td></td>
<td>State whether or not each objective was met &amp; the patient's overall response.</td>
<td></td>
</tr>
</tbody>
</table>

* North American Nursing Diagnosis Association
<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>NURSING DIAGNOSIS</th>
<th>PLANNING</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Patient Goal/Objectives</td>
<td>Nursing Intervention</td>
</tr>
</tbody>
</table>

NURSING CARE PLAN
## RNSG 1362 CLINICAL EVALUATION

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Midterm</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE NURSE AS A MEMBER OF THE PROFESSION:</strong></td>
<td>Student</td>
<td>Faculty</td>
</tr>
<tr>
<td>1. Follow legal-ethical framework for the practice of nursing in Texas.</td>
<td></td>
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</tr>
<tr>
<td>a. Demonstrate professional behavior and accountability within limits of nursing knowledge.</td>
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<tr>
<td>b. Follow the Texas Nurse Practice Act.</td>
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<tr>
<td>c. Follow the ANA Code of Ethics.</td>
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<tr>
<td>d. Follow the faculty's instructions.</td>
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<tr>
<td>e. Follow the Panola Student Handbook policies and ADN dress code.</td>
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<tr>
<td>f. Follow the rules and policies of assigned agency.</td>
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<tr>
<td>2. Participate in clinical self-evaluations in a professional manner.</td>
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<tr>
<td>a. Document specific behaviors student has performed.</td>
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<tr>
<td>b. Use self-evaluation, reflection and feedback to modify and improve practice.</td>
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<tr>
<td><strong>THE NURSE AS A PROVIDER OF PATIENT-CENTERED CARE</strong></td>
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<tr>
<td>3. Develop clinical reasoning skills by applying the nursing process when providing culturally-appropriate, direct-care to a minimum of one to two adult clients.</td>
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<tr>
<td>a. Use structured and unstructured data collection tools to obtain patient and family history.</td>
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<tr>
<td>b. Perform a comprehensive holistic assessment on a nursing home client to identify health needs and monitor changes in health status. Perform partial health histories on other assigned clients.</td>
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<tr>
<td>c. Develop nursing care-plans for three different patients and in collaboration with patient, select goals and nursing interventions.</td>
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<tr>
<td>d. Implement fundamental, individualized nursing interventions for adult patient(s).</td>
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<tr>
<td>e. Report and document patient's responses to nursing interventions.</td>
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<tr>
<td>f. Communicate changes in patient status to other providers.</td>
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<tr>
<td>4. Assess for learning needs and provide client teaching in the nursing home and hospital settings.</td>
<td></td>
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<tr>
<td>a. Assess learning needs of patients and their families related to risk reduction and health promotion, maintenance, and restoration. Use self-evaluation, reflection and feedback to modify and improve practice.</td>
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<tr>
<td>b. Provide informal teaching for all clients.</td>
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<td>c. Develop and present a formal teaching plan.</td>
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<td>5. Locate and utilize resources which are optimal and cost-effective for patient care.</td>
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<tr>
<td><strong>THE NURSE AS A PATIENT SAFETY ADVOCATE</strong></td>
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</table>
| **6.** Promote a safe, effective environment.  
   a. Accurately identify patients.  
   b. Safely perform nursing measures and procedures including safe patient handling.  
   c. Safely calculate dosages and administer medications and treatments.  
   d. Clarify any order or treatment regimen believed to be inaccurate, contraindicated, or harmful to the patient.  
   e. Assess potential risk for patient harm related to accidents and implement measures to prevent risk of patient harm. |  |  |  |
| **7.** Seek assistance if practice requires behaviors or judgments outside of individual knowledge and expertise. |  |  |  |

<table>
<thead>
<tr>
<th><strong>THE NURSE AS A MEMBER OF THE HEALTH CARE TEAM</strong></th>
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</table>
| **8.** Gather data from patient chart and healthcare staff to formulate nursing plan of care.  
   a. Communicate changes in patient status and/or negative patient outcomes as a result of care provided. |  |  |  |
| **9.** Identify the patient’s right of self determination and choice.  
   a. Identify any unmet, basic patient needs and notify instructor.  
   b. Maintain confidentiality according to HIPPA guidelines. |  |  |  |
| **10.** Use technology in the delivery of patient care.  
   a. Use electronic equipment correctly to obtain patient data.  
   b. Identify, collect, process and report patient data to instructor. |  |  |  |
| **11.** Give examples of skills and patient-centered tasks that may legally and ethically be delegated to non-professional personnel. |  |  |  |
The clinical evaluation tool is structured along the five major areas of nursing function: Assessment, Nursing Diagnoses, Planning, Implementation, and Evaluations. The organization of the objectives/outcomes uses the four major roles of the practicing nurse: Member of the Profession, Provider of Patient-Centered Care, Patient Safety Advocate, and a Member of the Health Care Team. Grades for RNSG 1362 are derived by observing the student’s performance, evaluating required assignments and the student in the role of Member of the Profession, Provider of Patient-Centered Care, Patient Safety Advocate, and a Member of the Health Care Team.

<table>
<thead>
<tr>
<th>Points</th>
<th>Description</th>
<th>Assignment Grade Range</th>
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<tbody>
<tr>
<td>4</td>
<td>Consistently performs at an independent level. Meets the described objectives with self-direction. 90-100% on assignments = 4 points</td>
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<tr>
<td>3</td>
<td>Demonstrates consistent performance and improvement. Needs minimal guidance to meet described objectives. 80-89% on assignments = 3 points</td>
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<td>2</td>
<td>Satisfactory/safe level of performance. Meets objectives with consistent guidance. 75-79% on assignments = 2 points</td>
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<td>&lt;2</td>
<td>Unsatisfactory/Unsafe. Level of performance does not meet standards. Unable to meet objectives without frequent, direct, intensive guidance and instruction to avoid errors. This includes submitting late assignments, substandard assignments, failure to submit assignments and inconsistent performances from week to week. 74.99 or less on assignments, late assignments and failure to submit assignments = 0</td>
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</table>

The points for each course outcome are derived from a combination of Nursing Care Plans (NCP), Assignments (A), and/or Faculty Observations (FO). If a student receives a grade of zero (0) on any assignment or nursing care plans, the student will also receive a zero (0) on this clinical evaluation tool for the corresponding course outcome.

85% of course grade = Clinical Evaluation/Observation  
15% of course grade = Teaching Project/Care plans/Holistic Assessment
MID-TERM STUDENT EVALUATION

Evaluation of Students:

Evaluations of students will be completed on an ongoing basis, using the following criteria. Formally, the following tools, in addition to the “numbering tool,” will be used to enter into the e-value system as the show of clinical progress.

**Student strengths, as identified by student:** Consider your skills in……..

Assessment:

Patient contact /ADL’s:

Care Plans:

Critical Thinking:

**Student areas for improvement, as identified by student:** Consider ……

Your fears:

Use of resources:

Self direction:

---

**Student strengths, as identified by instructor:**

---

**Student areas for improvement, as identified by instructor:**

---

Student Signature  Date   Instructor Signature   Date
RNSG 1362

FINAL STUDENT EVALUATION

Student strengths, as identified by student:

Assessment:

Patient contact / ADL’s:

Care plans:

Critical thinking:

Student areas for improvement, as identified by student:

Fears:

Use of resources:

Self direction:

Student strengths, as identified by instructor:

Student areas for improvement, as identified by instructor:

_____________________________  __________________________
Instructor Signature        Date

_____________________________  __________________________
Student Signature           Date
# CLIENT INFORMATION SHEET

**LEAVE NO BLANKS**

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<tr>
<th>Pt. Initials:</th>
<th>Date of Care:</th>
<th>Admitting Medical Diagnosis:</th>
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<tr>
<td><strong>Current Vital Signs</strong></td>
<td><strong>T</strong></td>
<td><strong>P</strong></td>
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<td>Age:</td>
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<td>Sex:</td>
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<td>Religion:</td>
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<td>Marital Status:</td>
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<td>Advance Directive?</td>
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<td>Hx alcohol or substance abuse:</td>
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*Treatment and Special Orders: (include all such as TCDB, incentive spirometry, resp Tx, your nsg interventions, etc.)*

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<tr>
<th>Treatment/Procedure</th>
<th>Frequency</th>
<th>Rationale for Treatment/Procedure</th>
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<tr>
<th>Date</th>
<th>Diagnostic Test</th>
<th>Results</th>
<th>Rationale for test</th>
<th>Nursing implications</th>
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RNSG 1362
Chief Complaint (in quotes) and Brief History of Present Illness:

Past Medical History, Including Home Meds:

Pathophysiology of current and major medical diagnoses:
*Lab Data: Record only abnormal results and rationale related to their abnormality.

<table>
<thead>
<tr>
<th>Lab Test</th>
<th>Result (s) &amp; Date(s)</th>
<th>Normal Range</th>
<th>Brief Rationale for Abnormalities</th>
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</thead>
<tbody>
<tr>
<td>CBC</td>
<td>Date Date Date</td>
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<tr>
<td>WBC</td>
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<td>4.6 – 10.2</td>
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<td>RBC</td>
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<td>4.0 – 5.5</td>
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<td>Hgb</td>
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<td>12.2 – 16.2</td>
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<td>HCT</td>
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<td>37.7 – 47.9</td>
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<td>Platelets</td>
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<td>140 - 440</td>
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<td>Coagulation</td>
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<tr>
<td>PT/INR</td>
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<td>&gt;2.0 or 2.0-3.5</td>
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<td>PTT</td>
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<td>25-39 sec</td>
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<td>Bleeding Time</td>
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<td>2.5-10 minutes</td>
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<td>Electrolytes</td>
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<td>Na+</td>
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<td>136 – 145</td>
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<tr>
<td>K+</td>
<td></td>
<td>3.50 – 5.10</td>
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<td>Cl-</td>
<td></td>
<td>98 – 107</td>
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<tr>
<td>CO2</td>
<td></td>
<td>22.0 – 29.0</td>
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<tr>
<td>BUN</td>
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<td>6.0 – 20.0</td>
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<td>Glucose</td>
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<td>60 – 105</td>
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<td>Creatinine</td>
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<td>0.70 – 1.30</td>
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<td>UA</td>
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<td>straw - yellow</td>
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<td>Color</td>
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<td>Appearance</td>
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<td>Sp Gr</td>
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<td>1.003 – 1.030</td>
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<td>pH</td>
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<td>5.00 – 9.00</td>
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<td>Protein</td>
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<td>negative</td>
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<td>Glucose</td>
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<td>negative</td>
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<tr>
<td>Ketone</td>
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<td>negative</td>
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<tr>
<td>Blood</td>
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<td>negative</td>
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<tr>
<td>Bacteria</td>
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<td>Negative-few</td>
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<tr>
<td>Mucus</td>
<td></td>
<td>Negative-small</td>
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<tr>
<td>ABG (if available)</td>
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<tr>
<td>PH</td>
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<td>7.35-7.45</td>
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<td>PO2</td>
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<td>70-100 mm Hg</td>
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<td>PCO2</td>
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<td>35-45 mm Hg</td>
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<tr>
<td>HCO3</td>
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<td>22-26 mm Hg</td>
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<tr>
<td>O2 Sat</td>
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<td>96%-100%</td>
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</table>
TEACHING PRESENTATION GUIDELINES

1. Students will work in teams (team size will be decided with instructor).

2. Topics involved should relate to the learning needs of patient(s).

3. Topics will be assigned by the faculty. The presentations will be presented to faculty and classmates on day selected by faculty.

4. The same number of points will be assigned to each member of the team using the Evaluation Tool for Teaching Plan.

5. Each team member must present a portion of the teaching plan.

6. Presentations should be no longer than 45 minutes and no shorter than 20 minutes.

7. A paper discussing the teaching plan must be handed in by the due date on the calendar. The paper must follow APA format.

8. Presentations will be a combination of a related-case study, the pathophysiology and a current evidenced-based nursing journal article associated with the topic provided.

9. Case study may be a patient cared for during the semester by any of the team members in the group or a created example.
RNSG 1362
Attach this Tool to the Teaching Paper.

**EVALUATION TOOL FOR TEACHING PLAN**

<table>
<thead>
<tr>
<th>POINTS POSSIBLE</th>
<th>POINTS EARNED</th>
<th>These areas need to be addressed in your presentation AND your written paper.</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Case Scenario: Background information about topic and the related pathophysiology.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Subjective &amp; Objective Data: Subjective and Objective data to support a specific knowledge deficit diagnosis</td>
<td></td>
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<td>10</td>
<td>Barriers to Learning &amp; Learning Needs: Identify learning needs that you discovered in your assessment as you collected subjective and objective data. Considering all dimensions of the patient(s), specify their individual barriers to learning.</td>
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<td>10</td>
<td>Nursing Diagnosis: One nursing diagnosis for knowledge deficit, including “related to” and “as evidenced by” factors.</td>
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<td>10</td>
<td>Goals &amp; Objectives: Patient and audience directed.</td>
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<td>25</td>
<td>Teaching and Rationales: Identify whether the content that you are teaching is in the cognitive, affective, or psychomotor domain of learning. Include teaching content, teaching methods, teaching tools, &amp; community resources. Give rationale for each of these. Use a minimum of one current (within last 5 years) journal article as a rationale.</td>
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<td>10</td>
<td>Evaluation: Patient’s response to the teaching with subjective &amp; objective data to support whether goal was met, partially met, or not met.</td>
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<td>5</td>
<td>APA Format: American Psychological Association (6th Ed); Use correct spelling and grammar.</td>
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<td>100</td>
<td>GRADE: Grade will be determined by the written/oral teaching plan. All students receive the same grade. Every student must do equal amounts of work on the presentation.</td>
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</tbody>
</table>

Instructor: ___________________________   Date: __________

Students Names: _____________________________________________
In a simulated laboratory or an actual clinical setting and using standardized performance criteria, the student must demonstrate satisfactory/unsatisfactory completion of designated competencies. Skills outside this list, without the approval of your clinical instructor should not be completed. Only one date is required (month and year), with an indication of the skill being completed in simulation or in the clinical setting.

**Skills Checklist**

<table>
<thead>
<tr>
<th>Date</th>
<th>Competency/Skill</th>
<th>Sat.</th>
<th>N. I.</th>
<th>Unsat.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>BASIC CARE/ SKILLS</strong></td>
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<td></td>
<td>Handwashing</td>
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<td></td>
<td>Standard Precautions</td>
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<td>Oral Care/ Denture Care</td>
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<td>Back Rub</td>
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<td>Skin Care</td>
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<td></td>
<td>Foot/Nail Care (non-diabetic)</td>
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<td></td>
<td>Perineal Care: a. Male  b. Female</td>
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<td></td>
<td>Shave a Male Client</td>
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<td></td>
<td>Bedmaking: a. Occupied  b. Unoccupied</td>
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<td></td>
<td>Provide Nutrition: a. Assist others with Meals  Body Mechanics</td>
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<td></td>
<td>Positioning of Client</td>
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<td></td>
<td>Use of Wheelchair/ Assistive Devices</td>
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<td>Transfer Techniques</td>
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<td>Assist with Bedpan</td>
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<td></td>
<td>Assist with Urinal/Condom Cath</td>
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<td></td>
<td>Age-Appropriate Collection of Specimens:</td>
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<tr>
<td></td>
<td>a. Urine: Sterile, Midstream, Foley</td>
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<td></td>
<td>b. Stool: Occult, OVA &amp; Parasites</td>
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<td></td>
<td>c. Sputum</td>
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<td>Glucometer/Fingersticks</td>
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<td>Apply Anti-Embolism Stockings/SCDs</td>
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<td></td>
<td><strong>STERILE TECHNIQUE</strong></td>
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<td></td>
<td>Sterile Gloving</td>
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<td>Apply Sterile Dressing</td>
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<td>Insert Foley / In &amp; Out Cath: a. Male  b. Female</td>
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<td></td>
<td><strong>ASSESSMENT</strong></td>
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</tbody>
</table>
9. Musculoskeletal & ROM
10. Neurological
11. Mental Status
12. Integumentary
13. Use of Age-Appropriate Techniques

Nursing History/Data Collection

MEDICATION ADMINISTRATION


Ophthalmic

Otic

Inhalation

Subcutaneous


Intradermal

Transdermal: a. Patch b. Cream

Suppositories: a. Vaginal b. Rectal

Insulin: a. Regular b. Lantus c. Mixed d. NPH

Measurement of Liquid Meds

Reconstitution of Powder Medications

DOCUMENTATION

Participate in pt admission documentation
Participate in pt discharge documentation
Participate in other documentation

SENSORY ALTERATIONS

1. Irrigation of eye
2. Apply eye patch
3. Perform irrigation of ear
4. Therapeutic baths
5. Complete Braden Scale assessment
6. Apply moist compresses
7. Prepare/change dressing for > stage I ulcer

MOBILITY

1. Teach use of walker
2. Perform passive ROM exercises
3. Provide cast care/splint care/traction care
4. Provide wound care for a joint replacement
5. Wrap amputation stump

INTEGUMENTARY

Ostomy Care: a. Colostomy b. Ileostomy

Phototherapy

Decubitus Care

HEMATOLOGIC CONDITIONS

1. Observe/Demonstrate blood administration
2. Demonstrate adm of blood products
3. Demonstrate protective isolation

GASTROINTESTINAL

Insertion/Removal of NG Tube

Provide feedings via: a. PEG Tube b. NG Tube
c. Gastrostomy/button d. Gavage

Measure Abdominal Girth

Care of Tubes: a. PEG b. T-tube c. NG
RNSG 1362

Enema Administration:
  a. Fleets
  b. Tap Water
  c. Saline
  d. Oil Retention
Check Client for Impaction

REGULATORY MECHANISMS

1. Calculate Current Cal Intake of Diet for 1 pt
   a. BMR
   b. BMI
   c. Caloric Requirements
   d. Calc Gms of carbs, protein, fats consumed

2. Weigh Client per scales:
   a. Balanced Scale
   b. Bed Scale
   c. Infant Scale

3. Record Intake & Output:
   a. Urimeter
   b. 24-Hour I & O Record
   c. Weigh Diaper
   d. Chest Tubes
   e. Drains

URINARY DYSFUNCTION

1. Palpate full bladder
2. 24 hr urine collection:
   a. Initiate
   b. Monitor/doc
3. Demonstrate straining of urine
4. Care of patient with Renal Failure

OXYGENATION: Ventilation/Transport

1. Monitor/apply pulse oximeter
2. Observe:
   a. cool air mist
   b. mini-nebulizer
3. Assess and record breath sounds
4. Suction:
   a. Nasopharyngeal
   b. Trach
5. Demonstrate use of incentive spirometer
6. Provide oxygen therapy via:
   a. nasal cannula
   b. face mask
   c. ambu bag
7. Teach breathing techniques:
   a. pursed lip
   b. diaphragmatic/abdominal
8. Perform tracheostomy care
9. Monitor/apply apnea monitor
10. Teach MDI use

PERFUSION

1. Observe 12-lead EKG
2. Identify S1 and S2
3. Calculate fluid gain/loss via weight
4. Identify/grade all peripheral pulses
5. Assess orthostatic hypotension

Student (spell name and sign): _______________________
Faculty: _______________________

Date: _______________________

All of these competencies are to be entered into your E-Value portfolio. The same list exists there and you are responsible for identifying that you completed these competencies. It will also be necessary for you to list the medical and nursing diagnoses that you have used within your care plans. This process will become evident to you as you progress through the semester. You will be given the necessary information to get into the e-value site.

It may be necessary to carry this paper list to identify accurate dates to enter into the evalue account. But DO NOT get behind in entering your information. Waiting until the end of the semester is not an option. Clinical instructors will review your entries often during the semester.
OR/GI LAB EXPERIENCE
Complete this form after observing in the operating room or GI lab (as applicable). Some students may not have the opportunity for this type of experience. Every attempt will be made to allow this experience.

Name__________________________________    Date___________________________

1. Identify the type of surgery/procedure you observed:

2. Identify three methods of aseptic technique you observed:

3. List the members of the surgical/procedural team and their educational background

4. What medications were given?

5. What equipment was in the “room”?

6. Describe the collegiality and role of the surgical/procedural team

7. How were the client’s psychosocial needs addressed and met in the OR/GI Lab?