SUFFOLK COUNTY COMMUNITY COLLEGE

AMMERMAN CAMPUS

DEPARTMENT OF NURSING

NR 40 CLINICAL FOLDER

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GUIDELINES FOR COMMUNITY GROUP TEACHING PROJECT (ACE 4 – 5 hours)

Each clinical group will present a teaching project for a group of clients in a community setting on a clinical day.

1. Select a site based on adult health assessment needs from the Zip Code Project Developed in NR20.
2. Make arrangements with the site as to the time and date of the teaching session.
3. Choose a health teaching topic related to adult health (do not choose a mental health topic).
4. Focus on prevention of disease and health promotion.
5. Collaborate with members of the student team (clinical group) to develop a teaching plan.
6. Select and utilize educational materials for distribution to clients.
7. Choose and/or develop audiovisual aides for presentation of the topic.
8. Submit a teaching outline with objectives for the learners (the audience)
9. Review project with instructor prior to presentation.
10. Deliver the presentation.
11. Evaluate the effectiveness of the presentation.

Note: Not every student will make the actual presentation but every student will have collaborated to develop the teaching project, select or develop audiovisual aides and choose educational materials.

GUIDELINES FOR COMMUNITY AGENCY ASSIGNMENT

Note: The community agency chosen must provide services related to a medical-surgical stressor or problem. Please review your topic with your clinical instructor.

Objectives:
1. Identifies a community outpatient agency serving local residents.
2. Identifies the services provided by the agency to meet the needs of the community.
3. Identifies additional services needed to meet the community needs.
4. Identifies the roles of professional and non-professional staff members.
5. Assesses agency ability to meet health care needs of individuals and/or families.
6. Identifies the role of the outpatient agency in prevention of illness and in the continuity of care.
7. Identifies the role of the nurse in referring patients to community agencies.

Directions for written report:
One 2-page report on community agency/support group experience should include:

1. What services does the facility offer?
2. How does the agency measure their effectiveness in meeting the client’s needs?
3. How is the facility funded?
4. What are the strong points of the facility?
5. What services could be added?
6. How did this experience help you as a member of the health team?
Option

Analyze a web site that services patients and families experiencing adult physical health stressors

Analysis Of Web-Based Support For Adult Medical/Surgical Stressors

The purpose of this assignment is to develop skills in identifying and analyzing health related resources offered to the general public on the internet that is used by clients experiencing stressors discussed in NR40. The set of evaluative criteria was adapted from the article, "Whom do you Trust? Evaluating Internet Health resources." This article was written by Barbara Schloman and published in 1999 Online Journal of Issues in Nursing published January 28, 1999. It explores issues related to the value of electronic resources of information and sets criteria for selecting credible sources for health professionals and their clients.

http://www.nursing world.org/ojin/infocol/info_1.htm

- Select a web site that provides information to clients and their families experiencing a stressor that is relevant to NR40 content.

- Review the website and answer the following questions and provide supporting data for any conclusions drawn:

1. Who is responsible for creating the website?

   Identify the credentials of the creators, determine if there is institutional affiliation that lends credibility for the website and list any financial sponsorship that may be indicate that there are other stakeholders in the information that it provides.

2. Does the website identify its intended audience? Does it have a clearly written mission and vision statement or purpose that is readily available and understandable to the first time user? Is it a resource for factual information or does it focus on supporting a particular point of view or single minded purpose that reflects an opinion that may or may not be supported in the literature?

3. Is the information provided readable, understandable, and free from errors in grammar and syntax? Is the information provided based on the latest evidence that supports the guidelines that it provides? Does it provide guidance, information or support documents that are unusual or distinct from other resources for the same stressor? If so, does this resource enhance the service of the website or detract from the reliability from the site?

4. Is the information current? When was the last time the information was updated?

5. Is the site well designed and easily navigated? Is the information presented logically using graphics when appropriate and identify a contact person for clarification? Would you recommend any changes to the site to enhance its design?
OBJECTIVES FOR HOME CARE

The student will expand knowledge and skills to provide and manage care for clients in the home care environment by observing and assisting the home care nurse in:

1. Utilizing the nursing process for clients in the Home Care Setting.
2. Maintaining a safe, therapeutic environment for the client in the home setting.
3. Applying principles of asepsis to client care in the home environment.
4. Obtaining physician’s orders, clarifying these orders and obtaining necessary revisions as needed (student observation only).
5. Organizing and participating in direct patient care.
6. Participating in health teaching with the client and/or family members.
7. Coordinating and delegating Nursing, Home Health Aide, Physical Therapy and other services delivered to the client.
8. Documenting in detail the effectiveness of interventions in relation to expected outcomes.
9. Communicating patient information effectively, orally and in writing to appropriate personnel to facilitate continuity of care.
10. Coordinating discharge planning and preparing discharge summaries and instructions.
11. Demonstrates an understanding of the relationship of progress towards client outcomes and to reimbursement of services.

Day Students assignment:
1. Illustrate with examples from your home care experience, indicating how the nurse or student implemented some or all of the above objectives for home care nursing ---2-3 pages typed or neatly written.
2. Summarize one article related to home care nursing. Include author, title and name of the journal. Submit with above paper.

Weekend & Evening Students Assignment:

Review 3 articles from Nursing journals that relate to Home Care and address at least of three of the objectives of home care and how they were met in these articles.
**Objectives of Emergency Department Experience:**

a) Identify role of nurse in admission of patient and family
b) Assist in assessing patient’s physical and emotional status and establishing priorities based on this assessment.
c) Participate in interviewing patient and family.
d) Prepare patients for examination.
e) Provide emotional support for patients and families.
f) Plan for and implement nursing action to meet these needs.
g) Be aware of the necessity for teamwork in emergency care.
h) Identify student’s role as a member of the ED team.
i) Plan for and implement nursing actions so as to participate effectively in ED team operation.
j) Observe and participate in patient transportation to other hospital departments.
k) Recognize the need for follow-up care upon discharge from ED.
l) Assist in planning follow-up care of ED. patients.
m) Recognize the legal implications involved in ED. Care and the nurses’ role as a member of the health care team in the ED.

**Expectation of Students in Emergency Department:**

Overview of Emergency Room

a) Routines
b) Procedures & Equipment
   1. immediate and life-saving procedures
   2. equipment for life-threatening intervention
   3. demonstration of equipment use
c) Legal aspects of nurses’ responsibility in Emergency Department
d) life-threatening crises – nursing intervention
e) consents – police cases – surgical and medical permits

Student Should Be Able To:

A. receives and position patients for examinations
B. take V.S. and make patient observations
C. interview patient and family members
D. utilize aseptic techniques
E. assist with surgical and medical procedures and examinations
F. report and record observations
G. recognize complications
H. assist in planning and implementing follow-up care

*Plan to report on objectives met or observed during this experience*
SUFFOLK COUNTY COMMUNITY COLLEGE
NURSING DEPARTMENT

OBJECTIVES FOR STUDENTS IN ICU/CCU

To Identify:

1. Expanded role of the nurse in an intensive specialty unit.
2. Basic complications utilizing observations, hemodynamic monitoring, and specialized equipment.
3. Measures appropriate to the treatment and prevention of common complications.
4. The psychological response of the patient to the specialty unit.
5. Measures appropriate to the alleviation of stressors.
7. The role of the patient and family in his rehabilitation.
8. The protocols used in determining patient’s nursing care needs.
9. The effects of major drugs utilized in each unit.
10. The nurses’ role in cardiac arrest occurring in the specialized unit.
11. The standard equipment utilized during emergency and other procedures (including drugs).
12. Criteria used in placing/discharging patients in a specialized unit.

*Plan to report on objectives met or observed during this experience*
OBJECTIVES FOR STUDENT ROTATION TO CARDIAC CATH LAB

1. Identify role of nurse in the cardiac cath lab
2. Assist in determining client’s physical and psychological readiness for cardiac catheterization
3. Determine client’s knowledge level of procedure
4. Use therapeutic measures to decrease fear and anxiety in the client
5. Review protocols utilized for pre and post-procedure assessment of client
6. Assist with client care throughout the diagnostic procedure
7. Seek to understand hemodynamic monitoring and calculations obtained during cardiac catheterization and relate these to cardiac health/disease

*Plan to report on objectives met or observed during this experience

OBJECTIVES FOR STUDENT ROTATION TO CARDIAC REHAB UNIT

1. Identify role of the nurse in rehabilitation phase of cardiac care
2. Discuss the role of the client and family in rehabilitation
3. Differentiate between acute and rehab phase of care
4. Assist with intake assessment to the rehab unit
5. Discuss with the client any feelings or concerns he or she might have about the stress of cardiac illness and use therapeutic measures to decrease anxiety
6. Interview client and/or family to determine factors associated with cardiac stressors
7. Participate with nurse in assessing client during prescribed exercise
8. Participate in implementing nursing protocols to meet client needs
9. Identify criteria used to initiate, continue or discontinue rehab session
10. Observe and assist with client education for health promotion and maintenance

*Plan to report on objectives met or observed during this experience
OBJECTIVES FOR ACE DAY (LEADERSHIP MANAGEMENT AND CODE BLUE)

LEADERSHIP MANAGEMENT OBJECTIVES

1. Compare and contrast 4 theories of motivation and discuss their implications for nursing practice.
2. Describe concepts of self-motivation and how to use them to motivate yourself.
3. Describe the principles of successfully motivating others.
4. Describe key concepts underlying effective delegation.

CODE BLUE OBJECTIVES

1. Identify normal cardiac electrical activity.
2. Identify common fatal cardiac dysrhythmias.
3. Describe roles of members of the cardiac arrest team.
4. Plan for management of cardiac dysrythmias/cardiac arrest.
5. Identify commonly used drugs and treatments used in management of dysrythmias/cardiac arrest.
OBJECTIVES FOR DISTRICT MEDICATION ASSIGNMENT

The student will:

Administer medications for a group of six patients using a number of different routes. (po, sub q, IVPB, and via n/g tube)

Identify questionable med orders.

Identify appropriate lab data that is to be checked prior to medication administration.

Note parameters for medications administered.

Identify the usual dose, indications, therapeutic effect, adverse effects, nursing implications and patient teaching for each medication prior to administration.

Administer the medications within a one hour period.

Expectations for District Medication Assignment

STUDENTS WILL BE ASSIGNED A DATE BY WHICH TO COMPLETE THE DISTRICT MEDICATION ASSIGNMENT.

Make an appointment with the PA’s to complete the assignment.

Come to the lab with the Chart Worksheet completed in the first two sections.
Work in pairs to complete assignment.
Each student must complete the assignment.

Follow the procedure for medication administration.

1. Check medications against the original doctor’s order.
2. Check any pertinent lab data.
3. Make any special notations.
4. Administer the medications utilizing the five rights.
5. Do any medication calculations and set the IV pumps correctly.
6. After both students have completed the assignment they review the Situation Catalogue to see if they have correctly identified any special needs of the patients (ex: if a med should have been held).
7. Student is responsible to obtain a completion certificate from the PA, and to give this certificate to their clinical instructor prior to district medication assignment.
8. FAILURE TO COMPLETE THE ASSIGNMENT IN THE ASSIGNED TIME WILL RESULT IN A CLINICAL FAILURE FOR EACH CLINICAL DAY FOR WHICH THE ASSIGNMENT IS NOT COMPLETED
DISTRICT MEDICATION CHART WORKSHEET

NAME _______________________________________ DATE ______________________

DIRECTIONS FOR USE OF CHART WORK SHEET.

1. CHART WORKSHEET MUST BE COMPLETED PRIOR TO MED LAB
2. EACH STUDENT IS EXPECTED TO COMPLETE THE ASSIGNMENT WITHIN ONE HOUR (TWO HOUR MAXIMUM FOR PARTNERS)
3. VALIDATE ALL MEDICATIONS ON MAR AGAINST THE DOCTOR’S ORDERS.
4. LOOK UP EACH DRUG AND LIST AT LEAST TWO MAJOR SIDE EFFECTS.
5. YOU ARE TO ADMINISTER ALL 10 AM MEDICATIONS (TIMES HAVE BEEN CHANGED FOR SOME MEDS TO ALLOW FOR ADMINISTRATION EX: COUMADIN IS NORMALLY GIVEN IN THE EVENING, PROCRIT IS TO BE ADMINISTERED ON THE DAY THAT YOU DO THE SIMULATION)
6. SOME MEDS REQUIRE CHECKS OF LAB DATA. USE THE LAB DATA THAT HAS A DATE CLOSEST TO THE DATE THAT YOU ARE DOING THIS SIMULATION. (Example the date you are doing this simulation is 9/12; you can use the lab data for 9/11 or 9/13).
7. STUDENTS ARE TO REVIEW PROTOCOLS FOR HEPARIN AND COUMADIN ADMINISTRATION PRIOR TO LAB – REVIEW APTT AND PT IN LAB MANUAL (FISHBACK)
8. IF PARAMETERS ARE NEEDED CHECK THE VITAL SIGNS ON YOUR PARTNER AND USE THESE AS THE REQUIRED PARAMETERS.
9. SPECIAL NEEDS- EX: LAB DATA IS ABNORMAL AND MED MAY HAVE TO BE HELD OR THE PHYSICIAN NEEDS TO BE NOTIFIED FOR AN INCREASE OR DECREASE OF DOSAGE OF A MED.
10. AFTER BOTH YOU AND YOUR PARTNER HAVE COMPLETED THE SIMULATION YOU ARE TO REVIEW THE POSSIBLE FINDINGS IN THE SITUATION CATALOGUE. THE PROFESSIONAL ASSISTANT HAS A COPY FOR YOUR REVIEW. THE PROFESSIONAL ASSISTANT DOES NOT REVIEW THE SITUATION CATALOGUE WITH YOU.
11. AFTER COMPLETION OF THE ASSIGNMENT THE PROFESSIONAL ASSISTANT WILL GIVE YOU A COMPLETION CERTIFICATE. GIVE THE COMPLETION CERTIFICATE TO YOUR CLINICAL INSTRUCTOR. YOU WILL THEN BE ASSIGNED DISTRICT MEDICATIONS AT THE HOSPITAL.
<table>
<thead>
<tr>
<th>PATIENT 1</th>
<th>MEDICATIONS</th>
<th>LIST THERAPEUTIC AND TWO MAJOR SIDE EFFECTS OF EACH DRUG</th>
<th>SAFE DOSE</th>
<th>LAB CHECKS IF ANY WITH DATE</th>
<th>PARAMETERS IF ANY</th>
<th>SPECIAL NEEDS</th>
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<td>HEPARIN 5000 UNITS SC q12h</td>
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<td>QUINAPRIL 20 mg po bid, hold for systolic BP &lt;100</td>
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<td>SAFE DOSE</td>
<td>LAB CHECKS IF ANY WITH DATE</td>
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<td>Lasix 20 mg qd via GT</td>
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<td>KCL 20 mEq qd via GT</td>
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<td>Vancomycin 1 gm IVPB q 12h</td>
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<td>Procrit 10,000 units SC</td>
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<td>Procainamide HCL 500 mg po q 12h</td>
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NR33/40 CLINICAL REQUIREMENTS

1. Arrive and be prepared for clinical pre-conference at shift start (arriving late 2 times equals an absence)

2. Profit from constructive suggestions made to you (i.e. if you are corrected for a procedure error once, it is expected that you will not repeat that mistake a second time.

3. You will be expected to know generic as well as trade names of any medication that you are asked to administer.

4. Communicate with your instructor in a professional manner and maintain all commitments/appointments with yourself and that instructor. Questions/clarifications during clinical practicum are to be directed to your clinical instructor initially not nursing staff.

5. Communicate in a professional manner with clients, peers and nursing staff at all times. Address clients by last name (i.e. Mr. Jones, Ms. James).

6. Structure your clinical experience according to assignment, being guided by priorities, time management and organization.

7. The client's chart is a legal document, therefore all entries must be correct, professionally stated and reviewed by your instructor before entry into the record. Have sample charting ready for review at least one hour before time to leave the unit.

8. Contact and utilize the teaching/learning center, computer center, for individual and additional support and assistance if needed or assigned.

9. Use the nursing lab on your own time to practice and reinforce skills. You may be asked by your instructor to make a video of a skill you are having difficulty with.

10. Clinical assignments must be submitted on the dates specified by the clinical instructor. A clinical failure will be recorded for assignments received after the designated date. Course failure will result unless all assignments are submitted. Submit assignments in a large envelope to your clinical instructor. List materials enclosed.

11. If you anticipate being absent, please call the nursing unit no later than two hours before clinical practicum starts.
TEAMS

1. Assignment of two or more patients will be given to each team member and the team leader will have one less difficult patient or no patient. (A specific assignment is given for the purposes of the care plan but you will all share the work.)

2. After the assignment is received, all team members go the RN or RN'S together to listen to the report.

3. The team makes walking rounds to do a quick assessment and observation of the patients’ in the team: PRIORITIZE, PLAN, ORGANIZE, AND COLLABORATE.
   a) Pain
   b) IV not infusing, IV bag almost empty
   c) Tubes not draining
   d) machines beeping
   e) Patient crying
   f) Patient bleeding
   g) Patient fell OOB
   h) Patient having difficulty breathing
   i) Teaching needs

   Make an environmental check of the room. Are side rails up if necessary?

4. After walking rounds and report, decide how you will break up the work to help each other to give the best care. PRIORITIZE, PLAN, ORGANIZÉ, AND COLLABORATE:
   a) Which patients can perform self care?
   b) What treatments have to be done?
   c) Which patients need 2 people to get them OOB, to bathe them, change a dressing etc?
   d) Decide what needs to be done first. i.e. relieving pain takes priority over a bath.
   e) What specimens need to be collected?
   f) Do patients have to be prepared for the OR, testing or physical therapy?
   g) Check charts for current orders and plan to check charts frequently during the day.

5. Each team member makes a complete head to toe assessment of their patients needs.

TEAM LEADER’S RESPONSIBILITIES

1. Be knowledgeable about all the patients the team is caring for.
2. Obtain reports from other team members several times during the day. Make rounds several times observe, ask questions. Listen to what team members tell you but also make your own assessments and observations.
3. If there are problems you can't solve speak with the instructor or primary nurse
4. Before post-conference report to primary nurse on all patients in the team. As you would for individual patient reports ---VS, pain status, wound status, I and 0, problems with any system, emotional problems, improvement in condition, (results of lab and diagnostic tests. Students are not permitted to take any telephone reports or orders independently.)
5. Encourage team members to write nurse’s notes ASAP. Help them if you are able to.
6. Make sure I&O, VS, restraint, neuro check, and bedside activity forms etc are completed for the 8 hour or 5 hour shift so the nursing instructor can sign them. If you are working a full day, you are responsible for completing the above forms and adding up the I&O's.
OTHER POINTS

* See how efficient you can be
* Ask each other for help
* The team leader may have to direct one team member to assist another.
* Delegate non-nurse tasks to nursing assistants when necessary, if any difficulty call instructor or at least begin to realize what non-nurse tasks are.

MEDICATIONS

Every student must be prepared to administer medications each day. Each student will have a chance to give out all the meds for a group of patients

GIVING AND TAKING REPORT

* Report takes place at the end of the shift nurse to nurse or when transferring clients from one unit to another. (e.g. from PACU to surgical floor)
* Nurses also report to physicians and other health care professionals.
* Because the nurse is the person who is with the client 24 hours a day-the nurse is responsible for determining significant changes in a client’s condition and for reporting these findings to the appropriate team member.

CHANGE OF SHIFT REPORT

Given by the primary nurse (team leader) to the nurse replacing him or by the charge nurse to the new nurse who assumes responsibility for continuing care of the client. The report may be given: orally, written, audio taped, walking rounds with nurses from both shifts.

CONTENTS OF THE REPORT

Information shared by nurses during a report includes:
- Basic information about each client. Name, room#, current diagnosis, past medical history and allergies.
- Current appraisal of each client's health status, present condition, results of pertinent diagnostic studies and clients response to medical therapy.
- Approach the report from head to toe including where the client stands in relation to identified nursing diagnoses and goal/outcome achievement. Ex.-Had poor gas exchange--admitted with left heart failure - placed in semi -fowler’s position, received 0² and Lasix, dyspnea and crackles have now decreased. Had deficient knowledge regarding colostomy care, now patient is able to perform self care.
- Current order-especially newly changed orders.
- MD prescribed orders, appropriate lab data to be assessed prior to medication administration, IV fluids, diet, and activity level.
- Nurse prescribed orders e.g. turn q 2 hours.
- Summary of each newly admitted client--including diagnosis, age, plan of therapy, general condition.
- Report of clients transferred or discharged.

NOTE: It is important to avoid unprofessional comments about clients that could predispose oncoming nurses to view and respond to clients negatively.
**Expectations of Pre-Conference**

After your instructor gives you your patient assignment and the focus for the day, begin to think about the following:

a.) What do you think you will need to assess, monitor and implement based on the patient’s medical diagnosis and condition?
b.) What problems do you think the patient may have?
c.) What do you think the priorities may be for this patient?

**How to Gather Information**

a.) Utilize the Daily Nursing Process Plan
b.) Instructors report
c.) Report from staff nurse
d.) Physical, psychosocial environmental assessment performed by you
e.) MD orders
f.) MD progress record and history and physical
g.) Nurse's Admission Assessment
h.) Last nurse's note
i.) Lab reports, x-rays etc.
Determine all medications, treatment, IV's your patient is receiving even if you are not administering them.

**Expectations at Post-Conference**

Students will be expected to have the following information for post-conference:

- Results of assessment (e.g. clinical manifestations, home care needs)
- Nursing diagnoses/problems. Patient education for each diagnosis when appropriate
- All the medications your patient is taking and how they relate to his problems, symptoms.
- Results of lab tests,
- Did your interventions work, what could you have done better or what else could you have done?
- How did you feel about the day's experience, share experiences, feelings?
- We will evaluate how the team functioned
- Team leader will give instructor report on all patients, unless instructor listens while it's being given to primary nurse
- Each team member will give the instructor more specifics with nursing diagnoses on their individual patients (Remember complete those Daily Nursing Process Forms).
Arrive on unit on time. Your instructor will give you the names and room numbers of the clients that you will be administering medications to.

Be sure to report to the primary nurse and remind her that you will be administering medications.

Check doctors orders with MAR.

Place a check mark in pencil under the date next to the time you will be giving the med. Must be careful that the patient has not already received the med.

If you can't find order dates in doctor's orders, check MAR or kardex.

Be aware of special expirations of some medications. Example; antibiotics may be good for only 5 to 7 days. Heparin sub q may be good for 3-7 days. Standard meds can be good for 14 to 28 days. The expiration dates depend on the individual institution. Know your institution's policy; ask or check the procedure manual.

*Obtain a separate medication cart (not one being used by other med. Nurses, if possible) to place patient medication boxes in.

Obtain separate med. loose leaf book from instructor and place MARS along with room dividers in the book for those patients to whom you'll be administering meds.

Check med. boxes to determine if all meds are present. If they are not, call pharmacy and send in sufficient time to maintain proper administration time. Be prepared to state patient's name, room # and exact order to pharmacist, even though they have a copy of the original MD order in the pharmacy. You may have to fax the order or bring it to the pharmacy.

For those institutions that use military time: 8am= 0800, 10am=1000, 12pm=1200, 2pm=1400, 6pm=1800, 10pm=2200.

If you are to administer IVPB's prepare to administer them first. Put them in med. box if they don't need to remain refrigerated. Meds that are to be refrigerated should be removed from the refrigerator at least 15-30 minutes prior administration. Assess IV site and check to see if IV tubing needs to be changed (date) and bring along primary and secondary tubing as needed. If on pump, you need pump tubing. If the IV has and additive such as Potassium, make sure that the medication is compatible with the solution or another IV site may be necessary or a separate saline flush must be set up. Remember there are certain solutions that should never have anything piggybacked into them.

Review method of administering IV meds through central lines or IV locks if no maintenance IV.

* Always remember to look at allergy section of med. sheet as you give out meds, for each patient Allergies should also be listed on the front of each pt's chart.

* Make sure you have water, cups, alcohol sponges, applesauce, pill crusher, spoons, straws, and appropriate size syringe if giving meds via NG or G tube.

* Know both generic and trade name of the drugs, action, side effects, & usual dose of all meds to be administered.

Check all parameters as necessary prior to administration of meds. Ex- B/P and apical rate as well as any pertinent lab values.

Be alert to any meds that cannot be crushed and or removed from capsules. There are many. Be especially alert for daily dosing of extended release, or controlled release.

* Prepare meds in med cups in original package (don't open any) and don't pour any meds from med bottles.

Don't draw up any medication without the instructor's supervision.

The instructor will review each med with you prior to administration. BE SURE TO IDENTIFY ANY
MEDICATION THAT NEEDS TO BE BROKEN IN HALF.
☐ Unit dose medications opened at bedside)
☐ Check Facility policy for bringing MAR into the client’s room especially if the client is on isolation.
☐ Remember you must use two forms of ID of the client (or fail for the day if you don't). Name and date of birth.
☐ DO NOT GIVE ANY MED AT ANY TIME UNLESS SUPERVISED BY THE INSTRUCTOR
☐ Administer meds to patient and document with instructor present.
☐ Enter fluid type and volumes for all IVPB’s on I&O sheet
☐ Monitor patient for therapeutic and adverse effects of medications
SUFFOLK COUNTY COMMUNITY COLLEGE
NURSING CARE PLAN

STUDENT'S NAME: ___________________________ DATE: ________________

SURGICAL PROCEDURE: _______________________

_________________________ DATE OF
PATIENT'S INITIALS: _____ AGE: _____ CARE: __________

DEFINITION OF SURGICAL PROCEDURE: ___________

___________________________________________

MEDICAL DIAGNOSIS: __________________________

___________________________________________

<table>
<thead>
<tr>
<th>ASSESSMENT DATA FOR NURSING DIAGNOSIS</th>
<th>NURSING DIAGNOSIS COLLABORATIVE PROBLEMS</th>
<th>EXPECTED OUTCOMES WITH INDICATORS</th>
<th>NURSING INTERVENTIONS</th>
<th>SCIENTIFIC RATIONALE FOR NURSING INTERVENTIONS</th>
<th>REALISTIC EVALUATION</th>
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</thead>
<tbody>
<tr>
<td>Effectiveness of Nursing Interventions</td>
<td>Attainment of Expected Outcomes</td>
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Revised 5/06
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<th>ASSESSMENT DATA FOR NURSING DIAGNOSIS</th>
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<td></td>
<td></td>
<td>Effectiveness of Nursing Interventions</td>
</tr>
<tr>
<td>Complete Drug Order</td>
<td>Generic Classification</td>
<td>Action of Drug</td>
<td>Therapeutic Effects</td>
<td>Why is This Client Receiving the Drug?</td>
<td>Nursing Responsibilities</td>
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*Index cards may be used but must include all the necessary information.

7/04
Guidelines for Nursing Care Plans for Faculty

The following guidelines are to assist faculty in assessment of student nursing care plans as well as help clinical faculty reinforce expectations with students.

- The rubric is used to grade all nursing care plans
- Rubric grades must be placed on clinical evaluation forms at mid and end of semester.
- Reference list should be typed and in APA format.
- Students should use different diagnoses for each care plan within a course.
- Each scientific rationale must have a reference cited in APA format (author, page #).
- Each nursing care plan must include a bib card about an article related to the particular patient used in the care plan. The bib card must list the reference in APA format and include a brief summary of the article.
- Nursing interventions must include the specific medications/IV solutions etc. the patient is receiving.
- Students may not plagiarize each others care plans.
- All nursing care plans must be submitted in a large brown envelope with student name and diagnostic sheet on the outside.
- The care plan fails if the total score is less than 28/40. Only whole numbers are used in grading.
- If the care plan fails the student receives a clinical failure for the day on the evaluation form.
- If the care plan fails remediation includes the following:
  - The student must write up and submit a reflection of what went wrong.
  - The care plan must be remediated and resubmitted until an acceptable score is achieved.
  - The clinical instructor should have the student resubmit any section of the care plan that receives a score of less than 2 on the rubric.
  - All of the above must be reflected on the students clinical evaluation form.

Specific Guidelines NR 40
- One nursing care plan is required
- The nursing care plan should have at least 5 nursing diagnoses/collaborative problems
- Each nursing diagnosis should have a minimum of 5 nursing interventions.
CRITICAL THINKING RUBRIC TO ANALYZE THE APPLICATION OF NURSING PROCESS IN STUDENT NURSING CARE PLANS

PURPOSE OF THE RUBRIC

This critical thinking rubric is designed to analyze the application of nursing process in student nursing care plans and can be used by both faculty and students.

COMPONENTS OF THE RUBRIC

Each criterion contains performance criteria to demonstrate critical thinking for each step of the nursing process used in the development of a nursing care plan. The performance criteria describe behaviors and traits that are linked to a level of performance. There are four levels of performance. The levels of performance represent the degrees in which critical thinking is applied to accomplish the step in care planning. Level one is a beginner level of performance that reflects an absence of critical thinking whereas level four represents well developed critical thinking skills that reflect the student's ability to perform higher-ordered learning.

USING THE RUBRIC

Students

Students can use the rubric to facilitate nursing care plan preparation and development. The emphasis on systematicity and truth seeking behaviors will facilitate college level students progress in critical thinking skills. Prior to submission for faculty review, the student will be able to perform a self-assessment to identify levels of performance in each of the steps of nursing process and identify areas for future development. The student's ability to identify with level three and level four performances will enhance their self-confidence in the reasoning abilities and develop their disposition to critical thinking.

Grading of Care Plan:

The care plan is only graded in whole numbers. The minimum acceptable score is 28/40. The student will be asked to resubmit or remediate the care plan if any section on the rubric receives a score of less than 2. The care plan will be remediated until an acceptable score is achieved.

Rev. 5/05, 6/07
CRITICAL THINKING RUBRIC TO ANALYZE THE APPLICATION OF NURSING PROCESS IN NURSING CARE PLANS

ASSESSMENT FORM

4: All subjective and objective data is collected and is recorded using the appropriate terminology. Any data that is not collected is adequately explained in the blank spaces. Additional data is collected through the use of inquiry flawlessly, applying knowledge about the individual's disease and the patient's circumstances.

3: Most subjective and objective data is collected and is recorded using the appropriate terminology. Any data that is not collected is adequately explained in the blank spaces. Additional data is collected through the use of inquiry most of the time, applying basic knowledge about the individual's disease and the patient's circumstances.

2: Some subjective and objective data is collected. Blank spaces in the form are not explained adequately. There is incomplete use of inquiry to collect information.

1: Some subjective and objective data is collected. Blank spaces in the form are not explained. There is an absence of the use of inquiry to collect information relevant to the individual's disease and circumstances.

MEDICATION SHEET

4: All current medications are written on a separate piece of paper or index card and contain the required information. The information is complete. The student identifies potential problems and teaching needs individualized to the patient being cared for that is incorporated into the plan of care.

3: Most or all current medications are written on a separate piece of paper or index card and contain most or all of the required information. The information is complete. The student identifies some potential problems/teaching needs.

2: Some or all current medications are written on a separate piece of paper or index card and contain most or all of the required information. The information is incomplete with some omissions noted.

1: Some or all current medications are written on a separate piece of paper or index card and contain most or all of the required information. The information is incomplete with many omissions noted.
LAB DATA/DIAGNOSTIC TESTS

4: Pertinent lab data and diagnostic test results are recorded. Analysis of data recorded helps to confirm, clarify and direct patient care and is incorporated into the plan of care.

3: Most pertinent lab data and diagnostic test results are recorded. Some data that is irrelevant may be recorded but does not negatively impact patient outcome. Most data recorded helps to confirm, clarify and direct patient care.

2: Some pertinent lab data and diagnostic test results are recorded. Most data that is irrelevant may be recorded but does not negatively impact patient outcome. Absence of pertinent data is not explained.

1: Lab data and diagnostic test results may or may not be recorded. Significant omissions are noted that could lead to a negative impact on patient outcome.

REFERENCES

4: References are recorded in the appropriate space. Varied and appropriate references reflect the student's pursuit of the best knowledge in preparing the plan of care for the patient. APA format is used to list references.

3: References are recorded in the appropriate space. References reflect the student's pursuit of the basic knowledge in preparing the plan of care for the patient.

2: References are recorded in the appropriate space. References reflect the student's inability to identify resources that can provide the appropriate knowledge to guide the plan of care.

1: References are recorded in the appropriate space. References are omitted/limited or irrelevant to aid the student's attainment of the appropriate knowledge to guide the plan of care.

PRIORITIZATION

4: The nursing diagnoses are evaluated individually and are ranked in priority order to best reflect the coordination of care appropriate to the patient.

3: The nursing diagnoses are evaluated individually and are ranked in priority order and reflect a significant amount of coordination of care appropriate to the patient.
2: The nursing diagnoses are evaluated individually and are ranked in a priority order that indicates flawed decision making.

1: The nursing diagnoses are evaluated individually against a framework that does not facilitate prioritization of nursing diagnoses.

DIAGNOSES

4: The nursing diagnoses/collaborative problems selected reflect the accurate interpretation of the subjective and objective data analyzed. Subjective and objective data are listed appropriately as supporting data for the nursing diagnosis. All nursing diagnoses use NANDA terminology. All actual nursing diagnoses use 3 part statements (PES format). Risk nursing diagnosis use 2 part statements and syndrome diagnoses use 1 part statements.

3: The nursing diagnoses selected reflect the adequate interpretation of the subjective and objective data analyzed but are not always the best choice from the possible diagnoses that could be interpreted from the data. PES format is used correctly.

2: The nursing diagnoses selected reflect the inadequate interpretation of the subjective and objective data analyzed and result in a flawed plan of care. PES format is not always complete or used correctly.

1: The nursing diagnoses selected reflect that no effort to interpret information was applied resulting in a flawed plan of care. PES format is usually not complete or used correctly.

THE FOLLOWING CRITERIA ARE SUBSETS OF CRITERIA ESTABLISHED IN THE NURSING DIAGNOSIS OF THE RUBRIC. IF THE CARE PLAN RECEIVES A SCORE OF "2" OR BELOW, THE NEXT FOUR CRITERIA (OUTCOME CRITERIA, INTERVENTIONS, RATIONALE, EVALUATION) SHOULD NOT BE SCORED.

OUTCOME CRITERIA -

4: Measurable criteria are identified all of the time and contain verb and time element. The criteria identified generally are individualized to the patient and will lead to the control of the related factors that contribute to the nursing diagnosis.

3: Most of the outcome criteria are measurable and are identified to achieve goals will lead to the resolution or control of the related factors that contribute to the nursing diagnosis.
2: Some of the outcome criteria are measurable and are identified to achieve goals will lead to the resolution or control of the related factors that contribute to the nursing diagnosis but are poorly developed.

1: Some of the outcome criteria identified to achieve goals will lead to the resolution or control of the related factors that contribute to the nursing diagnosis purely by coincidence.

INTERVENTIONS

4: Specific interventions can easily be linked to specific outcomes. The interventions are realistic and appropriate to the patient's current status.

3: Specific interventions can be linked to specific outcomes. The interventions are realistic and usually appropriate to the patient's current status.

2: Interventions developed can be linked to specific outcomes but may be independent. The interventions may not be realistic and appropriate to the patient's current status.

1: Interventions developed are incomplete. Inappropriate interventions may be included in the plan of care.

RATIONALE

4: Rationales for each intervention contain comprehensive scientific reasoning that succinctly identifies why the intervention was selected.

3: Rationales for each intervention usually explain the intervention adequately and justify its inclusion.

2: Rationales for each intervention do not explain the intervention adequately and consequently its inclusion can not be justified.

1: Rationales for each intervention when included do not attempt to explain the intervention and consequently its inclusion can not be justified.

EVALUATION

4: The appropriate subjective and objective data is selected through review of the interventions related to ongoing assessment. The subjective and objective data that measures the outcome is collected and analyzed correctly.

3: The appropriate subjective and objective data is selected most of the time, through review of the interventions related to ongoing assessment that reflects adequate analysis.
2: The appropriate subjective and objective data is selected some of the time, perhaps through review of the interventions related to ongoing assessment or perhaps the data was collected coincidentally. Subjective and objective data is collected most of the time, but there appears to be no pattern to the data collection and it is rarely with consideration of the outcomes that are required to be measured.

1: Subjective and objective data is selected to reflect evaluation without consideration of the outcome criteria. Subjective and objective data may or may not be collected. Data collection is not subjected to analysis.

Disk#3Anderson
Revised 6/07
ANALYSIS OF APPLICATION OF NURSING PROCESS IN STUDENT NURSING CARE PLANS

STUDENT NAME ________________________________ COURSE ______________________________

ASSESSMENT DATE _____________________________ FACULTY ASSESSOR __________________________

SCORE: PLEASE ENTER THE LEVEL OF PERFORMANCE IDENTIFIED IN THE RUBRIC FOR EACH CRITERION.

STRENGTHS: DESCRIBE HOW THE PERFORMANCE WAS OF HIGH QUALITY AND COMMENDABLE. LABEL THE ASSESSMENT, SELECTING FROM THE LIST OF CRITICAL THINKING SKILLS AND BEHAVIORS, THAT DESCRIBES THE PERFORMANCE.

AREAS OF IMPROVEMENT: IDENTIFY CHANGES THAT COULD BE MADE TO IMPROVE PERFORMANCE IN THE FUTURE EMPHASIZING THE CRITICAL THINKING BEHAVIORS THAT SHOULD BE DEVELOPED.

INSIGHTS: REFLECT ON "NURSE KNOWING", "INTUITIONS", AND PERSONAL EXPERIENCE THAT WILL ENHANCE THE STUDENT UNDERSTANDING OF THE PATIENT SCENARIO AND FACILITATE APPLICATION TO NEW CONTEXTS.
<table>
<thead>
<tr>
<th>PERFORMANCE CRITERIA</th>
<th>SCORE</th>
<th>STRENGTHS</th>
<th>AREAS FOR IMPROVEMENT</th>
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</thead>
<tbody>
<tr>
<td>ASSESSMENT FORM</td>
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<tr>
<td>Include Daily Nursing Process Plan with a Nurse’s Note.</td>
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<tr>
<td>MEDICATION SHEETS</td>
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<tr>
<td>Including IV solutions/PRN medications.</td>
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<tr>
<td>LAB/DIAGNOSTIC TESTS</td>
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<tr>
<td>Include on Daily Nursing Process Plan and submit an additional sheet with interpretation.</td>
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<tr>
<td>PRIORITY SHEET</td>
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<tr>
<td>List all relevant diagnoses from systematic analysis that incorporates complete diagnostic statements in PES format.</td>
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<tr>
<td>REFERENCE LIST</td>
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<tr>
<td>On a separate piece of paper in APA format. Minimum of 4 references plus a summary of an article from a professional journal that is relevant to the client.</td>
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<tr>
<td>PERFORMANCE CRITERIA</td>
<td>SCORE</td>
<td>STRENGTHS</td>
<td>AREAS FOR IMPROVEMENT</td>
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<tr>
<td>NURSING DIAGNOSES</td>
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<tr>
<td>List pertinent subjective and objective data as defining characteristics to support diagnoses.</td>
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<tr>
<td>OUTCOME IDENTIFICATION</td>
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<tr>
<td>Include short and long term measurable goals.</td>
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<tr>
<td>INTERVENTIONS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Must be client specific.</td>
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<tr>
<td>RATIONALE</td>
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<tr>
<td>Scientific rationale for interventions. Cite sources in APA format.</td>
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<tr>
<td>EVALUATION</td>
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<tr>
<td>Explain why goals were met/unmet. Include specific data on effectiveness of interventions.</td>
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</table>

TOTAL SCORE: ________  INSIGHTS:
STUDENT RESPONSIBILITY FOR SAFE CLINICAL PRACTICE
GUIDELINES IN DETERMINING STUDENT CLINICAL GRADE

The clinical component of each nursing course provides nursing students with the opportunity to apply nursing principles in a practice setting. This is an essential skill for every competent practitioner of nursing.

The four overriding criteria for a satisfactory passing grade in the clinical area are:

1. Using the steps of the nursing process for scientific problem solving.
2. Maintaining medical and surgical asepsis.
3. Maintaining physical safety.

The critical behavior for evaluating student performance is the student’s ability to make clinical decisions for safe patient care. Such decision making reflects the ability of nursing students to apply nursing principles in a variety of situations. Meeting these criteria constitutes competent performance and a satisfactory passing grade.

When a student jeopardizes patient care by violating one of these principles, it shall constitute a failure for that clinical day.* A student fails a course when repeated failures occur. The specific standard for failure in each course is:

1. NR20 – Three (3) failed clinical days
2. NR33 – Two (2) failed clinical days
3. NR 24 Two (2) failed clinical days
4. NR36 – Two (2) failed clinical days
5. NR40 – Two (2) failed clinical days
6. NR46 – Two (2) failed clinical days
7. NR48 – Two (2) failed clinical days

*Please note that a failed clinical evaluation will constitute a failed clinical day.

Student’s responsibilities in this situation include:

1. Taking responsibility for one’s own actions.
2. Identify own error. Ask for assistance.
3. Develop and utilize strategies to assist in clinical decision making.
4. Please refer to document entitled “Guidelines for student written report for student incident resulting in student warning or failed clinical day.”

Faculty responsibilities in this situation include:

1. Counseling the student.
2. Providing a written notification regarding the failure.
3. Provide recommendations for corrective action.
Guidelines for Student Written Report of Clinical Incident  
Resulting in clinical warning or Failed Clinical Day

Explanation

This is an additional assignment that is given when the faculty identifies student decisions and/or actions that fail to meet the course objectives or standards of nursing practice during a given clinical class. The assignment is made in the spirit of student-centered learning and continued professional development. It provides a framework that assists the student to analyze clinical events, to consult the nursing literature, and to plan future nursing goals for themselves that are in keeping with professional standards.

Instructions to Faculty

The student’s written report should be submitted on the clinical day following the critical incident. The faculty must discuss the critical incident with the student before making this assignment. The completion of the written assignment provides tangible evidence of the student’s perspective regarding the incident. Further discussion with the student or further action may/may not be necessary depending upon the insight demonstrated in the written report as well as the student’s subsequent clinical practice.

Instructions to Students

1. Provide a written report of the critical incident to the clinical instructor.
2. The report is due on the next clinical day following the critical incident.
3. The report should consist of your answers to three basic questions.

A. **What happened?**  
   Describe the details of the incident.  
   What were your nursing actions? What was the patient’s response? What were the actual and the potential consequences for the patient? Include any and all details you deem pertinent.

B. **What should have happened?**  
   Based upon your meeting with your clinical instructor after the incident, and based upon the research you have done since the incident, what should have happened in this clinical circumstance?

C. **What Nursing Practices will you implement in the future to prevent the recurrence of similar incidents?**

4. The report should include a bibliography of at least one pertinent nursing reference.
SUFFOLK COUNTY COMMUNITY COLLEGE
SCHOOL OF NURSING
CLINICAL EVALUATION

Name: _______________________________ #Of Clinical Experiences: ______
Course: NR40 Adult Health Nursing II #Of Written Assignments Required: ______
Clinical Agency: ___________________________ #Of Written Assignments Submitted: ______
Date: From: _____________ To: _____________ #Of Absences: ______

EVALUATION CRITERIA - NR40 ADULT HEALTH NURSING II

All areas are critical. In Part I, a minimum rating of 2 or better in each category must be achieved on
the final evaluation to receive a passing grade. In Part II, a rating of satisfactory must be achieved on
the final evaluation to receive a passing grade.

<table>
<thead>
<tr>
<th>I. PERFORMANCE OBJECTIVES FOR CLINICAL EVALUATION</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>NA/NO</th>
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<tbody>
<tr>
<td><strong>A. ASSESSMENT:</strong></td>
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<tr>
<td>1. Assesses physiological and psychological status of patient and/or family members to identify actual or potential health problems.</td>
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<td>2. Gathers pertinent information from members of the health team and other resources.</td>
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<tr>
<td>3. Applies interviewing principles in the development of a database.</td>
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<tr>
<td>5. Demonstrates appropriate physical assessment skills in the development of a database.</td>
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<td>6. Validates conflicting data.</td>
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<td>7. Assesses health care delivery system to identify actual or potential problems.</td>
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<td>8. Assesses patients’ readiness to learn.</td>
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<tr>
<td><strong>B. PLANNING:</strong></td>
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<tr>
<td>1. Utilizes scientific principles and critical thinking to develop a holistically based care plan.</td>
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<tr>
<td>2. Establishes Nursing Diagnoses in priority order.</td>
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<tr>
<td>3. Plans nursing action to assist patients in meeting their needs.</td>
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<tr>
<td>4. Proposes alterations in patient’s care to reflect changes in patient needs.</td>
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<tr>
<td>5. Identifies significant cultural, religious, psychosocial and environmental data when formulating plan.</td>
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<tr>
<td>6. Develop appropriate teaching plan to meet health needs of individual patients and groups.</td>
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<tr>
<td>7. Includes appropriate community resources in planning to meet health needs of the patient.</td>
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<tr>
<td>8. Prioritizes care according to patients needs.</td>
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<tr>
<td>9. Incorporates discharge plan into plan of care.</td>
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<tr>
<td><strong>C. IMPLEMENTATION:</strong></td>
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<tr>
<td>1. Uses appropriate communication channels to accomplish goals relative to plan.</td>
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<tr>
<td>2. Initiates nursing actions as a member of the health team.</td>
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<tr>
<td>3. Prioritizes nursing implementation strategies for individual patients.</td>
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</table>
### I. PERFORMANCE OBJECTIVES FOR CLINICAL EVALUATION

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<thead>
<tr>
<th></th>
<th></th>
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<th>NA/NO</th>
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<tbody>
<tr>
<td>4.</td>
<td>Utilizes nursing actions to address patients’ and families’ health promotion, maintenance and restoration needs.</td>
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<tr>
<td>5.</td>
<td>Exhibits a caring attitude toward patients and families.</td>
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<td>6.</td>
<td>Interacts appropriately with patients.</td>
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<td>7.</td>
<td>Modifies nursing actions to promote optimal level of wellness for each patient.</td>
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<td>8.</td>
<td>Demonstrates the ability to plan and delegate nursing responsibilities.</td>
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<td>9.</td>
<td>Collaborates with members of the multidisciplinary team to provide comprehensive care.</td>
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<td>10.</td>
<td>Accountable for delegated nursing care.</td>
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<tr>
<td>11.</td>
<td>Consults with the instructor and/or nursing staff, when appropriate, before modifying care.</td>
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<tr>
<td>12.</td>
<td>Investigates appropriate community resources for patients and families.</td>
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<tr>
<td>13.</td>
<td>Establishes priorities of nursing care for a group of patients.</td>
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<tr>
<td>14.</td>
<td>Administers medications accurately, and in accordance with agency protocol.</td>
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<tr>
<td>15.</td>
<td>Implements teaching plan for patients and/or families.</td>
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<tr>
<td>16.</td>
<td>Incorporates discharge planning in nursing care plan.</td>
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<tr>
<td>17.</td>
<td>Serves as an advocate for patients and families.</td>
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#### D. EVALUATION:

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<tr>
<th></th>
<th></th>
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<th>NA/NO</th>
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<tbody>
<tr>
<td>1.</td>
<td>Evaluates effectiveness of nursing actions on the patient.</td>
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<tr>
<td>2.</td>
<td>Identifies factors that interfere with the effectiveness of nursing interventions.</td>
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<tr>
<td>3.</td>
<td>Evaluates the effectiveness of a teaching plan for the patient and/or family.</td>
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<tr>
<td>5.</td>
<td>Revises nursing care plan based on patients’ response to interventions.</td>
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<tr>
<td>6.</td>
<td>Reviews social system changes that impact delivery of regional health care.</td>
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</tbody>
</table>
II. CRITERIA FOR EVALUATING PROFESSIONAL DEVELOPMENT

<table>
<thead>
<tr>
<th>A. SAFETY:</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
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<tbody>
<tr>
<td>2. Interprets information and directions correctly.</td>
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<tr>
<td>3. Maintains patient safety incorporating developmental level.</td>
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<tr>
<td>4. Reports own errors</td>
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<tr>
<td>5. Uses aseptic technique correctly.</td>
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<table>
<thead>
<tr>
<th>B. SKILLS IN COMMUNICATION:</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Speaks clearly and effectively in performing nursing role.</td>
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<tr>
<td>2. Expresses ideas clearly in writing.</td>
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<tr>
<td>3. Interacts professionally with members of the health team.</td>
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<td>4. Asks relevant and appropriate questions.</td>
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<thead>
<tr>
<th>C. PROFESSIONAL STANDARDS:</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
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</thead>
<tbody>
<tr>
<td>1. Accepts responsibility for and maintains accountability for own nursing practice.</td>
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<tr>
<td>2. Maintains accountability for nursing care delegated to others.</td>
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<tr>
<td>4. Maintains ethical standards of practice.</td>
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<tr>
<td>5. Maintains legal responsibilities in nursing practice.</td>
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<tr>
<td>6. Utilizes independent learning for professional development.</td>
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<table>
<thead>
<tr>
<th>D. CRITICAL THINKING:</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
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</thead>
<tbody>
<tr>
<td>1. Organizes information effectively.</td>
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<tr>
<td>2. Prioritizes and utilizes interventions in a timely manner.</td>
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<td>3. Analyzes data utilizing conceptual framework.</td>
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<tr>
<td>4. Identifies problems in a timely manner.</td>
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<td>5. Clarifies information via academic literature and independent research.</td>
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<td>6. Develops and evaluates patient teaching.</td>
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<thead>
<tr>
<th>E. INTERPERSONAL RELATIONSHIPS:</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
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</thead>
<tbody>
<tr>
<td>1. Participates effectively as a member of a group.</td>
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<tr>
<td>2. Utilizes constructive criticism and changes behavior accordingly.</td>
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<tr>
<td>3. Discusses the relationship of the nurse to other health team members.</td>
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<tr>
<td>4. Utilizes leadership and delegation skills appropriately.</td>
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<thead>
<tr>
<th>F. RESPONSIBILITY FOR LEARNING:</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
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<tbody>
<tr>
<td>1. Evaluates own nursing competencies and changes behavior accordingly.</td>
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<tr>
<td>2. Shows initiative in seeking additional information.</td>
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<td>3. Utilizes resources to enhance knowledge.</td>
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<thead>
<tr>
<th>G. PERSONAL RESPONSIBILITY:</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
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<tbody>
<tr>
<td>1. Reports to clinical facility on time.</td>
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<tr>
<td>2. Submits written assignments on time.</td>
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<tr>
<td>3. Clinical absences do not exceed policy limit.</td>
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<td>4. Presents a professional appearance.</td>
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<tr>
<td>5. Identifies appropriate alternatives when unable to meet a course obligation.</td>
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