SUFFOLK COUNTY COMMUNITY COLLEGE

SCHOOL OF NURSING

NUR 240 CLINICAL FOLDER
1. Student clinical assignments overview
2. Objectives for Student Rotations to ICU/CCU/ER/CATH LAB
3. Objectives for ACE Days
4. Objectives for Simulated District Med Assignment
5. Medication Administration for a Group of Patients
6. NUR240 Clinical requirements
7. Nursing Care Plan Criteria, Format and Rubric
8. Student Responsibility for Safe Clinical Practice
9. Discharge Planning/Home Care Assignment
10. Clinical Presentation Guidelines
11. NUR240 Clinical Evaluation Tool

Print the following documents from the School of Nursing Webpage;
http://department.sunysuffolk.edu/Nursing
1. Nursing Care Assessment Form (8 pages)
2. Patient Care Plan
3. Daily Nursing Process Plan
COURSE DESCRIPTION: NUR240 – Medical Surgical Nursing II
Focus is on identification of actual and potential stressors that lead to maladaptation as manifested in dysfunctional health patterns in the adult. Emphasis is the nursing process to prevent disease and/or promote adaptation to effects of stress in acute and chronically ill clients with multiple health problems. The needs and concerns of culturally and spiritually diverse individuals, families and communities will be integrated throughout the curriculum.

CLINICAL EXPERIENCE: Pass/Fail - See Guidelines for Determining Student Clinical Grade. Assignments must be submitted on the specific date designated by the instructor. All clinical work must be completed by the last clinical day. Failure in the clinical area constitutes a failure for the entire course. Each student will receive a written mid-term and final evaluation of clinical performance. A “failed” mid-term evaluation is considered one failed clinical day.

Student Health Policies and Requirements: published in the SCCC Nursing Student Handbook. Failure to provide the required health records in the clinical area constitutes being unprepared for clinical and thus results in a failed clinical day for each day that the student is in noncompliance. Current CPR (American Heart Association – BLS for healthcare provider) must be maintained for the duration of this course. All assignments will be submitted to clinical instructor in a large envelope with “Clinical Assignments” record attached to front of envelope.

Nursing Process Paper: Pass/Fail Due Date: _________________

Discharge Summary/Community Agency Report: Pass/Fail Due Date: _________________

Clinical Presentation: Pass/Fail Due Date: _________________

Mid-semesterral clinical evaluation to begin on or before the 7th week

Final clinical evaluation to be given on last clinical day during ACE #3

Rotation to “specialty units” ICU/ER/Cath Lab Dates TBD by clinical instructor
ACE Days  Alternative Clinical Experiences will be held on campus unless otherwise noted. Rooms to be arranged by lecturer.

| ACE #1   | Part A: Skills practice in nursing lab.  |
|         | SBAR Communication Exercise           |
|         | Simulated District Med Administration  |
| Part B: | Universal Orientation and/or Hospital specific orientation |
|         | Leadership & Management Packet        |
| ACE #2  | Simulation Lab: Mock Code/ACLS Protocol |
|         | Microsims Hospital                    |
|         | EKG Rhythm Strip Review               |
| ACE #3  | Part A: Clinical Presentations        |
|         | Part B: ATI RN Med-Surg               |
|         | ATI Pharmacology (For final semester students) |
|         | Final Clinical Evaluations with Clinical Instructor |

**WRITTEN ASSIGNMENTS:** Assignments must be submitted on the specific date designated by the instructor. It is expected that all work will follow college standards of writing. Late assignments in the clinical area may be assigned a “failed clinical day” at the discretion of the instructor.

**FAILURE** in clinical results in **FAILURE** for the **ENTIRE COURSE**.

**CHEATING:** Cheating in any aspect of academic work results in a **ZERO (0) grade for that work. This includes plagiarism.**

**CLINICAL SKILLS**
Students entering NR133/136, NR246 and NR240 are expected to be able to perform all nursing skills that were taught in prior nursing courses. In cases where the student may not have had the opportunity to practice the skill in an actual clinical situation, the student should be prepared to demonstrate proficiency by correctly stating all the steps involved in performing a particular skill/procedure and by demonstrating the skill in the nursing practice lab. Students are responsible to independently practice in the nursing lab during their out-of-class time in order to gain skill proficiency.

**ATTENDANCE POLICY:** Please refer to the nursing student handbook

**LATTENESS POLICY**
Tardiness is closely monitored in the Nursing Program. Students are expected to be on time and lateness will not be tolerated. Students should arrive to clinical site promptly at the assigned time prepared to work. Any student who arrives to clinical after the start time will be considered late for that clinical experience and will be counseled by the faculty member.

**Final grade will be negatively affected by absence, lateness and early departure from classes or clinical.**

ATI Testing: students must bring ATI paper/pencil, ID number and computer ID number to assessment.

Street clothes are to be worn whenever a student is on campus.
SUFFOLK COUNTY COMMUNITY COLLEGE
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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
OBJECTIVES FOR STUDENT ROTATION TO 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 ACTIVITIES:

1. 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.

2. MOCK CODE
   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 dysrhythmias/cardiac arrest utilizing ACLS protocols
   5. Identify commonly used drugs and treatments used in management of dysrhythmias/cardiac arrest.
   7. Use of Microsims Virtual Hospital and SIM Man

3. SBAR COMMUNICATION EXERCISE: GIVING AND TAKING REPORT (Handoff Communications)

   * The Joint Commission in its 2009 National Patient Safety Goals has identified – Improve the effectiveness of communication among caregivers as its number 2 Goal. Accuracy and completeness of Handoff Communications has been identified as an extremely important tool to achieve this goal. The utilization of SBAR communications is encouraged
   * Report takes place at the beginning and 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.
   * 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.

THE JOINT COMMISSION: 2010 National Patient Safety Goals Hospital Program

Goal 1 – Improve the accuracy of patient identification.
Goal 2 – Improve the effectiveness of communication among caregivers.
Goal 3 – Improve the safety of using medications.
Goal7- Reduce the risk of hospital care associate infections.
Goal 8- Accurately and completely reconcile medications across the continuum of care.
Goal 9- Reduce the risk of patient harm resulting from falls.
Goal 13- Encourage patient’s active involvement in their own care as a patient safety strategy.
Goal 15- The organization identifies safety risks inherent in the patient population.
Goal 16- Improve recognition and response to changes in a patient’s condition.

http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/
**OBJECTIVES FOR ON CAMPUS SIMULATED DISTRICT MEDICATION ASSIGNMENT**

1. The student will administer medications for a group of patients using a number of different routes.
   - (po, sub q, IVPB, and via n/g tube)
2. Identify questionable med orders.
3. Identify appropriate lab data that is to be checked prior to medication administration.
4. Note parameters for medications administered.
5. Identify the usual dose, indications, therapeutic effect, adverse effects, nursing implications and patient teaching for each medication prior to administration.
6. Administer the medications within one hour period.

**Instructions for Simulated District Medication Assignment**

Complete district meds worksheets for each patient scenario.

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).

**MEDICATION ADMINISTRATION IN THE CLINICAL SETTING**

Students must pass dosage calculation quiz in order to administer medications

**Objective:** To gain experience in administering medications to a group of patients

Every student must be prepared to administer medications each day.
MEDICATION ADMINISTRATION FOR A GROUP OF PATIENTS

§ 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 doctor’s orders with MAR.
§ If you can't find order dates in doctor’s orders, check MAR.
§ 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 separate MAR binder 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.
§ STUDENTS ARE NOT PERMITTED TO ADMINISTER ANY IV PUSH MEDICATIONS
§ 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. Unit dose medications opened at bedside)
§ 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
§ Check Facility policy for bringing MAR into the client’s room especially if the client is on isolation. Remember you must check 2 client identifiers.
§ 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

NUR133/240 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.
TEAM LEADER ASSIGNMENT

1. The team leader will assign two or more patients to each team member and the team leader will have one less difficult patient or no patient.
2. The team leader makes walking rounds to do a quick assessment and observation of the patients’ in the team: PRIORITIZE, PLAN, ORGANIZE, AND COLLABORATE.
3. Be knowledgeable about all the patients the team is caring for.
4. 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.
5. If there are problems you can't solve speak with the instructor or primary nurse
6. 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 & O, 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.
7. Encourage team members to complete documentation in a timely manner
8. 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 I&O's.
10. Facilitate post-conference reports/discussion.
11. Delegate non-nurse tasks to nursing assistants when necessary.

Expectations of Pre-Conference

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

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

Expectations of 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
- Each team member will report to the instructor on their individual patients
- Review completed Daily Nursing Process Forms
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 O 2 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.
- Develop an efficient report “form”

NOTE: It is important to avoid unprofessional comments about clients that could predispose oncoming nurses to view and respond to clients negatively.

How to Gather Information
- Utilize the Daily Nursing Process Plan
- Instructor’s report
- Report from primary nurse
- Physical, psychosocial environmental assessment
- MD orders
- MD progress record and history and physical
- Nurse's Admission Assessment
- Progress notes
- Lab reports, x-rays etc

Guidelines for NUR 240 Nursing Process Plan/Concept Map
- One concept map/nursing care plan is required
- The nursing process plan should have at least 4 nursing diagnoses/collaborative problems
- Each nursing diagnosis should have a minimum of 5 nursing interventions.
- One diagnosis should be related to discharge planning
- Submit grading rubric with paper
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. NUR101 – Three (3) failed clinical days
2. NUR133 – Two (2) failed clinical days
3. NUR124 – Two (2) failed clinical days
4. NUR136 – Two (2) failed clinical days
5. NUR240 – Two (2) failed clinical days
6. NUR246 – Two (2) failed clinical days
7. NUR248 – 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. Refer to Faculty Handbook Steps For Counseling A Student Concerning A Clinical Warning Or A Failed Clinical Day.

**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.
REPORT OF FAILED CLINICAL DAY

Learning Activities

1. Utilize the nursing practice lab to simulate:
   a. Practice independently to become familiar with:

   b. Arrange an appointment with a nursing faculty member for supervised practice of this skill.

   c. Demonstrate competency in ____________________________ in clinical area.

2. View video tapes on the following topics:
   And/or complete the following Computer Assisted Instructional (CAI) programs:

3. Discuss the principles of the above video tapes/CAI with assigned clinical instructor.

4. Review text material on the following topics:

5. Apply this knowledge and these skills in the clinical setting.

CONCLUSION: Student must successfully complete all the recommendations of this learning guide in order to progress in the Nursing program. The student agrees to provide the faculty with a written summary of the specified learning activities he/she has completed by __________________. (date)

Student Signature: ____________________________ Date ____________________

Student Comments:

Faculty Signature: ____________________________ Date ____________________

Faculty Comments:

Note: The clinical faculty member is responsible to distribute three copies of this report as follows:
Student, Clinical Faculty and student file by way of the course lecturer.
FFL/ds rev 5/07
NUR 240 Discharge Planning/Home Care Assignment

The student will expand knowledge and skill to a patient ready for discharge by providing patient teaching and management of care for clients in home care setting.

Assignment Objectives:

1. Review concepts of patient teaching and adult learning theory.
2. Utilize the nursing process for patients in the Home Care setting.
3. Describe the role of the RN in discharge planning at your facility.
4. Apply principles of teaching learning theory when developing a teaching plan.
5. Implement at least one teaching strategy for a selected client preparing for discharge and who requires home care.
6. Discuss appropriate discharge planning/home care with care manager/discharge planner.
7. Identify one community agency appropriate for patient’s health care needs.
8. Maintains a safe therapeutic environment for the patient in the home setting.
9. Demonstrates an understanding of the relationship of progress towards patient outcomes and to reimbursement of services.

Discharge Planning/Home Care Requirements

1. Summarize the role of the RN in discharge planning and home care. (May be done as a post conference discussion rather than written summary at discretion of instructor.)

2. **On date of care:** the student will select an appropriate patient anticipating discharge and requiring home care follow up.
   - Collect data and plan for teaching intervention using Home Care Planning Assessment worksheet. Discuss plan with clinical instructor and implement at least 1 teaching strategy.
   - Evaluate effectiveness of your teaching via such methods as patient return demonstration or restatement of key points to remember.

3. **Written Summary:**
   - Discuss patient’s needs, plan for discharge and home care. Include:
     a. Assessment data pertinent for discharge plan/home care follow up: (for ex, wound care, medication administration, activity, diet etc.)
     b. Home environment.
     c. ALL learning needs that should be met before discharge. Consider current hospitalization as well as chronic needs. Identify and implement 1 teaching strategy
     d. Patient/significant other learning style and barriers to learning.
     e. Evaluate effectiveness of teaching.

4. Select an appropriate community agency. Describe the services provided and how will your patient benefit from these services.

5. Summarize one article from a professional journal that relates to home care. Identify how this applies to your client. Do not submit copy of article unless requested by your instructor.
**NUR 240 Discharge Planning/Home Care Assignment**

Criteria for grading – Attach this page to your paper. Students must meet all of the criteria in order to receive a passing grade.

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Criteria Met</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1. Summary of the role of the RN (may be verbal post conference discussion at discretion of clinical instructor)</td>
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<td>2. Select an appropriate patient with discharge needs and requiring home care follow up.</td>
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<td>3. Submit 3 page written summary illustrating teaching strategy and home care. (See Requirements #3 &amp; #4). DO NOT include a step by step check list of the topic taught.</td>
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<tr>
<td>4. Appropriate article summary and application to patient. Do not submit article unless directed to by clinical instructor.</td>
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CLINICAL PRESENTATION:
CHOICE AT THE DISCRETION OF CLINICAL INSTRUCTOR

CLINICAL PRESENTATION #1
NUR 240 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 NUR101.
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.
CLINICAL PRESENTATION #2
NUR 240 Nursing Grand Rounds

Objective: Each clinical group will present an evolving case study appropriate for RN students on an ACE day. Choose an Adult Med-Surg topic. Topic can be from NUR133/240. Follow the format of the case study work sheet. Collaborate with members of the student team (clinical group) to develop, select and utilize educational materials for distribution to students. Choose and/or develop audiovisual aides for presentation of the case study. Review project with instructor prior to presentation. Deliver the presentation. Evaluate the effectiveness of the presentation. Use Winningham – Preusser text, Critical Thinking, as a guide.

1. Each clinical group will divide into 2 groups. Each group will select a topic of interest.
2. Selected topic must be approved by clinical instructor and course lecturer. Contact course lecturer to avoid duplication of topics. Topic must be approved before you begin working on project.
3. Develop evolving case study that shows progression of patient’s disease process, with complications.
4. Case study must be higher level learning geared toward RN students utilizing Evidence Based Practice. Case study may include experiences on your particular clinical unit, as well as Critical Thinking case study text.
5. Use format from Critical Thinking Case Study text. Usually begins with initial presentation, then observations and questions geared toward your target audience.
6. Presentation should be developed using the attached worksheet to assign portions of the case study and areas to be addressed. Pay particular attention to medications and use this as an opportunity to teach your peers about medications unique to your patients disease and diagnosis.
7. Presentation should be scholarly, well researched use of websites, AV/media/powerpoints and patient teaching materials is strongly urged.
8. Time frame for each presentation is approximately 20 minutes
9. 1 copy of case study worksheet to be turned into clinical instructor and 1 copy to course lecturer at least 2 weeks prior to actual presentation and should include reference page in APA format.

Criteria For Grading:
1. Works effectively as a team as demonstrated by respectful communication with each other and shared workload
2. Selected topic/scenario approved by clinical instructor and course lecturer
3. Develop evolving case study that shows progression of pt’s disease process, with complications
4. Case study must be higher level learning geared toward RN students incorporating EBP
5. Use format from Critical Thinking Case Study text. Includes initial presentation, observations and questions toward your target audience
6. Presentation developed using all the sections of the attached worksheets.
7. Submit the completed worksheets with a review sheet of the medications used for your pt’s disease and diagnosis. Include a reference page in APA format
8. Demonstrates professional dress, posture, mannerisms when doing oral presentation
Nursing Grand Rounds Worksheet

Clinical Vignette:

How does case study progress? (Complications, etc):

1. Student Names Medications Handout – brand & generic names. Class, indications, contraindications, significant side effects, food and drug interactions, pt educations, nursing implications (eg Lab values) consider appropriate lab values.

2. Student Names Treatments, interventions, and therapeutic procedures. Method of delivery; purpose/desired outcome, indications, contraindications, and precautions.

3. Student Names Laboratory tests and diagnostic procedures. What is it, when was it done, and why? Correlate to medical condition and medications.

4. Student Names Cultural and psychosocial issues and their significance:

5. Student Names National Patient Safety Goals addressed

Objective: Students will examine the clinical setting and determine areas in which quality improvement could be made in the clinical microsystem. These improvements in the workplace and patient care will benefit the students’ understanding of: systems; change theory; patient safety goals; teamwork; critical thinking.

General Requirements

- Each Clinical group will determine a specific area on the clinical unit that they would like to see changed.

- Obtain approval of your change project idea from your clinical Professor.

- Develop a written plan of the change project.

- As you develop your plan, consider that it is a general plan that may need to be adapted as you investigate further, please consult with your Professor.

- Present the proposed change project to your clinical group and/or to the staff on the unit. This will be decided by your clinical Professor.

- Assessment

- Identify a need for change and document rationales and sources of information. State at least two outcomes that you will assess.

- Assess for potential problems in implementing the change project. (For example: how will the suggestion of change be received by staff and administrators, what is the cost?)

Planning

- Describe the specific materials that are to be used and/or changed.

Implementation

- State the place and time when your change project is planned for implementation.

Evaluation

Specifically describe how you will evaluate the effectiveness of your change project.

Criteria for grading:

- Thoroughly present in writing all parts of the change project.
- Document research in APA format.
- Paper must be typed and five to ten pages in length.
# SUFFOLK COUNTY COMMUNITY COLLEGE
# NURSING PROCESS RUBRIC

<table>
<thead>
<tr>
<th>Student Name __________________________</th>
<th>Submission Date</th>
<th>Resubmission Date__</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSESSMENT:</strong></td>
<td>(✓) 5/5✓ = Outstanding</td>
<td>4/5 ✓ = Satisfactory</td>
</tr>
<tr>
<td>1. Collects subjective and objective data that is consistent, pertinent and accurate.</td>
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<tr>
<td>2. Describes general observations, health history, diagnostic studies and physical assessment in data collection.</td>
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<tr>
<td>3. Includes complete Daily Nursing Process Plan with Nurses Note.</td>
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<tr>
<td>4. Any omissions in data collection are thoroughly explained.</td>
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<tr>
<td>5. Additional data is collected and explained through the use of inquiry.</td>
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<tr>
<td><strong>LAB / DIAGNOSTIC TESTS:</strong></td>
<td>(✓) 3/3✓ = Outstanding</td>
<td>2/3 ✓ = Satisfactory</td>
</tr>
<tr>
<td>1. Pertinent lab and diagnostic data are recorded.</td>
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<tr>
<td>2. Lab and diagnostic tests are included on daily nursing process plan and an additional sheet is submitted with interpretation.</td>
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<tr>
<td>3. Lab and diagnostic data are integrated into plan of care.</td>
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<tr>
<td><strong>MEDICATION SHEETS:</strong></td>
<td>(✓) 3/3✓ = Outstanding</td>
<td>2/3 ✓ = Satisfactory</td>
</tr>
<tr>
<td>1. Identifies all current medications including intravenous solutions and PRN medications.</td>
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<tr>
<td>2. Completes comprehensive medication form.</td>
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<tr>
<td>3. Integrates current medications into plan of care.</td>
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<tr>
<td><strong>NURSING DIAGNOSIS:</strong></td>
<td>(✓) 5/5✓ = Outstanding</td>
<td>4/5 ✓ = Satisfactory</td>
</tr>
<tr>
<td>1. Selects _________(# dependent on nsg course) NANDA approved nursing diagnoses from priority list to be used in development of plan of care.</td>
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<tr>
<td>2. Provides adequate supporting data for each diagnosis selected.</td>
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<tr>
<td>3. Formulates each diagnostic statement using PES components.</td>
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<tr>
<td>4. Individualizes each diagnostic statement to reflect actual and potential client problems.</td>
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</tbody>
</table>
5. Includes a separate list of all appropriate nursing diagnostic statements in priority order.

**OUTCOME CRITERIA:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>√</th>
<th>3/3 = Outstanding</th>
<th>2/3 = Satisfactory</th>
<th>&lt;2 = Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Relates each expected outcome to the appropriate diagnosis.</td>
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<tr>
<td>2. Chooses expected outcomes which are realistic and measurable.</td>
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<tr>
<td>3. Selects expected outcomes that are patient centered.</td>
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</table>

**NURSING INTERVENTIONS:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>√</th>
<th>5/5 = Outstanding</th>
<th>4/5 = Satisfactory</th>
<th>&lt;4 = Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identifies 5 or more interventions for each diagnosis.</td>
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<tr>
<td>2. Prioritizes realistic nursing interventions.</td>
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<td>3. Relates nursing interventions to diagnosis and outcomes.</td>
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<tr>
<td>4. Provides appropriate rationale for each intervention / rationale is cited in APA format.</td>
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<tr>
<td>5. Individualizes interventions which are patient centered.</td>
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</table>

**EVALUATION:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>√</th>
<th>3/3 = Outstanding</th>
<th>2/3 = Satisfactory</th>
<th>&lt;2 = Unsatisfactory</th>
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</thead>
<tbody>
<tr>
<td>1. Identifies if outcome was met or unmet.</td>
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<tr>
<td>2. Identifies specific data on effectiveness of all interventions.</td>
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<td>3. Identifies if plan should be continued or if revisions are needed.</td>
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</table>

**REFERENCE LIST:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>√</th>
<th>3/3 = Outstanding</th>
<th>2/3 = Satisfactory</th>
<th>&lt;2 = Unsatisfactory</th>
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<tbody>
<tr>
<td>1. Has varied, current and appropriate references.</td>
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<tr>
<td>2. APA format is correctly used.</td>
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<tr>
<td>3. An article summary, relevant to the client and from a professional nursing journal is included.</td>
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**FORMAT:**

- Outstanding
- Satisfactory
- Unsatisfactory

- No errors in spelling, grammar, punctuation. Consistent, accurate use of terminology. Precise language. Legible print, black ink.
- Multiple errors (>5) in spelling, grammar, punctuation. Inconsistent use of terminology. Unclear language, illegible.

**Comments:**

Must achieve Satisfactory in all criteria to pass

Grade: ____________________
SUFFOLK COUNTY COMMUNITY COLLEGE
SCHOOL OF NURSING
CLINICAL EVALUATION
LEVEL II

Name: ___________________________________      Mid Semester _____ Final _______
Clinical Agency: _________________________      NUR240 _____
                                      NUR246 _____ NUR248 _____
                                      # Of Absences: ______
Date: From: _____________ To: _____________      Per # Of Clinical Experiences ______

EVALUATION CRITERIA

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.

<table>
<thead>
<tr>
<th>I. PROFESSIONAL BEHAVIOR</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>NA / NO</th>
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<tbody>
<tr>
<td>A. Adheres to standards of professional practice.</td>
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<tr>
<td>B. Demonstrates accountability for personal actions and delegated actions.</td>
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<tr>
<td>C. Practices nursing within legal, ethical and regulatory frameworks.</td>
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<tr>
<td>D. Utilizes and incorporates resources for life long learning.</td>
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<tr>
<td>E. Demonstrates leadership in the nursing role.</td>
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<tr>
<td>F. Initiates actions that facilitate empowerment for the nursing profession.</td>
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<td>G. Utilizes constructive criticism, evaluates own nursing competencies and changes behavior accordingly.</td>
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<tr>
<td>H. Reports to clinical facility on time.</td>
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<tr>
<td>I. Submits written assignments on time.</td>
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<tr>
<td>J. Clinical absences do not exceed policy limit.</td>
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<tr>
<td>K. Presents a professional appearance.</td>
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<tr>
<td>L. Identifies appropriate alternatives when unable to meet a course obligation.</td>
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<tr>
<td>M. Reports errors of omission/commission in a timely manner.</td>
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<tr>
<td>N. Satisfactory completion of all written assignments</td>
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</table>

II. COMMUNICATION

| A. Identifies similarities and differences on a position and supports their position with current nursing literature. |   |   |   |         |
| B. Applies advanced techniques of therapeutic communication with clients, significant others and members of the health care team. |   |   |   |         |
| C. Employs group dynamic strategies when communicating with team members. |   |   |   |         |
| D. Demonstrates increasing ability to communicate relevant, accurate and complete information for groups of clients verbally and in written documentation. |   |   |   |         |

III. ASSESSMENT

| A. Analyzes health status of clients with multiple health problems. |   |   |   |         |
| B. Demonstrates advanced skill in completing a health history. |   |   |   |         |
| C. Integrates prior knowledge in assessing the effects of stressors on clients, families and communities. |   |   |   |         |
| D. Prioritizes responses to actual or potential health problems and to nursing interventions for individuals/groups of clients in a timely manner. |   |   |   |         |

IV. CLINICAL DECISION MAKING

| A. Analyzes data pertaining to dysfunctional health patterns and stressors of the individual, family and the community. |   |   |   |         |
| B. Utilizes evidence-based practice in order to formulate clinical decisions. |   |   |   |         |
C. Maintains accurate and safe care and an awareness of current National Patient Safety Goals.

D. Develops diagnoses and plans care that focuses on actual or potential health problems, promotion, wellness and restoration.

E. Modifies client care as indicated by evaluation of outcomes.

<table>
<thead>
<tr>
<th>V. CARING INTERVENTIONS</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>NA /NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Initiates and performs effective and preventative nursing measures to facilitate health promotion and maintenance in clients and groups.</td>
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<tr>
<td>B. Acts as an advocate and synthesizes understanding of cultural, spiritual, and developmental needs when caring for individuals/families in order to provide sensitive, holistic nursing care.</td>
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<tr>
<td>C. Demonstrates aseptic techniques correctly.</td>
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<tr>
<td>D. Administers medications accurately and in accordance with agency protocol.</td>
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<table>
<thead>
<tr>
<th>VI. TEACHING AND LEARNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Develops teaching/discharge plans to assist individuals and groups to promote health and manage acute and chronic health problems.</td>
</tr>
<tr>
<td>B. Identifies learning needs of the individual and family and modifies interventions according to developmental level.</td>
</tr>
<tr>
<td>C. Utilizes teaching and learning concepts in leadership/management in assigned setting.</td>
</tr>
<tr>
<td>D. Informs patient and family about appropriate community resources.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VII. COLLABORATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Collaborates with peers and multidisciplinary team members to deliver cost effective, quality care to individuals, families and communities.</td>
</tr>
<tr>
<td>B. Conveys mutual respect, trust, support and utilization of each discipline’s role and contributions to health care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VIII. MANAGING CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Applies principles of effective motivation.</td>
</tr>
<tr>
<td>B. Utilizes key concepts underlying effective delegation.</td>
</tr>
<tr>
<td>C. Demonstrates leadership management skills when working with the multidisciplinary health team members to deliver care to groups of clients.</td>
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<tr>
<td>D. Applies strategies of change theory with the health care team.</td>
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<tr>
<td>E. Employs techniques that can be used in evaluating the work of others.</td>
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<tr>
<td>F. Utilizes conflict resolution skills.</td>
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<tr>
<td>G. Assesses visionary skills and identifies a plan to become more innovative.</td>
</tr>
</tbody>
</table>

**KEY TO PERFORMANCE APPRAISAL**

3 = Performance meets clinical objectives and exceeds requirements
2 = Performance meets clinical objectives
1 = Performance does not meet clinical objectives
N/A = Not applicable
N/O = Not observed

Revised 2/02/09
5/2010 DC