



NURSING ONE
CLINICAL SYLLABUS
NUR 1023L

TABLE OF CONTENTS

GENERAL CLASS AND COURSE INFORMATION.....	1
PROFESSORS CONTACT INFORMATION.....	3
CLASS REQUIREMENTS	3
CLASS POLICIES & METHODOLOGY	4
COLLEGE POLICIES AND WEB INFORMATION	7
DEPARTMENT CONTACT INFORMATION:	8
GETTING STARTED	9
COURSE GUIDELINES AND FORMS	10
GUIDELINES FOR DOCUMENTATION	16
WRITTEN ASSIGNMENTS.....	20
DAILY HOLISTIC ASSESSMENT TOOL (FOR ADULTS & WELL ELDER) (DHAT)	26
COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (FOR WELL ELDER) (CHAT)	ERROR! BOOKMARK NOT DEFINED.
NURSING CARE PLAN	32
INTERPERSONAL PROCESS RECORDING (IPR).....	35
GUIDELINES FOR WRITING AN INTERPERSONAL PROCESS RECORDING ..	36
CRITERIA AND EVALUATION TOOL	38
BODY OF INTERPERSONAL PROCESS RECORDING (IPR).....	40
COMMUNITY LINKS PAPER.....	56
CLINICAL EVALUATION OF PERFORMANCE	89

Course Syllabus – Classroom (Clinical) Courses

GENERAL CLASS AND COURSE INFORMATION

Course number: NUR 1023L

Class Reference Number: Multiple

Term: 2012-1

Course Title: Nursing I Clinical

Credit/Contact hours: 3 credits/8 clinical hours

Course Description:

The beginning nursing student will integrate content from classroom learning activities and skills lab practice experiences. Care will be provided to selected clients across the lifespan in a variety of settings. Focus is on assessment and wellness. Special fee required.

Course Learning Outcomes: As a result of taking this course, the student will be able to

1	Provide care to all assigned clients in a professional manner, demonstrating awareness of legal/ethical principles.
2	Utilize critical thinking skills, the five concepts of human functioning and holistic assessment of the client to implement the nursing process.
3	Maintain a safe environment during all aspects of client care.
4	Use therapeutic communication with all assigned clients and colleagues.
5	State the rationale for all aspects of care administered to assigned clients including laboratory, nutritional and medication order.
6	Assist all assigned clients with activities of daily living, based on the assessment of the client's developmental level.
7	Demonstrate the use of the "ten rights" of medication administration.
8	Administer medications to assigned clients, after dosages are verified by clinical instructor and/or staff nurse with 100% accuracy.
9	Perform basic nursing skills in the clinical setting upon availability. These skills may include, providing personal hygiene, physical assessment, documentation, catheterization, tube feeding, medication administration (with exception of intravenous route), dressing changes, maintaining oxygen therapy, assisting clients with ambulation and assisting clients with nutritional needs.
10	Document the client care and teaching provided on the Daily Holistic Assessment Tool (DHAT).
11	Discuss client care priorities and goal attainment issues in relation to the nursing process during the clinical post conference.
12	Integrate the five concepts of human functioning with all nursing process related assignments.
13	Document implementation of all aspects of the nursing process for a selected client using the Comprehensive Holistic Assessment Tool (CHAT).
14	Analyze one therapeutic interaction with a client utilizing the Interpersonal Process Recording.
15	Safely manage all aspects of care for two or more assigned clients.

[Course Outline for NUR1023L - NURSING 1 CLINICAL](#)

Course Syllabus – Classroom (Clinical) Courses

Class Schedule: The clinical experiences will be Mondays and Tuesdays for the Fulltime Program. The hours will be 0730 – 1330 or 1330-1930. The Weekend/Evening section will hold clinical experiences on Saturday.

Disclaimer - Changes may be made to the syllabus at any time during the term by announcement of the professor. It is the responsibility of the student to make any adjustments as announced.

Textbooks Information: Textbooks are listed as Required and Recommended.

Required:

1. Syllabus NUR 1023L (Fall 2012-1/Spring 2012-2)

Textbooks are listed in the NUR 1023 syllabus.

You may purchase your textbook(s) at any one of Palm Beach State College's campus bookstores or [online](#).

The Electronic [Essential Nursing Resources](#) Video list is recommended & available in [MTIS](#) (Media Technology and Instructional Services) located on the first floor of the LLRC.

Course Syllabus – Classroom (Clinical) Courses

All students enrolled in a Nursing course are required to obtain and read the current [Nursing Student Handbook](#) and the [Palm Beach State College Student Handbook](#). All Nursing students are responsible for the information contained in these publications. Both of these publications are published on the Palm Beach State College web site.

Web Content Information: This course does not have a web component.

PROFESSORS CONTACT INFORMATION

<p>Mary Biderman, MSN, RN Professor I AH 301, 561/868-3041 Email</p>	<p>Deb Copeland, MSN, RN Professor I AH 206, 561/868-3431 Email</p>
<p>Leslie Kent, RN, MS Professor I AH 201, (561) 868-3436 Email</p>	<p>D. J. Marshall, MSN, RN Professor II AH 107, 561/868-3440 Email</p>
<p>Barbara Pryzby, MSN Associate Professor I AH211, (561) 868-3430 Email</p>	<p>Ann Sipes, MS, RN Professor I AH 307, (561) 868-3444 Email</p>
<p>Office Hours are Posted on the Faculty Web Pages and Outside Office</p>	

CLASS REQUIREMENTS

Assignments: Clinical assignments will be made to maximize your learning. Written assignments due for NUR 1023L are as follows:

- Student Survey and Self-Assessment
- Basic Medication Preparation Requirements
- Daily Holistic Assessment Tool (DHAT)
- Interpersonal Process Recording (IPR)
- Community Links Assignment with Well Elder
- Comprehensive Holistic Assessment Tool (CHAT)
- Service Learning Experience
- Weekly long Term care Assignments
- Electronic Nursing Care Plan (Nurse square)

Course Syllabus – Classroom (Clinical) Courses

Late Assignment Policy: Late assignments will not be accepted unless prior authorization has been granted by the instructor of record.

Grading Scale & Policy: the nursing department utilizes the satisfactory/unsatisfactory grading system. In order to pass this course the students must receive a satisfactory clinical evaluation on the “Evaluation and Clinical Performance Tool,” submit satisfactory clinical papers on the date due, and meet all clinical objectives. Any student who is not performing at a satisfactory level will receive a Performance Improvement Plan (PIP). The purpose of this plan is to inform the student of any deficiencies and also to provide the student with a strategy for success.

Each student must successfully complete each of the first semester nursing courses to proceed to the second semester of the program.

Tests, Quizzes, and Final Examination Schedule: There will be ongoing evaluation of student performance and application of theory and skills in the clinical area. A Performance Improvement Plan (PIP) will be provided to any student who is not meeting clinical standards. The student is expected to report to the Skills Lab for remediation in the area(s) identified on the PIP. The “Evaluation and Clinical Performance Tool,” will be reviewed with each student at Midterm and at the end of scheduled Clinicals for a Final Clinical Evaluation, to assess progress and plan for continued advancement or remediation as needed (please review tool at the end of this syllabus).

Make-up Policy: Please refer to Nursing Student Handbook for Clinical Make-up Policy.

CLASS POLICIES & METHODOLOGY

Attendance: Attendance will be taken on all clinical days and college wide policies related to attendance will be followed. Failure to meet the clinical requirements of the course (even if related to absence) will result in a clinical failure for the course. There will be **no excused clinical absences or tardiness**. Missing even one clinical experience may jeopardize your ability to meet the clinical objectives of your course. All unmet criteria will be addressed through a PIP (performance improvement plan)

NURSING DEPARTMENT ATTENDANCE

All students are expected to attend all classes and clinical/labs. In the event of an absence due to extenuating circumstances, the student is expected to notify the appropriate faculty member prior to the start of clinical.

Electronic Device Use: Hand-held devices are allowed in class for researching data, only. The use of Hand-held devices that are iPod capable are encouraged to facilitate downloadable information as learning strategies and study tools. **Cell phones must be turned off in clinical, class, and are prohibited in the campus Testing Centers.**

Email Policy: All students have access to a college email account. It is the responsibility of the student to activate this account in order to be kept current with college, program and course information. College email must be checked weekly, at least. Faculty will contact students via college email, so be certain to check this email account twice weekly for any updates or changes to coursework or schedules.

Course Syllabus – Classroom (Clinical) Courses

Equipment & Supplies: Skills Lab Kits will be distributed during Skills Lab classes. Please bring the following with you to the clinical area:

1. Stethoscope – purchased separately
2. Black pen and notebook – purchased separately
3. Bandage scissors – issued in skills lab kits
4. Goggles – issued in skills lab kits
5. Pen light – purchased separately

See nursing student handbook for the following policies:

- Work Schedule
- Tardiness
- Attire/Dress Code
- Behavior
- Clinical Safety Protocol

Professor's Expectations:

Each clinical group has a faculty team responsible for planning and supervising the activities of the clinical group. The faculty has a strong clinical background and desire to share their expertise and professionalism. In addition to clinical responsibilities, clinical instructors are responsible for evaluating each student's clinical performance and written assignments and are available for consultations to meet individual student's needs.

One goal of the faculty is to promote student learning from each clinical experience through planned individual and group activities. The faculty expects students to be prepared for each clinical experience and to demonstrate personal and professional effort in meeting the demands of the course clinical objectives.

Clinical Hours and Attendance

Assignment for your clinical group is confirmed by the full-time faculty during the first week, and **may not be changed after that time.**

In addition each student must perform 4 hours of approved service learning experience and complete college evaluation and reflection assignment.

Students who become ill are required to notify their clinical instructor. Calls should be placed directly to the clinical instructor ASAP **before** the clinical experience. It is the student's responsibility to discuss with the clinical instructor the reason for the absence. The instructor will then notify the student of the possibility and requirements necessary to complete the course objectives.

During your clinical orientation your clinical instructor will provide the: Name of agency; Unit assigned; Time to report; and Phone number of instructor/contact person on unit, and parking instructions. Directions to facilities will be provided.

Methods of Instruction: Methods suitable for adaptation and implementation to the clinical area include:

Teaching Strategies

1. Hands on clinical application of theory with facilitation by clinical faculty.
2. Role playing.

Course Syllabus – Classroom (Clinical) Courses

3. Pre-conference: An organized focused time prior to beginning clinical facilitated by clinical faculty, which “grounds” the student’s clinical activities.
4. Post-conference: An organized focused time after the day’s clinical experience to support the integration of experiences.
5. Alternative Instructor facilitated learning experiences.
6. Simulations

Evaluation Methods

- A. Attendance and Participation
- B. Written and verbal evaluations at mid-term and end of term.
(Please review the “Evaluation of Clinical Performance” Tool which is located at the end of this syllabus).
- C. Evaluation of written and verbal assignments.

Unique Requirements of the Class: Clinical experiences are required to successfully complete this course:

1. Your first clinical experiences will begin on campus.
2. You will be oriented to your clinical facility by your clinical faculty. This will include an orientation of your clinical practice setting and a thorough review of your clinical requirements/responsibilities.
3. You will be integrating content from lecture, skills lab classes & pharmacology you’re your clinical experiences.
4. Please note that in the event of an unforeseen emergency or circumstances beyond our control, we reserve the right to schedule exams and or instructional activities during other times as necessary as a means to ensure every opportunity for the students to successfully complete the course
5. Individual instructors will inform students of telephone procedures for absence, tardiness, or emergencies for the clinical experiences.
6. Medication Administration during the clinical experience is dependent on successful completion of NUR 1022L Nursing Skills Lab Unit on medication administration.
7. Student Portfolio must be kept current and be available on site.

Clinical Experience: Each student will be assigned about half the semester in an acute care setting and about half the semester in a long term care setting. The student will be responsible for delivering total care to 1-2 clients on selected clinical units. The nursing process will be utilized to assist clients in achieving optimum health through goal attainment. Clients with diagnoses discussed in theory class will be assigned whenever possible to facilitate student application of newly acquired knowledge.

Assignments will be made to maximize your learning. Discuss any specific learning experiences you are lacking with your clinical instructor

Observational Clinical Experience: As an adjunct to your clinical experience, your clinical instructor **may** assign you to an ‘off the floor’ observational clinical experience. This experience may take place in areas such as: endoscopy, operating room, wound care. This is a bonus to your learning and not a student right. You are not to perform nursing care in these areas. You are to observe only. For each observational clinical experience, you need to complete the ‘Observational Clinical Experience’ questionnaire that follows.

Confidentiality: Confidentiality is a strict must! Any breach of confidentiality will be grounds for immediate disciplinary action.

COLLEGE POLICIES AND WEB INFORMATION

Academic Dishonesty

Academic dishonesty includes the following actions, as well as other similar conduct aimed at making false representation with respect to the student's academic performance:

(1) Cheating on an exam, (2) Collaborating with others on work to be presented, if contrary to the stated rules of the course, (3) Submitting, if contrary to the rules of the course, work previously submitted in another course, (4) Knowingly and intentionally assisting another student in any of the above actions, including assistance in an arrangement whereby work, classroom performance, examination, or other activity is submitted or performed by a person other than the student under whose name the work is submitted or performed, (5) Plagiarism.

Please refer to the **Palm Beach State College** [Student Handbook](#)

Classroom Etiquette and Student Behavior Guidelines

Students will demonstrate respect for professors and fellow students. Behavior that is disruptive to a positive learning environment reported by the professor will result in a warning on the first instance; the second instance might result in expulsion from the course or campus.

Computer Competency Component

Each student will, to the satisfaction of the instructor, demonstrate a fundamental understanding of basic computer operations through various instructor-determined exercises and/or assignments. These exercises/assignments are included in this syllabus.

Disability Support Services

Students with disabilities are advised, in compliance with federal and state laws, that accommodations and services are available through the office of [Disability Support Services](#) (DSS). It is the student's responsibility to contact [Disabled Student Services Advisors](#) and to submit appropriate documentation prior to receiving services.

Eating, Drinking and Smoking

Eating and drinking are confined to areas designated on the campus. Smoking is not permitted in any College building and only in areas designated at each campus.

Student Responsibility Policy

When a student attends the College, s/he becomes subject to its jurisdiction. Students are expected to conduct themselves in a responsible manner, in all areas of campus life. By enrolling, they pledge to obey the rules and regulations of the College and are responsible for observing all College policies and procedures as published in the student handbook, the College catalog and other College publications. The student will be responsible for preparing for class, participating in class, and completing assignments on time.

Palm Beach State College [Websites of Interest](#) for Students.

Course Syllabus – Classroom (Clinical) Courses

Withdrawal Policy for Individual Courses: The last day to withdraw from a College course with a "W" grade in this course is posted on the college calendar. It is the responsibility of the student to use the PantherWeb system or visit a campus Registrar's office to withdraw. Without a formal withdrawal from the courses, lack of attendance will result in failure. An official withdrawal entitles the student to a grade of "W" in the class. Withdrawal or lack of participation in even one nursing course (NUR 1023, NUR 1023L, NUR 1022L, or NUR 1141 or NUR 2140) will result in being removed from all the nursing courses as all nursing course are to be taken concurrently.

DEPARTMENT CONTACT INFORMATION:

Kellie Bassell, MSN, EdS, RN
Nursing Program Director
AH 110 (561) 868-3412
Fax (561) 868-3452
[Email](#)

Course Syllabus – Classroom (Clinical) Courses

GETTING STARTED

1. Make sure you have all the computer system requirements as listed in the Computer Requirements section of this syllabus.
2. Obtain course materials. The textbook(s) can be purchased at the Palm Beach State College campus bookstore or [online](#).
3. Log onto the course web site [Online Learning - Blackboard Campus](#). Use your PantherWeb logon information.
4. Once inside the course website, read the "Mandatory Online Orientation" and complete the *Orientation Quiz*.
5. Print the course guidelines, forms and the clinical evaluation of performance tool that follow this section of the syllabus.
6. Begin completing your assignments as listed on the course calendar and/or class schedule.

Disclaimer

Changes may be made to the syllabus at any time during the term by announcement of the professor. It is the responsibility of the student to make any adjustments as announced.

COURSE GUIDELINES AND FORMS

Course Syllabus – Classroom (Clinical) Courses

PRE OR POST CONFERENCE GUIDELINES

Preconference

Prior to student rendering of direct client care a clinical preconference will be held. The time and location of the preconference is at the discretion of the clinical instructor. The focus will be reviewed, goals for the day established and learning needs identified.

The preconference is intended to be a brief, but important, review of the day's activities. Clinical instructors will assist the clinical group in identifying care priorities, learning opportunities and organizational needs. Nursing care plans for each client may also be randomly chosen for discussion.

Post Conference

Post conferences are intended to discuss nursing care challenges of interest for the benefit of all the students in the conference group and to share ideas for meeting these challenges. The location and time for clinical post conferences will be scheduled by the clinical instructor.

The clinical instructor will facilitate the post conference discussion. Each student is expected to participate in evaluating the day's goals and learning experiences. Activities relevant to the clinical focus will be discussed with emphasis on expected and actual outcomes of care, alternative interventions and staff nurse responsibilities in the overall management of care for the client.

Student Objectives The student will:

1. Identify the client.
2. State client needs.
3. Describe pertinent observations in a review of systems manner.
4. Report situation and potential or real problems experienced.
5. Discuss nursing approach/solution to these.
6. List the drugs administered, and state the action, dose, desired effect, untoward effects and method of administration for each.
7. List treatments, and state the purpose of, and client's response to each.
8. IV solutions.
9. Labs/pertinent to patient.
10. Teaching.

Course Syllabus – Classroom (Clinical) Courses

Student Guide for Discussion

1. Who is my client? (for example, age, marital status, psychosocial history, medical conditions and mental status).
2. State significant events of this hospitalization (admitting diagnosis, surgery, emotional crises, fracture).
3. What are your client's needs TODAY? (Describe client situation, your observations, potential or real problems and your approach).
 - a. Basic daily needs
 - b. Needs requiring special attention
4. What medications were administered, or is your client receiving?
 - a. Why?
 - b. What were the positive and negative effects?
 - c. What safety measures were used?
5. What treatments were done?
 - a. Why were these done?
 - b. What special principles or safety measures were involved?
6. Did I meet my client's needs? Explain your answer.
7. What could I do to improve my nursing care of this client?
8. What were my feelings about taking care of this client?
9. Presentation of special topics.

Course Syllabus – Classroom (Clinical) Courses

CLINICAL ORIENTATION

Focus: Orientation to the Clinical setting

The student will:

1. Learn the physical layout of the clinical area.
2. Review and be familiar with the OSHA guidelines regarding universal precautions as related to the clinical setting; know where to find protective equipment, sharps disposal boxes and infection control manuals located on the unit.
3. Discuss the ethical, legal issues involved in the nursing care of the members of the Nursing Care Units.
4. Identify the chain of command as it relates to the clinical area.
5. Be familiar with usual routines for the unit:
 - a. vital signs
 - b. meal time
 - c. visiting policies
6. Be introduced to the charting system for the clinical facility.
7. Be introduced to policies related to IV's and medication administration.
8. Discuss nursing responsibilities related to medication administration.
9. Review school policies as they relate to clinical attendance, e.g. absenteeism, tardiness, etc.
10. Be oriented to clinical assignments, time of clinical experience, location and time of pre and post conferences and other scheduled clinical experiences in this course.
11. Review the clinical evaluation tool.
12. Discuss the role of the associate degree nurse as provider of care, manager of care and member of the profession.
13. Discuss the issues of confidentiality related to the clinical setting.
14. Review the requirements for papers related to this course.
15. Review lab, library and computer assisted tutoring available to assist student learning.

Course Syllabus – Classroom (Clinical) Courses

ORIENTATION SCAVENGER HUNT

Locate the Following

Resources

Policy and procedure books
OSHA information
Infection Control procedures
Charting guidelines
Textbooks & other resources
Nursing staff assignments

Medication Room

How/where are narcotics dispensed?
Where are emergency drugs kept/code cart?
Where are clients medications kept?

Emergency (Crash) Cart with defibrillator

Emergency oxygen
Emergency equipment
Restraints
Suction equipment
What equipment do you need to suction?

Patient Medical Records

Lab results
Transcribed orders
Advanced directive guidelines
Patient teaching information
Drug information
Teaching videos

Nutrition Room

Ice machine

Nourishments

Tube feedings

What equipment do you need to initiate a tube feeding?

Treatment Room

Catheterization and irrigation supplies
Sterile dressings and supplies
How are they charged to the patient?
Tape
Syringes & needles

Equipment

Wheelchairs
Backboards
IV poles
Accucheck
Bedside commode
Cardio-respiratory monitors
Oxygen saturation monitors

Locate the following:

Fire alarms and exits
Emergency outlets
Human resources
Radiology
Laboratory
Pharmacy
Cafeteria
Emergency Department, ICU, Endoscopy
OR, PACU
Chapel
Parking lot (for students)

Clean Holding

Linen cart
Bedpans/urinals, bath & emesis basins

Familiarize yourself with bed controls, client call button, sharps containers, lighting & emergency call lights in rooms.

Course Syllabus – Classroom (Clinical) Courses

OBSERVATIONAL CLINICAL EXPERIENCE

Objectives:

1. The student will describe the clinical experience that was observed.
2. The student will identify the primary population served.
3. The student will describe the similarities and differences of this population as compared to the primary population on his/her assigned clinical unit.
4. The student will describe the healthcare professional he/she shadowed; in terms of educational requirements (credentialing, certifications, etc.) and essential job responsibilities.
5. The student will discuss how these responsibilities differ from the essential responsibilities of the nurses on his/her assigned clinical unit.
6. The student will discuss the likelihood of pursuing a job in this area.

Record of Observations:

Name: _____ Date: _____

Observational Experience: _____

Name and title of nurse shadowed: _____

1. Credentials of nurse (advanced degree, certification, years of experience, or training) necessary to perform role.
2. What are the essential job responsibilities of the nurse?
3. How do these responsibilities differ from the essential responsibilities of the nurses on your assigned clinical unit?
4. Describe the primary population served.
5. Describe the similarities and differences of this population as compared to the population on your assigned clinical unit.
6. What did you observe?
7. What was the best / most interesting part of the experience?
8. What did you like least about the experience?
9. Is this an area that you would consider working? Why or Why not?
10. Had you thought about working in this area before today?
11. Would you recommend this expertise to a fellow student? Why or Why not?

GUIDELINES FOR DOCUMENTATION

Course Syllabus – Classroom (Clinical) Courses

GUIDELINES FOR CHARTING

1. Follow agency policy regarding notes - format, frequency.
2. Must use **black** ball point pen, only, and print or write legibly.
4. Precede each entry with date and time.
5. Do not erase or completely mark out a mistake. Draw a single line through the error and sign it.
6. Always sign your name, on any entry you have made on flow sheets or nurse's notes, according to agency policy. Ex. Nancy Nurse, S.N., Palm Beach State College.
7. Avoid using the word "patient" - some facilities chart the clients' name.
8. Chart in chronological order, recording on every line so the order cannot be altered.
9. Do not write between the lines. If you inadvertently omit a note - make a late entry.
10. Record information as close as possible to the time you deliver care. Do not document in advance.
11. Write notes only for clients you have cared for.
12. Never change your documentation to cover up for someone else's mistakes.
13. Eliminate bias from your notes. Document objectively. Do not generalize. Be specific.
15. Indicate in the record that you not only know what complications may occur - but that you are seeking to prevent them.
16. Document problems as they occur, the interventions, and the evaluation of the patient status.
17. Document the safeguards you use to protect your patient.
18. Record your clients' response to medications and treatment.
19. Record any significant symptoms or changes in the clients' conditions.
20. Record physician visits.
21. Document discussion of questionable medical orders, and the directions for confirming, canceling, or changing them.
22. If something goes wrong - document the mistake or accident in the nurse's notes, and on the incident report. Do not document "completion of incident report" in patient record.
23. Avoid vague words like – "normal", "good", "bad", or "adequate."
24. Use proper spelling - keep a dictionary handy. Do **not** use abbreviations.

GUIDELINES FOR NARRATIVE NURSING NOTES

1. PSYCHO-SOCIAL

Overall appearance and behavior (anxious, afraid, impatient, angry), emotional response to current treatment/hospitalization, self-concept/body image changes, grieving, limitations in intellectual capacity, cultural factors (beliefs, response to pain), ineffective family coping.

2. SKIN

Change in skin pigmentation (color), texture (turgor), temperature, eruptions, rashes, unusual hair growth or loss.

3. NEURO

Headache, nervousness, sleep disturbance, vertigo, syncope, sensory or motor disturbance, paralysis/paresis, paresthesia/hyperesthesia/hypoesthesia, memory loss, nightmares, twitching, convulsions, tremors, dysphagia, handwriting changes, mental status, level of consciousness (ability to follow command), disorientation, pupil size and reaction.

4. CARDIOVASCULAR

Dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, hypertension, claudication, varicose veins, thrombophlebitis, chest pain, heart rate (palpitations, rhythm changes, heart murmur), edema (pedal, sacral, periorbital), heart sounds, pulses (peripheral, apical, jugular veins), and capillary refill.

5. RESPIRATORY

Breath sounds (clear or adventitious: wheezing, rales, etc.), character of breathing (rate, rhythm (unlabored/labored, dyspnea, shallow, etc.), chest movement, cough, expectoration, hemoptysis, night sweats, sneezing, rhinorrhea, oxygen, chest drainage tubes, sputum specimens and characteristics, oral hygiene, post-op coughing and deep breathing exercises, incentive spirometry, position of bed, pulse oximeter/apnea monitor.

6. GI/METABOLIC

Dietary habits, appetite, food intolerance, use of antacids, indigestion, nausea, vomiting, distension, abdominal pains, abdominal masses, jaundice, hematemesis, bowel habits, diarrhea, constipation (laxative use), melena, stool formation and description, hemorrhoids, incontinence, abdominal surgery, bowel sounds, abdominal tubes/drains, ostomies, diaphoresis, TPN, diabetes/thyroid, goiter, polyphagia, inspection, auscultation, percussion, palpation.

7. GU/GYN

Dysuria, polyuria, oliguria, hematuria, pyuria, calculi, force of stream, output (color, amount, etc.), strain urine, retention, bladder distention, frequency, hesitancy, nocturia, incontinence, discharge (type, color, odors), care of tubes (foley, suprapubic), LMP (vaginal discharge/bleeding), rashes.

8. MUSCULOSKELETAL

Muscle weakness, pain, aches, cramps, atrophy, back or joint stiffness, deformities, dislocation, fractures, radicular pain, casts, ambulation, therapy, use of devices, elevation/immobilization of extremities or body parts, traction.

CLINICAL EXPECTATIONS REGARDING MEDICATION ADMINISTRATION

1. Check medication sheets at beginning of shift to verify administration schedules.
2. Look up all meds to be given and know the following:
 - a. Drug Name
 - b. Classification
 - c. Uses
 - d. Action in Body
 - e. Normal Dosage
 - f. Side Effects
 - g. Nursing Interventions
 - h. Pertinent lab or assessment data in relation to medication effects.
 - i. Contraindications
 - j. Pertinent teaching points to educate the client

(You may use the required Drug Guide - but you must be prepared before giving the med.)
3. All drugs must be given on time. There is a 30-minute leeway before or after administration time. Be ready.
4. PRN meds MAY NOT be given until the ordered time limit.
5. All meds must be **checked** by instructor to verify dosage.
6. **All** injectable meds must be prepared and administered with instructor present.
7. All meds must be charted as given **immediately after** being administered.
8. PRN meds are a priority. If patient needs a PRN, the procedure is to:
 - a. Check MAR for appropriate order and when last dose was given.
 - b. Obtain med with instructor.
 - d. Prepare med.
 - e. Administer med.
 - f. Chart med.
 - g. Reassess patient within 30-60 min.
9. ALWAYS maintain close communication with your Clinical Instructor regarding your patient's status.
10. All students are required to successfully pass the ProCalc Medication Administration Exam by the deadline date with a minimum score of 80% for NUR 1023L. In addition, students must pass Procalc for Semester 2 by the deadline date with a minimum score of 85%.

WRITTEN ASSIGNMENTS

Course Syllabus – Classroom (Clinical) Courses

ACUTE CARE ROTATION

The following is a guide for the required clinical assignments during the Acute Care Rotation.

WEEK # 1	<u>ORIENTATION DAY</u> Orientation to Unit Scavenger Hunt
WEEK # 2	COMMUNICATIONS Initiate IPR
WEEK # 3	IPR Due
WEEK # 4	DHAT (first 2 pages) Medications and Lab sheets Or Nursing Care Plan using Nursesquare SPICES Assessment
WEEK # 5	DHAT (first 2 pages) Medications and Lab sheets Or Nursing Care Plan using Nursesquare SPICES Assessment
WEEK # 6	Full DHAT Medications and Lab sheets 2 Nursing Care Plans Or Nursing Care Plan using Nursesquare SPICES Assessment
WEEK # 7	Full DHAT Medications and Lab sheets 2 Nursing Care Plans 1 Teaching plan Or Nursing Care Plan using Nursesquare SPICES Assessment

Mid-Term and Final Evaluations are held on Campus
(Time to be scheduled with individual clinical instructor)

Course Syllabus – Classroom (Clinical) Courses

STUDENT SURVEY AND SELF-ASSESSMENT

STUDENT OBJECTIVE: Be able to state personal goals, strengths, weaknesses, liabilities, and teacher expectations.

Reaching your goal of becoming a nurse will demand a combined effort from you and your faculty. Getting to know each other is important; the following survey/assessment will get things off to a good start. **Please complete as thoroughly as possible and give to your clinical instructor the first week. (in Bold)**

1. Name: _____ Age: _____

2. Reason for choosing nursing as a career?

3. Have you had any previous experience in other nursing schools?

4. Your expectations of this program?

5. What is your goal for your career in nursing?

Course Syllabus – Classroom (Clinical) Courses

CLINICAL SIMULATION

Learning Outcomes:

- Demonstrate critical thinking AEB individual and collaborative performance within the assigned scenario.
- Utilize appropriate theory and skills to implement the nursing process individualizing it to meet client unique needs.
- Manage complex patient needs in an effective and safe environment.

Preparation: The Simulation day is considered a clinical day, so please arrive on time, simulation starts at 8:30 am. Wear your uniform and identification badge and bring your stethoscope. Please bring a blank copy of the clinical paperwork (DHAT, labs, medications, & care plan forms). Also, bring a drug book, laboratory and diagnostic manual and the nursing diagnosis handbook.

Patient Care and Intervention: Students may be divided into 2 groups for the simulation experience. Students will be assigned specific roles for the simulation. Based on the clinical scenario presented, the students must develop a plan of care including nursing actions (interventions) necessary to stabilize the patient. Skills performance will occur at the bedside. (Some information may be only available after the completion of skills). At the end of the simulation, a comprehensive debriefing will take place.

Skill Development: The mannequin / human simulator will be utilized for physical assessment and nursing care. During the simulation, students may be asked to perform any skill previously learned.

Paperwork: Document the assessment findings of this patient utilizing appropriate semester paperwork based on the scenario presented. Also, include medication sheet, lab sheet and care plan. The group will work together to complete this paperwork. The group should brainstorm to develop a list of possible nursing diagnoses; then prioritize the diagnoses. Three (3) diagnoses should be identified as priority and fully developed in a comprehensive care plan (be sure to include at least one psychosocial nursing diagnosis).

****Any discussions or paperwork generated by the simulation experience MUST stay within the simulation group. Sharing of the simulation information (verbal or written) outside of the group will be considered a HIPPA violation and result in a Personal Improvement Plan (PIP).****

**DAILY HOLISTIC ASSESSMENT TOOL (for Adults & Well Elder)
(DHAT)**

Student Name: _____ Date: _____

Adult Daily Holistic Assessment Tool (DHAT)

Client Initials _____ Age _____ DOB _____ Gender _____ Date _____

WT _____ HT _____ Admission Date: _____ Allergies _____

Admission Diagnosis / Current Diagnosis:

Secondary Diagnosis: _____

Pathophysiology (textbook reference): _____

Initial Assessment	Time:
Vital Signs	T _____ P _____ RR _____ B/P _____
Sensory / Perception / Cognition:	
LOC / Visual or auditory deficits	† awake † alert † oriented † asleep † confused † obtunded † none specify: _____
Mood	† appropriate † depressed † anxious † angry † euphoric † labile
Behavior	† cooperative † uncooperative † apprehensive † agitated † lethargic
Speech / Primary language	† clear † appropriate † inappropriate † aphasia † impaired hearing Primary language: _____
Pupils	(L) _____ mm † brisk † sluggish † nonreactive (R) _____ mm † brisk † sluggish † nonreactive PERRLA
Pain	Score: _____ location: _____ description: _____ medicated Y* N
Growth & Development (Erikson) Stage	(Actual Stage) _____ AEB _____
* Alteration in S/P/C	none present R/T _____
Cellular Integrity:	
Skin temperature / moisture	† warm † cool † cold † dry † moist † diaphoretic
Color / turgor	† pink † pale † cyanotic † mottled † jaundiced † elastic † tenting
Edema	† none † present † location _____ pitting +1 +2 +3 +4
Mucous membranes	† pink † pale † moist † dry † lesions
Rash / lesion / wound	† none † present site describe _____ _____ location _____
* Alteration in Skin Integrity	none present R/T _____
Oxygenation:	
Respiratory: Effort	† unlabored † dyspneic † nasal flaring † abdominal † stridor † grunting † retractions Regular irregular

Student Name: _____ Date: _____

Lung sounds	† RUL _____ † RML _____ † RLL _____ † LUL _____ † LLL _____ Clear Decreased Absent Rales Rhonchi Wheezes
O ₂ therapy / O ₂ saturation	† none † O ₂ therapy _____ lpm / % † NC † Mask † Oxyhood saturation level _____%
Cough / Respiratory Treatments	† nonproductive † productive _____ tx's _____
*Impaired Gas Exchange	none present R/T _____
Cardiovascular: Apical	† regular † irregular † S1 † S2 † PMI † Murmur
Extremities: Capillary refill / peripheral pulses	< > _____ seconds {0 – 3} R/L brachial _____ R/L radial _____ R/L dorsal pedalis _____ R/L posterior tibial _____ other _____
Monitors	none specify: _____ †O ₂ saturation † cardiorespiratory † other _____ † alarm parameters verified and on
*Alteration in tissue perfusion	none present R/T _____
Regulation:	
Abdomen / LBM Diet _____	† soft † firm † rigid † distended † round † flat † tenderness / LBM _____ † continent † incontinent
Bowel sounds	RLQ ___ RUQ ___ LUQ ___ LLQ ___ + present absent ++hyperactive +/-hypoactive
NG / GT	none specify _____
*Alteration in nutrition	none present R/T _____ size ___ † gravity † suction
GU	† no problems † foley † dysuria † hematuria † frequency † continent † incontinent LMP_
Intravenous Fluids	† none specify/solution & rate _____
* Alteration in elimination	† none For shift: total in _____ total out _____ † present R/T _____
Mobility:	
Muscle tone / strength / Range Of Motion	† strength equal bilaterally UE and LE † weakness (specify) _____ † Full Range Of Motion † limitations: _____
Gait / fall risk	† steady † unsteady † pre-ambulatory † paralysis /describe _____
Functional ability	† independent † total assistance † requires assistance (explain) _____
Casts / Assistance devices	none specify _____
*Alteration in Mobility	none present R/T _____
*for abnormal findings, see additional notes	
SN signature:	

Course Syllabus – Classroom (Clinical) Courses

LAB WORK AND DIAGNOSTIC TESTS (Make Copies)

TEST	RESULTS	NORMALS	DATES	REASON WHY TEST ORDERED FOR YOUR CLIENT	NURSING SIGNIFICANCE

Course Syllabus – Classroom (Clinical) Courses

MEDICATION SHEET

DATE:		STUDENT:				
PATIENT NAME:		ALLERGIES:				
DRUG NAMES	SPECIFIC INDICATIONS/ REASON GIVEN TO YOUR CLIENT	MECHANISM OF ACTION	CLIENT DOSE/ROUTE/SAFE DOSAGE RANGE	MAJOR SIDE EFFECTS	DRUG/DRUG OR DRUG/DIET INTERACTIONS AND CONTRAINDICATIONS	CLIENT SPECIFIC NURSING IMPLICATIONS
TRADE: GENERIC: CLASSIFICATION:						
TRADE: GENERIC: CLASSIFICATION:						
TRADE: GENERIC: CLASSIFICATION:						

SPICES Assessment

During the acute care rotation a special assessment, the SPICES Assessment will be performed on all clients over the age of 65 years of age. Information on the use of this assessment and the assessment tool can be accessed, downloaded and printed from the following website:

www.consultgerirn.org

Students are to review this information and bring a print copy of the tool to clinical each day.

Course Syllabus – Classroom (Clinical) Courses

INTERPERSONAL PROCESS RECORDING (IPR)

GUIDELINES FOR WRITING AN INTERPERSONAL PROCESS RECORDING

OBJECTIVES:

This IPR is to focus on an actual interaction between student nurse and a patient or the patient's significant other during the clinical experience.

2An IPR is an opportunity for the nurse to evaluate the effectiveness of therapeutic communication skills. **This is not a patient teaching or data gathering exercise.** Therefore, the focus of this exercise is Therapeutic Communication.

GENERAL INSTRUCTIONS:

1. **The introduction** is to be typed in narrative format. The introduction is an essential part of the IPR in order to acquaint the reader with the setting, and circumstances in which the interaction took place. This should include the client's facial expression, voice quality, appropriateness of dress and grooming and room environment. Refer to Criteria and Evaluation Tool for IPR for content.
2. **The body of the IPR** (client verbatim – nurse verbatim section), is to be written in the 5-column format found in the syllabus or at the PALM BEACH STATE COLLEGE Nursing website. Make copies of the format as needed. Verbatim statements of the nurse and the client during the interaction should be documented. Time lapses and silences should be noted, as well as the length of the silence. This section is to be written in an objective fashion, without any interpretations on the part of the student. Refer to Criteria and Evaluation Tool for IPR for directions. The body of the IPR must include at least six responses between client and nurse. A "response" is client and student each talk once. Minimally the client and student must each speak six times.
3. **Non-verbal behavior** of nurse and client section is to be used for recording communication and behavior that is not verbalized. Significant gestures, facial expressions, body postures, tones of voice, eye contact, etc., should be noted – both the client's and the nurse's. For example, it should be recorded that the voice dropped to a whisper when he spoke about his mother's death. Examples of behavioral "clues" to anxiety should be included.
4. **Interpretation of interaction** section includes your ideas as to what was going on – in a dynamic sense – during the interaction. How did you perceive the client to feel? How did you feel? You should also not any associative looseness and/or flight of ideas, as well as disorders of thinking that were present and defense mechanisms that were employed by the nurse or client. Any shifts in the conversation made by either the client or the nurse should be noted.

Your interpretations should be supported with theoretical knowledge. You should include the phases of the interaction (introductory, working and termination) and the therapeutic techniques that you have used.

5. **Alternative responses** section is one of the most important parts of the IPR and is heavily weighted in terms of evaluation. This section provides the student with an opportunity to look back on the interaction and to formulate responses that might have been more effective than the one used.

Course Syllabus – Classroom (Clinical) Courses

Although the interaction itself may have been ineffective in achieving the stated goal, it can still be a learning experience, and be a guide for future interactions.

Each alternative response should be accompanied by a rationale (either theoretical or your own logic) as to why it might promote more effective communication. **Every student response must have an alternate or it will be returned to be redone.**

6. **The summary** of the IPR is to be typed in narrative form and should relate to the initial goal identified. The student should include the strengths and weaknesses of the interaction as well as writing objectives for client care based on his/her interpretation. The student should include objectives for his or her own improvement. The participation of both the nurse and the client should be evaluated. References should be cited in a bibliography. Refer to Criteria and Evaluation Tool for IPR for content.
7. **Bibliography** - Any references used should be footnoted and a bibliography attached. Correct APA bibliographical form must be used.
8. Credit will be deducted for spelling and grammatical errors. Any paper which does not meet the requirements will be returned to the student to be redone.
9. **Criteria and Evaluation tool must be submitted with the paper for the instructor to mark for grading.**

Course Syllabus – Classroom (Clinical) Courses

**CRITERIA AND EVALUATION TOOL
FOR INTERPERSONAL PROCESS RECORDING (IPR)
(SUBMIT TO INSTRUCTOR)**

STUDENT NAME: _____

Satisfactory	Unsatisfactory	
		1. Introduction includes: (To be typed)
		A. Date of interaction
		B. Duration of interaction
		C. Description of location where interaction took place
		D. Client’s initials, age, gender
		E. Client’s personal, interpersonal and social strengths and weaknesses.
		F. Admitting diagnosis and other pertinent medical diagnoses
		G. Initial therapeutic communication goal of interaction. State any changes as interaction occurred.
		2. Body of IPR includes: (May be typed or legible handwriting)
		A. Exact verbal statements of client and nurse. (At least six responses between client and nurse.)
		B. Non-verbal communications of client and nurse include: affect, speech quality, observations of body language, personal space.
		C. All verbal and nonverbal communications of the client and nurse are analyzed (interpreted) using appropriate terminology.
		D. State alternate communication techniques for each of the nurse’s actual responses utilizing a variety of communication skills.
		E. State rationale for alternate responses.
		3. Summary statements includes: (To be typed)
		A. Whether objectives were met, and if not, why not.
		B. Evaluate your therapeutic communication techniques in this interaction.

Course Syllabus – Classroom (Clinical) Courses

Satisfactory	Unsatisfactory	
		C. Identify what you learned regarding the clients personal, interpersonal and social systems.
		D. Identify therapeutic communication techniques that you perceive will be helpful for you to use in future interactions.
		E. Assess and identify your personal and interpersonal strengths and weaknesses.
		F. State interactions you plan to utilize to address the identified personal and interpersonal needs.
		4. Reference of at least two resources used to interpret/analyze interaction and to acquire therapeutic communication techniques.
		5. Submitted on time.
		6. Used appropriate format for introduction, body of IPR with five-column format and summary.

Comments:

Course Syllabus – Classroom (Clinical) Courses

BODY OF INTERPERSONAL PROCESS RECORDING (IPR)

Nurse Verbatim	Patient Verbatim	Non-verbal behaviors of nurse and patient	Interpretation of interaction with use of appropriate terminology	Alternate responses with rationale (what you could have said & why)

Course Syllabus – Classroom (Clinical) Courses

LONG TERM CARE ROTATION

The following is a guide for the required clinical assignments during the Long Term Care Rotation.

- WEEK # 1** ORIENTATION DAY
Complete Attitudes and Assessment Activities
Presentation on Funding Options
Orientation to Unit, Scavenger Hunt
- WEEK # 2** COMMUNICATION
Initiate IPR
- WEEK # 3** COGNITIVE ASSESSMENT
IPR Due
- WEEK # 4** FUNCTIONAL ASSESSMENT
- WEEK # 5** SAFETY : FALL RISK ASSESSMENT AND MEDICATION ASSESSMENT
- WEEK # 6** NUTRITIONAL ASSESSMENT
- WEEK # 7** SUMMARY OF EXPERIENCE (REFLECTION)

Mid-term and Final Evaluations are held on Campus.
(Time to be scheduled with individual clinical instructor)

Course Syllabus – Classroom (Clinical) Courses

LONG TERM ROTATION

Purpose: The purpose of this clinical experience is to enhance the student's understanding of the special problems related to the older adult in the long term care setting.

Student Activities:

Students should have completed the following activities PRIOR to first day of this rotation.

READ:

(Located at www.consultgerim.org/resources under Evidence Based Geriatric Topics:

Age-Related Changes

Frailty and Its Implications of Care

Healthcare Decision Making

Decision Making in the Older Adults with Dementia

Each week students in long term care will complete preparation for that week's activity PRIOR to the clinical day.

Course Syllabus – Classroom (Clinical) Courses

**INDIVIDUALIZED AGING PROJECT
PROJECTED AGE OF SELF
(SUBMIT TO INSTRUCTOR DURING FIRST WEEK)
ORIENTATION**

Projected Age of Student _____
Draw your aged self.

Draw environment you wish to have.

Describe roles you will have and note those you will have relinquished.

Make a statement of the legacy you wish to leave.

What social activities will be important to you?

Course Syllabus – Classroom (Clinical) Courses

**INDIVIDUALIZED AGING PROJECT
STUDENT SELF-DIRECTED ATTITUDE ASSESSMENT
(SUBMIT TO INSTRUCTOR DURING FIRST WEEK)
ORIENTATION**

1. A person can be considered old when _____

2. Words that society uses to describe the elderly are _____

3. Growing old means _____

4. Seeing an old person makes me feel _____

5. The best thing about getting old is _____

6. The worst thing about getting old is _____

7. How many elders do you personally know? _____

8. What influence have they (see #7) had on you? _____

Course Syllabus – Classroom (Clinical) Courses

9. Why is “getting old” an issue today? _____

10. Most elderly live in _____

11. Economically, older people are _____

12. Socially older people are _____

13. Culturally the elderly _____

14. The spiritual needs of the elderly are _____

15. Health-wise older people are _____

16. Mentally older people are _____

Course Syllabus – Classroom (Clinical) Courses

17. Sexually older people are _____

18. What will your greatest challenge as a health care professional be regarding care of the elderly? ____

19. What are your own personal goals regarding your aging process? _____

Course Syllabus – Classroom (Clinical) Courses

LONG TERM CARE ROTATION

INDIVIDUALIZED AGING PROJECT

WEEK ONE

COMMUNICATION

OUTCOMES:

Completing the clinical experience will enable the learner to:

1. Demonstrate therapeutic communication and interpersonal skills.
2. Recognize the value of attentive listening.
3. Discuss special considerations for communicating with the elderly.
4. Evaluate his/her own communication patterns.
5. Share experience with clinical group at post conference.
6. Complete an IPR.

Preparation Activities:

View: (3) Therapeutic Communication Videos located under Web links in Blackboard for NUR 1023

- a. Basic Components of Communication
- b. Opening & Questioning & Use of Silence
- c. Responding & Caring

Review the following guides:

1. Practical pointers for student communication with the elderly.
2. Interviewing format
3. Caring communication
4. Caring behaviors
5. Guidelines for obtaining a life history.

Course Syllabus – Classroom (Clinical) Courses

STUDENT GUIDELINES FOR INTERVIEWING (DO NOT SUBMIT TO INSTRUCTOR)

WEEK ONE

Introduce self and purpose of the interview.

Obtain permission from individual to be interviewed.

Be aware of yourself and the interviewee:

- Gestures
- Posture
- Voice tone and rate of speech
- Distance between you and interviewee
- Hearing deficit
- Vision deficit.

1. Questions concerning what, how, when, and where sustain the interview; those asking “why” may be difficult to answer.
2. Questions requiring a “yes” or “no” answer may inhibit flow of conversation, e.g., “Are you satisfied with your health care? Instead you might ask, What has your health care been like?”
3. Avoid judgment, e.g., “That is good” or “That is bad.” Rather, “Did you feel that was O.K. (or) not O.K.?”
4. When you feel it is time to bring closure to the interview, state “I have only a few more minutes, is there anything else you would like to talk about?”
5. Always give feedback about what you have learned in the interview and ask in what way the interview has been useful or helpful to the interviewee.
6. Thank the person for sharing their time and their views.
7. Set up a specific time for the next interview and inform them of the focus of the next interview.
8. Do not share addresses or phone numbers or go to the home of a stranger.
9. If the person is willing ask them to sign a contract (in syllabus) for the next nine interviews. If they seem reluctant explain that it is for their protection but they have a right not to sign. It will be necessary in that case to explain that you are not capable at this time of giving advise related to health but if they have a specific problem you will find a resource for them.
10. Summarize the interview according to guidelines on “Summary of Visit with Elder” form.
11. In the event an immediate problem is encountered with the interviewee contact your lab instructor as soon as possible for assistance.

Course Syllabus – Classroom (Clinical) Courses

INDIVIDUALIZED AGING PROJECT PRACTICAL POINTERS FOR STUDENT COMMUNICATION WITH THE ELDERLY (DO NOT SUBMIT TO INSTRUCTOR)

WEEK ONE

1. Always assess the elder's visual and hearing abilities and arrange with direct eye contact your sitting/distance, 12 inches to 2 feet, so that you are most comfortable and the outcome is successful.
2. Because the elderly person has decreasing energies to cope with the tasks of everyday living, the visitor may have to invest proportionately more energy into the visit.
3. The visitor needs to pace the visit according to the elderly person's fluctuating energy levels and physical conditions.
4. The use of appropriate touch can be a meaningful communication bridge.
5. Avoid information overload by: speaking slowly; using short sentences; dealing with one thought at a time; and asking for feedback to be certain meaningful communication has taken place. The elderly person needs 15% more time to respond.
6. Enhance the aged feelings of self-esteem by both encouraging his maximum participation and acknowledge his role of being an authority on aging. He is the product of his total life experiences and he is the only one who knows what these experiences have been. His past plays a significant part in current functioning.
7. Importance of choices - express confidence in the person's ability to make choices and follow through.
8. Motivation to participate in an activity will be increased if:
 - A. an older person is intrigued by a task rather than perceiving it as "just busy work";
 - B. the role or activity conveys the message the "you are important";
 - C. there is a possibility of forming meaningful relationships.
9. The use of reminiscence is an effective tool in linking relevant past events to present situation.
10. Some elderly do not have the strength to cope with the confusion of bureaucracies. So if necessary, be an advocate. Connect the elderly person with appropriate resources in the community.

Course Syllabus – Classroom (Clinical) Courses

STUDENT GUIDELINES FOR OBTAINING A LIFE HISTORY (DO NOT SUBMIT TO INSTRUCTOR)

WEEK ONE

CHILDHOOD - GROWING UP:

1. What is your first memory from your childhood?
2. What childhood trip is most vivid for you?
3. What is your most vivid historical memory?
4. Did you have any fears while growing up? (i.e., fear of nuclear war of today)
5. What did your parents make you do that you hated doing?
6. What did you used to do in the evening, before the days of radio and television?
7. What kinds of chores did you have to do as a child?
8. What social events and/or occasions did you look forward to?
9. What do you remember about going to school?
10. How did your family take care of you when you were ill?

YOUNG ADULTHOOD:

1. What was life like as a young adult who was dating? What kinds of things did you do on a date?
2. Who was the 1st president you voted for? Do you remember why you voted for him?
3. (If married) What do you remember best about your wedding ceremony or wedding day?
4. How many children?
5. What was it like to be a young parent? Was parenting different than it is today?
6. What is your occupation?
 - A. If you had it to do over again, would you pick that profession?
7. What do you remember most about being a young adult (age 20-40)?

LATER ADULTHOOD:

1. Have you ever lived outside the U.S.? If yes, where?
2. Do you have parents or grandparents that were immigrants? If so, from where?
3. Have you decided where and how you want to live out the rest of your life?
4. Is there someone in your life with whom you can have a close, warm relationship?
5. Do you feel your living arrangements are satisfactory?
6. Have you had to adjust your standard of living since retiring?
7. What do you do to keep your health?
8. How many grandchildren? Great grandchildren?
9. How often do you have contact with your children and grandchildren? Other relatives?
10. What do you let your grandchildren do that your children could not do?
11. What kinds of interests do you have outside of the family?
12. Do you have any hobbies or ever collected anything?
13. Have you ever played a musical instrument?
14. What is your strongest asset?
15. What is the best gift you've ever received?
16. What is the most extravagant thing you've ever done?
17. What are you most proud of having done?
18. What is the most important rule you've lived by?
19. Who has had the most influence in your life? And how?
20. What would you still like to do that you haven't done yet?
21. Something amusing in life experiences?
22. Best advice for today's youth?

Course Syllabus – Classroom (Clinical) Courses

LONG TERM CARE ROTATION INDIVIDUALIZED AGING PROJECT

WEEK TWO COGNITIVE ASSESSMENT

OUTCOMES:

Completing the clinical experience will enable the learner to:

1. Recognize aspects related to cognitive functioning for the elderly individual.
2. Conduct a mini-cognitive assessment on assigned resident.
3. Share experience with clinical group at post conference.
4. Identify available community resources for those with cognitive impairment.

Preparation Activities:

1. Complete Article and Video
 - a. Try This ISSUE 3- Mental Assessment of Older Adults: The Mini-Cog
 - b. Print Instructions on conducting the mini-cog.
2. Read Evidence-Based Geriatric Topics:
 - a. Delirium – Nursing Standard of Practice Protocol: Delirium: Prevention, Early Recognition, and Treatment
 - b. Depression- Nursing Standard of Practice Protocol

3. Answer the question:

What community resources are available for persons (and their families) with cognitive impairment?

Course Syllabus – Classroom (Clinical) Courses

LONG TERM CARE ROTATION INDIVIDUALIZED AGING PROJECT

WEEK THREE FUNCTIONAL ASSESSMENT

OUTCOMES:

Completing the clinical experience will enable the learner to:

1. Recognize components included in a functional assessment.
2. Complete assessments for Activities of Daily Living (ADL) on assigned elderly resident.
3. Identify community resources to support ADL and IADL for home-based persons.
4. Share experience in clinical group during post conference.

Preparation Activities:

1. Complete Article and Video
 - a. Try This ISSUE 2 Katz Index of Independence in Activities of Daily Living (ADL).
 - b. Print Functional Assessment Tool
2. Read Evidence-Based Geriatric Topics:
 - a. Function: Nursing Standard of Practice Protocol: Assessment of Function in Acute Care
3. Answer the following question:
 - a. What resources are found in the community to support ADL for home-based persons?

Course Syllabus – Classroom (Clinical) Courses

LONG TERM CARE ROTATION INDIVIDUALIZED AGING PROJECT

WEEK FOUR SAFETY

OUTCOMES:

Completing the clinical experience will enable the learner to:

1. Recognize safety issues for the older adult resident.
2. Complete Fall Risk Assessment on assigned resident.
3. Identify safety information/resources for the home-based person .
4. Monitor medication use in the older adult
5. Share experience in clinical group during post-conference.

Preparation Activities:

1. Complete Article and Video
Try This ISSUE 8 Fall Risk Assessment
Try This ISSUE 16 – Medication Safety
2. Read Evidence-Based Geriatric Topics:
 - a. Falls
 - b. Physical Restraints
 - c. Medication Safety
3. Answer the following question:
 - a. What safety information/resources could the nurse provide for the home-based person?

Course Syllabus – Classroom (Clinical) Courses

LONG TERM CARE ROTATION INDIVIDUALIZED AGING PROJECT

WEEK FIVE NUTRITION

OUTCOMES:

Completing the clinical experience will enable the learner to:

1. Identify components of a nutritional assessment.
2. Complete nutritional assessment on assigned elderly resident
3. Identify community nutritional resources available for home-based persons.
4. Share experience in clinical group during post-conference.

Preparation Activities:

1. Complete Article and Video
Try This ISSUE 9 Assessing Nutrition in Older Adults
Print Nutritional Assessment Tool
2. Read Evidence-Based Geriatric Topics:
 - a. Nursing Standard Practice Protocol – Nutrition in Aging
 - b. Nursing Standard Practice Protocol – Assessment and Management of Mealtime Difficulties
3. Answer the following question:

What community resources are available for the home- based person and what are the eligibility requirements?

Course Syllabus – Classroom (Clinical) Courses

LONG TERM CARE ROTATION --SUMMARY OF EXPERIENCE INDIVIDUALIZED AGING-REFLECTION EXERCISE

Directions: You may choose to write this narrative story, or you may digitally tell this story. Based on your experience, you may use the questions listed below as a guide:

Introduction

1. Introduce your resident.

Overview

1. What were your concerns for the resident, for the resident's family?
2. How would you include the resident and family as a co-collaborator in the resident's family?
3. What were the real and potential barriers for the resident receiving effective care?

Functional Capabilities

1. What was the resident and/or caregiver's understanding of the resident's functional status?
2. What is the baseline functional ability of this resident? What data/evidence is used to support this?

Expectations of Outcomes of Care

1. What are the resident and/or family expectations of outcomes of care?
2. What is the family or caregiver's understanding of the resident's definition of quality of life?
3. What does the resident know about his encounter with the health care system?
4. What does the caregiver understand to be the basis of the encounter?

Safety

1. What is the resident and/or caregivers understanding of patient safety concerns?
2. What were the risks and benefits of the safety concerns?
3. How did I know that the right decision was made about keeping the client safe?

Summary

1. Describe what you have learned through this experience.

COMMUNITY LINKS ASSIGNMENT
WITH
WELL ELDER

Course Syllabus – Classroom (Clinical) Courses

COMMUNITY LINKS ASSIGNMENT THE WELL ELDER

PURPOSE

The purpose of this paper is to enhance the student's understanding of special problems related to the elderly in today's society which includes losses, isolation, change in extended family structure, nutrition, safety, support system emphasis and community resources.

Process: The student will select an individual that is over 65 years old, not in an acute hospital setting or in a nursing home. Palm Beach State College Clinical Faculty must approve the selection. The student will need to identify a safe location to meet with the individual in one-hour sessions for six weeks.

Requirements/Grading Criteria:

Satisfactory completion is achieved when all of the following elements are present:

Papers should be preferably typed or legibly hand written.

All weekly assignments are successfully completed and within the time allotted.

Date Due: Per course calendar.

Course Syllabus – Classroom (Clinical) Courses

**GUIDELINE FOR WRITING THE COMMUNITY LINKS ASSIGNMENT
FOCUS: THE WELL ELDER
(SUBMIT EACH WEEK TO INSTRUCTOR WITH ASSIGNMENT)**

Student Name: _____

Date: _____

Elder's Age & Gender: _____

Satisfactory	Unsatisfactory	
		1. Utilizes guideline related to weekly focus.
		Week 1 Communication
		Week 2 Growth & Development
		Week 3 Safety
		Week 4 Nutrition
		Week 5 Grief/Loss/Coping
		Week 6 Comprehensive Holistic Assessment
		2. Shares experiences with clinical group by describing your impressions, general reactions and feelings related to your interaction with a well elder, as well as specific information related to objectives.

Comments:

WELL ELDER

**Course Syllabus – Classroom (Clinical) Courses
(DO NOT SUBMIT TO INSTRUCTOR)**

WEEK ONE

General Guidelines:

1. Follow an independent individual who is 65 years of age or older and living in the community.
2. Make six weekly visits lasting 60 minutes utilizing guidelines related to a specified area of focus.
3. Summarize each visit using the “Summary of Visit with Elder” form.
4. Contact faculty for problems that arise or whenever assistance is needed.

Week One

Topic: Communication

Objectives: Completing this clinical experience will enable the learner to:

1. Demonstrate therapeutic communication and interpersonal skills.
2. Recognize the value of attentive listening (since not all problems of the elderly can be alleviated).
3. Discuss special considerations for communicating with the elderly.
4. Evaluate his/her own communication patterns.
5. Share experience with clinical group at post conference.
6. Complete an IPR

Preparation Activities:

5. Review the following:
 - practical pointers
 - interviewing format
 - caring communication
 - caring behaviors
 - guidelines for life history

Student Learning Experience:

1. Explain purpose, length, and duration of visits. Prepare for termination.
2. Ask individual for a verbal agreement to meet 6 times with you.
3. Practice therapeutic communication skills.
4. Begin life history interviews.

Student Guides:

Practical Pointers for Student
Interview Format
Caring Nursing Behaviors
Caring Communication
Life History Tool
“Summary of Visit with Elder” Form(s)

Discussion Guidelines for use in summary following first interview:

1. Discuss impressions, general reactions and feelings to your first visit.
2. Identify at least one communication barrier.
3. Identify at least one therapeutic communication skill utilized.
4. Describe your perspective of client’s response to interview.
5. Identify the practical pointers you utilized when communicating with your client.

Course Syllabus – Classroom (Clinical) Courses

**SUMMARY OF VISIT WITH ELDER
(SUBMIT TO INSTRUCTOR)**

WEEK ONE

Due: _____

Your Name: _____ No. of Visits: _____

Place of meeting: _____

Time: _____

Elder's age: _____ Sex: _____

1. Describe impressions, general reactions, and feelings related to first visit.

2. Identify at least one communication barrier.

3. Identify at least one therapeutic communication skill utilized.

4. Describe your perspective of client's response to interview.

5. Identify the practical pointers you utilized when communicating with your client.

Course Syllabus – Classroom (Clinical) Courses

**GUIDELINE FOR WRITING THE COMMUNITY LINKS ASSIGNMENT
FOCUS: THE WELL ELDER
(SUBMIT EACH WEEK TO INSTRUCTOR WITH ASSIGNMENT)**

WEEK ONE THROUGH SIX

Student Name: _____

Date: _____

Elder's Age & Gender: _____

Satisfactory	Unsatisfactory	
		1. Utilizes guideline related to weekly focus.
		Week 1 Communication
		Week 2 Growth & Development
		Week 3 Safety
		Week 4 Nutrition
		Week 5 Grief/Loss/Coping
		Week 6 Comprehensive Holistic assessment
		2. Shares experiences with clinical group by describing your impressions, general reactions and feelings related to your interaction with a well elder, as well as specific information related to objectives.

Comments:

Course Syllabus – Classroom (Clinical) Courses
STUDENT GUIDE FOR CLINICAL EXPERIENCE WITH A WELL ELDER
(DO NOT SUBMIT TO INSTRUCTOR)

WEEK TWO

Topic: Growth and Development

Objectives: Completing this clinical experience will enable the learner to:

1. Identify development tasks of the aged adult.
2. Determine an elder's developmental status after obtaining a life history.
3. Examine own attitudes about aging.
4. Share experience with clinical group in post conference.

Preparation Activities:

1. Review developmental tasks of the aged adult.
2. Determine from your elders' life histories which developmental tasks of earlier stages were met or not met?

Student Learning Experience:

1. Continue life history interview utilizing therapeutic communication skills.
2. Discuss with your elder their perception of the life changes of old age.
3. Note comments made by your elder that made you aware of their developmental issues.

Student Guides:

The Aged Family: Developmental Tasks

Discussion Guidelines:

1. Discuss impressions, general reactions, and feelings about the second interview.
2. Refer to "The Aged Family: Developmental Tasks," and identify those which are met or not met by your elder.
3. State which developmental tasks your client has met or not met.
4. Discuss possible reasons specific developmental tasks have not been met.

STUDENT GUIDE FOR ASSESSING THE AGED FAMILY DEVELOPMENTAL TASKS

(DO NOT SUBMIT TO INSTRUCTOR)

WEEK TWO

The following developmental tasks are to be achieved by the aging couple as a family as well as by the aging person alone:

1. Decide where and how to live out the remaining years.
2. Continue a supportive, close, warm relationship with the spouse or significant other, including a satisfying sexual relationship.
3. Find a satisfactory home or living arrangement and establish a safe, comfortable household routine to fit health and economic status.
4. Adjust living standards to retirement income; supplement retirement income if possible with remunerative activity.
5. Maintain maximum level of health; care of self physically and emotionally by getting regular health examinations and needed medical or dental care, eating an adequate diet, and maintaining personal hygiene.
6. Maintain contact with children, grandchildren, and other living relatives, finding emotional satisfaction with them.
7. Maintain interest in people outside the family, and in social, civic, and political responsibility.
8. Pursue new interests and maintain former activities in order to gain status, recognition, and a feeling of being needed.
9. Find meaning in life after retirement and in facing inevitable illness and death of oneself and spouse as well as other loved ones.
10. Work out a significant philosophy of life, finding comfort in a philosophy or religion.
11. Adjust to the death of spouse and other loved ones.

Course Syllabus – Classroom (Clinical) Courses

STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER (DO NOT SUBMIT TO INSTRUCTOR)

WEEK THREE

Topic: Safety

Objectives: Completing this clinical experience will enable the learner to:

1. Identify potential environmental safety hazards;
2. Identify physical changes that increase the aged adult's susceptibility to falls and trauma;
3. Conduct a home safety assessment; and
4. Intervene to reduce safety hazards in the aged adult's environment.
5. List three (3) resources in the community, which provide equipment for the elderly.
6. Begin the development of a Community Resource List for the Elderly.
7. Begin the development of an Internet Resource List.
8. Share resources with clinical group in post conference.

Preparation Activities:

1. Review Home Safety Assessment Tool.
2. Discuss experiences in your own life that could have been prevented with adequate information and preventative actions.
3. Identify precipitants to accidents/trauma.

Student Learning Experiences:

1. Discuss any accidents the elder has experienced.
2. Assist elder in making a home safety evaluation by using the home safety assessment tool.
3. Assist the elder in identifying safety measure related to any danger.
4. Recommend home modifications and/or refer to community resources as appropriate.

Student Guides:

Home Safety Assessment Tool
Helpful Household Gadgets
Community Resources List (self-developed)

Discussion Guidelines:

1. Discuss impressions and general reactions.
2. Identify a safety hazard discovered in your elder's home.
3. Discuss interventions (including modifications and community resources).

Course Syllabus – Classroom (Clinical) Courses

HOME SAFETY ASSESSMENT (SUBMIT TO INSTRUCTOR)

WEEK THREE

Throughout the interior of the home there are several common features, which should be carefully checked for safety. For example:

	YES	NO
Are scatter rugs firmly anchored with rubber backing?	_____	_____
Are electrical cords in good repair, especially a heating pad?	_____	_____
Light, heat and ventilation:		
Is there adequate night lighting?	_____	_____
Are stairways continually lighted?	_____	_____
Is temperature within a comfortable range?	_____	_____
Is the heater adequately ventilated?	_____	_____
Is there cross ventilation?	_____	_____
Is furniture sturdy enough to give support?	_____	_____
Is there a minimum of clutter allowing room for easy mobility as well as fire hazard?	_____	_____
Are smoke detectors present (at least one on each level of home)?	_____	_____
Are emergency telephone numbers posted in a handy place to read? (ambulance, doctor, fire department, nearest relative, 911)	_____	_____
If you are alone for a period of time do you have someone who checks on you?	_____	_____
If you have limited vision, does phone have enlarged dial?	_____	_____
If you have impaired hearing, does phone have amplified receiver?	_____	_____
If you have small pets do they ever get in your way, causing you to trip or fall?	_____	_____

The kitchen can be evaluated for the following:

Is the stove free of grease and clear of flammable objects?	_____	_____
Is baking soda available in case of grease fire?	_____	_____
Are matches safely stored if there is not a pilot light on stove?	_____	_____
Is the refrigerator working properly?	_____	_____
Is the sink draining well?	_____	_____
Is food being stored properly?	_____	_____
Is trash taken out daily?	_____	_____
Is there a sturdy step stool available?	_____	_____
Are there skid proof mats on the floor?	_____	_____

In the bathroom are the following safety features observed:

If needed, are handrails beside the tub and toilet?	_____	_____
Are skid-proof mats in the bathtub and/or shower?	_____	_____
Are electrical outlets and appliances a safe distance from the bathtub?	_____	_____

Course Syllabus – Classroom (Clinical) Courses

Outside the home the following points should be considered:

	YES	NO
Walks and stairs:		
Are there raised or uneven places on the sidewalks?	_____	_____
Are stairs in good repair?	_____	_____
Are the bottom and top stairs painted white or a bright color to improve visibility?	_____	_____
Are handrails securely fastened?	_____	_____
Are screens on doors and windows in good repair?	_____	_____
Is there an alternate exit from the house?	_____	_____
Is there an alarm system or burglar proofing?	_____	_____

Course Syllabus – Classroom (Clinical) Courses
HELPFUL HOUSEHOLD GADGETS

WEEK THREE

<u>ITEM</u>	<u>WHERE TO BUY (Code #)</u>
A. Bathroom	
Bath sponge	1, 5
Grab bar to fit outside wall of tub (temporary)	5
Grab bar straight (permanent)	2
Hose clamps	3
Long handled bath sponge	1, 2, 3, 8
Non-slip plastic tub decals	1, 2, 3, 5, 8
Plastic tub mat with suction cups	1, 2, 3, 5, 8
Raised toilet seat	5
Rubber soap holder with suction cups	1, 2, 3, 5, 8
Shower hose extension	1, 2, 3, 5
Toilet guard rails	5
Tub stools	5
Tub transfer seats	5
B. Kitchen	
Jar opener	1, 2, 3, 5
Kitchen Stool	1, 3, 5
Metal tongs	1, 2, 3, 5
Rubber jar grip	1, 2, 3, 5, 8
Rubbermaid pullout shelves, lazy susans, canisters, etc.	1, 2, 3, 5
Wheeled cart	5
Wheeled glider chair	5
C. Furniture	
*Chair and bed risers	
*Easy life chairs	
Pronged, plastic furniture coasters	1, 3, 5
*Stair glider	
Two-sided stick carpet tape	1, 3
D. Dressing Aids	
Buttoner	1, 5
Elastic shoe laces	4
Velcro	4

Course Syllabus – Classroom (Clinical) Courses

ITEM	WHERE TO BUY (Code #)
<u>E. Communication Aids</u>	
Enlarged telephone dial	6
Raised line checkbook	10
Telephone amplifier	9
<u>F. Pastime and Hobby Aids</u>	
Bar magnifying glass	6
Easy threading needles	1, 4
Large print books	11, 12
Needle threader	1, 4
Pocket magnifying glass	1, 5
Talking books	11, 12
<u>G. Miscellaneous</u>	
Colored cloth tape (for marking)	1, 2, 3, 5
Fluorescent safety tape	1, 3, 5
Long handled dust pan	1, 3
Magnet on a pole (for reaching)	1, 3
Self-sticking dots and numbers (for marking)	1, 6
Velcro colors	1, 2
Wide angle car mirrors	

WHERE TO BUY

Local

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Discount department stores
(i.e., K-Mart, Wal-Mart, Target, Sears, J.C. Penney's) 2. Drug stores 3. Hardware stores 4. Fabric stores 5. Large department stores 6. Office Supply | <ol style="list-style-type: none"> 7. Bookstores 8. Grocery stores 9. Local phone company 10. Banks 11. County library services for the blind 12. Libraries |
|--|---|

COMMUNITY RESOURCES LIST

(SUBMIT TO INSTRUCTOR)

WEEK THREE

NUR 1023L - Nursing I
Revised June, 2011

Course Syllabus – Classroom (Clinical) Courses

RESOURCE LIST:

INTERNET RESOURCE LIST:

Course Syllabus – Classroom (Clinical) Courses

SUMMARY OF VISIT WITH ELDER
(SUBMIT TO INSTRUCTOR)

WEEK THREE

Due: _____

Your Name: _____ No. of Visits: _____

Place of meeting: _____

Time: _____

Elder's age: _____ Sex: _____

1. List any accidents the elder has experienced.
 -

2. Describe the potential environmental safety hazards you identified during the safety assessment.

3. Explain how the elder's safety needs are being met (or unmet) in relationship to Maslow's hierarchy.

4. Describe any physical changes the elder has that increase his susceptibility to falls.

5. Explain any safety measures you taught or recommended to the elder.

Course Syllabus – Classroom (Clinical) Courses

STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER (DO NOT SUBMIT TO INSTRUCTOR)

WEEK FOUR

Topic: Nutrition

Objective: Completing this clinical experience will enable the learner to:

1. Discuss physical changes related to nutritional status in the elderly.
2. Identify factors that may place aged individuals at risk for malnutrition.
3. Conduct a baseline nutrition screening.
4. Discuss intervention for achieving and/or maintaining an adequate nutritional status in the elderly.
5. List 3 resources in Palm Beach County that provide nutritional services to the elderly.

Preparation Activities:

1. Review physical changes affecting nutrition in the elderly. (Text & Learning Guide)
2. Discuss sociological factors affecting nutrition in the elderly.
3. Review intervention strategies and community resources.
4. Review Nutrition Screening Tool.
5. Record the past 24-hour diet intake of the elder.
6. Discuss preparation for termination visit.

Student Learning Experience:

1. Assess nutritional status of the elder using the nutrition-screening tool.
2. Identify potential or actual nutrition problems.
3. Discuss basic food groups with elder.
4. Provide information about community resources if appropriate.
5. Prepare for termination by reminding the elder this is final visit.
6. Tell the elder how you benefited from the experience.

Student Guides:

Nutritional Screening Tool
Community Resources

Discussion Guidelines:

1. Discuss impressions and general reactions.
2. Identify one actual or potential nutrition problem of the elder.
3. Name one intervention you utilized.
4. What specific factors (physical and/or sociological) affect the elder's nutrition?
5. Share insights and what you have learned as a result of the "Well Elder" experience.

Course Syllabus – Classroom (Clinical) Courses

NUTRITION SCREENING TOOL
(SUBMIT TO INSTRUCTOR)

WEEK FOUR

Height: _____ Weight: _____ Ideal Body Weight: _____ Weight 6 mo. Ago: _____

How many teeth: _____ Status: _____

Date last dental exam: _____ Dentures: _____ Partial: _____ Complete: _____
Fit: _____

Chewing problems: What makes it better? What makes it worse?

Swallowing problems:

Appetite:

Use of Vitamins/Mineral Supp.:

Use of Laxatives:

Use of Alcohol:

Does individual have any health problems that affect his/her ability to eat or drink?

Does individual have any problems that affect his/her ability to prepare food?

How does individual get to the store to buy groceries?
(Identify problems with transportation, mobility, ability to carry grocery bags, etc.)

Does individual have access to:

running water	yes _____	no _____
refrigeration	yes _____	no _____
cooking facilities	yes _____	no _____

24-Hour Diet Recall

“I would like you to tell me everything you ate and drank from the time you got up in the morning until you went to bed at night and what you ate during the night. Include snacks and drinks of all kinds.”
(Record amount and type of food or drink and time taken.)

Was the 24-hour nutritional intake nutritionally sound?

Yes _____ No _____

What changes would you recommend?

**COMMUNITY RESOURCES FOR NUTRITIONAL SUPPORT
(SUBMIT TO INSTRUCTOR)**

WEEK FOUR

Resource List:

**STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER
(DO NOT SUBMIT TO INSTRUCTOR)**

WEEK FIVE

Topic: Grief/Loss/Coping

Objectives: Completing this clinical experience will enable the learner to:

1. Discuss losses experienced by the elderly related to: productivity, relocation, relationships with others, and death.
2. Identify factors, which influence adaptation to loss.
3. Verbalize understanding of the grief process; and
4. Identify coping mechanisms utilized by the aged person.
5. Share experience with clinical group at post conference.

Preparation Activities:

1. Share a significant loss you have experienced, your reaction, and coping measures. Who was most helpful and why? What things were said to you that were not helpful?
2. Discuss losses experienced by older adults.
3. Review coping mechanisms utilized by older adults.
4. Review the grief process.
5. Review Grief/Loss/Coping Tool.

Student Learning Experience:

1. Ask the elder about their grief and losses and how they cope. They can teach you how to cope with loss. Focus on their ability and methods of coping.

Student Guides:

Grief/Loss/Coping Tool

Course Syllabus – Classroom (Clinical) Courses

GRIEF/LOSS/COPING TOOL (DO NOT SUBMIT TO INSTRUCTOR)

WEEK FIVE

1. What changes have you experienced as you've grown older?

If elder doesn't respond, some of the questions below may be asked to direct conversation. Remember, ask open-ended questions. Listen to your elder. Do not feel compelled to ask the sample questions. Allow the individual to tell you what it is like to grow old.

Sample questions:

What changes have you experienced with retirement? Change in status or position? Change in the way you feel about yourself?

How has your health changed? Loss of sight, vision, taste? Loss of balance? Loss of endurance?

Have you lost a loved one?

Do you have anyone close to you who can provide support and comfort you?

What financial changes have you experienced?

Have you had to adjust your standard of living due to a change in income?

Have your living arrangements changed?

Have you had to give up any personal possessions?

Has your level of independence changed any?

Have you experienced changes in your social life?

Have you experienced changes in the types of activities you engage in?

2. For each change or loss mentioned by your elder ask, “How did it make you feel?”

(Common feelings include hurt, anger, hostility, frustration, abandonment, helplessness, loneliness, weakness, guilt, bitterness, resentment, dread, shame, sadness, relief, comfort, content, acceptance.)

3. For each change or loss mentioned by your elder ask, “How have you adjusted?”

Discussion Guidelines:

1. Discuss your impressions and general reactions.
2. Identify at least three losses your elder has experienced.
3. Name one way your elder coped with a loss.
4. Identify where your elder is in the grief process.

Course Syllabus – Classroom (Clinical) Courses

STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER (DO NOT SUBMIT TO INSTRUCTOR)

WEEK SIX

**Topic: Comprehensive Holistic Assessment Tool (CHAT) & Daily Holistic Assessment Tool (D.H.A.T.)
OR use Nurse Squared**

Objectives: Completing this clinical experience will enable the learner to:

1. Conduct and record a nursing health history.
2. Identify factors that promote wellness.
3. Identify barriers to health promotion.
4. Demonstrate the use of appropriate communication and interpersonal skills when interviewing the elderly person.
5. Develop a teaching plan based on the client's nursing health history.

Preparation Activities:

1. Review guidelines for obtaining a nursing health history.

Student Learning Experience:

1. Conduct and record a nursing health history using the Palm Beach State College CHAT.
 2. Prepare a teaching plan based on the elder's learning needs.
1. Prepare the elder for termination of the therapeutic relationship by reminding him/her that the next visit will be your last.

Student Guidelines:

Palm Beach State College Comprehensive Holistic Assessment Tool (C.H.A.T.)
Daily Holistic Assessment Tool (D.H.A.T.)
Medication form
Teaching Care Plan
Nursing Care Plan or
Nurse Squared

Discussion Guidelines:

1. How does the elder perceive his/her health?
2. How do you perceive the elder's health?
3. Where do you think the elder is on the wellness-illness continuum?
4. Identify factors that promote wellness in the elder.
5. Identify anything that interferes with the elder's health and well-being.

AT THE END OF WEEK SIX, SUBMIT A CHAT, DHAT, MEDICATION FORM, 2 NURSING CARE PLANS (1 psych/social and 1 teaching care plan) or use Nurse Squared

Course Syllabus – Classroom (Clinical) Courses

Admission Assessment: Comprehensive Holistic Assessment Tool (CHAT)

Client Initials: _____ DOB: _____ Age: _____ Wt: _____

Diagnosis: _____

**attach daily assessment

Patient Admission Information:

I. PERCEPTUAL / SENSORY / COGNITION

Communicating: *pattern involving sending messages*

Name preferred: _____ Sex: _____ Age: _____

Date: _____

Informant: Patient Parent Spouse Other _____ Admitted from: Home ED OR

Other _____

At time of interview patient is: alert appropriate relaxed agitated anxious tearful sleepy other _____

Primary language: _____ Interpreter needed: _____

Relating: *pattern involving established bonds*

Role: *marital status, children, parents, siblings:* _____

Significant others / Primary caregiver: _____

Lives with: _____

Recent changes in family: No if Yes, explain: _____

History of physical / sexual / emotional abuse: _____ Do you feel safe at home? _____

Are you in a relationship in which you or your child have been hurt or threatened? _____

In the past year, has someone close to you hit, kicked, punched, slapped, or shoved you or your child? _____

Occupation / Educational experience: _____

Patient / parent concern related to role responsibilities (school, work, financial, caregiver): _____

Socialization / support systems: _____

Valuing: *pattern involving spiritual growth*

Religious preference: _____ Spiritual needs: _____

Cultural preferences / needs: _____

Knowing: *pattern involving the means associated with information*

Medical History:

Chief complaint: _____

Previous / Ongoing Health problems (symptoms, length of illness, treatment) _____

Course Syllabus – Classroom (Clinical) Courses

Previous Hospitalizations / Surgery _____

Immunizations: Up to date Needs _____

Infectious Disease Exposure: None Chicken Pox Rubella Measles Mumps TB Hepatitis

List all medications in use (prescription, OTC, herbals) – see attached medication sheet

List all allergies (medications, food, environment and reaction)

Medication / Food / Environment	Reaction

Risk factors: (smoking, family history, etc.): _____

Substance use: Alcohol (type) _____ drinks/day Cigarettes:
 _____ per day

Illicit drug use: _____ Rx drug use: _____

Perception / Knowledge of Health / Illness: _____

Readiness to learn (ready, willing, and able): _____

Comprehension: Ability to grasp concepts and respond to questions: HIGH MEDIUM LOW

Motivational Level: asks questions eager to learn anxious uninterested uncooperative
 disinterested

denies need for education

Memory: No problem Limited short term memory Limited long term memory

Learning Barriers: None Language Cultural / Religious Emotional Hearing Vision Dexterity

Describe: _____

Feeling: *pattern involving the subjective awareness of information*

Comfort / Pain: (Is patient in pain? Chronic? Acute? What methods relieve pain, provide comfort?): _____

Emotional Integrity: (lonely, sad, depressed, angry, joy): _____

Perceiving: *pattern involving the reception of information:*

Sensory Perception: (Able to receive information via all senses? Deficits noted?): _____

Visual: _____ Contacts: _____ Eyeglasses: _____

Hearing: _____ Earaches: _____ Hearing Aids: _____

Course Syllabus – Classroom (Clinical) Courses

Choosing: *pattern involving the selection of alternatives*

Coping / Stress Management Measures: _____

Support systems: _____

II. MOBILITY

Moving: *pattern involving activity*

See daily assessment for physical assessment component

Functional ability: (*independent, if not specify deficits and needs*): _____

Assistive devices required: _____

Orthopedic equipment: _____

Physical Therapy: _____

Age related hazards of mobility: _____

Fall Risk: _____

Recreation / Play: _____

Self care: _____

III. OXYGENATION

See daily assessment for physical assessment component

Home nebulizer / O₂ / CR monitor: _____

IV. CELLULAR INTEGRITY

See daily assessment for physical assessment component

Skin integrity risk factors: none obesity incontinent urine/feces emaciated immobility prematurity

altered LOC altered sensation breakdown present Home treatment plan: _____

V. REGULATION

Exchanging: *pattern involving mutual giving and receiving*

See daily assessment for physical assessment component

Recent weight loss or gain: _____

Therapeutic diet: _____ Dietary restrictions: _____

Suck quality: _____ Loose teeth: _____ Dentures: _____ Problems: _____

Sleep patterns: _____

Sexually active: _____ Sexual preference: _____ Birth Control: _____ Problems: _____

LMP: _____ Menarche (age): _____ Menopause (age): _____ BSE: _____

Difficulties: _____

Reproductive History: # of pregnancies: _____ # of births: _____ # of living children: _____

Problems: _____

Testes: _____ TSE: _____ Circumcised: _____ Problems: _____

Additional Comments: _____

Course Syllabus – Classroom (Clinical) Courses

Discharge Plan: _____

**SUMMARY OF VISIT WITH ELDER
(SUBMIT TO INSTRUCTOR)**

WEEK SIX

SERVICE-LEARNING EXPERIENCE**



Proud member of:

Ralph Waldo Emerson:

"It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself."

What is Service-Learning?

Palm Beach State defines service-learning as "a teaching method that increases student engagement and success through community involvement to apply theories or skills being taught in a course. Service-learning furthers the learning objectives of the academic courses, addresses community and civic needs, and requires students to reflect on their activity in order to gain an appreciation for the relationship between civics and academics. "

At Palm Beach State we envision a College that is a diverse community of active learners where achievement occurs in an environment without boundaries. We envision a responsive collaborative institution committed to the ongoing renaissance and enrichment of its community. Service-learning provides a teaching method to assist faculty, students and the community in fulfilling the College vision.

Albert Schweitzer:

"I don't know what your destiny will be, but one thing I do know: the only ones among you who will be really happy are those who have sought and found how to serve."

Students:

Students that participate in service-learning components understand that the "service" performed includes class participation, addressing the community needs, and reflection activities.

Benefits for the Students:

- Enhances Learning
- Connects theory to practice
- Encourages life-long commitment to service
- Fosters civic responsibility
- Explores majors and careers
- Enhances employability
- Receive job offers and scholarships
- Improves self-esteem
- Makes a difference in the community

Course Syllabus – Classroom (Clinical) Courses

What is Reflection?

Reflection means the process of thinking about what we do and processing it to draw meaning from our experiences. Reflection is an intentional endeavor to discover specific connections between something we do and the consequences which result.

Reflection exercises connect service to educational theory and larger social issues, foster critical thinking and active citizenship, and help in the evaluation of students' progress.

SERVICE LEARNING ASSIGNMENT GUIDELINES

Students will select a service learning activity and obtain approval from their clinical instructor. This activity must be a hands-on experience. Observational experiences do not meet the criteria as outlined by Palm Beach State College or the nursing program. You will participate in at least a four hour experience during the first semester.

Once the activity is approved, students can obtain a copy of the Service Learning Log and Evaluation of the experience at the following links:

[Student Log Sheet](#)

http://www.palmbeachstate.edu/Documents/Service_Learning/Student_Log_Sheet.pdf

[Student Site Evaluation Form](#)

http://www.palmbeachstate.edu/Documents/Service_Learning/Student_Site_Evaluation.pdf

Upon completion of this experience the following must be turned into the clinical instructor by the designated due date:

- a. **A reflection paper on the experience,**
- b. **The site evaluation log**
- c. **A site evaluation of the experience**

*Service Learning is a requirement in every semester of the Nursing Program.

CLINICAL EVALUATION OF PERFORMANCE

Course Syllabus – Classroom (Clinical) Courses
NURSING PROGRAM
CLINICAL EVALUATION OF PERFORMANCE

These objectives represent the expected minimal outcomes for the student upon completion of the clinical components of the nursing program and reflects the program concepts and threads. **Outcomes are based on the students ability to apply the nursing process to clinical practice and reflect continuing growth and improvement both within and among courses.

During each course’s orientation to the clinical experience, the evaluation process is reviewed both programmatically and in relation to specifics of the course.

EVALUATION CRITERIA

4. Pass – Self Directed Independent Level
3. Pass – Moving toward Independent Level
2. Unsatisfactory – Needs Improvement (requires completion of a “Performance Improvement Plan”)
1. Failure – Dependent Level (requires completion of a “Performance Improvement Plan”)

(Each of the above areas is defined on page 3 and specifically in relation to the stated outcome).

OUTCOMES

A student must receive a “Pass” (3 or 4) criteria rating on all objectives identified for the current clinical course in order to pass by the end of the term. An “Unsatisfactory/failure” (1 or 2) criteria rating on any clinical course objective means an unsatisfactory grade regardless of the ratings on other items. All objectives identified as 1 or 2 at the mid-term, must improve to a criteria rating of 3 or 4 to successfully pass the clinical course.

Course Syllabus – Classroom (Clinical) Courses
DEFINITIONS FOR EVALUATION CRITERIA

4. Pass - Self-Directed Independent Level

- ✓ Performs safely and accurately during the performance* and without* supportive cues from the instructor.
- ✓ Demonstrates dexterity* and coordination,* while performing the skill.
- ✓ Completes the skill in minimal amount of time*.
- ✓ Focuses on the patient* while giving care.
- ✓ Appears relaxed and confident during performance.
- ✓ Applies knowledge of the principles of the skill accurately.*

3. Pass - Moving toward Independent Level

- ✓ Performs safely and accurately during the performance* with occasional directive cue* from the instructor.
- ✓ Demonstrates coordination and dexterity*, but uses some unnecessary energy* to complete the skill.
- ✓ Generally appears relaxed and confident most of time with occasional display of anxiety.
- ✓ Completes the skill within a reasonable time* frame.
- ✓ Focuses on the patient initially, but as the skills progresses, focuses on the task.*
- ✓ Applies knowledge of the principles of the skill accurately with occasional cue from the instructor.*

2. Unsatisfactory - Needs Improvement

- ✓ Performs safely and accurately with frequent direction or cues from the instructor ** during the performance.
- ✓ Requires frequent direction or cues * from the instructor.
- ✓ Demonstrates partial lack of dexterity *; is awkward.
- ✓ Takes a longer time * to complete the skill.
- ✓ Wastes energy* due to poor planning/anxiety.
- ✓ Focuses primarily on the task, not on the client*.
- ✓ Needs direction in application of the principles of the task*.

1. Failure - Dependent Level

- ✓ Performs the skill in an unsafe* manner.
- ✓ Requires constant supportive and directive cues* from the instructor.
- ✓ Takes an unreasonable length* of time to complete the skill.
- ✓ Lacks organization* due to poor planning.
- ✓ Wastes energy* due to disorganization or incompetence.
- ✓ Focuses entirely on the skill or own behavior*.
- ✓ Unable to identify or apply the principles of the skill.*

* *Distinctive Criteria for Competency Level*

Course Syllabus – Classroom (Clinical) Courses

NURSING PROGRAM

CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student's Name: _____

Student ID #: _____

NUR 1023L

Course Grade: _____

Absences: _____

Tardiness: _____

Completion Date: _____

Instructor: _____

MIDTERM COMMENTS: Date: _____

P _____

F _____

Student Signature: _____

Faculty Signature: _____

FINAL COMMENTS: Date: _____

P _____

F _____

Student Signature: _____

Faculty Signature: _____

Course Syllabus – Classroom (Clinical) Courses

NURSING PROGRAM
CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student's Name: _____

Student ID #: _____

NUR 1213L

Course Grade: _____

Absences: _____

Tardiness: _____

Completion Date: _____

Instructor: _____

MIDTERM COMMENTS: Date: _____

P _____

F _____

Student Signature: _____

Faculty Signature: _____

FINAL COMMENTS: Date: _____

P _____

F _____

Student Signature: _____

Faculty Signature: _____

Course Syllabus – Classroom (Clinical) Courses

NURSING PROGRAM
CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student's Name: _____

Student ID #: _____

NUR 2261L

Course Grade: _____

Absences: _____

Tardiness: _____

Completion Date: _____

Instructor: _____

MIDTERM COMMENTS: Date: _____

P _____

F _____

Student Signature: _____

Faculty Signature: _____

FINAL COMMENTS: Date: _____

P _____

F _____

Student Signature: _____

Faculty Signature: _____

Course Syllabus – Classroom (Clinical) Courses

NURSING PROGRAM
CLINICAL EVALUATION TOOL CUMULATIVE RECORD

Student's Name: _____

Student ID #: _____

NUR 2712C

Course Grade: _____

Absences: _____

Tardiness: _____

Completion Date: _____

Instructor: _____

MIDTERM COMMENTS: Date: _____

P _____

F _____

Student Signature: _____

Faculty Signature: _____

FINAL COMMENTS: Date: _____

P _____

F _____

Student Signature: _____

Faculty Signature: _____

Course Syllabus – Classroom (Clinical) Courses

EVALUATION OF CLINICAL PERFORMANCE

STUDENT NAME: _____

STUDENT ID #: _____

Date	1023L	1213L	2215L	2712C		
MT					Critical to all Courses	NURSING PROCESS - The Student Will:
F						A. Demonstrate biopsychosocial assessment skills in collection and analysis of data to identify the needs of the client. <ol style="list-style-type: none"> 1. Has difficulty in observing and assessing data despite guidance and supervision from instructor. 2. Needs frequent direction in order to assess needs of client. 3. Observes and assesses data with minimal assistance from the instructor. 4. Independently observes and assesses data.
MT					Critical to all courses	B. Formulate goals based on data. <ol style="list-style-type: none"> 1. Has difficulty formulating patient behavioral objectives. 2. Requires frequent input in order to formulate client behavioral objectives. 3. Formulates patient behavioral objectives with minimal assistance from the instructor. 4. Independently formulates patient behavioral objectives correctly based on data.
F						
MT					Critical to all courses	C. Uses critical thinking to formulate a plan of care based on client oriented behavioral objectives. <ol style="list-style-type: none"> 1. Unable to use critical thinking to formulate a plan of care. 2. Requires frequent direction from instructor to use critical thinking to formulate a plan of care. 3. Applies critical thinking while formulating a plan of care with occasional support from instructor. 4. Applies critical thinking while formulating a plan of care.
F						
MT					Critical to all courses	D. Write a plan of care based on patient oriented behavioral objectives.. <ol style="list-style-type: none"> 1. Has difficulty identifying nursing diagnosis in priority, planning nursing actions, identifying scientific rationale and evaluating the plan, despite guidance and supervision of instructor. 2. Needs frequent direction in order to write a plan of care based on client behavioral objectives. 3. Identifies nursing diagnosis in priority, plans nursing actions, identifies scientific rationale and evaluates the plan with minimal assistance from instructor. 4. Independently identifies nursing diagnosis in priority, plans nursing actions, identifies scientific rationale and evaluates the plan.
F						
MT					Critical to all courses	E. Implement nursing measures to meet <u>prioritized client</u> need. <ol style="list-style-type: none"> 1. Some planning but does not take into consideration patient data; and/or is not able to establish priorities. 2. Wastes energy due to poor planning in order to implement nursing measures to meet prioritized client need. 3. Assignment planned, priorities established, and usually carried through as intended except for unexpected circumstances. 4. Assignment planned and organized so as to afford patient and family maximum comfort.
F						

Course Syllabus – Classroom (Clinical) Courses

Date	1023L	1213L	2215L	2712C		
MT					Critical to all courses	<p>F. Evaluate the effectiveness of nursing interventions and adapts plan of care accordingly.</p> <ol style="list-style-type: none"> 1. Requires constant support to evaluate effectiveness of interventions. 2. Requires frequent support to evaluate effectiveness of interventions. 3. Requires minimal assistance to evaluate effectiveness of interventions. 4. Correctly evaluates effectiveness of interventions.
F						
MT					Critical to all courses	<p>G. Report and record nursing process.</p> <ol style="list-style-type: none"> 1. Has difficulty in observing and recording data, despite guidance and supervision from instructor: database is incomplete. 2. Needs frequent direction from instructor during reporting and recording of nursing process. 3. Able to observe and record data, with minimal assistance from instructor: database is complete, descriptive and accurate. 4. Independently observes and records data; database is complete, descriptive and accurate.
F						
MT					Critical to all courses	<p>H. Performs technical aspects of care.</p> <ol style="list-style-type: none"> 1. Makes errors, recognizes and corrects a few of them, requires much supervision and/or prompting from instructor. 2. Demonstrates partial lack of dexterity while performing technical aspects of care. 3. Makes minimal errors or omissions, recognizes and corrects most of them; requires little supervision and/or prompting from instructor 4. Consistently performs skills accurately and efficiently without requiring prompting from instructor.
F						
MT					Critical to all courses	<p>I. Explain rationale for performing basic nursing skills and technical procedures.</p> <ol style="list-style-type: none"> 1. Seldom applies previously learned principles; requires much guidance. 2. Occasionally applies previously learned principles; requires frequent guidance. 3. Usually applies previously learned principles; requires minimal guidance. 4. Consistently and independently applies previously learned principles.
F						
MT					Critical to all courses	<p>J. Calculate, prepare and administer medications accurately.</p> <ol style="list-style-type: none"> 1. Makes errors in securing correct medications, calculating dosages; preparing and administering medications; and requires prompting to correct errors. 2. Performs safely and accurately with frequent direction or cues from the instructor during the performance. 3. Makes minimal errors in securing correct medication; calculating dosages; preparing and administering medications; and, recognizes and corrects errors with minimal assistance. 4. Is accurate and efficient in securing correct medication, calculating dosages, preparing and administering medications.
F						
MT					Critical to all courses	<p>K. Discuss relevant data regarding medications.</p> <ol style="list-style-type: none"> 1. Unable to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs.

Course Syllabus – Classroom (Clinical) Courses

Date	1023L	1213L	2215L	2712C		
F						<ol style="list-style-type: none"> 2. Needs frequent direction from instructor in order to state physiologic action of drugs, etc. 3. Usually able to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs. 4. Is accurate and efficient in stating physiologic action of drugs, recognizing behavior & behavioral changes to drugs, and adapting nursing care according to the effect.
MT					Critical to all courses	<p style="border: 1px solid black; padding: 2px;">TEACHING-CLIENT/FAMILY - The Student will:</p> <ol style="list-style-type: none"> L. Perform appropriate teaching with clients and/or families applying principles of learning and teaching. <ol style="list-style-type: none"> 1. Rarely able to apply principles of teaching and learning, requires much guidance. 2. Sometimes able to apply principles of teaching and learning, requires frequent guidance. 3. Usually able to apply principles of teaching and learning, requires minimal guidance. 4. Consistently and independently able to apply principles of teaching and learning.
F						
MT					Critical to all courses	<p style="border: 1px solid black; padding: 2px;">COMMUNICATION - The student will</p> <ol style="list-style-type: none"> M. Collaborate effectively with other members of the health team to promote continuity of care. <ol style="list-style-type: none"> 1. Communication is rarely effective and requires much guidance. 2. Communication is occasionally effective and requires frequent prompting. 3. Communication is usually effective and requires minimal guidance. 4. Communication is consistently effective and is done independently.
F						
MT					Critical to all courses	<ol style="list-style-type: none"> N. Present appropriate and therapeutic responses to patient situations, including appropriate facial expressions, body language and responses. <ol style="list-style-type: none"> 1. With guidance, unable to adapt to patient's circumstances; little insight into personal behaviors and responses; no change in behaviors. 2. With frequent guidance, is able to adapt to patient's circumstances; occasional insight into personal behaviors and responses; occasional change in behaviors. 3. With minimal guidance, able to adapt to patient's circumstances; insight into personal behaviors and responses; shows change in behavior. 4. Adapts readily to patient circumstances. Good insight into personal behaviors.
F						
MT					Critical to all courses	<ol style="list-style-type: none"> O. Establish purposeful interpersonal relationships and demonstrate effective communications with the client and/or family members. <ol style="list-style-type: none"> 1. Communication is rarely effective and requires guidance. 2. Communication is occasionally effective but requires guidance. 3. Communication is usually effective and requires minimal guidance. 4. Communication is effective and independent.
F						

Course Syllabus – Classroom (Clinical) Courses

Date	1023L	1213L	2215L	2712C		
MT					Critical to all courses	<p style="text-align: center;">JUDGEMENT, RESPONSIBILITY, & ACCOUNTABILITY - The student will</p> <p>P. Perform nursing measures with respect to client’s dignity, safety and confidentiality.</p> <ol style="list-style-type: none"> 1. Client’s dignity, safety and confidentiality over-looked; error(s) made were actually or potentially dangerous to the welfare to the patient. 2. Client’s dignity, safety and confidentiality occasionally over-looked; error(s) made were not actually or potentially dangerous to the welfare of the patient. 3. Client’s dignity, safety and confidentiality usually considered and demonstrated; error(s) made were not dangerous to the welfare of the patient. 4. Client’s dignity, safety and confidentiality consistently considered and demonstrated.
F						
MT					Critical to all courses	<p>Q. Display judgment and objectivity in situations. Makes decisions that reflect both knowledge of fact and sound judgment.</p> <ol style="list-style-type: none"> 1. Has difficulty functioning after initial direction; needs repeated explanations. 2. Requires frequent directions; occasionally demonstrates acceptable use of judgment and objectivity in some situations. 3. Able to follow initial directions; demonstrates acceptable use of judgment and objectivity in most situations. 4. Rarely needs direction; is consistently able to make judgments independently and with objectivity.
F						
MT					Critical to all courses	<p>R. Oral and/or written assignments meet established criteria as stated in course syllabus.</p> <ol style="list-style-type: none"> 1. Preparations/assignments that contain spelling and grammar errors, lack depth, are incomplete and unsatisfactory. 2. Preparations/assignments are occasionally done that meet established criteria. 3. Preparations/assignments are usually complete and satisfactory. 4. Preparations/assignments display consistent in-depth content and usually go beyond the requirements for the assignment.
F						
MT					Critical to all courses	<p>S. Accept and profit from constructive criticism.</p> <ol style="list-style-type: none"> 1. Rarely accepts and profits from constructive criticism. 2. Occasionally accepts and profits from constructive criticism. 3. Usually accepts and sometimes profits from constructive criticism. 4. Accepts and profits from constructive criticism.
F						
MT					Critical to all courses	<p>T. Actively participate in clinical conferences.</p> <ol style="list-style-type: none"> 1. Seldom participates in post conferences or displays inappropriate behavior. 2. Occasionally participates with frequent cues from instructor. 3. Usually participates in post conferences. 4. Consistently contributes to post conferences.
F						

Course Syllabus – Classroom (Clinical) Courses

Date	1023L	1213L	2215L	2712C		
MT					Critical to all courses	U. Correlate classroom theory to clinical practice. <ol style="list-style-type: none"> 1. Shows little or no knowledge beyond immediately defined nursing care. 2. Occasionally correlate theory to clinical practice. 3. Usually correlates theory to clinical practice to implement care. 4. Consistently correlates theory to clinical practice to implement care.
F						
MT					Critical to all courses	V. Demonstrate self-direction and assume responsibility for his/her own growth and learning. <ol style="list-style-type: none"> 1. Lacks initiative; is non-assertive and does not follow through with responsibility. 2. Needs direction in order to move toward assuming responsibility for his/her own growth and learning. 3. Usually demonstrates initiative and assertiveness, and usually follows through with responsibility. 4. Consistently demonstrates initiative, assertiveness, self-direction and creativity; goes beyond required tasks.
F						
MT					Critical to all courses	W. Organize assignments so that completed in a specified amount of time. <ol style="list-style-type: none"> 1. Does not complete assignment on time. 2. Occasionally completes assignments on time. 3. Usually completes assignment on time. 4. Consistently completes assignment on time.
F						
MT					Critical to all courses	X. Adhere to the nursing department's and course standards regarding professional behavior. <ol style="list-style-type: none"> 1. Does not adhere to these standards. 2. Occasionally adheres to these standards. 3. Usually adheres to these standards. 4. Consistently adheres to standards.
F						
MT					Critical to all courses	Y. Utilize an appropriate assertive approach to clients, family, health care team, visitors and faculty. <ol style="list-style-type: none"> 1. Approach is often inappropriate. 2. Approach is occasionally appropriate. 3. Approach is usually appropriate. 4. Uses appropriate assertive approach.
F						