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.
NUR 1023L: Supporting Documentation

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.
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.
ORIENTATION SCAVENGER HUNT

Locate the Following

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

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

**Medication Room**
- How/where are narcotics dispensed?
- Where are emergency drugs kept/code cart?
- Where are clients medications kept?

**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)

**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

**Clean Holding**
- Linen cart
- Bedpans/urinals, bath & emesis basins

**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

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

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?
6. Ambitions, ideals, and interests?

7. Do you have specific experience or education in any other fields or do you hold any college degrees?

8. Home background and family relationships or support systems (attitude of family toward nursing as a career choice; family responsibility; if married, how many children, etc.)

9. Are you presently employed? If so, where are you employed and in what capacity?

10. Have you had any experience working in the medical field? (CNA or PCT, LPN, EMT, work in Dr.’s office, etc.)


<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12. In what ways is faculty most helpful to you?

13. Would you rather have faculty give you detailed and explicit instruction and demonstrations regarding procedures, or do you prefer a general overview and time to figure things out for yourself?

14. Are there any questions you would like to ask about your faculty (for example, philosophy of teaching, strengths, weaknesses), which might make the student-faculty relationship more productive and meaningful?
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.
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.
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
NUR 1023L: Supporting Documentation

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

Student Site Evaluation Form

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.
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.

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

<table>
<thead>
<tr>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction includes: (To be typed)</td>
<td></td>
</tr>
<tr>
<td>A. Date of interaction</td>
<td></td>
</tr>
<tr>
<td>B. Duration of interaction</td>
<td></td>
</tr>
<tr>
<td>C. Description of location where interaction took place</td>
<td></td>
</tr>
<tr>
<td>D. Client’s initials, age, gender</td>
<td></td>
</tr>
<tr>
<td>E. Client’s personal, interpersonal and social strengths and weaknesses.</td>
<td></td>
</tr>
<tr>
<td>F. Admitting diagnosis and other pertinent medical diagnoses</td>
<td></td>
</tr>
<tr>
<td>G. Initial therapeutic communication goal of interaction. State any changes as interaction occurred.</td>
<td></td>
</tr>
<tr>
<td>2. Body of IPR includes: (May be typed or legible handwriting)</td>
<td></td>
</tr>
<tr>
<td>A. Exact verbal statements of client and nurse. (At least six responses between client and nurse.)</td>
<td></td>
</tr>
<tr>
<td>B. Non-verbal communications of client and nurse include: affect, speech quality, observations of body language, personal space.</td>
<td></td>
</tr>
<tr>
<td>C. All verbal and nonverbal communications of the client and nurse are analyzed (interpreted) using appropriate terminology.</td>
<td></td>
</tr>
<tr>
<td>D. State alternate communication techniques for each of the nurse’s actual responses utilizing a variety of communication skills.</td>
<td></td>
</tr>
<tr>
<td>E. State rationale for alternate responses.</td>
<td></td>
</tr>
<tr>
<td>3. Summary statements includes: (To be typed)</td>
<td></td>
</tr>
<tr>
<td>A. Whether objectives were met, and if not, why not.</td>
<td></td>
</tr>
<tr>
<td>B. Evaluate your therapeutic communication techniques in this interaction.</td>
<td></td>
</tr>
<tr>
<td>Satisfactory</td>
<td>Unsatisfactory</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td>C. Identify what you learned regarding the clients personal, interpersonal and social systems.</td>
</tr>
<tr>
<td></td>
<td>D. Identify therapeutic communication techniques that you perceive will be helpful for you to use in future interactions.</td>
</tr>
<tr>
<td></td>
<td>E. Assess and identify your personal and interpersonal strengths and weaknesses.</td>
</tr>
<tr>
<td></td>
<td>F. State interactions you plan to utilize to address the identified personal and interpersonal needs.</td>
</tr>
<tr>
<td></td>
<td>4. Reference of at least two resources used to interpret/analyze interaction and to acquire therapeutic communication techniques.</td>
</tr>
<tr>
<td></td>
<td>5. Submitted on time.</td>
</tr>
<tr>
<td></td>
<td>6. Used appropriate format for introduction, body of IPR with five-column format and summary.</td>
</tr>
</tbody>
</table>

Comments:
# BODY OF INTERPERSONAL PROCESS RECORDING (IPR)

<table>
<thead>
<tr>
<th>Nurse Verbatim</th>
<th>Patient Verbatim</th>
<th>Non-verbal behaviors of nurse and patient</th>
<th>Interpretation of interaction with use of appropriate terminology</th>
<th>Alternate responses with rationale (what you could have said &amp; why)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INDIVIDUALIZED AGING PROJECT
PROJECTED AGE OF SELF
(SUBMIT TO INSTRUCTOR DURING FIRST WEEK)
ORIENTATION

Projected Age of Student__________
Draw environment you wish to have.

Draw your aged self.

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?
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? ______________________________________
   _____________________________________________
   _____________________________________________
   _____________________________________________
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 ________________________________________________

________________________________________________________________________

________________________________________________________________________
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?
NUR 1023L: Supporting Documentation

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.
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.
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.
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?
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?
NUR 1023L: Supporting Documentation

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.

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?
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?
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.

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:
   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?
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 are 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
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.
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: _______________________________________________________

<table>
<thead>
<tr>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Utilizes guideline related to weekly focus.</td>
</tr>
<tr>
<td></td>
<td>Week 1 Communication</td>
</tr>
<tr>
<td></td>
<td>Week 2 Growth &amp; Development</td>
</tr>
<tr>
<td></td>
<td>Week 3 Safety</td>
</tr>
<tr>
<td></td>
<td>Week 4 Nutrition</td>
</tr>
<tr>
<td></td>
<td>Week 5 Grief/Loss/Coping</td>
</tr>
<tr>
<td></td>
<td>Week 6 Comprehensive Holistic assessment</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

Comments:
WELL ELDER
(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:
1. 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.

SUMMARY OF VISIT WITH ELDER
(SUBMIT TO INSTRUCTOR)
NUR 1023L: Supporting Documentation

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

WEEK TWO

Due: ________________

Your Name: ___________________________________________ No. of Visits: __________

Place of meeting: ___________________________________________

Time: ______________________________________________________

Elder’s age: ____________________________ Sex: ________________

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

2. Explain which developmental tasks your client has met or not met (refer to “The Aged Family: Developmental Tasks”).

3. Describe possible reasons specific developmental tasks have not been met.
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.
7. Begin the development of an Internet Resource List.
8. Share resources with clinical group in post conference.

Preparation Activities:
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).
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:

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? ________ ________
Outside the home the following points should be considered:

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

### WEEK THREE

<table>
<thead>
<tr>
<th>ITEM</th>
<th>WHERE TO BUY (Code #)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Bathroom</strong></td>
<td></td>
</tr>
<tr>
<td>Bath sponge</td>
<td>1, 5</td>
</tr>
<tr>
<td>Grab bar to fit outside wall of tub (temporary)</td>
<td>5</td>
</tr>
<tr>
<td>Grab bar straight (permanent)</td>
<td>2</td>
</tr>
<tr>
<td>Hose clamps</td>
<td>3</td>
</tr>
<tr>
<td>Long handled bath sponge</td>
<td>1, 2, 3, 8</td>
</tr>
<tr>
<td>Non-slip plastic tub decals</td>
<td>1, 2, 3, 5, 8</td>
</tr>
<tr>
<td>Plastic tub mat with suction cups</td>
<td>1, 2, 3, 5, 8</td>
</tr>
<tr>
<td>Raised toilet seat</td>
<td>5</td>
</tr>
<tr>
<td>Rubber soap holder with suction cups</td>
<td>1, 2, 3, 5, 8</td>
</tr>
<tr>
<td>Shower hose extension</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Toilet guard rails</td>
<td>5</td>
</tr>
<tr>
<td>Tub stools</td>
<td>5</td>
</tr>
<tr>
<td>Tub transfer seats</td>
<td>5</td>
</tr>
<tr>
<td><strong>B. Kitchen</strong></td>
<td></td>
</tr>
<tr>
<td>Jar opener</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Kitchen Stool</td>
<td>1, 3, 5</td>
</tr>
<tr>
<td>Metal tongs</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Rubber jar grip</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Rubbermaid pullout shelves, lazy susans, canisters, etc.</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Wheeled cart</td>
<td>5</td>
</tr>
<tr>
<td>Wheeled glider chair</td>
<td>5</td>
</tr>
<tr>
<td><strong>C. Furniture</strong></td>
<td></td>
</tr>
<tr>
<td>*Chair and bed risers</td>
<td></td>
</tr>
<tr>
<td>*Easy life chairs</td>
<td></td>
</tr>
<tr>
<td>Pronged, plastic furniture coasters</td>
<td>1, 3, 5</td>
</tr>
<tr>
<td>*Stair glider</td>
<td></td>
</tr>
<tr>
<td>Two-sided stick carpet tape</td>
<td>1, 3</td>
</tr>
<tr>
<td><strong>D. Dressing Aids</strong></td>
<td></td>
</tr>
<tr>
<td>Buttoner</td>
<td>1, 5</td>
</tr>
</tbody>
</table>
### NUR 1023L: Supporting Documentation

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

#### WHERE TO BUY

**Local**

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
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
RESOURCE LIST:

INTERNET RESOURCE LIST:
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.
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.
NUR 1023L: Supporting Documentation

SUMMARY OF VISIT WITH ELDER
(Submit to Instructor)

WEEK FOUR

Due: ____________________

Your Name: ___________________________ No. of Visits: ______________

Place of meeting: __________________________

Time: __________________________

Elder’s Age: ___________ Sex: ___________

1. Describe specific factors (physical and/or sociological that affect the elder’s nutrition.

2. Describe at least one actual or potential nutritional problem of the elder.

3. Explain one way you prepared the elder for closure of the experience.

4. What has been most valuable for you in this overall experience?
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
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, and 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.
SUMMARY OF VISIT WITH ELDER
(SUBMIT TO INSTRUCTOR)

WEEK FIVE

Due: ______________

Your Name: ___________________________________________ No. of Visits: ______________

Place of meeting: __________________________________________

Time: __________________________________________

Elder’s age: ____________________________ Sex: __________________________

1. Describe losses the elder has experienced related to:
   a. Productivity
   b. Relocation
   c. Relationships with others
   d. Death

2. Explain factors, which influenced the elder’s adaptation to loss.

3. Describe coping behaviors the elder uses.

4. Prepare the elder for termination of the therapeutic relationship by reminding him/her that the next visit will be your last.
WEEK SIX

Topic: Comprehensive Holistic Assessment (Nursing History) & Daily Holistic Assessment (System Assessment) Using Electronic Documentation System

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 Simchart.
2. Prepare a teaching plan based on the elder’s learning needs.

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.
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** 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 the 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
NUR 1023L: Supporting Documentation

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: ___________________________

NURSING PROGRAM

Palm Beach State College
<table>
<thead>
<tr>
<th>Student’s Name: ________________________________</th>
<th>Student ID #: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUR 1213L</td>
<td></td>
</tr>
<tr>
<td>Course Grade: _________  Absences: _________  Tardiness: _________  Completion Date: ________________</td>
<td></td>
</tr>
<tr>
<td>Instructor: ________________________________</td>
<td></td>
</tr>
<tr>
<td>MIDTERM COMMENTS:  Date: _______________  P _________  F ___________</td>
<td></td>
</tr>
<tr>
<td>Student Signature: ____________________________</td>
<td>Faculty Signature: ____________________</td>
</tr>
<tr>
<td>FINAL COMMENTS:  Date: _______________  P _________  F ___________</td>
<td></td>
</tr>
<tr>
<td>Student Signature: ____________________________</td>
<td>Faculty Signature: ____________________</td>
</tr>
</tbody>
</table>
# NURSING PROGRAM
## CLINICAL EVALUATION TOOL CUMULATIVE RECORD

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Student ID #:</th>
</tr>
</thead>
</table>

---

## NUR 2261L

<table>
<thead>
<tr>
<th>Course Grade:</th>
<th>Absences:</th>
<th>Tardiness:</th>
<th>Completion Date:</th>
</tr>
</thead>
</table>

| Instructor: |

### MIDTERM COMMENTS:

**Date:**

<table>
<thead>
<tr>
<th>P</th>
<th>F</th>
</tr>
</thead>
</table>

| Student Signature: | Faculty Signature: |

---

### FINAL COMMENTS:

**Date:**

<table>
<thead>
<tr>
<th>P</th>
<th>F</th>
</tr>
</thead>
</table>

| Student Signature: | Faculty Signature: |
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: ________________________________
# EVALUATION OF CLINICAL PERFORMANCE

<table>
<thead>
<tr>
<th>Date</th>
<th>1023L</th>
<th>1213L</th>
<th>2215L</th>
<th>2712C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Critical to all Courses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NURSING PROCESS - The Student Will:

**A. Demonstrate biopsychosocial assessment skills in collection and analysis of data to identify the needs of the client.**
- Has difficulty in observing and assessing data despite guidance and supervision from instructor.
- Needs frequent direction in order to assess needs of client.
- Observes and assesses data with minimal assistance from the instructor.
- Independently observes and assesses data.

**B. Formulate goals based on data.**
- Has difficulty formulating patient behavioral objectives.
- Requires frequent input in order to formulate client behavioral objectives.
- Formulates patient behavioral objectives with minimal assistance from the instructor.
- Independently formulates patient behavioral objectives correctly based on data.

**C. Uses critical thinking to formulate a plan of care based on client oriented behavioral objectives.**
- Unable to use critical thinking to formulate a plan of care.
- Requires frequent direction from instructor to use critical thinking to formulate a plan of care.
- Applies critical thinking while formulating a plan of care with occasional support from instructor.
- Applies critical thinking while formulating a plan of care.

**D. Write a plan of care based on patient oriented behavioral objectives.**
- Has difficulty identifying nursing diagnosis in priority, planning nursing actions, identifying scientific rationale and evaluating the plan, despite guidance and supervision of instructor.
- Needs frequent direction in order to write a plan of care based on client behavioral objectives.
- Identifies nursing diagnosis in priority, plans nursing actions, identifies scientific rationale and evaluates the plan with minimal assistance from instructor.
- Independently identifies nursing diagnosis in priority, plans nursing actions, identifies scientific rationale and evaluates the plan.

**E. Implement nursing measures to meet prioritized client need.**
- Some planning but does not take into consideration patient data; and/or is not able to establish priorities.
- Wastes energy due to poor planning in order to implement nursing measures to meet prioritized client need.
- Assignment planned, priorities established, and usually carried through as intended except for unexpected circumstances.
- Assignment planned and organized so as to afford patient and family maximum comfort.
<table>
<thead>
<tr>
<th>Date</th>
<th>1023L</th>
<th>1213L</th>
<th>2215L</th>
<th>2712C</th>
</tr>
</thead>
<tbody>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Critical to all courses**

F. Evaluate the effectiveness of nursing interventions and adapts plan of care accordingly.
   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.

G. Report and record nursing process.
   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.

H. Performs technical aspects of care.
   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.

I. Explain rationale for performing basic nursing skills and technical procedures.
   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.

J. Calculate, prepare and administer medications accurately.
   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.

K. Discuss relevant data regarding medications.
   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.
# NUR 1023L: Supporting Documentation

## Date 1023L 1213L 2215L 2712C

<table>
<thead>
<tr>
<th>Date</th>
<th>1023L</th>
<th>1213L</th>
<th>2215L</th>
<th>2712C</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TEACHING-CLIENT/FAMILY - The Student will:

- **L.** Perform appropriate teaching with clients and/or families applying principles of learning and teaching.
  - 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.

### COMMUNICATION - The student will

- **M.** Collaborate effectively with other members of the health team to promote continuity of care.
  - 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.

### Critical to all courses

- **N.** Present appropriate and therapeutic responses to patient situations, including appropriate facial expressions, body language, and responses.
  - 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.

- **O.** Establish purposeful interpersonal relationships and demonstrate effective communications with the client and/or family members.
  - 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.
<table>
<thead>
<tr>
<th>Date</th>
<th>1023L</th>
<th>1213L</th>
<th>2215L</th>
<th>2712C</th>
</tr>
</thead>
<tbody>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td>Critical to all courses</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td>Critical to all courses</td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td>Critical to all courses</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td>Critical to all courses</td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td>Critical to all courses</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td>Critical to all courses</td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td>Critical to all courses</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td>Critical to all courses</td>
<td></td>
</tr>
</tbody>
</table>

**JUDGEMENT, RESPONSIBILITY, & ACCOUNTABILITY - The student will**

- **P.** Perform nursing measures with respect to client’s dignity, safety and confidentiality.
  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.

- **Q.** Display judgment and objectivity in situations. Makes decisions that reflect both knowledge of fact and sound judgment.
  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.

- **R.** Oral and/or written assignments meet established criteria as stated in course syllabus.
  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.

- **S.** Accept and profit from constructive criticism.
  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.

- **T.** Actively participate in clinical conferences.
  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.
### NUR 1023L: Supporting Documentation

<table>
<thead>
<tr>
<th>Date</th>
<th>1023L</th>
<th>1213L</th>
<th>2215L</th>
<th>2712C</th>
</tr>
</thead>
<tbody>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td><strong>Critical to all courses</strong></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td><strong>Critical to all courses</strong></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td><strong>Critical to all courses</strong></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td><strong>Critical to all courses</strong></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td><strong>Critical to all courses</strong></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td><strong>Critical to all courses</strong></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td></td>
<td></td>
<td><strong>Critical to all courses</strong></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td><strong>Critical to all courses</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### U. Correlate classroom theory to clinical practice.
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.

#### V. Demonstrate self-direction and assume responsibility for his/her own growth and learning.
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.

#### W. Organize assignments so that completed in a specified amount of time.
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.

#### X. Adhere to the nursing department’s and course standards regarding professional behavior.
1. Does not adhere to these standards.
2. Occasionally adheres to these standards.
3. Usually adheres to these standards.
4. Consistently adheres to standards.

#### Y. Utilize an appropriate assertive approach to clients, family, health care team, visitors and faculty.
1. Approach is often inappropriate.
2. Approach is occasionally appropriate.
3. Approach is usually appropriate.
4. Uses appropriate assertive approach.