NURSING II CLINICAL

COURSE SYLLABUS

NUR 1213L
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GENERAL CLASS AND COURSE INFORMATION

Course Number: NUR 1213L    Class Reference Number: Multiple    Term: 2013-2

Course Title: Nursing II Clinical    Credit/Contact Hours: 4 Credits/12 Clinical Hours

Course Description:
The continuing nursing student will integrate content from classroom learning activities and skills lab when caring for individuals with commonly occurring human responses progressing to less commonly occurring responses to health challenges. Practice involves, but is not limited to: well childbearing families, adult, geriatric clients in a variety of settings within the community. Special fee required.

Course Learning Outcomes: As a result of taking this course, using commonly occurring and progressing to less commonly occurring human responses to health challenges from within the concepts of oxygenation, cellular integrity, regulation, sensory/perception/cognition, and mobility, the student will be able to:

1. Apply the nursing process in the care of clients across the life-span utilizing the principles of growth and development.
2. Utilize theories of Holism and Goal Attainment while implementing the nursing process.
3. Describe interventions based on personal, interpersonal and social system transactions to promote optimum health in acute care, and community health settings.
4. Identify effective communication skills utilized with clients, families and interdisciplinary health team members, to meet the identified health teaching/learning needs of individuals with commonly and selected less commonly occurring human responses to health challenges.
5. Utilize critical thinking in the development of nursing plans of care in diverse settings to client populations across the lifespan to facilitate the ability to facilitate wellness and the ability to progress to an optimum level of health.
6. Apply the principles of nutrition and diet therapy to promote wellness in individuals with selected commonly and less commonly occurring human responses to health challenges.
7. Initiate leadership and management skills necessary for effective delegation and supervision of peers, LPNs and UAPs.
8. Identify safe, accurate, technical skills in rendering direct client care across the lifespan, demonstrating proficiency in use of computer technology.
9. Incorporate health care teaching as appropriate across the lifespan assisting clients and their families to attain and maintain wellness or an optimum level of health.
10. Describe the flexibility of nursing roles as a member of the health care interdisciplinary team in acute care settings and diverse settings.
11. Distinguish the pharmacologic interventions for client populations experiencing selected commonly and less commonly occurring human responses to health challenges.

Course Outline for NUR1213L - NURSING 2 CLINICAL
Course Syllabus – Clinical Course

Class Schedule: Clinical days and hours vary depending on the availability of clinical sites. Each student in NUR 1213L will be scheduled for an equivalent of 12 clinical hours per week. Requests for days off for religious reasons must be scheduled with the clinical instructor in advance. In addition, each student must attend 1 approved community experience; 1 Psychiatric clinical experience; and no more than 2 clinical simulation experiences.

Textbooks Information: Textbooks are listed as Required and Recommended in the NUR 1213 course 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.

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

Full-time Faculty: Contact information for full-time faculty is listed here:

<table>
<thead>
<tr>
<th>Carol Alexander, MSN, RN</th>
<th>Deborah Copeland, MSN, RN</th>
</tr>
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<tbody>
<tr>
<td>BA 124 / (561) 868-3426</td>
<td>AH 207, (561) 868-3431</td>
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<td>Lake Worth campus</td>
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<table>
<thead>
<tr>
<th>Buddy Herrington, MSN, RN</th>
<th>Margaret Holmes-DeGraw, MSN, ARNP, CNM</th>
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<tbody>
<tr>
<td>AH 205, (561) 868-3428</td>
<td>AH 306, (561) 868-3438</td>
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<table>
<thead>
<tr>
<th>Leslie Kent, MSN, RN</th>
<th>Winsome Vassell, MSN, ARNP, RN</th>
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<tbody>
<tr>
<td>AH 201/ (561) 868-3436</td>
<td>AH 213, (561) 868-3576</td>
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Office Hours are Posted on the Faculty Web Pages and Outside Office
ASSIGNMENTS: Clinical assignments will be made to maximize your learning. Please see Course Guidelines, Forms and Tools for required criteria. Written assignments will include:

- RN² (RN Squared) electronic documentation
- Daily Holistic Assessment Tools (DHAT)
- Interpersonal Recordings (IPR)
- Comprehensive Holistic Assessment Tools (CHAT)
- Community Experience Papers

Specific Clinical Assignments will include the following: The clinical assignments in Nursing II are related to your clinical experience as both a Patient Care Provider and Patient Care Manager. No points toward your academic grade will be given for these assignments, but satisfactory completion of these assignments is needed for a passing (satisfactory) clinical grade. Students coming to the clinical area unprepared to meet the requirements of the clinical assignment are at risk of receiving a failing clinical grade due to unsatisfactory performance. Students may be dismissed from the clinical area and receive an absent for the day.

Orientation Day Assignment: Each student is required to read, print, sign, and obtain a witnessed signature, on the "Ethical Agreement" and submit it to the instructor at the first class meeting (See Nursing Student Handbook for form). Each student should place a second copy of the signed form in their student portfolio.

Patient Assignments: Assignments will be made to maximize your learning. Discuss any specific learning experiences you want with your clinical instructor. Students are expected to come to clinical prepared. Be prepared to discuss your anticipated plan of care in pre-conference.

IV Therapy Guidelines: Review IV Therapy guidelines from NUR 1214L Syllabus. Institutional guidelines, policies and procedures will be followed.

Charting Guidelines: Since charting requirements vary from agency to agency, you must follow the guidelines for the agency in which you are assigned. If you are unable to document in the facility record (computerized charting), a physical assessment and narrative nursing notes form will be available for your documentation. Review charting guidelines from NUR 1214L and/or NUR 1023L.

Pharmacology Requirements –
Students will be responsible for the administration of medications to their assigned clients in the hospital. Students are required to follow the facility’s policies for the administration and charting of medications.

Students will be held accountable for knowing the medications they are administering. Drug classification cards can be brought to the clinical area for use in discussing the medications with the clinical instructor. Students are encouraged to pay particular attention to those medications being discussed in the classroom. Student must know the following about each medication prior to administration:

- Medication classification
- Therapeutic dose range and route
- Mechanism of action
- Specific reason your client is receiving the drug
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- Common side effects
- Lab data pertinent to the drug
- Major nursing indications and client teaching areas for the drug

Late Assignment Policy: Late assignments will not be accepted unless prior authorization 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 “Clinical Evaluation Tool Cumulative Record,” submit satisfactory clinical papers on the date due, and meet all clinical objectives. Any student who is unable to meet the clinical objectives and 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 2nd semester nursing courses to proceed to the 3rd semester of the program. The 2nd semester nursing courses include all of the following:
- NUR1213 Nursing II
- NUR1213L Nursing II Clinical
- NUR1214L Nursing II Skills Lab

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 “Clinical Evaluation Tool Cumulative Record,” 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 included at the end of this syllabus).

Make-up Policy: Please refer to Nursing Student Handbook for Clinical Make-up Policy.
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CLASS POLICIES & METHODOLOGY

Attendance: Attendance on all clinical days is required. 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.

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. Please see the Nursing Student Handbook.

During your clinical orientation your clinical instructor will provide the telephone number and contact person for each of your clinical agencies. Directions to facilities will be provided.

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Nursing Department Attendance Policy

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 that clinical day.

Electronic Device Use: Hand-held devices are allowed in clinical for note-taking and 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.

Equipment & Supplies: Supplemental 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
See nursing student handbook for the following policies: All students are required to obtain and read the current PALM BEACH STATE COLLEGE Student Handbook and the current Nursing student Handbook. These documents are accessible on the college website. Nursing students should pay particular attention to the following policies:

- Student Preparedness
- Medication Administration Calculation Test
- Medical/CPR Requirements
- RN² (RN Squared)
- Written Assignments
- Nursing Curriculum Organization
- Work Schedule
- Tardiness
- Attire/Dress Code
- Behavior/Professional Conduct
- Clinical Safety Protocol

Professor’s Expectations: Each student will have a Student Portfolio that is kept current and will be available on site.

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 Instructor: ___________________________ Office Hours & Location: ________________

(See Guidelines for Pre- and Post-Conference; Student Guide for Discussion; and Clinical Orientation that are included in this syllabus.)

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

Teaching Strategies
1. Pre and Post Conferences.
2. Individual student/faculty interactions.
3. Written comprehensive holistic assessment and daily assessment.
4. Role modeling.
5. Clinical rounds.
7. Case Studies.
8. Hands on supervised clinical experiences.
10. Simulations & scenarios.
11. Group discussions.

Evaluation Methods
1. Evaluation of clinical performance (see Clinical evaluation tool)
2. Mid-rotation, Mid-term and Final evaluation conferences
3. Evaluation of written and verbal assignments
4. Attendance and participation

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

Clinical Experience
Each student will be based in an acute care hospital caring for adult or geriatric clients. Students rotate amongst a team of Medical-Surgical and Psychiatric Liaison faculty. Clinical assignments will be made at the beginning of each clinical day. The student will be responsible for delivering total care to two to three (2-3) 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.

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

The pre-conference 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 benefits 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, alternate interventions and staff nurse responsibilities in the overall management of care for the client.
Client Care Manager Experience

Each student will spend (1) clinical day practicing the role of client care manager. The responsibilities of the client care manager require planning and attention to detail. Client care managers are expected to inform the clinical faculty and/or staff nurse of this information so appropriate interventions can be instituted in a timely manner. Clinical instructors will make rounds with each client care manager to discuss the clients on the team and their nursing care needs. (The objectives, responsibilities and evaluation methods for this experience are contained in this clinical syllabus.)

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 that the student under whose name the work is submitted or performed, (5) Plagiarism.

Please refer to the Palm Beach State College Student Handbook for further information.

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 students attend the College, they become 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 students are responsible for preparing for class, participating in class, and completing assignments on time.

Palm Beach State College Websites of Interest

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 academic calendar. It is the responsibility of the student to use the PantherWeb system or visit a campus Registrar’s office to withdraw. An official withdrawal entitles the student to a grade of "W" in the class.

DEPARTMENT CONTACT INFORMATION:

Kellie Bassell, MSN, Ed.S., RN
Nursing Program Director
AH 110 (561) 868-3412
Fax (561) 868-3452
E-mail
Course Syllabus – Clinical Course

GETTING STARTED

1. Make sure you have all the computer system requirements as listed in the Computer Requirements section of this syllabus.

2. Update your profile on Pantherweb. The professor will communicate with you through your Palm Beach State College-issued email address.

3. Obtain course materials. The textbook(s) can be purchased at the Palm Beach State College campus bookstore or online.

4. Be sure you print the syllabus, clinical forms, and assignment sheet so that you know what is expected of you during the semester.

5. Print the course guidelines for simulation, community experience, case management assignment, IPR 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.

   Have fun!

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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, FORMS & TOOLS
Course Syllabus – Clinical Course

PRE OR POST CONFERENCE GUIDELINES

During Pre- and Post- Conferences, the following Objectives and Guide for Discussion will be utilized:

**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.

**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 – Clinical Course

CLINICAL ORIENTATION

**Focus:** Orientation to the Clinical setting utilizing the **Orientation Scavenger Hunt** which follows.

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 documentation and papers related to this course.

15. Review lab, library and computer assisted tutoring available to assist student learning.
Course Syllabus – Clinical Course

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

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

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
MEDICATIONS REQUIRED FOR CLINICAL
PHARMACOLOGY RESEARCH ITEMS FOR CLINICAL ROTATION

*Students are to review these medications prior to and during their respective clinical rotations. Students will be responsible for additional medications according to individual patient needs.

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<tr>
<th>SEMESTER 1 MED-SURG</th>
<th>SEMESTER 2 MED-SURG</th>
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<tbody>
<tr>
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<tr>
<td>Acyclovir</td>
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<td>Digoxin</td>
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<td>Guaifenesin</td>
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<td>Heparin</td>
<td>Epogen/Procrit</td>
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CLASSIFICATIONS

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<td>Antidysrhythmics</td>
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<td>Hypoglycemics</td>
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<td>Benzodiazepines</td>
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ACUTE CARE SETTINGS CLINICAL OBJECTIVES

Acute Care Setting Clinical Objectives: While on the Medical-Surgical units the student will satisfactorily complete:

- RN² (RN Squared) documentation as assigned
  - One weekly DHAT
  - CHATs on two Med/Surg clients
- Application of skills learned in 1022L and 1023L
- Utilization of the nursing process including critical thinking skills with all assignments
- Satisfactory completion of one IPR, submitted to CARP instructor
- Satisfactory client care manager experience
- Preparation assignments for and Reflection Paper after attendance at Simulation Experience
- Satisfactory completion of one Community Experience
- Demonstrate safe preparation and administration of medication

Alternate Clinical Experiences: While on the C.A.R.P. unit, the student will:

- Compare the various C.A.R.P. protocols for patients who are undergoing detoxification for the withdrawal of alcohol, opiates, amphetamines, barbiturates, hallucinogens and/or mixed substances
- Develop a holistic plan of care for a patient who is diagnosed with “Altered protection R/T biochemical and genetic predisposition to ethanol”
- Identify defense mechanisms used by family members and the patient in the CARP setting
- Recognize resources available for patients who are experiencing substance abuse problems
- Relate how substance abuse affects Palm Beach County, and list strategies that could help in prevention
- Contrast the nursing/medical care of patients who are being detoxified from substances in the C.A.R.P. setting with those who are in the general hospital
- Compare the assessment findings of those patients who would need to be sent to an Acute Care facility for detoxification (detox) and those that could be treated at C.A.R.P.
- Relate the gender differences that you observed with the male and female detox patient populations as well as any lifespan issues you observed.
- Satisfactory completion of one IPR, submitted to CARP instructor
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CHARTING GUIDELINES
GUIDELINES FOR CHARTING

Charting requirements vary from facility to facility, but the following guidelines can be used to help organize your assessment and charting activities. Most acute care facilities have adopted some type of checklist to document assessment findings. Charting forms/electronic screens also vary from facility to facility, however most utilize check-off sheets for documentation of assessment findings and allow for a narrative entry as needed. Students will be expected to complete nurses’ notes on all of their assigned patients.

1. Initial Visual Assessment:
This is an assessment done on your first visit to a client’s room. The goal of it is to quickly evaluate each client’s nursing care needs and to prioritize the care needs of multiple clients. As a student it will also help you identify your learning needs in completing the tasks involved in providing care to your client.

The initial visual assessment should be an active process. As you assess your client think about what you see, hear, smell, and touch.

The written assessment should include:
- general description of client’s physical appearance
- skin color and temperature
- level of consciousness
- rate and effort of respirations
- assessment of IV’s/fluids rate and sites
- treatment in progress-tube feedings, oxygen, drainage tubings
- safety equipment in use-side rails, restraints

2. Physical Assessment:
A physical assessment of each client is required to be documented daily in the acute care setting. Most assessments are done by anatomic systems and also include assessment of the skin and wounds, IV sites and equipment/safety devices in use.

Skill in completing a physical assessment requires practice and knowledge about the findings commonly found with a particular diagnosis. Following the head to toe assessment, it is important to focus on the client’s chief complaint. This will assist you to formulate a priority nursing diagnosis and nursing care plan. Try doing your physical assessments by the system approach. Articles with tips on assessment techniques are plentiful in the nursing literature.

The important focus of assessment charting is to document abnormal findings. If you are not sure how to correctly and adequately do this, consult with your clinical instructor.

3. Additional Nurse Notes:

Additional nurse’s notes are frequently necessary on clients to document changes in a client’s condition and responses to interventions. Charting should be limited to data pertinent to the client’s diagnoses, abnormal assessment findings, activities, and responses to interventions. Notes should be factual, clear, and concise and should not rerecord data charted elsewhere on the chart. Avoid subjective statements, but do describe clearly and factually any client behaviors that appear to be abnormal.
In addition to the above documentation, the Joint Commission that currently accredits acute care facilities requires nurse’s notes to focus on the outcomes of care. Once nursing diagnoses or problems have been established for a client, nursing is required to chart realistic, client specific outcomes of the care the client is receiving. The problems list is generally updated by the RN caring for the client, but student input into this charting is expected. RN² (RN Squared) and the clinical worksheets contain an area to document the outcomes of care you had in mind for your clients.

For facilities that allow students to chart in the medical record, students are required to check their notes with the clinical instructor before completing them in ink on the client’s chart. Charting can be done at the bedside and must be done in black ink. Use only approved Hospital abbreviations in all charting. Signatures and initials for each individual writing on a flow sheet are usually required in several places. A student’s name should be followed by SN, PALM BEACH STATE COLLEGE. Facilities also require the clinical instructor’s signature after student entries.

4. Miscellaneous Charting: Each facility has specific areas to document the following:

Vital signs: (includes pain assessment) _________________________________

Intake and output: _____________________________________________________

Activity: _____________________________________________________________

Treatments: ___________________________________________________________

BM’s & Weights: _______________________________________________________

Accuchecks: __________________________________________________________

IV Solutions: _________________________________________________________

Fluid intake from IVPB’s _______________________________________________

PRN Medications: _____________________________________________________

IV Flushes: ___________________________________________________________
WRITTEN PAPERS: CLINICAL EXPERIENCE GUIDES, FORMS, AND PAPER REQUIREMENTS
Course Syllabus – Clinical Course

CLINICAL PAPERS FORMAT AND GUIDELINES

You are required to submit papers this term as part of your clinical requirements. These papers must follow the nursing department criteria for written papers (see Student Nurse Handbook) and the guideline and Criteria and Evaluation Tool for each assignment

While on the Medical-Surgical units – the student will satisfactorily complete the following papers:

1. One Interpersonal Process Recording (IPR) and CARP experience paper, to be submitted to the CARP clinical instructor.

2. Two Comprehensive Holistic Assessment Tools (CHATs) with expanded Medication Sheet, Lab and diagnostic tests, Nursing Care Plan, using RN² (RN Squared).

3. One Community Experience Report/paper

4. Weekly Daily Holistic Assessment Tool (DHATs) with expanded Medication Sheet, Lab and Diagnostic Tests, and Nursing Care Plan, using RN² (RN Squared). Student will identify three nursing diagnoses and develop 3 comprehensive care plans. (One care plan is to be a Psych/Social focus; all med-surg related care plans are to include one patient/family teaching goal with interventions.)

5. Client Care Manager Experience Report/paper

6. Simulation experience paper.

The student is expected to:

- Apply skills learned in 1022L and 1023L
- Utilize the nursing process including critical thinking skills with all assignments
- Demonstrate safe preparation and administration of medication.

Students must complete all papers in a satisfactory manner as part of the clinical requirement.

Late papers will not be accepted without prior arrangements made with clinical faculty.

Copies of using RN² (RN Squared) documentation for each DHAT/CHAT will be due to your clinical instructor on the first clinical day of the following week. ONLY those papers, which are complete and handed in on time, will have the opportunity to be re-done ONCE according to the Performance Improvement Plan. Returned papers must be resubmitted on the next clinical day.

All papers must be the students own work. The nursing department adheres to all College Policies.

*Plagiarism is defined as “the unauthorized use of language and thoughts of another author and the representation of them as one’s own.” (New Webster’s, 1997) In addition, plagiarism means using another’s work without giving credit. You must put others’ words in quotation marks and cite your source(s) and must give citations when using others’ ideas, even if those ideas are paraphrased in your own words. (UCDavis.edu, 3/25/2000) (See Palm Beach State College Student Handbook)
FOCUS: Nursing Care of the Adult with more and less commonly occurring health challenges
DAILY HOLISTIC ASSESSMENT TOOL (DHAT)

FOCUS: DYNAMICS OF COMMONLY OCCURRING HEALTH CHALLENGES ACROSS THE LIFESPAN

DATES DUE: __________________________
Guidelines For Daily Holistic Assessment Tool (DHAT)

Date of birth: Do not need to fill in

Culture Needs: Identify the ethnic background for your patient.

Admitting Diagnosis: Indicate what your patient was admitted for

Secondary Diagnosis: Underlying health history

Pathophysiology: List and define any medical history. Use a reference to define.

Health Challenges: Subjective - indicate what the patient said to you. Objective – indicate what you see or can measure

Circumference, birth weight, and gestational age: N/A.

Lifespan: Indicate whether patient is an adolescent, early adulthood, middle adulthood or later adulthood.

Stage of Growth and Development According to Erickson: Indicate the anticipated stage of growth and development.

Actual Stage of Growth and Development: Select one appropriate for the individual and explain why client is in this stage.

Family Rate/Issues: Identify roles that this individual takes on within the family and identify any issues that are currently present or created by this hospitalization.

Allergies: List food, drug, chemicals and/or environmental.

SENSORY/PERCEPTION/COGNITION

L.O.C.: Identify whether the patient is awake, alert, lethargic.

Pupils: Assess pupils reaction to light.

Level of Orientation: Check as appropriate for your patient.

Hearing Aid: Check if your patient has a hearing aid, which ear(s). Write no if your patient does not have one.

Hard of Hearing: Check item if patient is hard of hearing, if not, write no.

Glasses/Contacts: Circle item if patient has either one or both. If patient has neither write none.

Mood: Fill in appropriate blank with yes or no.

Substance Abuse: *Identify how many packs or number of cigarettes per day. If patient does not smoke, write none. *Rx drugs: Write in yes or no. *ETOH: write in yes or no. *Illicit drugs: write in yes or no.

*Any yes answer should be followed up on back with further explanation and details.

History of abuse, memory & judgment/anxiety Level: Fill in the appropriate blank with yes or no.
MOBILITY

Activity Tolerance/Limitations: Identify any issues affecting mobility. Indicate how patient is tolerating activity.

Functional Ability: Indicate ability utilizing numbers.

Assistive Needs: Indicate ability utilizing numbers.

Fall Risk: Indicate yes or no.

OXYGENATION

RESPIRATORY:

Pattern & Rate: Identify the pattern of response and rate. Examples: even, labored, rapid.

Breath Sounds: Identify sounds as well as location of your assessment, i.e., clear bilaterally, rales right base, rhonchi, crackles, wheezing.

Oxygen Therapy: What type of oxygen therapy and how many liters.

Oxygen Saturation: Indicate percent if assessed or state not assessed.

TX’s: Respiratory treatments. If your patient is receiving treatment indicate what type and how often, otherwise write no.

CARDIOVASCULAR

Heart Sounds: Check that you heard normal heart sounds.

PMI: If in appropriate location, check yes.

Murmur: Did you hear a murmur? Indicate yes or no.

Pulse Deficit: check yes or no in appropriate space.

Apical Rate: Write in actual rate and circle either regular or irregular.

Fetal Heart Rate: N/A if patient is not pregnant.

Capillary Refill: Circle either brisk or slow and indicate the time in seconds for refill.

Homan’s sign: Indicate whether your patient has a positive or negative human sign on the right and left side.

Peripheral Pulses: Check your patients pedal pulses. Indicate whether they are present and the quality of the pulses.
Course Syllabus – Clinical Course

CELLULAR INTEGRITY

Skin Temperature: Assess your patient and check appropriate area.

Edema: If present circle and indicate location in space. Mark no if not present.

Wound: Indicate whether your patient has a laceration, or abdominal incision.

Drainage/Discharge: Using the REEDA method, assess your patients wound, then answer questions appropriately. Indicate yes or no for drainage. *Color: indicate if present and what color. *Odor: indicate yes or no.

Site/Wound Care: Indicate what you are doing for the stated wound, i.e.; pericare, topicals, sitz bath.

REGULATION

Nutrition: Mark adequate or poor based on your assessment and the patient’s nutritional status.

Therapeutic: Indicate type of diet.

Elimination Pattern: Indicate your patient’s pattern and check appropriate box.

LBM: Indicate date of last BM.

Bowel Sounds: Circle presents or absent. Indicate location.

Urinary: Identify patients voiding pattern. State if catheter is present.

Fluid Restriction: Indicate yes or no.

Intake/Output: Record totals for your shift.

Formula/Type: N/A

Intravenous Fluid: Indicate type of fluid infusing and rate. Identify site location and if a saline lock (MAP).

PRIORITY NURSING DIAGNOSIS

A total of three nursing diagnoses will be identified with each DHAT. One should be a psychosocial issue. Each med-surg care plan will have one patient/family teaching goal. The student will develop 3 complete nursing plans of care to be submitted the next clinical day.
Adult Daily Holistic Assessment Tool (DHAT)

Client Initials: ___  Age ___  Gender ___  Date ___  WT ___  HT ___  Adm. Date: ___  Allergies: ___

Admission Diagnosis / Current Diagnoses: ___________________________________________________________

Secondary Diagnoses: __________________________________________________________________________

Pathophysiology (textbook reference): __________________________________________________________________________________________

**Initial Assessment**

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>T</th>
<th>P</th>
<th>RR</th>
<th>B/P</th>
</tr>
</thead>
</table>

**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)**

(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

- regular
- irregular

Lung sounds

- RUL __________
- RML ________
- RLL ________
- LUL ________
- LLL ________
- Clear
- Decreased
- Absent
- Crackles
- Rhonchi
- Wheezes

O₂ therapy / O₂ saturation

- none
- O₂ 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: ______________
- O₂ saturation
- cardiorespiratory
- other __________
- alarm parameters verified and on

* Alteration in tissue perfusion

- none
- present R/T __________________

**Regulation:**

Abdomen / LBM

- soft
- firm
- rigid
- distended
- round
- flat
- tenderness / LBM __________

Diet

- continent
- incontinent
<table>
<thead>
<tr>
<th>Student Name: ___________________________</th>
<th>Date: ___________________________</th>
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</table>

<table>
<thead>
<tr>
<th>Bowel sounds</th>
<th>RLQ ___ RUQ ___ LUQ ___ LLQ ___ + present - absent ++hyperactive +/- hypoactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>NG / GT</td>
<td>none specify ____________</td>
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<tr>
<td></td>
<td><strong>Alteration in nutrition –or-</strong></td>
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<tr>
<td></td>
<td>*Alteration in Intake</td>
</tr>
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<td></td>
<td>none present R/T AEB</td>
</tr>
<tr>
<td>GU</td>
<td>no problems</td>
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<tr>
<td>Character of Urine</td>
<td>no problems</td>
</tr>
<tr>
<td>Intravenous Fluids</td>
<td>none</td>
</tr>
<tr>
<td>Intake</td>
<td>Shift total in: ______________</td>
</tr>
<tr>
<td>* Alteration in elimination</td>
<td>none present R/T AEB ____________</td>
</tr>
<tr>
<td>Output</td>
<td>Shift total in: ______________</td>
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</tbody>
</table>

**Mobility:**

<table>
<thead>
<tr>
<th>Muscle tone / strength / Range Of Motion</th>
<th>strength equal bilaterally UE and LE</th>
<th>weakness (specify) __________</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Full Range Of Motion</td>
<td>limitations: ______________</td>
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<tr>
<td>Gait / fall risk</td>
<td>steady</td>
<td>unsteady</td>
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<tr>
<td>Functional ability</td>
<td>independent</td>
<td>total assistance</td>
</tr>
<tr>
<td>Casts / Assistance devices</td>
<td>none</td>
<td>specify ____________________________</td>
</tr>
<tr>
<td>*Alteration in Mobility</td>
<td>none present R/T ____________________________</td>
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</table>

* for abnormal findings, see additional notes

SN signature: ___________________________

STATE AND PRIORITIZE 3 NURSING DIAGNOSES

1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________

NURSES NOTES:

_____________________________________________________________________________
_____________________________________________________________________________
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_____________________________________________________________________________
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SN Signature
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<tr>
<th>TEST</th>
<th>RESULTS</th>
<th>NORMALS</th>
<th>DATES</th>
<th>REASON FOR TEST (Specific to your client)</th>
<th>NURSING SIGNIFICANCE</th>
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## MEDICATION SHEET

<table>
<thead>
<tr>
<th>PATIENT ALLERGIES</th>
<th>DATE:</th>
<th>STUDENT:</th>
<th>TRADE/Generic NAME</th>
<th>CLASSIFICATION</th>
<th>SPECIFIC INDICATIONS/REASON GIVEN TO YOUR CLIENT</th>
<th>MECHANISM OF ACTION</th>
<th>PATIENT DOSE/FREQ ROUTE/SAFE DOSAGE RANGE (AGE SPECIFIC)</th>
<th>MAJOR SIDE EFFECTS</th>
<th>DRUG/DRUG OR DRUG/DIET INTERACTIONS AND CONTRAINDICATIONS</th>
<th>CLIENT SPECIFIC NURSING IMPLICATIONS</th>
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<tbody>
<tr>
<td>TRADE:</td>
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</table>
### Course Syllabus – Clinical Course

#### CLIENT INITIALS: ____________________________

___ DATE: ___

#### NURSING DIAGNOSIS: ____________________________

RT: ____________________________

AEB: ____________________________

#### NURSING CARE PLAN

**PRIORITY CONCEPT:**
- Oxy
- Reg
- Cell Integ
- Mob
- S/P/C

---

#### HUMAN PATTERN:
- Exchanging
- Valuing
- Perceiving
- Communicating
- Choosing
- Knowing
- Relating
- Moving
- Feeling

---

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Planning Goal</th>
<th>Implementation</th>
<th>Rationale</th>
<th>Evaluation</th>
<th>Goal Met?*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pertinent Data:</td>
<td>Desired Outcome (Specific/Measurable)</td>
<td>Nursing Interventions</td>
<td>Reason for Interventions</td>
<td>What Happened:</td>
<td>Yes</td>
</tr>
<tr>
<td>Subjective:</td>
<td></td>
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<tr>
<td>(What did client say – use direct quotations)</td>
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<tr>
<td>Objective:</td>
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<tr>
<td>(What did you see/hear/smell/feel – list findings)</td>
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</tbody>
</table>

*If the client goal was/was not met briefly describe why and what steps would be taken next:
### Course Syllabus – Clinical Course

#### Course Syllabus – Daily Holistic Assessment Tool (DHAT)

**DHAT**

**Grading Criteria**

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Grade</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Pt identification, Diagnosis and secondary diagnosis, allergies, Vital Signs</strong></td>
<td>1.____</td>
<td></td>
</tr>
<tr>
<td><strong>2. Pathophysiology: Assessment criteria, diagnostic data, treatment (Do not use dictionary as reference)</strong></td>
<td>2.____</td>
<td></td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. <em>S/P/C content</em> (Alteration in <em>S/P/C</em> indicated in final row of section)</td>
<td>1.____</td>
<td></td>
</tr>
<tr>
<td>2. <em>Cellular Integrity</em> (Alteration in Cellular Integrity indicated in final row of section)</td>
<td>2.____</td>
<td></td>
</tr>
<tr>
<td>3. <em>Respiratory</em> (Alteration in Gas Exchange indicated in final row of section)</td>
<td>3..____</td>
<td></td>
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<tr>
<td>4. <em>Cardiovascular</em> (Alteration in Tissue Perfusion indicated in final row of section)</td>
<td>4..____</td>
<td></td>
</tr>
<tr>
<td>5. <em>Regulation</em> (Alteration in Nutrition indicated in final row of section)</td>
<td>5..____</td>
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<tr>
<td>6. <em>Regulation</em> (Alteration in Elimination indicated in final row of section)</td>
<td>6.____</td>
<td></td>
</tr>
<tr>
<td>7. <em>Mobility</em> (Alteration in Mobility indicated in final row of section)</td>
<td>7.____</td>
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<tr>
<td>8. Three nursing diagnoses, in three parts, in order of priority.</td>
<td>8.____</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Note</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Address the patient condition</td>
<td>1.____</td>
<td></td>
</tr>
<tr>
<td>2. Describe the signs and symptoms of the patient</td>
<td>2.____</td>
<td></td>
</tr>
<tr>
<td>3. What was done concerning abnormal findings in included.</td>
<td>3.____</td>
<td></td>
</tr>
<tr>
<td>4. Morning activities and <strong>patient’s response</strong> to activities are noted</td>
<td>4.____</td>
<td></td>
</tr>
</tbody>
</table>
# Course Syllabus – Clinical Course

## DHAT

### Grading Criteria

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Clinical Date</th>
<th>Due Date</th>
</tr>
</thead>
</table>

#### Lab work and diagnostic tests

1. Abnormal lab work is recorded  
2. Normal lab values are recorded  
3. Tests expected for patient's medical diagnosis are recorded  
4. Reason why test was done for your patient's specific medical diagnosis  
5. Nursing significance specific to your patient

<table>
<thead>
<tr>
<th>Grade</th>
<th>Comments</th>
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#### Medication:

1. Medications given during your shift  
2. Medications given specific to your patient's medical diagnosis  
3. Why was your patient given this medication  
4. Mechanism of action of the drug  
5. Patient dose and safe dose range  
6. Major side effects  
7. Drug/drug, drug/diet interactions and contraindications  
8. Client specific Nursing Implications

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#### Nursing Care Plan: Applies to all (3) Care Plans

1. Subjective and Objective data are recorded  
2. Two Patient Goals which are measurable (number of times, patient demonstrates skill, etc.) are written  
3. Three interventions for each goal are recorded  
4. Rationale for the intervention is recorded  
5. The goal is evaluated according to what the patient did.  
6. Whether the goal was met or not is recorded and unmet goals are rewritten  
7. Care Plans are written on the three Nsg Dx identified on page 2 of the DHAT  
8. Three Nursing Care plans (1-psychosocial, med-surg related with patient/family teaching goals)

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**Key:**
0 = not completed, or answered but way off base  
1 = answered/completed but not correct, not appropriate, not related to patient or topic or not relevant  
2 = answered/completed and related to patient but missing some relevant pieces or problems not prioritized correctly  
3 = answered/completed completely related to patient, highest priority identified and all relevant pieces included
COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (CHAT)

MEDICAL – SURGICAL NURSING

FOCUS: To compare Holistic Nursing process papers with emphasis on Nursing Diagnosis, Planning, Analysis, Evaluation of care for Clients experiencing more or less commonly occurring health challenges across the lifespan

Dates Due: ____________________ M-S
GUIDELINES FOR COMPREHENSIVE HOLISTIC ASSESSMENT TOOL (CHAT)

1. The CHAT is a comprehensive nursing assessment tool designed to gather information in a holistic way. Please include the Medication sheet, Lab Work and Diagnostic Tests sheet, and Nursing Care Plan.

2. A nursing care plan is to be developed that includes nursing diagnosis, behavioral objectives, nursing interventions and evaluation of human responses. It is valuable to consider prioritizing your patient’s needs.

3. The Nursing Assessment Tool content is to be evaluated on a pass/fail basis, which will be determined based on completeness of the nursing process for the individual client needs.

4. You will be required to submit a CHAT which reflects your understanding of the 5 concepts of human functioning as they relate to human responses to health challenges.

*NOTE: It is recommended that students maintain medication cards (or computerized sheets) detailing generalized information regarding each medication. The medication sheet handed in with the CHAT must relate to the individual patient.
Admission Assessment: Comprehensive Holistic Assessment Tool (CHAT)

Client Initials: ___________  DOB: ___________  Age: ___________  Wt: ___________  Sex: ___________

Diagnosis: ________________________________________________________________

**attach daily assessment

Patient Admission Information:

I. PERCEPTUAL / SENSORY / COGNITION

Communicating: pattern involving sending messages

Name preferred: ___________________________________  Admission Date: _______  Date of Care: _______

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) ________________________________

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)

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<thead>
<tr>
<th>Medication / Food / Environment</th>
<th>Reaction</th>
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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: __________________________

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: ______________________________
__________________________________________________
__________________________________________________

Discharge Plan: ______________________________
__________________________________________________
__________________________________________________
__________________________________________________
**TEACHING CARE PLAN**

<table>
<thead>
<tr>
<th>KNOWLEDGE DEFICIT/LEARNING NEED</th>
<th>GOAL AND PLAN FOR TEACHING</th>
<th>EVALUATION</th>
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<tr>
<td>Goal:</td>
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<td>Plan:</td>
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CARP REQUIREMENTS
C.A.R.P. Community Clinical Experience

Comprehensive Alcoholism Rehabilitation Programs
5400 East Avenue
West Palm Beach, Fl
Phone: 844-6400

You will be scheduled for a one day clinical experience in the medical detox unit at CARP, referred to as M.A.P or the Medical Assessment Program.

On your scheduled day, please arrive at the facility at 7:45 am where you will meet your clinical instructor in the parking area outside of the main 5400 building.

Please call 844-6400 if you cannot be at the facility by 7:45 am for any reason, and leave a message with call back number for the instructor.

You must arrive in clinical uniform and bring your stethoscope, syllabus and a pen and be prepared to be providing patient care as part of this experience. Bring a bag lunch as cafeteria services are not available at this facility. You must bring signed confidentiality waiver with you to be able to attend this experience.

Clinical Objectives include:

- Students will increase understanding about the care of clients experiencing chemical dependency, and nursing assessment and management of withdrawal symptoms.
- Students will utilize therapeutic communication skills with clients during one to one interactions.
- Students will increase knowledge regarding resources for treatment of chemical dependency, and understand the 12 step process.

Directions:
To reach this facility from I-95, exit 45th street and go east, past Australian Avenue. After you have passed the railroad tracks, make a U-turn (in front of Oakwood Mental Health Center). Turn right immediately after U-turn, onto East Avenue. (note: turn right before the railroad tracks, do not cross the railroad tracks again.)

To reach this facility from US1: go west on 45th street, and pass Oakwood Mental Health Center, and turn right on East avenue before the railroad tracks.

Head down East Avenue, and pass Hanley Hazelton Center, and the Hospice of Palm Beach County, and you will see CARP on the right hand side. Enter the second CARP entrance, (pass the first Emergency Entrance)

Clinical paper: IPR will be due to the Palm Beach State College Instructor assigned to facilitate your CARP experience via email: (Please check the faculty web page for correct faculty college email address)
I _________________________________, a nursing student at Palm Beach State College, do understand and agree to the following while on my clinical rotation at C.A.R.P. (Comprehensive Alcoholism Rehabilitation Programs, Inc.) 5400 East Avenue, West Palm Beach, Florida 33407.

I understand and agree that I must hold in confidence all medical, social, and financial information concerning patients and their respective significant others of C.A.R.P.

I understand that the collection of any patient/family information whether by direct interview, review of documentation, staff conferences, or conversations with staff shall not be shared with anyone not directly associated with the C.A.R.P.

I understand that this statement does not authorize me to add, delete, remove, or change patient information contained in a patient chart, either active or non-active, and I am not authorized to make copies of any written patient information.

I understand that I will uphold the standards of C.A.R.P., and will at all times manifest the highest ethical behaviors.

________________________________________
Date

________________________________________
Palm Beach State College Student Signature

________________________________________
C.A.R.P. and/or Palm Beach State College Faculty Signature
INTERPERSONAL PROCESS RECORDING

FOCUS: To Demonstrate Effective Therapeutic Communication Skills With Clients And Their Significant Others

Date Due: _______________

Not completing this objective could result in failure of NUR 1213L.
GUIDELINES FOR WRITING AN INTERPERSONAL PROCESS RECORDING

1. This IPR is to focus on an actual interaction between student nurse and client (or client’s significant other).
2. An IPR is an opportunity for the nurse to evaluate the effectiveness of therapeutic communications skills. This is not a client teaching or data gathering exercise.
3. The introduction and summary are to be written in a narrative format on form provided. Refer to Criteria and Evaluation Tool for IPR for content.
4. The body of the IPR is to be written in the 5-column format found in syllabus. Make copies as needed. Refer to Criteria and Evaluation Tool for IPR for directions.
5. Refer to Criteria for Paper Submitted to Nursing Faculty found in Nursing Student Handbook.
6. Grading tool must be submitted with paper.

FORMAT DESCRIPTION:

CLIENT VERBATIM – NURSE VERBATIM
These sections should include the verbatim statements of the nurse and the client during the interaction. 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.

NON-VERBAL BEHAVIOR OF NURSE AND CLIENT
This 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 client’s voice dropped to a whisper when he spoke about his mother’s death. Examples of behavioral “clue” to anxiety should be included.

INTERPRETATION OF INTERACTION
You should give 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 or 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.

Identify your communications utilizing the underlined terminology in the following forms:
   1. Do’s and Don’ts of Therapeutic Communication.
   2. Unhelpful Do’s and Don’ts of Therapeutic Community
   3. Interpersonal Techniques

ALTERNATIVE RESPONSES
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 guide for future interactions.

Each alternative response should be accompanied by a rational (either theoretical or your own logic) as to why it might promote more effective communication.
INTERPERSONAL PROCESS RECORDING FORM

Name: ___________________________________________ Date: ______________________

INTRODUCTION INCLUDES:

A. Date of Interaction.
B. Duration of interaction.
C. Description of location where interaction took place.
D. Client’s initials, age, gender.
E. Stage of Growth and Development – give example to support personal, interpersonal and social strengths and weaknesses.
F. Admitting diagnosis and other pertinent medical diagnoses.
G. Bibliography of at least two resources used to interpret/analyze interaction and to acquire therapeutic communication techniques.

SUMMARY STATEMENTS INCLUDES:

A. Whether objectives were met, if not, why not.
B. Evaluate nurses therapeutic communication techniques.
C. Identify what you learned regarding the clients personal, interpersonal and social system.
D. Identify therapeutic communication techniques that you perceive will be helpful for you to use in future interactions.
E. Assess and identify your personal or interpersonal strengths and weaknesses.
F. State interactions you plan to utilize to address these needs.
BODY OF INTERPERSONAL PROCESS RECORDING (IPR)

<table>
<thead>
<tr>
<th>Client Verbatim</th>
<th>Nurse Verbatim</th>
<th>Non-verbal Behaviors of Nurse and Client</th>
<th>Interpretation of interaction with use of appropriate terminology</th>
<th>Alternate responses with rationale (what you could have said and why)</th>
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LEARNING GUIDE
SENSORY/PERCEPTION/COGNITION
DO’S AND DON’TS OF THERAPEUTIC COMMUNICATIONS

DO’S
1. Be Honest!
2. Maintain Confidentiality!
3. Listen to what the client is saying and doing as though you were attending a concert – that is – note variations and themes or verbal messages, non-verbal gesture, and symbolic messages.
4. BE AWARE OF YOUR RESPONSE to what the client is “saying”; what is your “gut-level” feeling – empathy, sympathy, apathy, defensiveness, identification . . .? How are you behaving?
5. Use Broad opening statements: summarize at end of interview.
6. Use SILENCE – both you and the client need time to “process” and respond to each other’s messages.
7. GIVE FEEDBACK AND VALIDATE the client’s messages – DO NOT ASSUME!!!
8. Respond to feelings, reality and content.
9. Have a goal for every interaction.
10. Use “I” messages – i.e., “I don’t understand . . .”; “this is what I understand you to be saying . . .”; “I do not like to be screamed at . . .”.
11. Deal with Here and Now issues.

DON’TS:
1. GIVE ADVICE – “I think you should . . .?” (must, ought)
2. USE CLICHÉS – “Everything will be O.K. soon.”
3. COMPARÉ – the client with others – “Everybody who is depressed comes out of it sooner or later.”
4. ARGUE – or get involved in POWER struggles – “the facts are . . .”; “this is why you are wrong . . .”; “Don’t you realize . . .”.
5. USE WHY!
6. TRY TO BE A “FRIEND” – avoid superficial chatter.
7. FORCE the RELATIONSHIP: TIME is ESSENTIAL for developing TRUST, INTIMACY, and SELF DISCLOSURE.
LEARNING GUIDE:
SENSORY/PERCEPTION/COGNITION

COMMUNICATIONS SKILLS - UNHELPFUL RESPONSES TO BE AVOIDED

**Patronizing responses:** These make the client feel childish, as if the person is not taken seriously, as if you are humoring the person.

**Giving advice or quick solutions:** These make you seem cold and uncaring, as if you don’t understand.

**Clichés, generalities or philosophical statement:** These have the effect of wiping out the client’s feelings, trivializing them, and also send the message that you don’t want to be bothered.

**Judgmental remarks:** These seem to indicate your approval or disapproval. They indicate to the client who you are viewing the person’s feelings from your perspective, not the person’s.

**Inadequate responses:** These offer nothing and avoid the issue. They indicate that either your mind is elsewhere or you couldn’t care less.

**Irrelevant responses:** These avoid the client’s feelings and make you seem uncaring.

**Condescending responses and put-downs:** These include sarcasm, ridicule, inappropriate attempts at humor, scolding and authoritarian reminders. They indicate to the helper that you think the person is silly or selfish or wrong to feel as the person does.

**Psychological interpretations:** These are unjustified speculations about another’s personality or relationships and can be both insulting and harmful to the client.

**Inappropriate self-sharing:** These switch the focus to you and your experiences, leaving the client rejected and showing you as more interested in yourself.

**Inaccurate empathy:** This occurs when you misperceive the client’s feelings by a mile and are way off the beam in your understanding of his reasons for those feelings, or indicate that you are willing to listen or incapable of understanding.
LEARNING GUIDE
SENSORY/PERCEPTION/COGNITION
INTERPERSONAL TECHNIQUES

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<thead>
<tr>
<th>THERAPEUTIC TECHNIQUES</th>
<th>EXAMPLES</th>
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<tbody>
<tr>
<td>1. Using Silence</td>
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<td>2. Accepting</td>
<td>Yes</td>
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<td></td>
<td>Uh hum</td>
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<td></td>
<td>I follow what you said</td>
</tr>
<tr>
<td></td>
<td>Nodding</td>
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<tr>
<td>3. Giving Recognition</td>
<td>Good morning, Mrs. S.</td>
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<td>You’ve tooled a leather wallet.</td>
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<td>I noticed that you’ve combed your hair.</td>
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<td>4. Offering Self</td>
<td>I’ll sit with you awhile.</td>
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<td>I’ll stay here with you.</td>
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<td>I’m interested in your comfort.</td>
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<td>5. Giving Broad Openings</td>
<td>Is there something you’d like to talk about?</td>
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<td>What are you thinking about?</td>
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<td>Where would you like to begin?</td>
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<tr>
<td>6. Offering General Leads</td>
<td>Is there something you’d like to talk about?</td>
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<td></td>
<td>What are you thinking about?</td>
</tr>
<tr>
<td></td>
<td>Where would you like to begin?</td>
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<tr>
<td>7. Placing the Event in Time or in</td>
<td>What seemed to lead up to . . .?</td>
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<tr>
<td>Sequence</td>
<td>Was this before or after . . .?</td>
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<td>When did this happen?</td>
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<td>Are you uncomfortable when you . . .?</td>
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<td>I notice that you’re biting your lips.</td>
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<td>It makes me uncomfortable when you . . .</td>
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<td>9. Encouraging Description of perceptions</td>
<td>Tell me when you feel anxious.</td>
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<td>What is happening?</td>
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<td>What does the voice seem to be saying?</td>
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<td>10. Encouraging Comparison</td>
<td>Was this something like . . .?</td>
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<td>Have you had similar experiences?</td>
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<td>11. Reflecting</td>
<td>Client: Do you think I should tell the doctor?</td>
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<td>Nurse: Do you think you should?</td>
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<td>Client: My brother spends all my money and then has the nerve to ask for more.</td>
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<td>Nurse: This causes you to feel angry.</td>
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<td>12. Exploring</td>
<td>Tell me more about that?</td>
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<td>Would you describe it more fully?</td>
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<td>What kind of work?</td>
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<tr>
<td>13. Giving Information</td>
<td>My name is . . .</td>
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<td></td>
<td>Visiting hours are . . .</td>
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<td>My purpose in being here is . . .</td>
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<td>I’m taking you to the . . .</td>
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<td>14. Seeking Clarification</td>
<td>I’m not sure that I follow.</td>
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<td>What would you say is the main point of what you said?</td>
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<tr>
<td><strong>THERAPEUTIC TECHNIQUES</strong></td>
<td><strong>EXAMPLES</strong></td>
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<td>---------------------------</td>
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</tr>
<tr>
<td>16. Presenting Reality</td>
<td>I see no one else in the room. That sound was a car backfiring. Your mother is not here. I’m a nurse.</td>
</tr>
<tr>
<td>17. Voicing Doubts</td>
<td>Isn’t that unusual? Really? That’s hard to believe.</td>
</tr>
<tr>
<td>18. Seeking Consensual Validation</td>
<td>Tell me whether my understanding of it agrees with yours. Are you using this word to convey the idea?</td>
</tr>
<tr>
<td>19. Verbalizing the Implied</td>
<td>Client: I can’t talk to you or to anyone. It’s a waste of time. Nurse: It’s as if you’re feeling that no one understands. Client: My wife pushes me around just like my mother and sister did. Nurse: Is it your impression that women are domineering?</td>
</tr>
<tr>
<td>20. Encouraging Evaluation</td>
<td>What are your feelings in regard to . . .? Does this contribute to your discomfort?</td>
</tr>
<tr>
<td>22. Suggesting Collaboration</td>
<td>Perhaps you and I can discuss and discover what produces your anxiety.</td>
</tr>
<tr>
<td>23. Summarizing</td>
<td>Have I got this straight? You’ve said that . . . During the past hour you and I have discussed . . .</td>
</tr>
<tr>
<td>24. Encouraging Formulation of a Plan of Action</td>
<td>What could you do to let your anger out harmlessly? Next time this comes up, what might you do to handle it?</td>
</tr>
</tbody>
</table>

INTERPERSONAL PROCESS RECORDING

EXAMPLE FOR STUDENT USE
IPR – CARP
Student Name:
Palm Beach State College - NUR 1213L
Date:_____
INTRODUCTION

On February 8, 2010, some classmates and I had the opportunity to visit the Comprehensive Alcoholism Rehabilitation Program (CARP). The CARP facility offers medical detoxification and residential programs, along with a homeless assessment program, and outpatient treatment. This facility is a non-profit organization located in West Palm Beach.

During our visit we had the chance to interact with some of the patients to get an idea what they were going through while achieving an understanding of the amount of pain and discomfort they were experiencing. We spoke with the patients’ one on one for duration of 15 minutes each. Most of the patients were detoxing from a form of opioid, benzodiazapine, and/or alcohol. The facility has a separate area for men and women with the nurses’ station centrally located in the middle. The beds were numbered and lined up along the walls.

Keisha is a 32 year old female who has been in the facility for 3 days at the time of our meeting. She has been addicted to crack/cocaine for the past 7 years. The Department of Children and Family recently have taken her two step children away from her and the biological father due to their drug addiction. Keisha understands why the children have been taken away and stated she wants to change her life around, which means she will need to change who she spends her time with as well. Diagnosis: Cocaine Dependence

My goal during this interaction was to establish trust with the patients. Having the patients open up and be able to express themselves was important to me and I feel that goal has been met, as the patients have verbalized their thoughts towards the continuation of their treatment with hopes of full recovery. State goal in client centered terms, ie The client will establish trust with student nurse as evidenced by verbalizing thoughts and feelings about addiction treatment and plan for recovery.
<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>Good morning. As you know I am a nursing student and we’re here to try and help you today. What is it that brought you here?</td>
<td>I came here to get clean.</td>
<td>I pulled up a chair while she sat up straighter in bed.</td>
<td>Therapeutic: Giving broad opening. Communicates a desire to begin a meaningful interaction. (Mohr, 2009) Excellent application of theory</td>
<td>Hi. My name is ______. I am here to spend the day with you to help monitor your condition. When did you arrive to CARP? Shows her that I am here for her benefit.</td>
</tr>
<tr>
<td>Get clean off of what?</td>
<td>I have been doing crack for the past 7 years.</td>
<td>She glanced over at me as if she was wondering if I was paying attention or not, which I was.</td>
<td>Therapeutic: Providing general leads. Encourages the client to verbalize. (Berman, 2008) good use of APA format</td>
<td>What are your goals to accomplish during your stay here? This would have been a more open ended question. yes, better</td>
</tr>
<tr>
<td>What made you want to get help after all those years?</td>
<td>My kids are in DCF and they told me in order to get them back I need to get clean. They told me I had to go get help.</td>
<td>The tone in her voice sounded if she didn’t really want to do this, but was willing to do it for the children.</td>
<td>Therapeutic: Focusing. Concentrating on the issue. (Mohr, 2009) Excellent!</td>
<td>It takes a big step to look for help. Tell me about what brought you to where you are today? Reassurance followed by an open ended question to make her feel comfortable to open up. good</td>
</tr>
<tr>
<td>Do you have any help from their father?</td>
<td>Yes, but he needs to get clean also. He needs to get drug tested to show he’s clean.</td>
<td>She looks discouraged. I leaned in closer to show interest.</td>
<td>Therapeutic: Being specific and tentative. (Berman, 2008) GOOD</td>
<td>Do you have any help from family and/or friends close by? This makes her think about receiving help in general, as opposed to just the father of the children. Perhaps you could have explored how the drug addiction interfered with her parenting here, in response to her last statement</td>
</tr>
<tr>
<td>Nurse Verbatim</td>
<td>Patient Verbatim</td>
<td>Non-verbal behaviors of nurse and patient</td>
<td>Interpretation of interaction with use of appropriate terminology</td>
<td>Alternate responses with rationale (what you could have said &amp; why)</td>
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<tr>
<td>Seems to me you have a lot of concerns.</td>
<td>I do. My kids are in a program now. I am ready to get my life back together.</td>
<td>The group is getting ready to go to lunch, but she is hesitant to go. It looks to me she is enjoying talking about her problems to someone else.</td>
<td>Therapeutic: Focusing. Concentrating on the issue. (Mohr, 2009) yes.</td>
<td>Describe what else concerns you. Broadens her thinking. ok.</td>
</tr>
<tr>
<td>Sounds like you are thinking clearer than you may have been in the past. Excellent point.</td>
<td>I have no choice. It is not the children’s fault; they shouldn’t have to go through this.</td>
<td>She headed off to lunch and wished me luck with school. I placed my hand on her back and wish her luck with her recovery.</td>
<td>Therapeutic: Using touch. Providing appropriate forms of touch to reinforce caring feelings. (Berman, 2008).</td>
<td>Keep your head up; you have already taken a big step by getting help. Reassurance. Yes it would be good to validate her statement of readiness for change.</td>
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</tbody>
</table>
CONCLUSION

Meeting Keisha was an interesting experience. I believe my goals have been met, as I felt comfortable sitting with her asking personal questions. The nurses’ therapeutic communication techniques were extremely helpful. For instance, beginning the conversation with a broad opening question allows the patient to answer more elaborately, as opposed to the option of answering “yes or no”. Providing general leads helps keep the conversation on track, while focusing shows the patient you are interested and/or concerned. I have learned that the way a conversation is approached from the beginning is what determines the kind of rapport you can built with the patient. You did a great job applying the theory to your interaction!!!

Next time I am in this experience, I feel I have gotten a better grasp of the proper way to approach a patient in this condition (the more practice the better). I feel I will have fewer nerves during my next interaction, as I feel a majority of these patients are open to talking about their issues while appreciating any feedback we can offer. Yes, sometimes some emotional support provided by the active listening process is very helpful for clients in a crisis.

I plan on studying these techniques to further my ability to hold a constructive, helpful conversation with patients in the future. Taking a few minutes prior to confronting these circumstances will benefit my future confrontations as well.

References


CRITERIA AND EVALUATION TOOL FOR IPR

**NAME:**

<table>
<thead>
<tr>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
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<tbody>
<tr>
<td>1. Introduction includes:</td>
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<tr>
<td>A. Date of interaction</td>
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<td>B. Duration of interaction</td>
<td></td>
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<td>C. Description of location where interaction took place</td>
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<tr>
<td>D. Client’s initials, age, gender</td>
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<td>E. Personal, interpersonal and social strengths and weaknesses</td>
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<td>F. Stage of Growth &amp; Development. Give example to support.</td>
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<td>G. Initial goal of interaction. State any changes as interaction occurred.</td>
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<tr>
<td>2. Body of IPR includes:</td>
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<tr>
<td>A. Exact verbal statements of client and nurse (At least 12 responses between client and nurse.</td>
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<tr>
<td>B. Non-verbal communications of client and nurse include: affect, speech quality, observations of body language, personal space.</td>
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<tr>
<td>C. All verbal and nonverbal communications of the client and nurse are analyzed (interpreted) using appropriate terminology</td>
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<tr>
<td>D. State alternate communication techniques for each of the nurse’s actual responses utilizing a variety of communication skills</td>
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<tr>
<td>E. State Rational for alternate responses</td>
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<td>3. Summary statements includes:</td>
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<tr>
<td>A. Whether objectives were met, if not, why not</td>
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<tr>
<td>B. Evaluate nurses therapeutic communication techniques</td>
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<tr>
<td>C. Identify what you learned regarding the client’s interpersonal and social systems</td>
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<tr>
<td>D. Identify therapeutic communication techniques that you perceive will be helpful for you to use in future interactions</td>
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<tr>
<td>E. Assess and identify your personal or interpersonal strengths and weaknesses</td>
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<tr>
<td>F. State interactions you plan to utilize to address these needs</td>
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<tr>
<td>4. Bibliography of at least two resources used to interpret/analyze interaction and to acquire therapeutic communication techniques.</td>
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<tr>
<td>5. Submitted on time</td>
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<tr>
<td>6. Used appropriate format for introduction, body of IPR with five-column format and summary.</td>
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<tr>
<td>7. Correct grammar, APA (5th Ed.) APA format &amp; style</td>
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</table>

**Comments:**

**Pass:**

**Fail:**

**Re-submit by:**

**Faculty Signature:**
COMMUNITY EXPERIENCE

FOCUS: TO IDENTIFY COMMUNITY RESOURCES AND THE NURSING ROLE IN EACH COMMUNITY SETTING

DATES DUE: _______________
COMMUNITY EXPERIENCE

**Purpose:** To gain awareness of local community resources/services available.

**Process:** The student will be assigned a community service/agency to visit. PALM BEACH STATE COLLEGE Clinical Faculty must approve the community facility prior to the visit. The community experience is considered a clinical day, therefore, each student must complete a total of 6 hours participating in this experience.

**Requirements/Grading Criteria:**
Satisfactory completion is achieved when all of the following elements are present:

1. Paper must be a narrative report of the community experience.
2. Paper must be typed, double spaced, and follow APA format.
3. Paper should include:
   - Name of Community Agency/Service
   - Date of Experience
   - Purpose of Agency
   - Objectives
     a. Inception
     b. Philosophy, Purpose, and Mission
     c. Clientele
     d. Services
     e. Referral Source(s)
     f. Funding Source(s)
     g. Fees (if any)
4. Answer the following questions within the body of the paper:
   a. What is the nursing role at this organization? If there is not a nursing role, how would this organization and its clientele benefit from establishing one?
   b. Insights you have gained?
   c. Evaluation of this experience
   d. How would you apply the knowledge gained from this experience to your nursing career?
   e. Your reaction?
   f. On a scale of 1-10, with 10 being the most positive, how would you rate this impact of the agency/event on the well-being of the community?
   g. How would you improve the agency/event?
   h. Summarize the activities you performed or participated in during this visit/event.
   i. What role does this agency/event play in the community?
   j. What type of client’s attend or participate in this agency/event? Explain how and why clients are referred.
   k. Would you recommend this experience to your fellow classmates? WHY or why not?
5. Include supporting documentation, policy/procedures and additional information.
6. Obtain appropriate signature and documentation from facility/person identifying date/time spent at the facility.

Date due: per course calendar.

**Not completing this objective could result in failure of NUR 1213L.**
COMMUNITY EXPERIENCE OPTIONS

- One experience is required
- Selection will be assigned by faculty.
- Some experiences may require students to go in pairs.
- Students are not permitted to do home visits.
- This must be done by the student outside of their clinical time.
- All contact must be at the specified agency.
- Let faculty know of any agency issues or problems.
- Students must dress professionally according to Nursing Department Guidelines. (See Nursing student Handbook for dress code) PALM BEACH STATE COLLEGE name badge must be worn except at those agencies requiring anonymity
- Good luck, have fun, be safe.
COMMUNITY EXPERIENCE FORM

Name: __________________________ Date: __________________________

Type of Experience: ____________________________________________

Adolescent/Early Adulthood: ___________ Middle/Later Adulthood: ___________ Age: __________

Name of Agency/Event Attended: ____________________________________________

Telephone number of contact person & signature (attach card and/or brochure):

_______________________________________________________________

Guidelines:

1. You will need to complete one community experience

2. Agency will be assigned by faculty.

3. Activity must be performed off clinical time. You have scheduled days off to allow you to complete this activity.

4. Contact person should sign your form.

5. Attach a card or brochure.

6. Please direct any questions to one of instructors prior to the due date.
COMMUNITY EXPERIENCE
GRADING CRITERIA

Student name: ____________________________________________ Date: _______________

Satisfactory completion is achieved when each of the following elements are present.

<table>
<thead>
<tr>
<th>GRADING CRITERIA</th>
<th>S</th>
<th>U</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Paper is typed</td>
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<td>Paper includes:</td>
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<tr>
<td>Name of Agency/Date of Experience</td>
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<tr>
<td>Objectives of Agency Visit are Described</td>
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<tr>
<td>a. Inception</td>
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<tr>
<td>b. Philosophy, mission, purpose</td>
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<td></td>
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<tr>
<td>c. Clientele</td>
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<tr>
<td>d. Services</td>
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<tr>
<td>e. Referral source(s)</td>
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<td>f. Funding source(s)</td>
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<td>g. Fees (if any)</td>
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<td>Questions Answered:</td>
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<td>Nursing Role? If no role, how would the organization</td>
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<td>and clientele benefit from one?</td>
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<tr>
<td>Insights you have gained?</td>
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<td>Evaluation of the experience</td>
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<td>Reaction to the experience</td>
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<td>Supporting documentation is included (pamphlets,</td>
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<td>brochures)</td>
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<td>Appropriate signature and documentation from</td>
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<td>facility/person identifying date/time spent at facility</td>
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<td>Total hours spent = 6</td>
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<td>Paper submitted on due date</td>
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SATISFACTORY (S)

UNSATISFACTORY (U)

IF UNSATISFACTORY, LIST REASONS

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NUR1213L – Nursing II Clinical
Revised December, 2012
CLIENT CARE MANAGER EXPERIENCE GUIDELINES
The student will:

1. With the guidance of the clinical instructor, identify which patients could be used for ease study presentations. Select, organize and assign patient groups to student peers.

2. Contact each student in a timely fashion to explain the patient assignment for daily care plan preparation. Information to be shared includes patient(s) initials, room number, medical diagnoses, general acuity level, meds, IV’s, DNR status, diet, activity level, and patient’s weight (peds).

3. Participate in assisting Student Nurses with performing technical skills necessary for specific patient care.

4. Evaluate peer documentation on the patient chart, graphics and medication record for completion and accuracy.

5. Communicate patient condition and response to nursing interventions and medical treatment to the patient’s primary nurse and healthcare team.

6. Make final rounds on team to assure completion of care and documentation at end of shift – assessments and nurse’s notes present, prn meds documented along with response within 1 hour, I & O totaled and documented, all VS charted, Foley catheters emptied, etc. (Instructor will assess quality of assessment content). Assure team members report off to Unit RN by assigned time.
CLIENT CARE MANAGER EXPERIENCE PURPOSE

As client care manager, students will frequently seek you out to discuss questionable or negative assessment findings. Client care managers are expected to inform the clinical faculty and/or staff nurse of this information so appropriate interventions can be instituted in a timely manner. Clinical instructors will make rounds with each client care manager to discuss the clients on the team and their nursing care needs.

Students will be assigned Team Leader responsibilities on a rotating basis and will be responsible for a team of other students and their assigned patients.

The purpose of the experience of patient care manager is to begin to understand the complexity of overall nursing care management. The patient care manager assignment will assist you in developing skills of organization, delegation and facilitation of patient management. The aim of patient care manager is to meet patient care goals through the nursing process, while focusing on managing different populations of people.

The secret is:
1. Assess the patients
2. Assign and delegate
3. Evaluate and Revise
OBJECTIVES OF PATIENT CARE MANAGER ASSIGNMENT

The student will:

1. Develop leadership skills through the management of selected patient groups assigned to student peers.

2. Assist the patient to attain optimum health and homeostasis utilize the theory of goal attainment by prioritizing patient care goals in collaboration with peers, patients, families, and health team members.

3. Relate the nursing process to the care of the selected group of patients assigned to peers.

4. Identify the principles of growth and development as related to personal, interpersonal and social needs of the selected patients.

5. Identify nutritional needs of the selected patients.

6. Utilize leadership skills with application of appropriate nutritional interventions.

7. Explore ethical/legal issues relevant to the selected patient group.

8. Contrast cultural influences that impact the selected patients’ hospitalization and/or health.

9. Relate knowledge of the principles and safe administration of medications ordered for the groups of patients assigned to peers.

10. Evaluate effective communication skills with peers, patients, families and health team members.

11. Develop accurate and safe technical skills, either by direct performance or by assisting peers.

12. Evaluate health care teaching of groups of patients and families assigned to peers.

13. Describe personal/professional growth achieved through the role of patient care manager.
RESPONSIBILITIES OF PATIENT CARE MANAGER ASSIGNMENT

1. Knowledge re: team members' assignments – patient(s) name, room number, diagnoses, special treatments/dressing changes, special equipment with patients, general acuity level, meds with lab monitoring (anticoagulants, hypoglycemics, etc.), IVs and times of IV meds, note patients with DNR status.

2. Rounds with team members after Preconference report to assess needs or potential problems.

3. Availability to team members throughout day for:
   a. assistance as needed with assignment – i.e. to help ambulate the patient who requires 2 assists, or to delegate assisting to another, etc., NOT TO DO SNs ASSIGNMENT.
   b. recurring rounds, sharing of instruction/information to members from instructor.
   c. notifying instructor of problems/concerns related to team members' assignments, patient condition concerns/changes, unusual occurrences, etc.
   d. assuring ordered care administered to patients on team – check med sheets and I & O etc. for documentation throughout day, assure ordered treatments completed as scheduled.

4. Make final rounds on team to assure assigned care complete, assure documentation complete at end of shift – assessments and nurses notes present, prn meds documented along with response within 1 hour, I & O totaled and documented, all VS charted, Foley catheters emptied, etc. (Instructor will assess quality of assessment content). Assure team members report off to unit RN by assigned time.

5. Advise instructor when all members assignments’ complete and team members leaving unit for post conference.
CLIENT CARE MANAGER EXPERIENCE EVALUATION

Guidelines for Client Care Manager Required Written Assignment:

The evaluation of your experience as a client care manager is an important part of the experience. As soon as possible after the experience, write down your thoughts. The required written assignment must be submitted according to PALM BEACH STATE COLLEGE Nursing Student Handbook written paper criteria. (The written assignment is due one week after the experience and must include the following:

1. Discuss your personal and professional goals for this clinical experience as a client care manager and your success in meeting them.

2. Discuss your anticipated learning needs for your experience as a client care manager and your success in meeting them.

3. Describe your client care management activity plan and its usefulness to you during this clinical experience.

4. Evaluate the interactions and activities done with your peers.

5. Evaluate the interactions and activities done with the client you spent the most time with.

6. What would you do differently next time?

Graded: Satisfactory or unsatisfactory by the Clinical Instructor.
# CLIENT CARE MANAGER WORKSHEET

<table>
<thead>
<tr>
<th>STUDENT</th>
<th>ROOM &amp; PT</th>
<th>DIAGNOSIS</th>
<th>VS</th>
<th>TREATMENT</th>
<th>LABS</th>
<th>IVs &amp; MEDS</th>
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Course Syllabus – Simulation Guidelines

SIMULATION GUIDELINES
CLINICAL SIMULATIONS

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 needs.
Manage complex patient needs in an effective and safe environment.

Preparation: The Simulation day is considered a clinical day. You are required to wear your complete clinical uniform and identification badge. You are expected to arrive on time. Please bring your clinical paperwork (including labs, medications, & care plan forms), your stethoscope, and your skills lab bag. It is suggested you bring a bag lunch that day. Access Blackboard prior to the simulation day and complete assignments and preparation readings and activities.

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 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 onto 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).**

Faculty Information:
Simulation is a means to have student’s practice “real world” situations in a safe and positive learning environment. Students may make errors in judgment that in a real world situation could have dire consequences. In simulations, students are given the opportunity to make these mistakes without causing “real” adverse effects; thereby, furthering development of critical thinking skills. These skills are essential to enhance judgment and confidence.

The student is given the “scenarios” from which they must analyze the case. It is helpful for them to utilize their DHAT to organize their assessment & thought process. Simulation is student driven (meaning – the student MUST ask all the questions and perform based on the answers provided). The instructor should not lead the student (this is sometimes challenging).

The actual “hands-on” assessment and intervention piece should take about 20 minutes for each portion of the scenario. Some skills practice may take longer. During this time the instructor should ONLY respond to the cues / questions from the student. The remainder of the time is to be utilized by the students “working up” the case. Looking up unfamiliar diagnoses, medications, labs, etc., formulating plan of care and nursing care plans. The students should collaborate utilizing a team approach for of the “patient”. Though roles must be delineated by the instructor (primary nurse, student nurse, family member, LPN, PCA, etc. These roles should change as the case progresses).

An essential component is debriefing. During the debriefing, the students will share their thoughts as to how the case unfolded. They will identify their own strengths and challenges, individually & collectively. Additionally their instructor will provide feedback and guidance and formalize the teaching-learning process.
Debriefing Essay Rubric

This reflection paper is due on: _________________________________.

Please email as an attachment to: ______@palmbeachstate.edu or: ____________________________

When your simulation essay is received by the instructor, you will receive a “S”= satisfactory for your simulation participation grade. If the essay is not completed and received by the due date indicated, you will not receive a satisfactory grade for the day.

Not completing this objective could result in failure of NUR 1213L.

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<tr>
<th>Debriefing Essay Expectations</th>
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<tr>
<td>This reflection paper is due on:</td>
<td>______ Submitted on time:</td>
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<td>Email as an attachment to: <a href="mailto:______@palmbeachstate.edu">______@palmbeachstate.edu</a></td>
<td>______ Submitted via email as word document.</td>
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<td>Reflective Debriefing: Please take a moment to think or reflect of objectives you feel you learned or achieved today. Please be specific and write your thoughts about this experience:</td>
<td>______ Answered all reflective debriefing essay questions.</td>
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<td>How will you implement or utilize the strategies you have learned today in your clinical simulation experience:</td>
<td>______ Lists strategies to implement or utilize future (using objectives).</td>
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<td>Specify areas for practice to expand your learning, improve performance, and confidence in the clinical area.</td>
<td>______ Discusses skills or areas of practice assessed through self reflection.</td>
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<td>State your plan to improve your clinical performance and confidence: use the back of this sheet or additional paper:</td>
<td>______ Plan stated.</td>
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EVALUATION OF CLINICAL PERFORMANCE
DEFINITIONS FOR EVALUATION CRITERIA

Satisfactory

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
NURSING PROGRAM

EVALUATION OF CLINICAL 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 student’s 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.
## NURSING PROCESS - The Student Will:

### A. Demonstrate biopsychosocial assessment skills in collection and analysis of data to identify the needs of the client.
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.

### B. Formulate goals based on data.
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.

### C. Uses critical thinking to formulate a plan of care based on client oriented behavioral objectives.
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.

### D. Write a plan of care based on patient oriented behavioral objectives.
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.

### E. Implement nursing measures to meet prioritized client need.
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.
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<td>Evaluate the effectiveness of nursing interventions and adapts plan of care accordingly.</td>
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<td>1. Requires constant support to evaluate effectiveness of interventions.</td>
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<td>2. Requires frequent support to evaluate effectiveness of interventions.</td>
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<td>3. Requires minimal assistance to evaluate effectiveness of interventions.</td>
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<td>Report and record nursing process.</td>
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<td>1. Has difficulty in observing and recording data, despite guidance and supervision from instructor: database is incomplete.</td>
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<td>2. Needs frequent direction from instructor during reporting and recording of nursing process.</td>
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<td>3. Able to observe and record data, with minimal assistance from instructor: database is complete, descriptive and accurate.</td>
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<td>4. Independently observes and records data; database is complete, descriptive and accurate.</td>
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<td>Performs technical aspects of care.</td>
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<td>1. Makes errors, recognizes and corrects a few of them, requires much supervision and/or prompting from instructor.</td>
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<td>2. Demonstrates partial lack of dexterity while performing technical aspects of care.</td>
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<td>3. Makes minimal errors or omissions, recognizes and corrects most of them; requires little supervision and/or prompting from instructor.</td>
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<td>4. Consistently performs skills accurately and efficiently without requiring prompting from instructor.</td>
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<td>Explain rationale for performing basic nursing skills and technical procedures.</td>
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<td>1. Seldom applies previously learned principles; requires much guidance.</td>
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<td>2. Occasionally applies previously learned principles; requires frequent guidance.</td>
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<td>3. Usually applies previously learned principles; requires minimal guidance.</td>
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<td>4. Consistently and independently applies previously learned principles.</td>
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<td>Calculate, prepare and administer medications accurately.</td>
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<td>1. Makes errors in securing correct medications, calculating dosages; preparing and administering medications; and requires prompting to correct errors.</td>
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<td>2. Performs safely and accurately with frequent direction or cues from the instructor during the performance.</td>
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<td>3. Makes minimal errors in securing correct medication; calculating dosages; preparing and administering medications; and, recognizes and corrects errors with minimal assistance.</td>
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<td>4. Is accurate and efficient in securing correct medication, calculating dosages, preparing and administering medications.</td>
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### EVALUATION OF CLINICAL PERFORMANCE

**STUDENT NAME:**

**STUDENT ID #:**

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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.
   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.

### 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.

### 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.
### EVALUATION OF CLINICAL PERFORMANCE

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#### Critical to all courses

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.

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

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#### Critical to all courses

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.

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#### Critical to all courses

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.

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#### Critical to all courses

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.

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#### Critical to all courses

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.
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| **MT** |       |       |       |       | 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. |
| **F** |       |       |       |       | **Critical to all courses** |
| **MT** |       |       |       |       | 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. |
| **F** |       |       |       |       | **Critical to all courses** |
| **MT** |       |       |       |       | 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. |
| **F** |       |       |       |       | **Critical to all courses** |
| **MT** |       |       |       |       | 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. |
| **F** |       |       |       |       | **Critical to all courses** |
| **MT** |       |       |       |       | 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. |
| **F** |       |       |       |       | **Critical to all courses** |
| **MT** |       |       |       |       | 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. |
| **F** |       |       |       |       | **Critical to all courses** |