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CLINICAL ORIENTATION

**Focus: Orientation** to the Clinical setting

The student will:

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

Locate the Following

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

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

**Emergency (Crash) Cart** with defibrillator
- Emergency oxygen
- Emergency equipment
- Restraints
- Suction equipment
- What equipment do you need to suction?

**Patient Medical Records**
- Lab results
- Transcribed orders
- Advanced directive guidelines
- Patient teaching information
- Drug information
- Teaching videos

**Nutrition Room**
- Ice machine
- Nourishments
- Tube feedings
- What equipment do you need to initiate a tube feeding?

**Treatment Room**
- Catheterization and irrigation supplies
- Sterile dressings and supplies
- How are they charged to the patient?

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

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

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

Familiarize yourself with bed controls, client call button, sharps containers, lighting & emergency call lights in rooms.
STUDENT SURVEY AND SELF-ASSESSMENT

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

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

1. Name: ____________________________________________ Age: ________

2. Reason for choosing nursing as a career?

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

4. Your expectations of this program?

5. What is your goal for your career in nursing?
6. Ambitions, ideals, and interests?

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

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

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

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


<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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</thead>
</table>

6
12. In what ways is faculty most helpful to you?

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

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

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

www.consultgerirn.org

Students are to review this information and bring a print copy of the tool to clinical each day.
<table>
<thead>
<tr>
<th>Initials</th>
<th>DX:</th>
<th>Diet</th>
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<tbody>
<tr>
<td>Age</td>
<td>M</td>
<td>F</td>
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<td>Stage of development:</td>
<td>Role:</td>
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<tr>
<td>Mood: appropriate depressed</td>
<td>Marital status/Sig other</td>
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<tr>
<td>Anxious angry euphoric labile</td>
<td>Children Siblings</td>
</tr>
<tr>
<td>Behavior: cooperative</td>
<td>Primary Caregiver</td>
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<tr>
<td>uncooperative apprehensive</td>
<td>Lives with:</td>
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<td>Agitated lethargic</td>
<td>Client concern related to role responsibilities:</td>
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<th>Isolation</th>
<th>MD:</th>
<th>Ht/Weight/BMI</th>
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<th>CARDIOVASCULAR</th>
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<tr>
<td>LOC: Awake Alert Oriented x</td>
<td>B/P HR AP</td>
<td>Rate:</td>
</tr>
<tr>
<td>Confused</td>
<td>Rate:</td>
<td>Even Uneven</td>
</tr>
<tr>
<td></td>
<td>Rhythm: Reg. Irreg</td>
<td>unlabeled labored</td>
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| Speech: clear, slurred, garbled, aphasic |

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<tr>
<th>Edema:</th>
<th>02 Sat:</th>
<th>R/A Device:</th>
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<tr>
<td>Location</td>
<td>Pitting non pitting</td>
<td>NC</td>
</tr>
<tr>
<td>None</td>
<td>1+</td>
<td>+2</td>
</tr>
<tr>
<td>+3</td>
<td>+4</td>
<td>Face mask- Venti-NRB</td>
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<th>Eyes: PERRLA Sclera</th>
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<td>&lt; 3 sec.</td>
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<tr>
<td>Peripheral Pulses:</td>
<td>+ / -</td>
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<tr>
<td>Weak (1+) Full (2+) Bounding (3+) doppler</td>
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<td>Chest pain</td>
<td>SOB</td>
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<td>Blurred vision</td>
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<td>Cough: Dry or Productive</td>
</tr>
<tr>
<td>Dizzy/vertigo</td>
<td></td>
<td>Color</td>
</tr>
<tr>
<td>Numbness/tingling</td>
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<td>Consistency</td>
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<td></td>
<td></td>
<td>Amount</td>
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<th>Nursing interventions:</th>
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<th>Nursing Interventions:</th>
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<tr>
<td>Neuro checks: q</td>
<td>TEDS</td>
<td>IS x volume:</td>
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<td>Reorient prn</td>
<td>SCDS</td>
<td>CDB</td>
</tr>
<tr>
<td>Seizure precautions</td>
<td>Tele monitor Y/N</td>
<td>Sputum Collection</td>
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<tr>
<td>ETOH protocol</td>
<td>Rhythm</td>
<td>Suctioning</td>
</tr>
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<td>Aspiration prevention/HOB</td>
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<td>Treatments:</td>
</tr>
<tr>
<td><strong>GASTROINTESTINAL</strong></td>
<td><strong>GENITOURINARY</strong></td>
<td><strong>SKIN</strong></td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td><strong>Inspect:</strong> large round flat Mass symmetrical umbilical Pulsations Non distended distended Abd girth:</td>
<td><strong>Inspect:</strong> Color</td>
<td><strong>Inspect:</strong></td>
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<tr>
<td></td>
<td>Clarity</td>
<td>Color: NFR pale pink jaundice</td>
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<tr>
<td></td>
<td>U/A:</td>
<td>Cyanosis rash ecchymosis</td>
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<td></td>
<td>Amt:</td>
<td>Mucous membranes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moist/dry</td>
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<tr>
<td><strong>Auscultate:</strong> Bowel Sounds: Present hypoactive hyperactive absent</td>
<td>Condom Cath</td>
<td>Palpate:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Temp: Warm or cool to touch</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Turgor: tenting or elastic</td>
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<tr>
<td></td>
<td></td>
<td>Texture: soft smooth</td>
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<tr>
<td></td>
<td></td>
<td>Tough dry</td>
</tr>
<tr>
<td><strong>Quadrants</strong> RL LL RU LU</td>
<td>Foley CBI</td>
<td>Palpate: Bladder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integrity: Intact</td>
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<tr>
<td></td>
<td></td>
<td>Incision: Staples sutures</td>
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<td></td>
<td>non-distended distended</td>
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<td></td>
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<td>Wounds: Location Stage:</td>
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<tr>
<td></td>
<td></td>
<td>Partial or full thickness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unstageable</td>
</tr>
<tr>
<td><strong>Palpate:</strong> soft firm tender non tender guarding</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>MUSCULOSKELETAL</td>
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<td>TUBES/DRAIN</td>
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<td><strong>Subjective:</strong> Appetite Nausea /Vomiting % meal: B____L_____D____</td>
<td><strong>Subjective:</strong> Pain Burning Frequency Urgency</td>
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<td>Location Stage:</td>
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<td>Partial or full thickness</td>
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<tr>
<td><strong>BM</strong> Last BM Flatus Color Consistency</td>
<td>Intake:</td>
<td>DSG: Location</td>
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<td>Weight:</td>
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<td><strong>Ortho:</strong> Cast Traction Sling Pins</td>
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<tr>
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<td>Neuro:</td>
<td>Temp:</td>
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<td></td>
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<td>HR RR BP</td>
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<tr>
<td><strong>Motor:</strong> Upper Extremity: Hand Grasps: equal; strong weak ROM: active passive limited</td>
<td>Cardiopulmonary:</td>
<td>Pain Scale:</td>
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<td></td>
<td>Lower Extremities: Pedal push: equal; strong weak Foot Drop L/R Contractures L/R ROM: active passive limited</td>
<td>Chest Tube Cardiac monitor</td>
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<td></td>
<td>Paralysis:</td>
<td>Ventilator:yes:<strong><strong>no:</strong></strong></td>
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<tr>
<td></td>
<td>Amputations:</td>
<td></td>
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<tr>
<td><strong>Safety Precautions Maintained:</strong> Bed locked, Low position Bed alarm is audible Fall precautions Extremity restriction Side rails up Call light within reach Restraints per order Sitter present Aspirations Skin: T &amp; P; Air mattress, Heel Protector;</td>
<td>ABD:</td>
<td>Diagnostics:</td>
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<td>NGT: _____</td>
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<tr>
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<td>Gastrostomy Foley Rectal tube Colostomy Urostomy</td>
<td>CXR</td>
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<td>CT MRI</td>
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<td>Doppler studies:</td>
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<td></td>
<td></td>
<td><strong>SKIN:</strong></td>
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<tr>
<td></td>
<td>JP Penrose Wound vac</td>
<td></td>
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<tr>
<td>Current knowledge of health/illness</td>
<td>Memory:</td>
<td>Limited short term memory</td>
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<tr>
<td></td>
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<td>Limited long term memory</td>
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<td>Readiness to Learn:</td>
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<tr>
<td>Ready willing able</td>
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<td>Comprehension:</td>
</tr>
<tr>
<td>If not, state reason:</td>
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<td>Ability to grasp concepts</td>
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<tr>
<td></td>
<td></td>
<td>Responds to questions</td>
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<td></td>
<td></td>
<td>Motivation level:</td>
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<tr>
<td></td>
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<td>Anxious uninterested</td>
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<td></td>
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<td>Cr</td>
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<td>Glu</td>
<td>BNP</td>
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<td>HCT</td>
<td>NA+</td>
<td>Liver enzymes</td>
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<td>PLATELET</td>
<td>K+</td>
<td>Prealbumin</td>
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<td>Coagulation</td>
<td>CL-</td>
<td>Albumin</td>
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<td>PTT</td>
<td>Ca+</td>
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<td>Mg+</td>
<td>CULTURES:</td>
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<td></td>
<td></td>
<td>Urine</td>
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<td></td>
<td></td>
<td>Blood</td>
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<tr>
<td></td>
<td></td>
<td>Sputum</td>
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<td></td>
<td></td>
<td>Wound</td>
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<td></td>
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<td>Body Fluids</td>
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Nurses
Notes:

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

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

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

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

Student Objectives The student will:

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

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

   (You may use the required Drug Guide - but you must be prepared before giving the med.)

3. All drugs must be given on time. There is a 30-minute leeway before or after administration time. Be ready.

4. PRN meds MAY NOT be given until the ordered time limit.

5. All meds must be checked by instructor to verify dosage.

6. All injectable meds must be prepared and administered with instructor present.

7. All meds must be charted as given immediately after being administered.

8. PRN meds are a priority. If patient needs a PRN, the procedure is to:
   a. Check MAR for appropriate order and when last dose was given.
   b. Obtain med with instructor.
   d. Prepare med.
   e. Administer med.
   f. Chart med.
   g. Reassess patient within 30-60 min.

9. ALWAYS maintain close communication with your Clinical Instructor regarding your patient’s status.
Ralph Waldo Emerson:  
"It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself."

What is Service-Learning?

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

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

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

Students:

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

Benefits for the Students:

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

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

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

SERVICE LEARNING ASSIGNMENT GUIDELINES

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

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

Student Log Sheet


Student Site Evaluation Form


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

a. The site evaluation log
b. A site evaluation of the experience

*Service Learning is a requirement in every semester of the Nursing Program.
GUIDELINES FOR WRITING AN INTERPERSONAL PROCESS RECORDING

OBJECTIVES:

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

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

GENERAL INSTRUCTIONS:

1. The introduction is to be typed in narrative format. The introduction is an essential part of the IPR in order to acquaint the reader with the setting, and circumstances in which the interaction took place. This should include the client’s facial expression, voice quality, appropriateness of dress and grooming and room environment. Refer to Criteria and Evaluation Tool for IPR for content.

2. The body of the IPR (client verbatim – nurse verbatim section), is to be written in the 5-column format found in the syllabus or at the PALM BEACH STATE COLLEGE Nursing website. Make copies of the format as needed. Verbatim statements of the nurse and the client during the interaction should be documented. Time lapses and silences should be noted, as well as the length of the silence. This section is to be written in an objective fashion, without any interpretations on the part of the student. Refer to Criteria and Evaluation Tool for IPR for directions. The body of the IPR must include at least six responses between client and nurse. A “response” is client and student each talk once. Minimally the client and student must each speak six times.

3. Non-verbal behavior of nurse and client section is to be used for recording communication and behavior that is not verbalized. Significant gestures, facial expressions, body postures, tones of voice, eye contact, etc., should be noted – both the client’s and the nurse’s. For example, it should be recorded that the voice dropped to a whisper when he spoke about his mother’s death. Examples of behavioral “clues” to anxiety should be included.

4. Interpretation of interaction section includes your ideas as to what was going on – in a dynamic sense – during the interaction. How did you perceive the client to feel? How did you feel? You should also not any associative looseness and/or flight of ideas, as well as disorders of thinking that were present and defense mechanisms that were employed by the nurse or client. Any shifts in the conversation made by either the client or the nurse should be noted.

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

5. Alternative responses section is one of the most important parts of the IPR and is heavily weighted in terms of evaluation. This section provides the student with an opportunity to look back on the
NUR 1023L: Supporting

interaction and to formulate responses that might have been more effective than the one used. Although the interaction itself may have been ineffective in achieving the stated goal, it can still be a learning experience, and be a guide for future interactions.

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

6. **The summary** of the IPR is to be typed in narrative form and should relate to the initial goal identified. The student should include the strengths and weaknesses of the interaction as well as writing objectives for client care based on his/her interpretation. The student should include objectives for his or her own improvement. The participation of both the nurse and the client should be evaluated. References should be cited in a bibliography. Refer to Criteria and Evaluation Tool for IPR for content.

7. **Bibliography** - Any references used should be footnoted and a bibliography attached. Correct APA bibliographical form must be used.

8. Credit will be deducted for spelling and grammatical errors. Any paper which does not meet the requirements will be returned to the student to be redone.

9. **Criteria and Evaluation tool must be submitted with the paper for the instructor to mark for grading.**
NUR 1023L: Supporting
CRITERIA AND EVALUATION TOOL
FOR INTERPERSONAL PROCESS RECORDING (IPR)
(SUBMIT TO INSTRUCTOR)

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### 1. Introduction includes: (To be typed)

- **A.** Date of interaction
- **B.** Duration of interaction
- **C.** Description of location where interaction took place
- **D.** Client’s initials, age, gender
- **E.** Client’s personal, interpersonal and social strengths and weaknesses.
- **F.** Admitting diagnosis and other pertinent medical diagnoses
- **G.** Initial therapeutic communication goal of interaction. State any changes as interaction occurred.

### 2. Body of IPR includes: (May be typed or legible handwriting)

- **A.** Exact verbal statements of client and nurse. *(At least six responses between client and nurse.)*
- **B.** Non-verbal communications of client and nurse include: affect, speech quality, observations of body language, personal space.
- **C.** All verbal and nonverbal communications of the client and nurse are analyzed (interpreted) using appropriate terminology.
- **D.** State alternate communication techniques for each of the nurse’s actual responses utilizing a variety of communication skills.
- **E.** State rationale for alternate responses.

### 3. Summary statements includes: (To be typed)

- **A.** Whether objectives were met, and if not, why not.
- **B.** Evaluate your therapeutic communication techniques in this interaction.
### NUR 1023L: Supporting

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

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

Projected Age of Student____________

Draw your aged self.

Draw environment you wish to have.

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

Make a statement of the legacy you wish to leave.

What social activities will be important to you?
1. A person can be considered old when __________________________________________
__________________________________________________
__________________________________________________

2. Words that society uses to describe the elderly are ____________________________
__________________________________________________
__________________________________________________

3. Growing old means _______________________________________________________
__________________________________________________
__________________________________________________

4. Seeing an old person makes me feel ________________________________
__________________________________________________
__________________________________________________

5. The best thing about getting old is _______________________________________
__________________________________________________
__________________________________________________

6. The worst thing about getting old is ______________________________________
__________________________________________________
__________________________________________________

7. How many elders do you personally know? ________________________________
__________________________________________________
__________________________________________________

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

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

10. Most elderly live in _________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

11. Economically, older people are ______________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

12. Socially older people are __________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

13. Culturally the elderly ________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________
14. The spiritual needs of the elderly are ____________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

15. Health-wise older people are __________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

16. Mentally older people are _____________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

17. Sexually older people are _____________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

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

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

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

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________
OUTCOMES:

Completing the clinical experience will enable the learner to:

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

Preparation Activities:

View: (3) Therapeutic Communication Videos located under Web links in Blackboard for NUR 1023
   a. Basic Components of Communication
   b. Opening & Questioning & Use of Silence
   c. Responding & Caring

Review the following guides:
   1. Practical pointers for student communication with the elderly.
   2. Interviewing format
   3. Caring communication
   4. Caring behaviors
   5. Guidelines for obtaining a life history.
NUR 1023L: Supporting Documentation

STUDENT GUIDELINES FOR INTERVIEWING
(DO NOT SUBMIT TO INSTRUCTOR)

WEEK ONE

Introduce self and purpose of the interview.

Obtain permission from individual to be interviewed.

Be aware of yourself and the interviewee:
- Gestures
- Posture
- Voice tone and rate of speech
- Distance between you and interviewee
- Hearing deficit
- Vision deficit.

1. Questions concerning what, how, when, and where sustain the interview; those asking “why” may be difficult to answer.

2. Questions requiring a “yes” or “no” answer may inhibit flow of conversation, e.g., “Are you satisfied with your health care? Instead you might ask, What has your health care been like?”

3. Avoid judgment, e.g., “That is good” or “That is bad.” Rather, “Did you feel that was O.K. (or) not O.K.?”

4. When you feel it is time to bring closure to the interview, state “I have only a few more minutes, is there anything else you would like to talk about?”

5. Always give feedback about what you have learned in the interview and ask in what way the interview has been useful or helpful to the interviewee.

6. Thank the person for sharing their time and their views.

7. Set up a specific time for the next interview and inform them of the focus of the next interview.

8. Do not share addresses or phone numbers or go to the home of a stranger.

9. If the person is willing ask them to sign a contract (in syllabus) for the next nine interviews. If they seem reluctant explain that it is for their protection but they have a right not to sign. It will be necessary in that case to explain that you are not capable at this time of giving advise related to health but if they have a specific problem you will find a resource for them.

10. Summarize the interview according to guidelines on “Summary of Visit with Elder” form.

11. In the event an immediate problem is encountered with the interviewee contact your lab instructor as soon as possible for assistance.
1. Always assess the elder’s visual and hearing abilities and arrange with direct eye contact your sitting/distance, 12 inches to 2 feet, so that you are most comfortable and the outcome is successful.

2. Because the elderly person has decreasing energies to cope with the tasks of everyday living, the visitor may have to invest proportionately more energy into the visit.

3. The visitor needs to pace the visit according to the elderly person’s fluctuating energy levels and physical conditions.

4. The use of appropriate touch can be a meaningful communication bridge.

5. Avoid information overload by: speaking slowly; using short sentences; dealing with one thought at a time; and asking for feedback to be certain meaningful communication has taken place. The elderly person needs 15% more time to respond.

6. Enhance the aged feelings of self-esteem by both encouraging his maximum participation and acknowledge his role of being an authority on aging. He is the product of his total life experiences and he is the only one who knows what these experiences have been. His past plays a significant part in current functioning.

7. Importance of choices - express confidence in the person’s ability to make choices and follow through.

8. Motivation to participate in an activity will be increased if:
   A. an older person is intrigued by a task rather than perceiving it as “just busy work”;
   B. the role or activity conveys the message the “you are important”; 
   C. there is a possibility of forming meaningful relationships.

9. The use of reminiscence is an effective tool in linking relevant past events to present situation.

10. Some elderly do not have the strength to cope with the confusion of bureaucracies. So if necessary, be an advocate. Connect the elderly person with appropriate resources in the community.
STUDENT GUIDELINES FOR OBTAINING A LIFE HISTORY
(DO NOT SUBMIT TO INSTRUCTOR)
WEEK ONE

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

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

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

OUTCOMES:
Completing the clinical experience will enable the learner to:

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

Preparation Activities:

1. Complete Article and Video
   a. Try This ISSUE 3- Mental Assessment of Older Adults: The Mini-Cog
   b. Print Instructions on conducting the mini-cog.
2. Read Evidence-Based Geriatric Topics:
   a. Delirium – Nursing Standard of Practice Protocol: Delirium: Prevention, Early Recognition, and Treatment
   b. Depression- Nursing Standard of Practice Protocol
3. Answer the question:
   What community resources are available for persons (and their families) with cognitive impairment?
WEEK THREE FUNCTIONAL ASSESSMENT

OUTCOMES:
Completing the clinical experience will enable the learner to:

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

Preparation Activities:

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

WEEK FOUR
SAFETY

OUTCOMES:
Completing the clinical experience will enable the learner to:

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

Preparation Activities:

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

OUTCOMES:

Completing the clinical experience will enable the learner to:

1. Identify components of a nutritional assessment.
2. Complete nutritional assessment on assigned elderly resident
3. Identify community nutritional resources available for home-based persons.

Preparation Activities:

1. Complete Article and Video
   Try This ISSUE 9 Assessing Nutrition in Older Adults
   Print Nutritional Assessment Tool
2. Read Evidence-Based Geriatric Topics:
   b. Nursing Standard Practice Protocol – Assessment and Management of Mealtime Difficulties
3. Answer the following question:
   What community resources are available for the home-based person and what are the eligibility requirements?
LONG TERM CARE ROTATION --SUMMARY OF EXPERIENCE
INDIVIDUALIZED AGING-REFLECTION EXERCISE

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

**Introduction**
1. Introduce your resident.

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

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

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

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

**Summary**
1. Describe what you have learned through this experience.
COMMUNITY LINKS ASSIGNMENT
THE WELL ELDER

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

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

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

Papers should be preferably typed or legibly hand written.

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

Date Due: Per course calendar.
GUIDELINE FOR WRITING THE COMMUNITY LINKS ASSIGNMENT FOCUS: THE WELL ELDER
(SUBMIT EACH WEEK TO INSTRUCTOR WITH ASSIGNMENT)
Due dates to follow:*Print a copy of this form and bring to your instructor with week 1 submission*

WEEK ONE THROUGH SIX
Student Name: ________________________________

Date: ________________________________________

Elder’s Age & Gender: __________________________

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

Comments:
WELL ELDER
(Do not submit to instructor)

WEEK ONE

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

Week One

Topic: Communication

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

Preparation Activities:
1. Review the following:
   • practical pointers
   • interviewing format
   • caring communication
   • caring behaviors
   • guidelines for life history

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

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

Discussion Guidelines for use in summary following first interview:
1. Discuss impressions, general reactions and feelings to your first visit.
2. Identify at least one communication barrier.
3. Identify at least one therapeutic communication skill utilized.
4. Describe your perspective of client’s response to interview.
5. Identify the practical pointers you utilized when communicating with your client.
SUMMARY OF VISIT WITH ELDER
(SUBMIT TO INSTRUCTOR)

WEEK ONE

Your Name: ________________________________ No. of Visits: ____________

Place of meeting: __________________________

Time: ______________________________________

Elder’s age: ____________________________ Sex: ____________________________

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

2. Identify at least one communication barrier.

3. Identify at least one therapeutic communication skill utilized.

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

5. Identify the practical pointers you utilized when communicating with your client.
STUDENT GUIDE FOR CLINICAL EXPERIENCE WITH A WELL ELDER  
(Do not submit to instructor)

WEEK TWO

Topic: Growth and Development

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

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

Preparation Activities:

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

Student Learning Experience:

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

Student Guides:

The Aged Family: Developmental Tasks

Discussion Guidelines:

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

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

1. Decide where and how to live out the remaining years.

2. Continue a supportive, close, warm relationship with the spouse or significant other, including a satisfying sexual relationship.

3. Find a satisfactory home or living arrangement and establish a safe, comfortable household routine to fit health and economic status.

4. Adjust living standards to retirement income; supplement retirement income if possible with remunerative activity.

5. Maintain maximum level of health; care of self physically and emotionally by getting regular health examinations and needed medical or dental care, eating an adequate diet, and maintaining personal hygiene.

6. Maintain contact with children, grandchildren, and other living relatives, finding emotional satisfaction with them.

7. Maintain interest in people outside the family, and in social, civic, and political responsibility.

8. Pursue new interests and maintain former activities in order to gain status, recognition, and a feeling of being needed.

9. Find meaning in life after retirement and in facing inevitable illness and death of oneself and spouse as well as other loved ones.

10. Work out a significant philosophy of life, finding comfort in a philosophy or religion.

11. Adjust to the death of spouse and other loved ones.
WEEK TWO

Due: ________________

Your Name: ____________________________ No. of Visits: ____________

Place of meeting: ____________________________

Time: ____________________________

Elder’s age: ____________________________ Sex: ____________________________

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

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

3. Describe possible reasons specific developmental tasks have not been met.
WEEK THREE

Topic:  Safety

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

Preparation Activities:
2. Discuss experiences in your own life that could have been prevented with adequate information and preventative actions.
3. Identify precipitants to accidents/trauma.

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

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

Discussion Guidelines:
1. Discuss impressions and general reactions.
2. Identify a safety hazard discovered in your elder’s home.
3. Discuss interventions (including modifications and community resources).
HOME SAFETY ASSESSMENT
(SUBMIT TO INSTRUCTOR)

WEEK THREE

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

Are scatter rugs firmly anchored with rubber backing?  
Are electrical cords in good repair, especially a heating pad?  
Light, heat and ventilation:
   - Is there adequate night lighting?  
   - Are stairways continually lighted?  
   - Is temperature within a comfortable range?  
   - Is the heater adequately ventilated?  
   - Is there cross ventilation?  
Is furniture sturdy enough to give support?  
Is there a minimum of clutter allowing room for easy mobility as well as fire hazard?  
Are smoke detectors present (at least one on each level of home)?  
Are emergency telephone numbers posted in a handy place to read? (ambulance, doctor, fire department, nearest relative, 911)  

If you are alone for a period of time do you have someone who checks on you?  
If you have limited vision, does phone have enlarged dial?  
If you have impaired hearing, does phone have amplified receiver?  
If you have small pets do they ever get in your way, causing you to trip or fall?  

The kitchen can be evaluated for the following:

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

YES  NO
In the bathroom are the following safety features observed:

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

Outside the home the following points should be considered:

Walks and stairs:  
Are there raised or uneven places on the sidewalks?  
Are stairs in good repair?  
Are the bottom and top stairs painted white or a bright color to improve visibility?  
Are handrails securely fastened?  
Are screens on doors and windows in good repair?  
Is there an alternate exit from the house?  
Is there an alarm system or burglar proofing?

### HELPFUL HOUSEHOLD GADGETS

#### WEEK THREE

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

**E. Communication Aids**
- Enlarged telephone dial | 6
- Raised line checkbook | 10
- Telephone amplifier | 9

**F. Pastime and Hobby Aids**
- Bar magnifying glass | 6
- Easy threading needles | 1, 4
- Large print books | 11, 12
- Needle threader | 1, 4
- Pocket magnifying glass | 1, 5
- Talking books | 11, 12

**G. Miscellaneous**
- Colored cloth tape (for marking) | 1, 2, 3, 5
- Fluorescent safety tape | 1, 3, 5
- Long handled dust pan | 1, 3
- Magnet on a pole (for reaching) | 1, 3
- Self-sticking dots and numbers (for marking) | 1, 6
- Needle threader | 1, 4
- Pocket magnifying glass | 1, 5
- Talking books | 11, 12

**WHERE TO BUY**

**Local**
- Discount department stores (i.e., K-Mart, Wal-Mart, Target, Sears, J.C. Penney’s) | 7. Bookstores
- Drug stores | 8. Grocery stores
- Hardware stores | 9. Local phone company
- Fabric stores | 10. Banks
- Large department stores | 11. County library services for the blind
- Office Supply | 12. Libraries
WEEK THREE

RESOURCE LIST:

INTERNET RESOURCE LIST:
SUMMARY OF VISIT WITH ELDER  
(SUBMIT TO INSTRUCTOR)

WEEK THREE

Due: ____________________

Your Name: ___________________________________________  No. of Visits: ____________

Place of meeting:  __________________________________________________________________

Time:  ___________________________________________________________________________

Elder’s age: ___________________________  Sex: ______________________

1. List any accidents the elder has experienced.

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

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

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

5. Explain any safety measures you taught or recommended to the elder.
STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER
(Do Not Submit to Instructor)

WEEK FOUR

Topic: Nutrition

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

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

Preparation Activities:

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

Student Learning Experience:

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

Student Guides:

Nutritional Screening Tool
Community Resources

Discussion Guidelines:

1. Discuss impressions and general reactions.
2. Identify one actual or potential nutrition problem of the elder.
3. Name one intervention you utilized.
4. What specific factors (physical and/or sociological) affect the elder’s nutrition?
5. Share insights and what you have learned as a result of the “Well Elder” experience.
SUMMARY OF VISIT WITH ELDER  
(SUBMIT TO INSTRUCTOR)

WEEK FOUR

Due: ____________________________

Your Name: ___________________________________________  No. of Visits: ________________

Place of meeting: ___________________________________________

Time: ____________________________________________________

Elder’s Age: ___________  Sex: ___________

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

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

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

4. What has been most valuable for you in this overall experience?
STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER
(DO NOT SUBMIT TO INSTRUCTOR)

WEEK FIVE

Topic:  **Grief/Loss/Coping**

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

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

Preparation Activities:

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

Student Learning Experience:

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

Student Guides:

Grief/Loss/Coping Tool
WEEK FIVE

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

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

Sample questions:

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

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

Have you lost a loved one?

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

What financial changes have you experienced?

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

Have your living arrangements changed?

Have you had to give up any personal possessions?

Has your level of independence changed any?

Have you experienced changes in your social life?

Have you experienced changes in the types of activities you engage in?
2. For each change or loss mentioned by your elder ask, “How did it make you feel?”

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

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

Discussion Guidelines:

1. Discuss your impressions and general reactions.
2. Identify at least three losses your elder has experienced.
3. Name one way your elder coped with a loss.
4. Identify where your elder is in the grief process.
SUMMARY OF VISIT WITH ELDER
(SUBMIT TO INSTRUCTOR)

WEEK FIVE

Due: ________________

Your Name: ___________________________________ No. of Visits: ________________

Place of meeting: ___________________________________________________________

Time: _____________________________________________________________________

Elder’s age: ____________________ Sex: ____________________________

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

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

3. Describe coping behaviors the elder uses.

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

Due: ______________________

Your Name: ___________________________ No. of Visits: __________

Place of meeting: _____________________________________________

Time: _______________________________________________________

Elder’s age: ___________________________ Sex: ___________________

1. How does the elder describe his/her health?

2. How do you perceive the elder’s health?

3. Identify factors that promote wellness in the elder.

4. Identify any factors that interfere with the elder’s health and well-being.

5. Demonstrate completing a Teaching Care Plan for your Well Elder Client.

Suggestions: What knowledge deficits did you assess in your meetings with the client?

What goals/outcomes do you feel the client will be successful in achieving in the short term and long term?

Knowing how the client learns, what teaching strategies will you utilize for teaching this client?
WELL ELDER WEEK 6: TEACHING PLAN

Include at least one problem on the next page.

1. State a knowledge deficit that currently applies to your elder.

2. List an objective related to your elder’s knowledge deficit.

3. Describe how you will meet the above objective.

4. Discuss your teaching plan with your clinical group in post conference.
# TEACHING CARE PLAN

<table>
<thead>
<tr>
<th>KNOWLEDGE DEFICIT/LEARNING NEED</th>
<th>GOAL AND PLAN FOR TEACHING</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal:</td>
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<tr>
<td>Plan:</td>
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NUR 1023L: Supporting Documentation

NUR 1023L – Supporting Documents
Revised November 2014
Criteria for Ongoing Clinical Evaluation

Independent (I):
The student demonstrates both efficiency of movement and deftness. Is able to utilize subtle perceptual cues to modify the behavior in order to achieve the desired effect. Demonstrates exceptional coordination and integration. Sequence of movements and communication are fluid, even, and intertwined. Economical use of movements, equipment, and conversation. Behavior demonstrated within an expedient time period. Appears confident, relaxed, and generally expends an appropriate amount of energy to accomplish the behavior. Behavior focuses on the patient/client rather than on self or the skill that is being performed.

Supervised (S):
The student is efficient and coordinated, but expends more personal energy or that of the patient/client to accomplish the behavior than does the independent performer. The student appears confident and focuses on the patient/client, but becomes distracted and focuses more on the skill as the skill becomes more complex. The behavior is accomplished during a reasonable time period, however, the student becomes flustered when confronted by unforeseen variables such as a STAT (immediate) order.

Assisted (A):
The student demonstrates skillfulness in portions of the behavior; remaining portions characterized by uncoordinated and/or inefficiency of movement. The student periodically appears anxious, worried, or flustered, but makes an effort to project confidence. Behavior outcomes take longer to accomplish than the supervised performer, and sometimes are late. Increased attention is focused on the student behavior, rather than on the patient/client.

Marginal (M):
The student’s performance is unskilled, inefficient, and wasteful of energy expenditure. Little thought appears to be given to the sequence of activities to be performed. A high level of anxiety is apparent. Completion of the behavior is considerably delayed to the extent that other activities are disrupted or omitted. Performance is *unsafe and requires continuous verbal and frequent physical cues from the instructor.

Dependent (D):
The student may attempt the behavior but is unsuccessful. Unreasonable energy may be expended in attempting the behavior, or the student may appear unable to move. Communication is inappropriate. The student’s behavior is *unsafe. Continuous verbal and physical cues are required.
## MIDTERM Self Reflection Evaluation Tool

<table>
<thead>
<tr>
<th>Professional Identity</th>
<th>Self-Reflection</th>
<th>D</th>
<th>M</th>
<th>A</th>
<th>S</th>
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<tbody>
<tr>
<td><strong>#1: Show accountability for nursing judgment and actions.</strong></td>
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<tr>
<td>1</td>
<td>Demonstrates self-care and awareness of standards for nursing care.</td>
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<td>2</td>
<td>Begins to incorporate the concepts of caring, advocacy and diversity into professional identity.</td>
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<td>3</td>
<td>Adheres to the nursing program and course standards regarding professional behavior.</td>
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<td>4</td>
<td>Demonstrates self-direction and assumes responsibility for his/her own growth and learning.</td>
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<td>5</td>
<td>Uses input from constructive criticism to make changes in own performances.</td>
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<td>6</td>
<td>Oral and/or written clinical assignments meet established grading criteria.</td>
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<td><strong>#2: Demonstrate caring, compassion, and respect for all persons and for human dignity.</strong></td>
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<td>7</td>
<td>Demonstrates integrity, responsibility, confidentiality, cultural and ethical principles in the delivery of patient-centered care.</td>
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<td><strong>#3: Identify behaviors that are consistent with safe, quality care in the promotion of a healthy work environment.</strong></td>
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<td>8</td>
<td>Demonstrates integrity, responsibility, confidentiality, cultural and ethical principles in relationship-centered care (patients, families, communities, health care team, and peers).</td>
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<td>9</td>
<td>Uses principles of safety when performing nursing measures.</td>
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<td><strong>Spirit of Inquiry</strong></td>
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<td><strong>#4: Translate knowledge into practice in order to promote quality and improve practice.</strong></td>
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<tr>
<td>1</td>
<td>Distinguishes priorities of care for clients based on the context of the clinical situation.</td>
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<td>2</td>
<td>Correlates classroom theory to clinical practice.</td>
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<td><strong>#5: Engage in self-reflection as a basis for improving own practice.</strong></td>
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<td>Begins to utilize critical thinking to develop deeper</td>
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<td>4</td>
<td>Actively participates in pre- and post-conference by providing feedback and insight.</td>
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<td><strong>#6: Incorporate evidence-based practices when planning patient-centered care.</strong></td>
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<td>5</td>
<td>Identifies current issues and trends recognizing their influence on patient care.</td>
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<td>6</td>
<td>Identifies nursing actions that embody evidence-based practice.</td>
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<td><strong>#7: Perform technical skills safely and accurately.</strong></td>
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<td>7</td>
<td>Demonstrates dexterity while performing technical aspects of care.</td>
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<td>8</td>
<td>Explains rationale for performing basic nursing skills and technical procedures.</td>
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<td><strong>#8: Document accurately in simulated EHR.</strong></td>
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<td>9</td>
<td>Begins to effectively use sources of information and technology necessary to improve documentation skills.</td>
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<td><strong>Nursing Judgement</strong></td>
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<td><strong>#9: Demonstrate an appreciation for diversity and others’ values.</strong></td>
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<tr>
<td>1</td>
<td>Demonstrates awareness of the client’s physical, emotional, cultural and spiritual needs, views, priorities, rights, while performing nursing care.</td>
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<td><strong>#10: Identify ethical challenges.</strong></td>
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<td>2</td>
<td>Considers the effects of one’s own values and beliefs on patient care.</td>
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<td><strong>#11 Act in accordance with legal and regulatory guidelines, including HIPAA.</strong></td>
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<td>3</td>
<td>Selects appropriate sources of information necessary to identify patient’s prescribed medications and care.</td>
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<td>4</td>
<td>Discusses relevant data regarding medications. Calculates, prepares medications accurately.</td>
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<td>5</td>
<td>Administers medications accurately.</td>
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<td><strong>#12 Communicate information effectively.</strong></td>
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<td>6</td>
<td>Locates and articulates stated facility and nursing program policies.</td>
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<td>7</td>
<td>Demonstrates appropriate and therapeutic responses to patient situations, including appropriate facial expressions, body language and responses.</td>
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<td>8</td>
<td>Begins to identify client’s and family’s learning needs.</td>
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</table>
verbal and written communication.

#13 **Work cooperatively with others.**

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<tbody>
<tr>
<td>10</td>
<td>Identifies and seeks help appropriately (from faculty or staff).</td>
</tr>
<tr>
<td>11</td>
<td>Identifies benefits of interdisciplinary collaboration to promote continuity of care.</td>
</tr>
<tr>
<td>12</td>
<td>Demonstrates cooperation with clients, families, peers, faculty, nursing staff and community members.</td>
</tr>
</tbody>
</table>

**Human Flourishing**

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<tr>
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</thead>
</table>

#14 **Recognize the needs of the patient which promote and restore health, integrity and self-determination.**

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#1: Show accountability for nursing judgment and actions.

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<thead>
<tr>
<th>No.</th>
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<tbody>
<tr>
<td>1</td>
<td>Demonstrates self-care and awareness of standards for nursing care.</td>
</tr>
<tr>
<td>2</td>
<td>Begins to incorporate the concepts of caring, advocacy and diversity into professional identity.</td>
</tr>
<tr>
<td>3</td>
<td>Adheres to the nursing program and course standards regarding professional behavior.</td>
</tr>
<tr>
<td>4</td>
<td>Demonstrates self-direction and assumes responsibility for his/her own growth and learning.</td>
</tr>
<tr>
<td>5</td>
<td>Uses input from constructive criticism to make changes in own performances.</td>
</tr>
<tr>
<td>6</td>
<td>Oral and/or written clinical assignments meet established grading criteria.</td>
</tr>
</tbody>
</table>

#2: Demonstrate caring, compassion, and respect for all persons and for human dignity.

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>7</td>
<td>Demonstrates integrity, responsibility, confidentiality, cultural and ethical principles in the delivery of patient-centered care.</td>
</tr>
</tbody>
</table>

#3: Identify behaviors that are consistent with safe, quality care in the promotion of a healthy work environment.

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Demonstrates integrity, responsibility, confidentiality, cultural and ethical principles in relationship-centered care (patients, families, communities, health care team, and peers).</td>
</tr>
<tr>
<td>9</td>
<td>Uses principles of safety when performing nursing measures.</td>
</tr>
</tbody>
</table>

Spirit of Inquiry

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<tbody>
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#4: Translate knowledge into practice in order to promote quality and improve practice.

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<tbody>
<tr>
<td>1</td>
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<td>2</td>
<td>Correlates classroom theory to clinical practice.</td>
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#5: Engage in self-reflection as a basis for improving own practice.

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</table>
meaning of holistic nursing care.

4 Actively participates in pre- and post-conference by providing feedback and insight.

### #6: Incorporate evidence-based practices when planning patient-centered care.

5 Identifies current issues and trends recognizing their influence on patient care.

6 Identifies nursing actions that embody evidence-based practice.

### #7: Perform technical skills safely and accurately.

7 Demonstrates dexterity while performing technical aspects of care.

8 Explains rationale for performing basic nursing skills and technical procedures.

### #8: Document accurately in simulated EHR.

9 Begins to effectively use sources of information and technology necessary to improve documentation skills.

### Nursing Judgement

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### #9: Demonstrate an appreciation for diversity and others’ values.

1 Demonstrates awareness of the client’s physical, emotional, cultural and spiritual needs, views, priorities, rights, while performing nursing care.

### #10: Identify ethical challenges.

2 Considers the effects of one's own values and beliefs on patient care.

### #11 Act in accordance with legal and regulatory guidelines, including HIPAA.

3 Selects appropriate sources of information necessary to identify patient’s prescribed medications and care.

4 Discusses relevant data regarding medications. Calculates, prepares medications accurately.

5 Administers medications accurately.

### #12 Communicate information effectively.

6 Locates and articulates stated facility and nursing program policies.

7 Demonstrates appropriate and therapeutic responses to patient situations, including appropriate facial expressions, body language and responses.

8 Begins to identify client’s and family’s learning needs.

9 Begins to utilize appropriate medical terminology for
#13 Work cooperatively with others.

10 Identifies and seeks help appropriately (from faculty or staff).

11 Identifies benefits of interdisciplinary collaboration to promote continuity of care.

12 Demonstrates cooperation with clients, families, peers, faculty, nursing staff and community members.

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Criteria for Ongoing Clinical Evaluation

Independent (I):
The student demonstrates both efficiency of movement and deftness. Is able to utilize subtle perceptual cues to modify the behavior in order to achieve the desired effect. Demonstrates exceptional coordination and integration. Sequence of movements and communication are fluid, even, and intertwined. Economical use of movements, equipment, and conversation. Behavior demonstrated within an expedient time period. Appears confident, relaxed, and generally expends an appropriate amount of energy to accomplish the behavior. Behavior focuses on the patient/client rather than on self or the skill that is being performed.

Supervised (S):
The student is efficient and coordinated, but expends more personal energy or that of the patient/client to accomplish the behavior than does the independent performer. The student appears confident and focuses on the patient/client, but becomes distracted and focuses more on the skill as the skill becomes more complex. The behavior is accomplished during a reasonable time period, however, the student becomes flustered when confronted by unforeseen variables such as a STAT (immediate) order.

Assisted (A):
The student demonstrates skillfulness in portions of the behavior; remaining portions characterized by uncoordinated and/or inefficiency of movement. The student periodically appears anxious, worried, or flustered, but makes an effort to project confidence. Behavior outcomes take longer to accomplish than the supervised performer, and sometimes are late. Increased attention is focused on the student behavior, rather than on the patient/client.

Marginal (M):
The student’s performance is unskilled, inefficient, and wasteful of energy expenditure. Little thought appears to be given to the sequence of activities to be performed. A high level of anxiety is apparent. Completion of the behavior is considerably delayed to the extent that other activities are disrupted or omitted. Performance is *unsafe and requires continuous verbal and frequent physical cues from the instructor.

Dependt (D):
The student may attempt the behavior but is unsuccessful. Unreasonable energy may be expended in attempting the behavior, or the student may appear unable to move. Communication is inappropriate. The student’s behavior is *unsafe. Continuous verbal and physical cues are required.

*Unsafe behavior is any behavior that does not meet the accepted standard of nursing care and/or is judged to be very likely to cause harm if allowed to proceed, or in fact causes harm. Harm may be physical, emotional, or psychosocial in nature and involve self or others in the environment.
<table>
<thead>
<tr>
<th>Scale Label</th>
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<th>Quality of Performance</th>
<th>Assistance required</th>
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<tbody>
<tr>
<td>Independent</td>
<td>Safe Accurate Action produces desired result Appropriate verbal and non-verbal behaviors</td>
<td>Proficient, coordinated, confident Occasional expenditure of excess energy Within an expedient time period</td>
<td>Without supportive cues</td>
</tr>
<tr>
<td>Supervised</td>
<td>Safe Accurate Action produces desired result Appropriate verbal and non-verbal behaviors</td>
<td>Efficient, coordinated, confident Some expenditure of excess energy Within an reasonable time period</td>
<td>Occasional supportive cues</td>
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<td>Assisted</td>
<td>Safe Accurate Action produces desired result Appropriate verbal and non-verbal behaviors</td>
<td>Skillful in parts of behavior Inefficient and un-coordinated. Expands excess energy Within an delayed time period</td>
<td>Frequent verbal and occasional physical and directive cues in addition to supportive cues.</td>
</tr>
<tr>
<td>Marginal</td>
<td>Unsafe Performs at risk Action does not produce desired result Inappropriate verbal and/or non-verbal behaviors</td>
<td>Unskilled, inefficient Considerable expenditure of excess energy Prolonged time period</td>
<td>Continuous verbal and frequent physical cues</td>
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<td>Dependent</td>
<td>Unsafe Unable to demonstrate desired behavior Inappropriate verbal and/or non-verbal behaviors</td>
<td>Unable to demonstrate procedure/behavior</td>
<td>Continuous verbal and frequent physical cues</td>
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NUR 1023L

Clinical Evaluation Tool

Student ________________

Instructor ________________ / _______________________

<table>
<thead>
<tr>
<th>Professional Identity</th>
<th>MIDTERM / FINAL</th>
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<tbody>
<tr>
<td>Implement one’s role as a nurse in ways that reflect integrity, responsibility,</td>
<td>D M A S I</td>
</tr>
<tr>
<td>ethical practices and evolving identity as a nurse committed to evidence based practice,</td>
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</tr>
<tr>
<td>caring, advocacy and safe, quality care for diverse clients within a family, group or</td>
<td></td>
</tr>
<tr>
<td>community</td>
<td></td>
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#1: Show accountability for nursing judgment and actions.

1. Demonstrates self-care and awareness of standards for nursing care.

2. Begins to incorporate the concepts of caring, advocacy and diversity into professional identity.

3. Adheres to the nursing program and course standards regarding professional behavior.

4. Demonstrates self-direction and assumes responsibility for his/her own growth and learning.

5. Uses input from constructive criticism to make changes in own performances.
6. Oral and/or written clinical assignments meet established grading criteria.

### #2: Demonstrate caring, compassion, and respect for all persons and for human dignity.

7. Demonstrates integrity, responsibility, confidentiality, cultural and ethical principles in the delivery of patient-centered care.

8. Demonstrates integrity, responsibility, confidentiality, cultural and ethical principles in relationship-centered care (patients, families, communities, health care team, and peers).

9. Uses principles of safety when performing nursing measures.

### Spirit of Inquiry

Examine the evidence that underlies clinical nursing practice to challenge the status quo, question underlying assumptions, and offer new insights to improve the quality of care for clients, families, groups and communities.

### #4: Translate knowledge into practice in order to promote quality and improve practice.

1. Distinguishes priorities of care for clients based on the context of the clinical situation.

2. Correlates classroom theory to clinical practice.
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<td>3. Begins to utilize critical thinking to develop deeper meaning of holistic nursing care.</td>
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#8: Document accurately in simulated EHR.

9. Begins to effectively use sources of information and technology necessary to improve documentation skills.

**Nursing Judgement**

Make judgments in practice substantiated with evidence, that integrate nursing science in the provision of safe, quality care that promotes the health of clients within a family, group, and community context.

#9: Demonstrate an appreciation for diversity and others’ values.

1. Demonstrates awareness of the client’s physical, emotional, cultural and spiritual needs, views, priorities, rights, while performing nursing care.
#10: Identify ethical challenges.

2. Considers the effects of one’s own values and beliefs on patient care.

#11 Act in accordance with legal and regulatory guidelines, including HIPAA.

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Examine the evidence that underlies clinical nursing practice to challenge the status quo, question underlying assumptions, and offer new insights to improve the quality of care for clients, families, groups and communities.
### Human Flourishing

Advocate for clients and families in ways that promote their self-determination, integrity, and ongoing growth as human beings.

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</tr>
</tbody>
</table>

Areas of Strength:

Areas to Work on:

Instructor Comments:

Student Comments:

<table>
<thead>
<tr>
<th>Student signature</th>
<th>__________________________</th>
<th>Instructor signature</th>
<th>__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final</td>
<td>Date:__________</td>
<td>Clinical Site:__________</td>
<td>Absences:__________</td>
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