Adult Daily Holistic Assessment Tool (DHAT)

Client Initials __________ Age __________ DOB __________ Gender ___________ Date ____________

WT __________ HT __________ Admission Date: ____________

Allergies ____________________________________________

Admission Diagnosis / Current Diagnosis: ____________________________________________________

Secondary Diagnosis: ________________________________

Pathophysiology (textbook reference): ______________________________________________________

<table>
<thead>
<tr>
<th>Initial Assessment</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs</td>
<td></td>
</tr>
<tr>
<td>T ___________ P _____________ RR _____________ B/P _____________</td>
<td></td>
</tr>
</tbody>
</table>

**Sensory / Perception / Cognition:**

- LOC / Visual or auditory deficits: □ awake □ alert □ oriented □ asleep □ confused □ obtunded  □ none specify: __________
- Mood: □ appropriate □ depressed □ anxious □ angry □ euphoric □ labile
- Behavior: □ cooperative □ uncooperative □ apprehensive □ agitated □ lethargic
- Speech / Primary language: □ clear □ appropriate □ inappropriate □ aphasia □ impaired hearing  □ Primary language: __________
- Pupils (L) ______mm □ brisk □ sluggish □ nonreactive □ nonreactive □ brisk □ sluggish □ nonreactive □ nonreactive
  □ PERRLA

Pain

- Score: ________ location: ________________ description: _____________ medicated Y* N

**Growth & Development (Erikson) Stage**

- (Actual Stage) ____________________________
- AEB ____________________________

* Alteration in S/P/C

- none present R/T ____________________________

**Cellular Integrity:**

- Skin temperature / moisture: □ warm □ cool □ cold □ dry □ moist □ diaphoretic
- Color / turgor: □ pink □ pale □ cyanotic □ mottled □ jaundiced □ elastic □ tenting
- Edema: □ none □ present □ location ____________________________ pitting +1 +2 +3 +4
- Mucous membranes: □ pink □ pale □ moist □ dry □ lesions
- Rash / lesion / wound: □ none □ present □ site describe ____________________________ location ____________________________

* Alteration in Skin Integrity

- none present R/T ____________________________

**Oxygenation:**

- Respiratory: Effort: □ unlabored □ dyspneic □ nasal flaring □ abdominal □ stridor □ grunting □ retractions
  □ Regular □ irregular
- Lung sounds

□ RUL ______ □ RML ______ □ RLL ______ □ LUL ______ □ LLL ______

□ Clear □ Decreased □ Absent □ Rales □ Rhonchi □ Wheezes
<table>
<thead>
<tr>
<th><strong>O₂ therapy / O₂ saturation</strong></th>
<th>□ none □ O₂ therapy ______ lpm / % □ NC □ Mask □ Oxyhood saturation level _______ %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cough / Respiratory Treatments</strong></td>
<td>□ nonproductive □ productive ___________ tx’s __________________________</td>
</tr>
<tr>
<td><strong>Impaired Gas Exchange</strong></td>
<td>none □ present R/T __________________________</td>
</tr>
<tr>
<td><strong>Cardiovascular: Apical</strong></td>
<td>□ regular □ irregular □ S1 □ S2 □ PMI □ Murmur</td>
</tr>
<tr>
<td><strong>Extremities: Capillary refill / peripheral pulses</strong></td>
<td>&lt; _______ seconds {0 – 3} □ R/L brachial _______ □ R/L radial _______ □ R/L dorsal pedalis _______</td>
</tr>
<tr>
<td></td>
<td>□ R/L posterior tibial _______ □ other __________________________</td>
</tr>
<tr>
<td><strong>Monitors</strong></td>
<td>none □ specify: __________________________ □ O₂ saturation □ cardiorespiratory □ other _______ □ alarm parameters verified and on</td>
</tr>
<tr>
<td><strong>Alteration in tissue perfusion</strong></td>
<td>none □ present R/T __________________________</td>
</tr>
</tbody>
</table>

**Regulation:**

<table>
<thead>
<tr>
<th><strong>Abdomen / LBM</strong></th>
<th>□ soft □ firm □ rigid □ distended □ round □ flat □ tenderness / LBM ________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diet</strong></td>
<td>□ continent □ incontinent</td>
</tr>
<tr>
<td><strong>Bowel sounds</strong></td>
<td>RLQ ___ RUQ ___ LUQ ___ LLQ ___ + present - absent ++hyperactive +/- hypactive</td>
</tr>
<tr>
<td><strong>NG / GT</strong></td>
<td>none □ specify __________________________</td>
</tr>
<tr>
<td><strong>Alteration in nutrition</strong></td>
<td>none □ present R/T __________________________ size ________ □ gravity □ suction</td>
</tr>
<tr>
<td><strong>GU</strong></td>
<td>□ no problems □ foley □ dysuria □ hematuria □ frequency □ continent □ incontinent □ LMP ______</td>
</tr>
<tr>
<td><strong>Intravenous Fluids</strong></td>
<td>□ none □ specify/solution &amp; rate __________________________</td>
</tr>
<tr>
<td><strong>Alteration in elimination</strong></td>
<td>□ none □ For shift: total in ______ total out ______ □ present R/T __________________________</td>
</tr>
</tbody>
</table>

**Mobility:**

<table>
<thead>
<tr>
<th><strong>Muscle tone / strength / Range Of Motion</strong></th>
<th>□ strength equal bilaterally UE and LE □ weakness (specify) ________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Full Range Of Motion □ limitations: __________________________</td>
</tr>
<tr>
<td><strong>Gait / fall risk</strong></td>
<td>□ steady □ unsteady □ pre-ambulatory □ paralysis /describe_______________</td>
</tr>
<tr>
<td><strong>Functional ability</strong></td>
<td>□ independent □ total assistance □ requires assistance (explain) __________________________</td>
</tr>
<tr>
<td><strong>Casts / Assistance devices</strong></td>
<td>none □ specify __________________________</td>
</tr>
<tr>
<td><strong>Alteration in Mobility</strong></td>
<td>none □ present R/T __________________________</td>
</tr>
<tr>
<td><strong>for abnormal findings, see additional notes</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SN signature:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**STATE AND PRIORITIZE 3 NURSING DIAGNOSES**

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

**NURSES NOTES:**

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

SN Signature
Admission Assessment: Comprehensive Holistic Assessment Tool (CHAT)

Client Initials: ______________ DOB: ___________ Age: _______________ Wt: ________________

Diagnosis:

**attach daily assessment

Patient Admission Information:

I. PERCEPTUAL / SENSORY / COGNITION

Communicating: *pattern involving sending messages*

Name preferred: ____________________________ Sex: _______ Age: _________ Date: ____________

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

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

Primary language: ____________________________ Interpreter needed: ____________________________

Relating: *pattern involving established bonds*

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

Significant others / Primary caregiver:

Lives with:

Recent changes in family: No if Yes, explain:

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

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

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

Occupation / Educational experience:

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

Socialization / support systems:

Valuing: *pattern involving spiritual growth*

Religious preference: ____________________________ Spiritual needs:

Cultural preferences / needs:
Knowing: pattern involving the means associated with information

Medical History:
Chief complaint:

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

Previous Hospitalizations / Surgery

Immunizations: Up to date Needs _______________

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

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

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

<table>
<thead>
<tr>
<th>Medication / Food / Environment</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

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

Substance use: Alcohol (type) ___________________________drinks/day  Cigarettes: ___________________________per day

Illicit drug use: ___________________________ Rx drug use:

Perception / Knowledge of Health / Illness:

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

Comprehension: Ability to grasp concepts and respond to questions: HIGH MEDIUM LOW
Motivational Level: asks questions eager to learn anxious interested uncooperative disinterested denies need for education
Memory: No problem Limited short term memory Limited long term memory
Learning Barriers: None Language Cultural / Religious Emotional Hearing Vision Dexterity
Describe:

Feeling: pattern involving the subjective awareness of information

Comfort / Pain: (Is patient in pain? Chronic? Acute? What methods relieve pain, provide comfort?):
Emotional Integrity: (lonely, sad, depressed, angry, joy):

**Perceiving:** *pattern involving the reception of information*
Sensory Perception: *(Able to receive information via all senses? Deficits noted?)*

<table>
<thead>
<tr>
<th>Visual:</th>
<th>Contacts:</th>
<th>Eyeglasses:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hearing:</th>
<th>Earaches:</th>
<th>Hearing Aids:</th>
</tr>
</thead>
</table>

**Choosing:** *pattern involving the selection of alternatives*
Coping / Stress Management Measures:

Support systems:

---

**II. MOBILITY**

**Moving:** *pattern involving activity*
See daily assessment for physical assessment component
Functional ability: *(independent, if not specify deficits and needs)*:

Assistive devices required:

Orthopedic equipment:

Physical Therapy:

Age related hazards of mobility:

Fall Risk:

Recreation / Play:

Self care:

**III. OXYGENATION**
See daily assessment for physical assessment component
Home nebulizer / O₂ / CR monitor:
IV. CELLULAR INTEGRITY
See daily assessment for physical assessment component
Skin integrity risk factors: none obesity incontinent urine/feces emaciated immobility prematurity altered LOC altered sensation breakdown present Home treatment plan:

V. REGULATION
Exchanging: pattern involving mutual giving and receiving
See daily assessment for physical assessment component
Recent weight loss or gain:

Therapeutic diet: _____________________________ Dietary restrictions:

Suck quality: __________ Loose teeth: __________ Dentures: ____________ Problems:

Sleep patterns:

Sexually active: __________ Sexual preference: ______ Birth Control: __________ Problems:

LMP: _______ Menarche (age): _______ Menopause (age): _______ BSE: __________
Difficulties: ______
Reproductive History: # of pregnancies: ______ # of births: ______ # of living children: ______ Problems:

Testes: _______ TSE: ______ Circumcised: ________________ Problems:

Additional Comments:

Discharge Plan:
PRE OR POST CONFERENCE GUIDELINES

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

Student Objectives: The student will:

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

Student Guide for Discussion

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

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

1. Learn the physical layout of the clinical area.

2. Review and be familiar with the OSHA guidelines regarding universal precautions as related to the clinical setting; know where to find protective equipment, sharps disposal boxes and infection control manuals located on the unit.

3. Discuss the ethical, legal issues involved in the nursing care of the members of the Nursing Care Units.

4. Identify the chain of command as it relates to the clinical area.

5. Be familiar with usual routines for the unit:
   a. vital signs
   b. meal time
   c. visiting policies

6. Be introduced to the charting system for the clinical facility.

1. Be introduced to policies related to IV’s and medication administration.

2. Discuss nursing responsibilities related to medication administration.

3. Review school policies as they relate to clinical attendance, e.g. absenteeism, tardiness, etc.

4. 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.

5. Review the clinical evaluation tool.

6. Discuss the role of the associate degree nurse as provider of care, manager of care and member of the profession.

7. Discuss the issues of confidentiality related to the clinical setting.

8. Review the requirements for documentation and papers related to this course.

15. Review lab, library and computer assisted tutoring available to assist student learning.
**ORIENTATION SCAVENGER HUNT**

**Locate the Following**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy and procedure books</td>
<td>Wheelchairs</td>
</tr>
<tr>
<td>OSHA information</td>
<td>Backboards</td>
</tr>
<tr>
<td>Infection Control procedures</td>
<td>IV poles</td>
</tr>
<tr>
<td>Charting guidelines</td>
<td>Accucheck</td>
</tr>
<tr>
<td>Textbooks &amp; other resources</td>
<td>Bedside commode</td>
</tr>
<tr>
<td>Nursing staff assignments</td>
<td>Cardio-respiratory monitors</td>
</tr>
<tr>
<td></td>
<td>Oxygen saturation monitors</td>
</tr>
</tbody>
</table>

**Medication Room**

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

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

**Patient Medical Records**

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

**Nutrition Room**

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

**Treatment Room**

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

**Locate the following:**

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

**Clean Holding**

- Linen cart
- Bedpans/urinals, bath & emesis basins

**Familiarize yourself with bed controls, client call button, sharps containers, lighting & emergency call lights in rooms.**
ACUTE CARE SETTINGS CLINICAL OBJECTIVES

**Acute Care Setting Clinical Objectives:** While on the Medical-Surgical units the student will satisfactorily complete: Electronic Health Care Record (EHR) documentation as assigned

- Application of skills learned in 1022L and 1023L
- Utilization of the nursing process including critical thinking skills with all assignments
- Satisfactory completion of one IPR, submitted to clinical instructor
- Satisfactory client care manager experience
- Preparation assignments for and Reflection Paper after attendance at Simulation Experience
- Satisfactory completion of one Service Learning Experience
- Demonstrate safe preparation and administration of medication

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

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

Satisfactory

4. Pass - Self-Directed Independent Level

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

3. Pass - Moving toward Independent Level

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

2. Unsatisfactory - Needs Improvement

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

1. Failure - Dependent Level

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

* Distinctive Criteria for Competency Level
EVALUATION OF CLINICAL PERFORMANCE

These objectives represent the expected minimal outcomes for the student upon completion of the clinical components of the nursing program and reflects the program concepts and threads.

**Outcomes are based on the student’s ability to apply the nursing process to clinical practice and reflect continuing growth and improvement both within and among courses.

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

EVALUATION CRITERIA

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

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

OUTCOMES

A student must receive a “Pass” (3 or 4) criteria rating on all objectives identified for the current clinical course in order to pass by the end of the term. An “Unsatisfactory/failure” (1 or 2) criteria rating on any clinical course objective means an unsatisfactory grade regardless of the ratings on other items. All objectives identified as 1 or 2 at the mid-term, must improve to a criteria rating of 3 or 4 to successfully pass the clinical course.
You are required to submit papers this term as part of your clinical requirements. These papers must follow the nursing department criteria for written papers (see Student Nurse Handbook) and the guideline and Criteria and Evaluation Tool for each assignment.

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

1. **One Interpersonal Process Recording (IPR) paper**, to be submitted to your clinical instructor.

2. **Weekly Electronic Health Care Record (EHR) documentation**, currently SimChart.
   - **TWO Admission Histories per semester**:
     - Systems Assessment must be included with this.
     - (Addressing all client care, see SimChart student instructions)
     - Discharge Planning must be included with this.
     - Discharge Summary must be included with this.
   - **WEEKLY Systems Assessment** (see later instructions)
     - Unless assigned IPR, Client Care Manager or Simulation Paper.
     - See instructions for completing SimChart.

3. **One Service Learning Paper**.

4. **One Client Care Manager Paper**.

5. **One Simulation Experience/Reflection Paper**.

The student is expected to:

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

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

Redo’s only require the portion of Simchart addressed for correction, these must be submitted to the CLINICAL INSTRUCTOR’S REDO FILE/FOLDER and are due the 1st day of the following clinical week.

Papers are due prior to attending the Monday clinical of the following week, no matter where you are scheduled to be. Late papers will not be accepted without prior arrangements made with clinical faculty.

Electronic Health Care Record (EHR) documentation will be due to your clinical instructor prior to the first clinical day of the following week. ONLY those assignments, which are complete and submitted on time, will have the opportunity to be re-done ONCE according to the Performance Improvement Plan. Returned/Redo papers must be resubmitted by the next clinical day.

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

*Plagiarism is defined as “the unauthorized use of language and thoughts of another author and the representation of them as one’s own.” (New Webster’s, 1997) In addition, plagiarism means using another’s work without giving credit. You must put others’ words in quotation marks and cite your source(s) and must give citations when using others’ ideas, even if those ideas are paraphrased in your own words. (UCDavis.edu, 3/25/2000) (See Palm Beach State College Student Handbook
NUR1213L: Supporting Documentation

2nd SEMESTER STUDENTS

SIMULATION INSTRUCTIONS

This is a comprehensive simulation.

Please see attached documents.

A. Please print off and bring to simulation all documents regarding the simulation scenario (Simulation Case Study Files).
B. In addition, you must bring to simulation the following:
   a. Lab book
   b. drug book
   c. Med-Surg textbook
C. Please be prepared by reading case study and become familiar with diagnoses, medications labs, etc.
D. Please come with scenario patient’s medications and lab test forms completed

Please remember to come to simulation in complete uniform and prepared for a ‘clinical’ day with stethoscope, pen, watch, penlight etc. Be on time! Plan for traffic, parking, delays etc. Meet the instructor at 8am in the 2nd floor lobby of the ETA building (northwest corner of college campus by Lake Worth road and Congress avenue).
C.A.R.P. Clinical Experience

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

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

On your scheduled day, please arrive at the facility at 8:30 am where you will meet your clinical instructor in the parking area outside of the main 5410 building.

Please call 844-6400 if you cannot be at the facility by 8:30 am for any reason, and leave a message with call back number for the instructor.

Directions:

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

Alternately, if traveling east, turn left off 45th Street onto Australian, turn right on 48th Street, turn left on East Avenue and follow to CARP on the right.

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

Head down East Avenue, and pass Hanley Hazelton Center, and the Hospice of Palm Beach County, and you will see CARP on the right hand side. Enter the second CARP entrance, (pass the first Emergency Entrance).
You must arrive in clinical uniform and bring your stethoscope, syllabus and a pen and be prepared to be providing patient care as part of this experience. Bring a bag lunch as cafeteria services are not available at this facility. You must bring signed confidentiality waiver with you to be able to attend this experience.

Clinical Objectives:

- Students will increase understanding about the care of clients experiencing chemical dependency, as well as nursing assessment and management of withdrawal symptoms.
- Students will increase knowledge regarding resources for treatment of chemical dependency, and understand the 12 step process.
- Reinforce and promote the application of therapeutic communication in the clinical setting.
- Reinforce appropriate therapeutic communication techniques, instilling that appropriate communication can be life altering to clients.
- Treatment of all clients in a non-judgmental manner, by employing dignity and respect during all encounters.

Methodology:

- Professor, as well as student, constructive critiques of therapeutic communication used in the clinical setting.
- Role playing to employ the use of these techniques in the clinical setting.
- Incorporation of improved therapeutic communication during role playing to reinforce positive outcomes. Reflection of interactions as they apply to student learning, growth and professionalism.

Preparation for CARP

- Prior to attending:
  - **Please print and bring confidentiality and liability waivers to C.A.R.P.**
  - Review therapeutic communication techniques.
  - Review examples of therapeutic communication under the IPR paperwork.
  - Review the barriers to therapeutic communication.
  - Be prepared to engage in therapeutic communication with clients.
Comprehensive Alcoholism Rehabilitation Programs, Inc.

PALM BEACH STATE COLLEGE NURSING PRACTICUM

8:30 a.m. – 9:35 a.m. Meeting in Outpatient Education Room, 5410 East Avenue Building.
CARP, Inc. Overview and Orientation
Confidentiality/Liability Waivers
Review Client Rights and Responsibilities
Marchman Act Information
Q & A

9:35 – 9:45 Break

9:50 a. m. – 12:30 p.m. Nursing Students and Instructor work with clients and staff on the Detox Unit

12:40 p.m. – 2:00 p.m. Debriefing and review of practicum experience with Instructor in Outpatient Education Room
Certificate of Completion Awards
Nursing Student/Practicum Participant Waiver of Liability

Welcome to the Comprehensive Alcoholism Rehabilitation Programs (CARP), Inc. We are pleased to have you as our guests to learn about Crisis Stabilization and Medical Detoxification from our Medical Admissions Program (MAP).

Our insurance policy requires that we have an accurate record of all guests, volunteers, and program participants. This is a form where you agree to release Comprehensive Alcoholism Rehabilitation Programs (CARP), Inc. of all liability while working with Comprehensive Alcoholism Rehabilitation Programs (CARP), Inc. This form is in effect for your period of participation in the Palm Beach State College Practicum Program.

This Release and Waiver of Liability (the “Release”) executed on this ______ day of ______ 20_____, by ____ (the “Nursing Student/Practicum Participant”) in favor of Comprehensive Alcoholism Rehabilitation Programs (CARP), Inc., a non-profit corporation, their directors, officers, employees, and agents (collectively, “CARP”). The Nursing Student/Practicum Participant desires to fulfill the requirements of the Palm Beach State College Nursing Practicum Program and engage in the activities related to the program. The Nursing Student/Practicum Participant understands that the Activities may include involvement with inebriated and possibly hostile individuals, with co-occurring disorders which may include, but are not limited to medical, mental health, criminality, and substance abuse disorders.

The Nursing Student/Practicum Participant hereby freely, voluntarily, and without duress executes this Release under the following terms:

Release and Waiver: Nursing Student/Practicum Participant does hereby release and forever discharge and hold harmless CARP and it successors and assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from Nursing Student/Practicum Participant Activities with CARP.

Nursing Student/Practicum Participant understands that this Release discharges CARP from any liability or claim that the Nursing Student/Practicum Participant may have against CARP with respect to any bodily injury, personal injury, illness, death, or property damage that may result from the Nursing Student/Practicum Participant’s Activities with CARP, whether causes by the negligence of CARP or its officers, directors, employees, or agents or otherwise.

Nursing Student/Practicum Participant also understands that CARP does not assume any responsibility for or obligation to provide financial assistance or other assistance, including but not limited to medical, health, or disability insurance in the event of injury or illness.

Medical Treatment: Nursing Student/Practicum Participant does hereby release and forever discharge CARP from any claim whatsoever which arises or may hereafter arise on account of any first aid, treatment, or service rendered in connection with the Nursing Student/Practicum Participant’s Activities with CARP.

Assumption of the Risk: The Nursing Student/Practicum Participant understands that the Activities includes work that may be hazardous to the Nursing Student/Practicum Participant, including, but not limited to, personal injury, exposure to disease, and other crisis situations.
Nursing Student/Practicum Participant hereby expressly and specifically assumes the risk of injury or harm in the Activities and releases CARP from all liability for injury, illness, death, or property damage resulting from the Activities.

**Insurance:** The Nursing Student/Practicum Participant understands that, except as otherwise agreed to by CARP in writing, CARP does not carry or maintain health, medical, or disability insurance for any Nursing Student/Practicum Participant. Accident Insurance is provided and is a medical insurance policy which covers accidents involving guests in the workplace or in other supervised activities. Accident Insurance pays after the Nursing Student/Practicum Participant’s insurance pays. If the Nursing Student/Practicum Participant has no insurance, the policy pays up to the limits of coverage.

Each Nursing Student/Practicum Participant is expected and encouraged to obtain his or her own medical or health insurance coverage.

**Photographic Release:** Nursing Student/Practicum Participant does hereby grant and convey unto CARP all rights, title, and interest in any and all photographic images and video or audio recordings made by CARP during the Nursing Student/Practicum Participant’s Activities with CARP, including, but not limited to, any royalties, proceeds, or other benefits derived from such photographs or recordings.

**Other:** Nursing Student/Practicum Participant expressly agrees that this Release is intended to be as broad and inclusive as permitted by the laws of the State of Florida and that this Release shall be governed by and interpreted in accordance with the laws of the State of Florida. Nursing Student/Practicum Participant agrees that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release which shall continue to be enforceable.

**IN WITNESS WHEREOF,** Nursing Student/Practicum Participant has executed this Release as of the date above for the duration of the Palm Beach State College Nursing Practicum Program.

Nursing Student/Practicum Participant **Name (Print Please):**

Nursing Student/Practicum Participant **Signature:**

Today’s Date: 

Nursing Student/Practicum Participant **Address:**

Phone number where you are most easy to reach:

Email:

Group/Organization: (if applicable)

In case of emergency, please contact:

Name

Relation

Address

Phone
Dear Visitor;

Welcome to Comprehensive Alcoholism Rehabilitation Programs (CARP)!

To protect our client’s anonymity and confidentiality, we at CARP strictly Adhere to the Federal and State laws which regulate Alcohol and Drug Treatment programs as stated in:

- Florida Statutes, 369. 112, 397. 053, 397. 095 and 397. 096
- Code of Federal Regulations, Title 42, Part 2
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

As a result of these laws and regulations, you are required to keep anything you may hear or anyone you may see during your visit strictly confidential!

By signing below, you acknowledge that you understand and agree to comply with the State and Federal confidentiality laws.

PRINT Name ____________________________ Signature ____________________________

Date _______________
CLIENT CARE MANAGER ACTIVITIES AND SKILLS BEFORE THE EXPERIENCE:

The student will:

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

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

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

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

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

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

CLIENT CARE MANAGER EXPERIENCE PURPOSE:

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

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

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

The secret is:

1. Assess the patients
2. Assign and delegate
3. Evaluate and Revise

OBJECTIVES OF CLIENT CARE MANAGER ASSIGNMENT:

The student will:

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

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

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

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

5. Identify nutritional needs of the selected patients.

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

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

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

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

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

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

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

13. Describe personal/professional growth achieved through the role of patient care manager.

RESPONSIBILITIES OF CLIENT CARE MANAGER ASSIGNMENT:

1. Knowledge re: team members’ assignments – patient(s) name, room number, diagnoses, special treatments/dressing changes, special equipment with patients, general acuity level, meds with
NUR1213L: Supporting Documentation

lab monitoring (anticoagulants, hypoglycemics, etc.), IVs and times of IV meds, note patients with DNR status.

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

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

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

5. Advise instructor when all members assignments’ complete and team members leaving unit for post conference.

CLIENT CARE MANAGER EXPERIENCE EVALUATION:

Guidelines for Client Care Manager Required Written Assignment:

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

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

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

3. Describe your client care management activity plan and its usefulness to you during this clinical experience.
4. Evaluate the interactions and activities done with your peers.

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

6. What would you do differently next time?

**Graded:** Satisfactory or unsatisfactory by the Clinical Instructor.

**CLIENT CARE MANAGER WORKSHEET:**

<table>
<thead>
<tr>
<th>STUDENT</th>
<th>ROOM &amp; PT</th>
<th>DIAGNOSIS</th>
<th>VS</th>
<th>TREATMENT</th>
<th>LABS</th>
<th>IVs &amp; MEDS</th>
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NUR1213L: Supporting Documentation

IPR

This IPR is to focus on an actual interaction between student nurse and client (or client’s significant other).

2. An IPR is an opportunity for the nurse to evaluate the effectiveness of therapeutic communication skills. This is not a client teaching or data gathering exercise.

3. The introduction and summary are to be written in a narrative format on form provided. Refer to Criteria and Evaluation Tool for IPR for content.

4. The body of the IPR is to be written in the 5-column format found in syllabus. Make copies as needed. Refer to Criteria and Evaluation Tool for IPR for directions.

5. Refer to Criteria for Paper Submitted to Nursing Faculty found in Nursing Student Handbook.

6. Grading tool must be submitted with paper.

FORMAT DESCRIPTION:

CLIENT VERBATIM – NURSE VERBATIM

These sections should include the verbatim statements of the nurse and the client during the interaction. Time lapses and silences should be noted, as well as the length of the silence. This section is to be written in an objective fashion, without any interpretations on the part of the student.

NON-VERBAL BEHAVIOR OF NURSE AND CLIENT

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

INTERPRETATION OF INTERACTION

You should give your ideas as to what was going on – in a dynamic sense – during the interaction. How did you perceive the client to feel? How did you feel? You should also note any associative looseness and/or flight of ideas, as well as disorders or thinking that were present and defense mechanisms that were employed by the nurse or client. Any shifts in the conversation made by either the client or the nurse should be noted. Your interpretations should be supported with theoretical knowledge.
Identify your communications utilizing the underlined terminology in the following forms:

1. Do’s and Don’ts of Therapeutic Communication.
2. Unhelpful Do’s and Don’ts of Therapeutic Communication.
3. Interpersonal Techniques

ALTERNATIVE RESPONSES

This section provides the student with an opportunity to look back on the interaction and to formulate responses that might have been more effective than the one used. Although the interaction itself may have been ineffective in achieving the stated goal, it can still be a learning experience, and be guide for future interactions.

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

Name:                                      Date:

INTRODUCTION INCLUDES:

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

SUMMARY STATEMENTS INCLUDES:

A. Whether objectives were met, if not, why not.
B. Evaluate nurse’s therapeutic communication techniques.
C. Identify what you learned regarding the clients personal, interpersonal and social system.
D. Identify therapeutic communication techniques that you perceive will be helpful for you to use in future interactions.

E. Assess and identify your personal or interpersonal strengths and weaknesses.

F. State interactions you plan to utilize to address these needs.
NUR1213L: Supporting Documentation

BODY OF INTERPERSONAL PROCESS RECORDING (IPR)

<table>
<thead>
<tr>
<th>Client Verbatim</th>
<th>Nurse Verbatim</th>
<th>Non-verbal Behaviors of Nurse and Client</th>
<th>Interpretation of interaction with use of appropriate terminology</th>
<th>Alternate responses with rationale (what you could have said and why)</th>
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LEARNING GUIDE

SENSORY/PERCEPTION/COGNITION

DO’S AND DON'TS OF THERAPEUTIC COMMUNICATIONS

DO’S

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

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Revised November, 2014
11. Deal with Here and Now issues.

DON’Ts:

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

LEARNING GUIDE:

SENSORY/PERCEPTION/COGNITION

COMMUNICATIONS SKILLS - UNHELPFUL RESPONSES TO BE AVOIDED

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

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

Clichés, generalities or philosophical statement: These have the effect of wiping out the client’s feelings, trivializing them, and also send the message that you don’t want to be bothered.
Judgmental remarks: These seem to indicate your approval or disapproval. They indicate to the client who you are viewing the person’s feelings from your perspective, not the person’s.

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

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

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

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

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

Inaccurate empathy: this occurs when you misperceive the client’s feelings by a mile and are way off the beam in your understanding of his reasons for those feelings, or indicate that you are willing to listen or incapable of understanding.

<table>
<thead>
<tr>
<th>THERAPEUTIC TECHNIQUES</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Using Silence</td>
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<tr>
<td>2. Accepting</td>
<td>Yes</td>
</tr>
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<td></td>
<td>Uh hum</td>
</tr>
<tr>
<td></td>
<td>I follow what you said</td>
</tr>
<tr>
<td></td>
<td>Nodding</td>
</tr>
<tr>
<td>3. Giving Recognition</td>
<td>Good morning, Mrs. S.</td>
</tr>
<tr>
<td></td>
<td>You’ve tooled a leather wallet.</td>
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<tr>
<td></td>
<td>I noticed that you’ve combed your hair.</td>
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<tr>
<td>4. Offering Self</td>
<td>I’ll sit with you awhile.</td>
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<td></td>
<td>I’ll stay here with you.</td>
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<td></td>
<td>I’m interested in your comfort.</td>
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<tr>
<td>5. Giving Broad Openings</td>
<td>Is there something you’d like to talk about? What are you thinking about? Where would you like to begin?</td>
</tr>
<tr>
<td>6. Offering General Leads</td>
<td>Is there something you’d like to talk about? What are you thinking about? Where would you like to begin?</td>
</tr>
<tr>
<td>7. Placing the Event in Time or in Sequence</td>
<td>What seemed to lead up to . . .? Was this before or after . . .? When did this happen?</td>
</tr>
<tr>
<td>8. Making Observations</td>
<td>You appear tense. Are you uncomfortable when you . . .? I notice that you’re biting your lips. It makes me uncomfortable when you . . .</td>
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<tr>
<td>9. Encouraging Description of perceptions</td>
<td>Tell me when you feel anxious. What is happening? What does the voice seem to be saying?</td>
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<tr>
<td>10. Encouraging Comparison</td>
<td>Was this something like . . .? Have you had similar experiences?</td>
</tr>
<tr>
<td>11. Reflecting</td>
<td><strong>Client:</strong> Do you think I should tell the doctor? <strong>Nurse:</strong> Do you think you should? <strong>Client:</strong> My brother spends all my money and then has the nerve to ask for more. <strong>Nurse:</strong> This causes you to feel angry.</td>
</tr>
<tr>
<td>13. Exploring</td>
<td>Tell me more about that? Would you describe it more fully? What kind of work?</td>
</tr>
<tr>
<td>14. Giving Information</td>
<td>My name is . . . Visiting hours are . . . My purpose in being here is . . . I’m taking you to the . . .</td>
</tr>
<tr>
<td>15. Seeking Clarification</td>
<td>I’m not sure that I follow. What would you say is the main point of what you said?</td>
</tr>
<tr>
<td>16. Presenting Reality</td>
<td>I see no one else in the room. That sound was a car backfiring. Your mother is not here. I’m a nurse.</td>
</tr>
<tr>
<td>17. Voicing Doubts</td>
<td>Isn’t that unusual? Really? That’s hard to believe.</td>
</tr>
<tr>
<td>18. Seeking Consensual Validation</td>
<td>Tell me whether my understanding of it agrees with yours. Are you using this word to convey the idea?</td>
</tr>
<tr>
<td>19. Verbalizing the Implied</td>
<td><strong>Client:</strong> I can’t talk to you or to anyone. It’s a waste of time. <strong>Nurse:</strong> It’s as if you’re feeling that no one understands. <strong>Client:</strong> My wife pushes me around just like my mother and sister did. <strong>Nurse:</strong> Is it your impression that women are</td>
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<td></td>
<td>domineering?</td>
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<tr>
<td>20. Encouraging Evaluation</td>
<td>What are your feelings in regard to . . .? Does this contribute to your discomfort?</td>
</tr>
</tbody>
</table>
| 21. Attempting to Translate into Feelings | Client: I’m dead  
Nurse: Are you suggesting that you feel lifeless? or: Is it that life seems without meaning?  
Client: I’m way out in the ocean.  
Nurse: It must be lonely. or: You seem to feel deserted. |
| 22. Suggesting Collaboration | Perhaps you and I can discuss and discover what produces your anxiety. |
| 23. Summarizing | Have I got this straight?  
You’ve said that . . .  
During the past hour you and I have discussed . . . |
| 24. Encouraging Formulation of a Plan of Action | What could you do to let your anger out harmlessly?  
Next time this comes up, what might you do to handle it? |

IPR Example

IPR

Student Name:

Palm Beach State College - NUR 1213L

Date:____
INTRODUCTION

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

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

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

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

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

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

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

References


CRITERIA AND EVALUATION TOOL FOR IPR

Name: _______________________

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

**Pass:**

**Fail:**

**Re-submit by:**

**Faculty Signature:**
### NURSING PROCESS - The Student Will:

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

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

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

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

#### E. Implement nursing measures to meet prioritized client need.
1. Some planning but does not take into consideration patient data; and/or is not able to establish priorities.
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<td>2. Wastes energy due to poor planning in order to implement nursing measures to meet prioritized client need.</td>
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<td>3. Assignment planned, priorities established, and usually carried through as intended except for unexpected circumstances.</td>
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<td>4. Assignment planned and organized so as to afford patient and family maximum comfort.</td>
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<td>F. Evaluate the effectiveness of nursing interventions and adapts plan of care accordingly.</td>
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<td>1. Requires constant support to evaluate effectiveness of interventions.</td>
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<td>2. Requires frequent support to evaluate effectiveness of interventions.</td>
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<td>3. Requires minimal assistance to evaluate effectiveness of interventions.</td>
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<td>G. Report and record nursing process.</td>
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<td>1. Has difficulty in observing and recording data, despite guidance and supervision from instructor: database is incomplete.</td>
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<td>2. Needs frequent direction from instructor during reporting and recording of nursing process.</td>
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<td>3. Able to observe and record data, with minimal assistance from instructor: database is complete, descriptive and accurate.</td>
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<td>4. Independently observes and records data; database is complete, descriptive and accurate.</td>
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<td>H. Performs technical aspects of care.</td>
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<td>1. Makes errors, recognizes and corrects a few of them, requires much supervision and/or prompting from instructor.</td>
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<td>2. Demonstrates partial lack of dexterity while performing technical aspects of care.</td>
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<td>3. Makes minimal errors or omissions, recognizes and corrects most of them; requires little supervision and/or prompting from instructor.</td>
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<td>4. Consistently performs skills accurately and efficiently without requiring prompting from instructor.</td>
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<td>I. Explain rationale for performing basic nursing skills and technical procedures.</td>
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<td>1. Seldom applies previously learned principles; requires much guidance.</td>
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<td>2. Occasionally applies previously learned principles; requires frequent guidance.</td>
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<td>3. Usually applies previously learned principles; requires minimal guidance.</td>
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<td>4. Consistently and independently applies previously learned principles.</td>
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<td>J. Calculate, prepare and administer medications accurately.</td>
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<td>1. Makes errors in securing correct medications, calculating dosages; preparing and administering medications;</td>
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NUR 1213L – Supporting Documents
Revised November, 2014
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K. Discuss relevant data regarding medications.
   1. Unable to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs.
   2. Needs frequent direction from instructor in order to state physiologic action of drugs, etc.
   3. Usually able to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs.
   4. Is accurate and efficient in stating physiologic action of drugs, recognizing behavior & behavioral changes to drugs, and adapting nursing care according to the effect.

| MT    |       |       |       |       |
| Critical to all courses |       |       |       |       |

TEACHING-CLIENT/FAMILY - The Student will:

L. Perform appropriate teaching with clients and/or families applying principles of learning and teaching.
   1. Rarely able to apply principles of teaching and learning, requires much guidance.
   2. Sometimes able to apply principles of teaching and learning, requires frequent guidance.
   3. Usually able to apply principles of teaching and learning, requires minimal guidance.
   4. Consistently and independently able to apply principles of teaching and learning.

| MT    |       |       |       |       |
| Critical to all courses |       |       |       |       |

COMMUNICATION - The student will

M. Collaborate effectively with other members of the health team to promote continuity of care.
   1. Communication is rarely effective and requires much guidance.
   2. Communication is occasionally effective and requires frequent prompting.
   3. Communication is usually effective and requires minimal guidance.
   4. Communication is consistently effective and is done independently.

| MT    |       |       |       |       |
| Critical to all courses |       |       |       |       |

N. Present appropriate and therapeutic responses to patient situations, including appropriate facial expressions, body language and responses.
   1. With guidance, unable to adapt to patient’s circumstances; little insight into personal behaviors and responses; no change in behaviors.
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<td>2. With frequent guidance, is able to adapt to patient’s circumstances; occasional insight into personal behaviors and responses; occasional change in behaviors. 3. With minimal guidance, able to adapt to patient’s circumstances; insight into personal behaviors and responses; shows change in behavior. 4. Adapts readily to patient circumstances. Good insight into personal behaviors.</td>
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<td>O. Establish purposeful interpersonal relationships and demonstrate effective communications with the client and/or family members. 1. Communication is rarely effective and requires guidance. 2. Communication is occasionally effective but requires guidance. 3. Communication is usually effective and requires minimal guidance. 4. Communication is effective and independent.</td>
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<td>P. Perform nursing measures with respect to client’s dignity, safety and confidentiality. 1. Client’s dignity, safety and confidentiality over-looked; error(s) made were actually or potentially dangerous to the welfare to the patient. 2. Client’s dignity, safety and confidentiality occasionally over-looked; error(s) made were not actually or potentially dangerous to the welfare of the patient. 3. Client’s dignity, safety and confidentiality usually considered and demonstrated; error(s) made were not dangerous to the welfare of the patient. 4. Client’s dignity, safety and confidentiality consistently considered and demonstrated.</td>
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<td>Q. Display judgment and objectivity in situations. Makes decisions that reflect both knowledge of fact and sound judgment. 1. Has difficulty functioning after initial direction; needs repeated explanations. 2. Requires frequent directions; occasionally demonstrates acceptable use of judgment and objectivity in some situations. 3. Able to follow initial directions; demonstrates acceptable use of judgment and objectivity in most situations. 4. Rarely needs direction; is consistently able to make judgments independently and with objectivity.</td>
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### EVALUATION OF CLINICAL PERFORMANCE

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**R.** Oral and/or written assignments meet established criteria as stated in course syllabus.
1. Preparations/assignments that contain spelling and grammar errors, lack depth, are incomplete and unsatisfactory.
2. Preparations/assignments are occasionally done that meet established criteria.
3. Preparations/assignments are usually complete and satisfactory.
4. Preparations/assignments display consistent in-depth content and usually go beyond the requirements for the assignment.

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

**S.** Accept and profit from constructive criticism.
1. Rarely accepts and profits from constructive criticism.
2. Occasionally accepts and profits from constructive criticism.
3. Usually accepts and sometimes profits from constructive criticism.
4. Accepts and profits from constructive criticism.

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

**T.** Actively participate in clinical conferences.
1. Seldom participates in post conferences or displays inappropriate behavior.
2. Occasionally participates with frequent cues from instructor.
3. Usually participates in post conferences.
4. Consistently contributes to post conferences.

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

**U.** Correlate classroom theory to clinical practice.
1. Shows little or no knowledge beyond immediately defined nursing care.
2. Occasionally correlate theory to clinical practice.
3. Usually correlates theory to clinical practice to implement care.
4. Consistently correlates theory to clinical practice to implement care.

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

**V.** Demonstrate self-direction and assume responsibility for his/her own growth and learning.
1. Lacks initiative; is non-assertive and does not follow through with responsibility.
2. Needs direction in order to move toward assuming responsibility for his/her own growth and learning.
3. Usually demonstrates initiative and assertiveness, and usually follows through with responsibility.
4. Consistently demonstrates initiative, assertiveness, self-direction and creativity; goes beyond required tasks.

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

**W.** Organize assignments so that completed in a specified amount of time.
1. Does not complete assignment on time.
2. Occasionally completes assignments on time.
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|      | 3. Usually completes assignment on time.  
|      | 4. Consistently completes assignment on time.  |
| MT   |        |       |       |       |
|      | Critical to all courses | X. Adhere to the nursing department’s and course standards regarding professional behavior.  
|      |    | | | |
|      | 1. Does not adhere to these standards.  
|      | 2. Occasionally adheres to these standards.  
|      | 3. Usually adheres to these standards.  
|      | 4. Consistently adheres to standards.  |
| F    |        |       |       |       |
|      | Critical to all courses | Y. Utilize an appropriate assertive approach to clients, family, health care team, visitors and faculty.  
|      |    | | | |
|      | 1. Approach is often inappropriate.  
|      | 2. Approach is occasionally appropriate.  
|      | 3. Approach is usually appropriate.  
|      | 4. Uses appropriate assertive approach.  |