

Appendices

HOW TO GET THE CHART TO HELP YOU DO YOUR PREP SHEET AND CARE PLAN

A. REVIEW EACH OF THE FOLLOWING RECORDS. ANALYZING THE INFORMATION ON EACH.

1. Vital sign sheet
2. Intake and output sheet
3. Physician's orders
4. Physician's progress notes, history and physical
5. Nurse's notes
6. Nurses' orders (Kardex)
7. Medication records
8. Nursing admission assessment
9. Admission record

B. ASK YOURSELF THE FOLLOWING QUESTIONS

1. Why was my client admitted to the hospital? (clinical area)
2. What medical interventions has my client undergone?
3. What is the expected plan of care for this client?

C. REVIEW THE LAST FIVE DAYS OF THE PATIENTS CHART

1. What are the actual and potential nursing diagnoses for this client? Place them in the priority of care.
2. Examine the lab and diagnostic tests that have abnormal results. What implications are these to your nursing care and the your client?
3. What medications is your client taking? Why is your client on these medications? Are they different than the ones your client takes at home? What are the nursing implications of these drugs?

D. WHY DO I NEED TO DO THIS?

1. It will assist you in giving safe client care.
2. It will speed up your time reading the chart, yet allow you to obtain the necessary baseline data.
3. It will allow you an appropriate, efficient and timely use of the client's chart.
4. It will assist you in developing skills in using the client's chart as a forerunner of giving care.

Adapted from:

Guttmen, Rivka. (1996). Orientation to the clients chart: A clinical learning tool. *Nurse Educator*, 21(5), 5-6.

**ILLUSTRATIVE BEHAVIOR TERMS FOR STATING LEARNING
OUTCOMES**

COGNITIVE DOMAIN

KNOWLEDGE	Defines, describes, identifies, labels, lists, matches, names, outline, reproduces, selects, states
COMPREHENSION	Converts, defends, distinguishes, estimated, explains, extends, generalizes, gives examples, infers, paraphrases, predicts, rewrites, summarizes
APPLICATION	Changes, computes, demonstrates, discovers, manipulates, modifies, operates, predicts, prepares, produces, relates, show, solves, uses
ANALYSIS	Breaks down, diagrams, differentiates, discriminates, distinguishes, identifies, illustrates, infers, outlines, points out, relates, selects, separates, subdivides
SYNTHESIS	Categorizes, combines, compiles, composes, creates, devises, designs, explains, generates, modifies, organizes, plans, rearranges, reconstructs, relates, reorganizes, revises, rewrites, summarizes, tells, writes
EVALUATION	Appraises, compares, concludes, contrasts, criticizes, describes, discriminates, explains, justifies, interprets, relates, summarizes, supports

AFFECTIVE DOMAIN

RECEIVING	Asks, chooses, describes, follows, gives, holds, identifies, locates, names, points to, selects, sits erect, replies, uses
RESPONDING	Answers, assists, complies, conforms, discusses, greets, helps, labels, performs, practices, presents, reads, recites, reports, selects, tells, writes
VALUING	Completes, describes, differentiates, explains, follows, forms, initiates, invites, joins, justifies, proposes, reads, reports, selects, shares, studies, works
ORGANIZATION	Adheres, alters, arranges, combines, compares, completes, defends, explains, generalizes, identifies, integrates, modifies, orders, organizes, prepares, relates, synthesizes

**CHARACTERIZATION BY A
VALUE OR VALUE COMPLEX**

Acts, discriminates, displays, influences, listens, modifies, performs, practices, proposes, qualifies, questions, revises, serves, solves, uses, verifies

PSYCHOMOTOR DOMAIN

PERCEPTION	Choose, describes, detects, differentiates, distinguishes, identifies, isolates, relates, selects, separates
SET	Begins, displays, explains, moves, proceeds, reacts, responds, shows, starts, volunteers
GUIDED RESPONSE	Assembles, builds, calibrates, constructs, dismantles, displays, dissects, fastens, fixes, grinds, heats, manipulates, measures, mends, mixes, organizes, sketches, works
MECHANISM COMPLEX OVERT RESPONSE	Same as guided response
ADAPTATION	Adapts, alters, changes, rearranges, reorganizes revises, varies
ORINATION	Arranges, combines, composes, constructs creates, designs, originates

Modified from Gronlund, N.S. (1978) Stating behavioral objectives for classroom instruction, (2nd ed.). New York: The Macmillan Co. Used with permission.

Student: _____ Date _____

ARKANSAS TECH UNIVERSITY
DEPARTMENT OF NURSING
NUR 3404 – PRACTICUM I

ASSESSMENT FORM SAMPLE

Personal/Medical Data:

Patient's initials: _____ Birth date: _____ Age: _____ Sex: _____

Height: _____ Weight: _____ Marital Status: _____ Race: _____

Religious Preference: _____ Usual Occupation: _____

Tobacco hx: _____ Alcohol/Drug hx: _____

Chief Complaint/Reason for seeking health care: _____

Why is your client in the hospital?

What led your client to seek a doctor's care?

Present Illness/Health Status: _____

What is your client's medical diagnosis: _____

How would your client define his/her health status: fair, poor, good, excellent: _____

Allergies:

What foods is your client allergic to: _____

What drugs is your client allergic to: _____

What inhalants/pollens is your client allergic to: _____

Skin/Mucus Membranes

Skin Integrity: _____ Intact?: _____ Elastic: _____

Turgor: _____ Recoil: _____ Moist: _____ Dry: _____

Scaly: _____ Color: _____

Temperature Range During Hospitalization: _____

What has been your client's temperature range during hospitalization?

Sensitivity of Extremities: _____ Hyper/Hypo sensitive: _____

Sensitivity Present: _____ Where: _____ Where does it stop: _____

Mucous Membranes Integrity: Intact: _____ Moist: _____ Dry: _____ Color: _____

Skin assessment:

Is there a problem/need here: _____ What is it: _____

Why is it a problem/need: _____

How will you solve/meet it? _____

Prevent it: _____ Treat it: _____ Correct it: _____

What more do you need to know: _____

Vital Signs/Cardiovascular

BP: _____ Pulse: _____ Resp: _____ Temp/Route: _____ SaO2 _____

Heart Sounds: _____ Capillary Refill: _____

Respiratory

Lung Sounds/Respiratory Effort: _____

Clear: _____ Adventous Ones Present: _____ Depth: _____

Use of Accessory Muscles: _____

Respirations During Activity: _____

Cough: Productive _____ Non-Productive _____

Sputum: (Color, amount, character) _____

Respiratory Assessment: _____

Abdomen

Bowel Sounds: _____

Hyper/Hypo Present in All 4 Quadrants: _____

Softness: _____ Distended: _____

Abdominal Assessment: _____

Fluids

Fluid Intake/Output Measure for the last 24hrs: _____

What fluids has your client consumed the last 24 hours: _____

IV, p.o., IVPB: _____ Total Amount: _____

Usual 24hr fluid intake: _____

What does your client usually drink? _____ What amount: _____

Factors affecting intake (vomiting, nausea, difficulty in swallowing, anorexia): _____

Fluid Assessment:

Is there a problem/need here: _____ What is it? _____

Why is it a problem or need: _____

How will you solve/meet it: _____

Prevent it: _____ Treat it: _____ Correct it: _____

What more do you need to know: _____

Elimination

Urine output last 24hr: _____ Voiding or Foley: _____

Last Amount: _____ Color: _____ Characteristics: _____

Last BM: _____ Amount: _____ Color: _____

Usual defecation pattern, characteristics: _____

Factors affecting elimination:

Diuretics: _____ Diarrhea: _____ Fluid Intake: _____ Food Intake: _____

Elimination Assessment: _____

Nutrition

Usual Diet/Foods Eaten (breakfast, lunch, dinner, snacks): _____

Nutritional Assessment:

Based on your collected data and your knowledge of nutrition, is this a problem or a need: _____

How: _____ Why: _____

What are your client's nutritional needs and how will they be met: _____

What more do you need to know? _____

Activity-Exercise

Amount tolerated at present: _____
(What can patient do without fatigue/ SOB?)

Amount/Types of Usual Exercise Prior to Hospitalization (day/week activity): _____

Self-care deficits (What areas of basic self care does he/she need assistance with?): _____

Activity-Exercise Assessment: _____

Sleep-Rest Pattern

Usual Pattern/Amount: _____

Sleep-Rest Assessment: _____

Cognitive-Perceptual

Cognitive-Perceptual Assessment: _____

Vision: _____ Hearing: _____ Smelling: _____

Taste: _____ Touch: _____

Pain

P = Provocation/Palliative: What provokes the pain: _____

What does the client do to improve/alleviate the pain: _____

Q = Quality: Describe the pain (dull/sharp/aching): _____

R = Region: Location: _____ Any radiation: _____

S = Severity: _____ (Number Scale 0-10)

T = Timing: When does it occur: _____ How long does it last: _____

Pain Assessment: _____

Coping-Stress Tolerance Pattern

Alarm Stage Evidence By (signs/symptoms of stress mechanism): _____

Usual Coping Pattern: What techniques does patient usually use: _____

_____ Is it working: _____

Evidence of Maladaptation: Evidence that coping mechanisms not working: _____

Patient verbalizes anxiety is not reduced: _____

Coping-Stress Tolerance Assessment: _____

Self-Perception

Self-Perception Assessment (anxious, fatigue, fear, hopelessness, powerlessness, self-concept disturbance): _____

Any S/S of maladaptation here: _____ Why: _____

Role Relationship

Role Relationship Assessment: _____

Relationship with others: _____ Usual Roles: _____

Able to perform usual roles? _____ Socially Active/Isolated: _____

Values/Beliefs

Spiritual (effect on situation): _____

Spiritual Assessment: _____

Medical History

Medical History: _____

Prior Surgeries: _____

Medical/Surgery Assessment: _____

Lab Test	Result	Normal	Lab Test	Result	Normal
CBC			ABG's		
WBC			pH		
RBC			pO2		
HGB			pCO2		
HCT			HCO3		
MCV			Base Excess		
MCH			Cardiac Enzymes		
MCHC			Troponin		
PLT			CPK		
Auto Diff			Myoglobin		
Lymphocytes			LDH		
Mid Cells			Lipid Panel		
Granulocytes			Cholesterol		
CMP			Triglycerides		
Glucose			HDL		
BUN			LDL		
Creatinine			Manual Diff		
Sodium			Neutrophils		
Potassium			Lymphocytes		
Chloride			Monocytes		
Bicarbonate			Eosinophils		
Calcium			Bands		
ALK Phosph			Misc. Labs		
ALT (SGPT)			BNP		
AST (SGOT)			Phosphorus		
Bilirubin			Digoxin level		
Albumin			B12		
Total Protein			Folate		
BUN:Creat			TSH		
Globulin			Dilantin level		
A/G Ratio			PT		
			INR		
			PTT		

Other labs: _____

Assessment of Abnormal Labs: Are the lab tests normal/abnormal: _____

What is the significance of the normal/abnormal lab test: _____

What will your nursing actions be: _____

Why would the lab test be abnormal: _____

Why were the lab tests done: _____

What factor could have influenced the results: _____

Medications: See Attached

Medication Assessment: _____

Diagnostic Tests: What tests have been done or will be done: _____

Why: _____ What do your actions need to be: _____

Diagnostic Tests Assessment: _____

Nursing Diagnoses Identified:

Primary: _____

Secondary: _____

Medication Format

Medication Generic/Brand	Dose/Route Time	Classification	Indications/Rationale (Why am I giving this med to my patient)	Side Effects	Nursing Considerations

ARKANSAS TECH UNIVERSITY
NUR 3404-Practicum 1

Textbook physiology of normal functioning based on patient's diagnosis.	Textbook variations in normal physiology based on patient's diagnosis.	Growth and development: Identify stage, list relevant behaviors, incorporate into care plan.
<p>Take the patient's diagnosis and explain in this column the normal anatomy and physiology of the malfunctioning body part. For example, CHF. Explain the normal anatomy and physiology of the heart and lungs. Emphasize physiology. What brought them to the hospital. At the nursing home, what sends them back to the hospital?</p>	<p>In this column, explain the pathophysiology of CHF, or the disease/condition. Explain why this is bad. How is ADL affected? How does this affect your patient? What are the signs/symptoms exhibited? What lab values would you expect? What results would you expect from diagnostic tests like EKG, EEG, CT Scan, x-ray...?</p>	<p>In this column, select what stage of growth and development the patient exhibits; explain the stage and the relevant behaviors; and discuss how this information is useful in planning the care of your patient. For example, Maslow or Erickson, or Havinghurst. Use this information in helping you select nursing interventions, rationales.</p> <ol style="list-style-type: none"> 1) What level of development is the client? 2) What are the developmental tasks for the client at this stage (level) of development? 3) What anticipatory guidance is needed?

ARKANSAS TECH UNIVERSITY
NUR 3404 Practicum 1
Care Plan Sample

DATE	NURSING DIAGNOSIS	OUTCOME	IMPLEMENTATION	RATIONALE	EVALUATION
<p>In this column, list the date you plan to use this diagnosis e.g., Tuesday's date or Wednesday's date</p>	<p>In this column, state the nursing diagnosis that you have selected for your patient based upon your assessment of the patient. The data that you need to make a nursing diagnosis comes from your assessment sheet, the chart, the interview of the patient, the patient's family, and other health care professionals. It should be written per NANDA. For example:</p> <p>Self-care deficit: feeding related to cognitive impairment, as evidenced by decreasing weight from previous month, eating half-portions of food offered, inability to get receptacle to mouth.</p>	<p>In this column, state what you want the patient to accomplish, when you want the patient to accomplish it. It needs to be written in clear, concise, concrete, and measurable terms. Begin with a goal, the overall picture for your patient. When he is released from the clinical area, what do you want him to have accomplished? For example:</p> <p>Pt. Will weigh #140 lbs by 12-1-9 by gaining 2 lbs/month.</p> <p><i>Outcomes are the short goals that are accomplished as the patient works toward the overall goal. For example:</i></p> <p>Patient will gain two pounds and feed self finger foods by 10-1-98.</p>	<p>In this column, state what interventions you are going to use to ensure that your patient meets the outcome stated in the previous column. Be specific. For example:</p> <p>Document and report any changes in patient's functional level. Weigh patient every morning at 7 a.m. and record. Report changes of more than 2 lb/week. Encourage patient to verbalize feelings and concerns about feeding deficits. Encourage patient to carry out aspects of feeding according to abilities.</p>	<p>In this column, state the scientific principles that explain why this intervention will allow you to accomplish the patient outcome stated. For example:</p> <p>Careful observation guides adjustment of actions to meet patient's needs.</p> <p>Ensure adequate nutrition and fluid balance.</p> <p>Helps patient come to terms with self-care deficit and achieve highest functional level. Gives patient a sense of achievement and control.</p>	<p>In this column, state whether or not patient outcome was met. For example:</p> <p>Patient gained 1 lb in one week. Able to feed self large finger foods at the end of the week.</p>

ARKANSAS TECH UNIVERSITY
Department of Nursing

Introduction: A brief notation indicating age, illness, setting, what Client was doing when approached.

Nurse: Verbal and Nonverbal	Patient: Verbal and Nonverbal	Principles that explain behavior and intervention: Feelings and observations
-----------------------------	-------------------------------	--

Date:	Interaction Number 12	Goals: To help patient identify situations arousing discomfort and how he handles them.
-------	-----------------------	---

Mr. E .had just returned forma home visit. He came over to me and said he had to check his clothes and would be right back. I said I would wait for him in the usual place. He returned ten minutes later at 8:10 a.m.

I was a little irritated that Mr. E would be late even though I knew it was ward policy that his clothes be checked at once. However, I waited in the usual place. Reinforcing trust by being on time and remaining there for the patient. Maintaining terms of contract.

How was you weekend?

Fine, and your?

Well, I was out on pass. I had a good time. I spent a lot of time straightening things up - putting summer clothes away and sorting out things. I could only work a few hours and then had to take a snooze. We had company too. My sister had just told people that I wasn't feeling well. She didn't tell them what was wrong and they expected to see me with casts or something. She left it to me to tell them what was wrong.

Focus conversation back to patient.

Fatigue may be emotional. Sleep can be a defense against a trying situation.

Patient's anxiety rose here, shown by much moving around in his chair, embarrassed laughter, and lack of eye contact. Sister probably gave responsibility to patient because of her own feelings.

How did you feel about telling them?

Oh, I had no feelings about it at all. They're friends and they understand. They've seen me upset and angry. They understand.

Denial of feelings as a protective mechanism. Hopes friends understand but not sure.

What do you do when you get angry?

Well, I count to ten. Mostly I keep it in. My friends realize that I don't get violent like some people.

Helping patient to be aware of his behavior in relation to stress.

ARKANSAS TECH UNIVERSITY
DEPARTMENT OF NURSING
NUR 3404
Practicum I

NAME:

OBJECTIVES COMPLETED

I-A-1	IA-2-a	IA-2-b	IA-2-c	IA-3	IA-4	IBC-1	IBC-2	IBC-3	IBC-4
ID-1	ID-2	ID-3	ID-4	ID-5	ID-6	ID-7	ID-8	ID-9	ID-10
ID-11	ID-12	ID-13	ID-14	ID-15-a	ID-15-b	ID-15-c	ID-15-d	ID-15-e	IE-1
IE-2	IE-3	IE-4	IE-5	IE-6	IIA-1	IIA-2	IIA-3	IIA-4	IIA-5
IIA-6	IIA-7	IIB-1	IIB-2	IIB-3	IIB-4	IIB-5	IIB-6	IIC-1	IIC-2
IIC-3	IIC-4	IID-1	IID-2	IID-3	IID-4	IIE-1	IIE-2	IIE-3	IIF-1
IIF-2-a	IIF-2-b	IIF-2-c	IIF-2-d	IIF-2-e	IIF-2-f	IIF-3	IIF-4	IIF-5	IIF-6-a
IIF-6-b	IIF-6-c	IIF-6-d	IIF-7	IIF-8	IIF-9	IIG-1	IIG-2	IIG-3	IIG-4
IIG-5	IIG-6	IIG-7	IIG-8	IIH-1	IIH-2	IIH-3	IIH-4	IIH-5	IIH-6
IIH-7	IIH-8	III-1	III-2	III-3	III-4	III-5	III-6	III-7	III-8
III-9	III-10	III-11	IIJ-1	IIJ-2	IIJ-3	IIJ-4	IIJ-5	IIJ-6	IIJ-7
IIK-1	IIK-2	IIK-3	IIK-4	IIK-5	IIK-6	IIK-7	IIIL-1	IIIL-2	IIIL-3
IIIL-4	IIM-1	IIM-2	IIM-3	IIM-4	IIM-5	IIM-6	IIM-7	IIM-8	IIM-9
IIN-1	IIN-2	IIN-3	IIN-4	IIO-1	IIO-2	IIO-3	IIO-4	IIP-1	IIP-2
IIP-3	IIP-4	IIP-5	IIP-6	IIP-7	IIP-8	IIP-9	IIQ-1	IIQ-2	IIQ-3
IIQ-4	IIQ-5	IIQ-6	IIR-1	IIR-2	IIR-3	IR-4	IR-5		

COMMENTS:

CLINICAL LOG

PRACTICUM I

NAME _____

CLINICAL INSTRUCTOR _____

Adapted From:

Cassidy, V. R., & Davidson, J. L. (1992). *A diary for effective clinical experiences in nursing*. Cortland, Illinois: Prairie Publications.

Directions

This clinical log was developed by Virginia Cassidy and Jane Davidson to help you reflect about your clinical experiences as a nursing student. Thoughtful reflection is useful in the process of self-evaluation.

Your first entry in the log, should reflect your overall goals for the semester. The remaining pages of the log have three kinds of entries: a ranking from high to low on four core areas of nursing practice, some open-ended statements to guide your thinking about your experiences, and your own personal impressions. An “other” category has also been included in the ranking component to provide for the self-evaluation of an area specific to the clinical course.

The log is designed so that you can make an entry as you begin the clinical experience, after each of your clinical experiences, at the midterm of the semester, and at the end of the semester. Ideally your daily entry should be written as soon as possible after the clinical experience so that your recollection of the events of the day are fresh in your mind. Your daily entries should be reviewed at the midterm to help you reflect on your clinical experience to date. Daily and the midterm entries should be reviewed at the end of the semester so that your entry at the end of the clinical experience accurately reflects the events of the past semester.

Questions to help you to reflect about your clinical experiences have been provided below. Review these questions to guide your thinking as you write your entries. You may also have some additional elements you would like to add.

Communication Skills: (Consider verbal and written skills)

How effective was my communication in talking to patients/families? What kinds of things did I discuss? How do I know I was communicating effectively?
--

How effective was my written communication? Was I able to write my thoughts clearly? Was I able to use nursing terminology effectively? How do I know?

Clinical Skills:

How effective was I in carrying out clinical procedures? How do I know?
--

Teaching Skills:

How effective was I in teaching activities involving my patient and the patient's family?
Were they receptive to my teaching?
How do I know they could carry out or understand what I taught?

Nursing Process:

Assessment:

How effective was I in conducting nursing assessment?
How do I know?

Nursing Diagnosis:

Was I able to effectively diagnose the problem?
How do I know?

Planning:

How effective was I in planning care?
How do I know?

Intervention:

How effective was I in implementing a plan of care?
How do I know?

Evaluation:

How effective were my interventions or my plan of care:
How do I know?

Other:

What other elements of nursing were important to me?
How effective was I in addressing these elements?
How do I know I was effective?

Write your thoughts about your daily experiences. You may choose to write about a particular experience or an aspect of the experience that is of concern to you. You may wish to choose some element at random. The questions that are provided will help you structure your thoughts. In addition, a space is provided for you to write your general personal impressions about each day.

GOALS FOR THE SEMESTER

Date: _____

Student's Name: _____

My personal goals in preparing to become a professional nurse this semester are...

How do my personal goals for this course relate to the course goals outlined in the syllabus?

This clinical course will help me to achieve my goals in the following ways:

TODAY'S ENTRY

STUDENT'S NAME: _____

DATE: _____

CLINICAL SITE: _____

CLINICAL ASSIGNMENT: _____

Objectives I planned to meet today:

How I met the objectives:

Why I didn't meet the objectives:

Place an X on the continuum where it best reflects your assessment.

	low				high
Communication Skills					
Verbal	___	/	___	/	___
Written	___	/	___	/	___
Clinical tasks	___	/	___	/	___
Teaching skills	___	/	___	/	___
Use of Nursing Process					
Assessment	___	/	___	/	___
Nursing Diagnosis	___	/	___	/	___
Planning	___	/	___	/	___
Implementation	___	/	___	/	___
Evaluation	___	/	___	/	___
Professionalism					
Standards of Care	___	/	___	/	___
Code of Ethics	___	/	___	/	___
Other _____	___	/	___	/	___

I felt good about...

I was uncomfortable with...

The decision I made during the clinical experience that stays most in my mind was...

I had problems with...

The thing that surprised me most about the experience was...

Things I would do differently next time are (state why)...

Overall, when I think about the experience, I learned...

Personal Impressions

Midterm Evaluation

Date: _____

Student's Name: _____

What are one or two areas in which I need to improve, and what particular steps can I take to make such improvements:

Place an X on the continuum where it best reflects your assessment.

	low				high
Communication Skills					
Verbal		/		/	
Written		/		/	
Clinical tasks		/		/	
Teaching skills		/		/	
Use of Nursing Process					
Assessment		/		/	
Nursing Diagnosis		/		/	
Planning		/		/	
Implementation		/		/	
Evaluation		/		/	
Professionalism					
Standards of Care		/		/	
Code of Ethics		/		/	
Other _____		/		/	

The patterns that I see as I reflect upon these past weeks are...

To me they mean that...

The changes that I see in myself as a professional nurse are...

My professional goals for the remainder of the semester are...

Because...

My plans for achieving these goals are...

Personal Impressions about the past weeks

End of Semester Evaluation

Date: _____

Student's Name: _____

What kinds of new questions about course content have you developed by now that you would not have thought of at the beginning of the semester?

Place an X on the continuum where it best reflects your assessment.

	low	high
Communication Skills		
Verbal	____/____/____/____/____	
Written	____/____/____/____/____	
Clinical tasks	____/____/____/____/____	
Teaching skills	____/____/____/____/____	
Use of Nursing Process		
Assessment	____/____/____/____/____	
Nursing Diagnosis	____/____/____/____/____	
Planning	____/____/____/____/____	
Implementation	____/____/____/____/____	
Evaluation	____/____/____/____/____	
Professionalism		
Standards of Care	____/____/____/____/____	
Code of Ethics	____/____/____/____/____	
Other _____	____/____/____/____/____	

I have learned the following about myself as an effective, professional nurse...

I learned this by...

My nursing approach has changed in the following ways because...

I learned the following about patient care...

My professional goals for the coming semester are...

My plans for achieving these goals are...

Personal Impressions about the past semester