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. Medication records (MARs)
7. Nursing admission assessment
8. 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 TWO 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 do these have for your nursing care and your client's outcomes?
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. (1996). Orientation to the clients chart: A clinical learning tool. *Nurse Educator, 21(5), 5-6.*

ILLUSTRATIVE BEHAVIOR TERMS FOR STATING LEARNING OUTCOMES

Modified with permission from:

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

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	Same as guided response
COMPLEX OVERT RESPONSE	Same as guided response
ADAPTATION	Adapts, alters, changes, rearranges, reorganizes revises, varies
ORIGINATION	Arranges, combines, composes, constructs creates, designs, originates

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NUR 3404-Practicum 1

Pre-Clinical Information

Textbook physiology of normal functioning based on patient's diagnosis. 1st block NORMAL patho	Textbook variations in normal physiology based on patient's diagnosis. Then next paragraph: ABNORMAL PATHO CAUSES R/T DIAGNOSIS	Next paragraph: ID growth and development stage, how you will care for the patient that day, what to look for, lab, etc.
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.	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 the diagnostic tests completed for the diagnosis, like EKG, EEG, CT Scan, x-ray...? What complications would you expect to see from this disease process?	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. 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? 4) How will you care for your patient? 5) What is part of your assessment and patient monitoring?

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Patient Initials: _____ Date: _____

NURSING DIAGNOSIS	**PLAN (Outcome)**	**IMPLEMENTATION**	**RATIONALE**	**EVALUATION**
PRIORITY # ___ Nsg Dx: The problem you have identified for your pt. R/T – What caused the problem AEB – data you have that supports this as a problem, including but not limited to: Diet Meds Labs Dx Tests Physical Assessment Textbook Info.	Goal comes from your nsg dx statement, not R/T or 2^0 Goal: What the pt is to accomplish during your clinical time. By accomplishing this goal you help to reduce, remove or eliminate most or all of the problem listed in column one. You will help to eliminate, reduce, or remove the data under AEB or the R/T. Must be pt specific, measurable, and with a specific time frame.	Actions you will take to meet the goal. May be actions pt will take. Should be a guideline that anyone can follow and meet the same, or do better than what you would do. Should be specific, with numbers, ranges, measurable. Each intervention should be associated with a goal. Should include actions <u>you took</u> during your clinical day. Should be aimed at meeting your goal.	Supports the chosen intervention. Should be specific. Should come from some type of reference book, not out of your head.	Look at your intervention and determine your pt's response to the intervention. Look at your goal. Did you meet the goal? Identify what changes you will make to your plan of care. Write these changes here.

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WEEKLY CLINICAL LOG

PRACTICUM I

This is a reflection of your daily clinical experience. The clinical instructor uses this to help assist you in areas of your clinical experience that may need improvement/exposure/communication, etc.

Directions

This clinical log was developed by Virginia Cassidy and Jane Davidson (1992) to help you reflect about your clinical experiences as a nursing student. Thoughtful reflection is useful in the process of self-evaluation. It has been revised to meet ATU's Level I needs.

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 is 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. You may also have some additional elements you would like to add.

The clinical log is to be completed weekly after your clinical experience. Respond to each question using proper grammar and full sentences. Submit the clinical log to Blackboard along with your weekly clinical paperwork.

1. What did you learn today that was the most beneficial?
2. What would you like to learn more about or what did you not fully understand?
3. What will you do to accomplish what you listed in #2?
4. If you could live today over, what would you do differently?
5. How do you feel about your experience today?
6. How did you feel about your medication administration today?
7. Give an example of how you utilized the critical thinking process today?
8. Give an example of what you could implement next time to improve your time management or flow of the day?
9. List the skills you performed today? What would you do differently next time?

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.

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DUE: FIRST SET CLINICAL PAPERWORK
TO BE COMPLETED IN BLACKBOARD

GOALS FOR THE SEMESTER

Date:_____ Student's Name:_____

THESE MUST BE SPECIFIC/MEASURABLE GOALS:

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:

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END OF THE SEMSTER EVALUATION
Due with Final Set Paperwork in Blackboard

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?

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

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NUR 3404-Practicum 1
Clinical Information

****PAPERWORK TO SUBMIT FOR EACH CLINICAL CAN BE FOUND ON BLACKBOARD****
(The following will help you complete your paperwork)

Adapted and used from the following: Schuster, P. M. (2002). *Concept Mapping: A critical-thinking approach to care planning.* Philadelphia, PA: F.A. Davis Company

Nursing Assessment Explanation

1. Student name and date of care
    a. Your name and date of care are important to place on your nursing assessment form. It is beneficial to your instructor and helps the instructor to keep your paper work separate from other students. It also helps you to review your paper work and see the progress that you have made from week to week.
2. Patient initials
    a. Never put the patient's name on your paper work. Only use initials. All information recorded on your patient's chart is confidential and falls under the HIPPA law. Ethical and legal ramifications are possible if any information about your patient, or can identify your patient is removed from the clinical setting. Clipboards that have your patient identification and information should not be left lying around where family members, friends, or even other healthcare workers not responsible in the care of your patient, may be seen. Never give information to others inside or outside the hospital, unless they are directly involved in your patient's care. Patient care should never be discussed in elevators, hallways, Wal-Mart, etc.
3. M/F
    a. Each page of the patient's chart should have a sticker on it that has this information on it. You will also find the information on the face sheet, located at the back of the chart. This is the page that the hospital registration department completes at the time of admission to the hospital or clinical site. There are many differences between the sexes that you need to know in order to better care for you patient. For example, communication, relationships, psychological, physiological, emotional and mental aspects of life.
4. Room #
    a. Located on the census sheet and/or the faxed med sheet. If you are making your own assignment, you will usually start off looking at a census sheet that has the patient's room number, name, diagnosis, and physician. It will also be found on the patient's chart, or the computer program being used by the clinical site.
5. DOB and age
    a. The patient's date of birth (DOB) and age will be found on every sheet on the chart by looking at the sticker on the chart page. It can also be found from the face sheet on the chart. This is usually located in the back of the chart. Age is associated with developmental tasks that a person must pass through as he/she experiences life. You have discussed various theories of growth and

development, such as Havinghurst and Maslow. Looking at your patient's age will give you an idea of what tasks have been accomplished and are to be accomplished and then you can take the health problems that you identify and determine how these problems can affect your patient's ability to accomplish the developmental tasks at hand.

6. Ht/Wt
    a. Part of the physical assessment, this information will usually be found in the admission nurse's notes. Your nursing care and the medical plan of care uses this information to determine weight loss, weight gain, medication dosage, outcome of care, fluid replacement, nutrition, etc. Both of these parameters reflect your patient's nutritional status. Some patients are weighed daily and this information is usually found on the graphics page.
7. Marital status
    a. This is located on the face sheet of the chart. It may also be found on the nursing admission sheet. It is an indication of an available social support system your patient may have in recovering from his/her health problems. It may also indicate reasons that you patient may or may not be adhering to his/her medical regimen. Spouses, or significant others need to be included in the care plan because they usually participate in the patient's health recovery.
8. Race
    a. This information is located on the face sheet in the back of the chart. View this section as a reflection of your patient's cultural window. Each race/culture have views on health, recovery, and adherence to the plan of care that you develop with your patient and the family and knowing these views will enable you to provide holistic care. Incorporating the cultural differences increases your patient/family adherence and cooperation in the developed plan of care.
9. LMP
    a. Last menstrual period. This information should be found on the nursing admission sheet. If not, and it is pertinent to your patient, obtain this information from your patient and record in the nurse's notes. Medications, diagnostic tests can affect the fetus.
    b. Another point to remember is that females are now beginning their menstrual periods as early as eight years of age. Sexual activity has increased among younger kids, not to mention rape or incest as a possible cause of pregnancy.
10. Tobacco use/Alcohol use
    a. This information should be found in the nursing admission notes and/or the history and physical. Obtaining this information alerts you to potential problems or causes of current health problems. It may also affect your care and the timing of that care for your patient. It will alert you to the need for education of the patient and compliance with the Arkansas Federation of Medical Care requirements for smoking cessation, and the Arkansas State law prohibiting smoking on hospital grounds.
11. Date of admission
    a. This information should be located on every chart form in the area of sticker information. It can

also be located on the face sheet. It is important to know how long the patient has been in the health care system. With the reimbursement of insurance companies, certain conditions are expected to be cared for on a limited time basis and knowing how long your patient has been in the system will alert you to insurance coverage, home health need, additional resource needs, and if the patient is on or off the expected course of treatment.

12. Physician

    a. Knowing who your patient's physician is alerts you to standing orders, method of communication, visitation times and usual methods of treatment. This can be found on each chart form in the sticker section. It can also be found on the face sheet.

    b. If a specialty physician has seen your patient, you will find this information on consultation reports. Based on the physician's specialty, you will know which physiological components of the body to assess most carefully because consultants usually focus on one body system.

13. Admitting Diagnosis

    a. This information is located on the face sheet, the history and physical and the nursing admission form. Usually this is a medical diagnosis or a surgical procedure. Though many may be listed, the admitting diagnosis will be the reason the patient was admitted to the hospital. Your physiology and pathophysiology will be completed on the admission diagnosis.

    b. If your patient is being admitted for a surgical procedure, review the physician's orders and/or consent form. The procedure should be spelled out on the consent form with no abbreviations being used.

    c. You may also find operative notes that the surgeon has made in reference to the procedure. Physiology on your prep sheet should correspond to the organ, bone, or system that the surgery is being performed. Pathophysiology should correspond as to what the problem is that surgery was required.

14. Other medical diagnoses

    a. Every health problem your patient has is usually included under this information found on the nursing admission form, the history and physical, the consultation form and sometimes on the face sheet. These are important to know because each diagnosis will affect the reason for admission and must be addressed while caring for your patient. You should look up each diagnosis for a definition, etiology, and other information that will assist you to care for your patient holistically.

15. Spiritual/Cultural beliefs affecting care

    a. Religion, beliefs, culture are important in rendering holistic care to your patient. These influence a patient's view of sickness and types of treatment that are considered acceptable to your patient. They may influence dietary practices. Death and dying may require certain rituals. To find this information, look at the face sheet and/or the nursing admission form.

16. Allergies

    a. To locate allergies that your patient may have, look on the nursing admission information, the

MARS, and/or the history and physical. You may find that they have food and medication allergies. For example, if your patient is allergic to latex, then they will also need to avoid kiwi. If they are allergic to kiwi they could possibly have a latex allergy. If a patient is allergic to penicillin, this should alert you to obtain more information from the patient if he/she is receiving the medication, Rocephin.

b. A person's reaction to an allergy is important to know because it can mean life or death. Having a family history of allergic reactions to medications or food does not necessarily mean your patient will have that allergy, but knowing how the family member reacted will alert you to be observant of your patient for the same or similar types of reactions.

17. History

a. This section of your assessment form is important to know because the patient's medical/surgical history can affect the success of the recovery of your patient. It can also alert you needs of your patient and what education does he/she have and what is needed.

b. This information can be located in the nursing admission form, the history and physical, and/or from the patient or family. If you are not familiar with the answers your find, you need to at least get out your medical dictionary and get a general idea about that condition.

18. General appearance

a. Obtained by closely observing your patient. After speaking with your patient and using your observational skills, what is your impression of the patient? If you do not know the definition of the words, look them up.

19. Notes:

a. Record your impressions here. If you discover a problem, notate it here. This is a place to jot down your thoughts/impressions/concerns/problems identified and will refresh your memory when you complete the assessment form.

20. Vital signs

a. Vital signs are temperature, pulse, respiration, blood pressure, pulse ox, and some consider pain to be the 5th vital sign. You obtain this information when you arrive on the floor. If the aides have completed this assessment, look at the results and compare it to the previous recordings. You will find these results on the posted I & O form, the graphic, or the aide may still have them in a pocket because he/she has not had time to record. If using computerized charting, the results may be in the computer notes.

b. Trends are what are important in vital signs. Fluctuations in vital signs are normal, but too high or too low deviations from the patient's normal are important for you to follow up on and investigate possible reasons for this deviation. Upward or downward trends require follow up also. Obtaining vital signs is more than just getting numbers. Temperatures reflect the immune system. Pulse and blood pressure reflect the cardiovascular system. Respirations reflect lung function. Pulse ox reflects oxygenation and ventilation. Pain assessment reflects many aspects of your patient's recovery process.

21. Skin

a. You complete this during your day of care of your patient. The initial skin assessment will be found in the nursing admission form. Your assessment should focus on moisture, color, turgor, edema, and oral mucous membranes must also be assessed for color and moisture. Notice if any lesions are present and describe these. If you are not familiar with the terms, look them up.

b. If your patient has a pressure ulcer, you will find additional forms in the patient chart that will reflect daily assessments, treatments and sometimes photographs of the area. They may be under physical therapy, consultation, nurse's notes, or under treatments. It is important to review these prior assessments and have an idea of what to expect when you do your assessment. You will be recording your assessment using the Braden Pressure Ulcer Risk Assessment, along with your subjective and objective assessment. If you are not familiar with this assessment, review it in your health assessment book. Also review what information is expected to be obtained in your assessment. You will record your findings in the nurse's notes and/or the skin assessment sheet.

c. Using the Braden Pressure Ulcer Risk Assessment form allows you to determine if your patient is at risk for pressure ulcers. The risk level is based on sensory perception, mobility, nutrition, activity and friction shear. Each section will be scored and then totaled. If the score is > 9, the patient is at a high risk.

d. Medicare has alerted all hospital facilities that they will not pay for treatments if the patient develops a pressure ulcer while in the hospital. Other insurances will soon follow. Common nursing diagnoses associated with the skin include, but are not limited to, **Skin integrity, Impaired; Skin integrity, Impaired, Risk for; Tissue integrity, Impaired.**

22. Respiratory

a. You will assess your patient's respiratory status by auscultation and inspection. You may palpate and percuss also. The depth, rate, rhythm, use of accessory muscles, effort, symmetry auscultation of breath sounds, skin color, presence of cough (productive/nonproductive), sputum production, use of oxygen therapy, type of oxygen therapy and the rate, and if night sweats are present, are just a few of the parameters you must success.

b. Common nursing diagnoses associated with the respiratory system include, but are not limited to, **Impaired gas exchange; Ineffective airway clearance; Aspiration, Risk for.**

23. Cardiovascular

a. Part of your routine assessment of your patient will be to assess heart sounds, regularity of the heart beat, jugular vein distension, pulses peripherally, nail bed color, cap refill/blanch, edema, presence of Homan's sign, and electrical pattern of the heart.

b. Common nursing diagnoses associated with the cardiovascular system include, but are not limited to, **Decreased cardiac output, Fluid volume deficit, fluid volume excess, Fluid volume, Risk for deficit/excess; Tissue perfusion, Ineffective (renal, cerebral, cardiopulmonary, gastrointestinal, and peripheral).**

24. Abdomen

a. Review the history and physical, progress notes, nursing admission notes and the prior shift's findings.

b. Assess all 4 quads by inspection, auscultation, palpation, and possibly percussion. Always auscultate first before you palpate. If no bowel sounds, then you should listen for 5 minutes or longer. Be knowledgeable about whether your patient should even have bowel sounds at this point of hospitalization/surgery.

c. Record your findings in the nurse's notes.

d. If tubes are present, describe where and the contents: color, consistency, odor, amount, etc. Some agencies record this information on the I & O sheets.

e. If an incision is present, document about the dressing: intact, dry, clean, color of drainage if drainage is present, quantity of drainage, etc.

25. Elimination

a. This includes urine output and bowel movements. Intake must equal output, or at least close to equal. I & O sheets are usually kept taped to a door in the room and both are added at the end of each shift and then recorded on the graphic sheet/flow sheet. Medications, diet, and fluid intake can be governed by the urine output. Recovery process of some health problems is also measured by the urine output. Typical measurements include foley catheter, urine, liquid stools, emesis, drains, colostomy bags, to name just a few.

b. Common nursing diagnoses associated with elimination include, but are not limited to, **Constipation; Constipation, Perceived; Constipation, Risk of; Incontinence, Bowel, Incontinence, Functional; Incontinence, Reflex; Incontinence, Risk for urge; Incontinence, Stress; Incontinence, Total; Incontinence, Urge; Self-care deficit, Toileting; Diarrhea; Urinary elimination, Impaired; Urinary retention.**

26. Musculoskeletal

a. This assessment involves ROM, edema, and assessment of DVT risk. You perform this on your patient with your initial assessment and depending on your findings, as needed or routinely. It will be recorded in your nurse's notes. It is wise to review the nurse's notes or ask the off going nurse for a description of the previous assessment for comparison purposes. Any patient, who has an immobilization device, should have sensation, motor, and circulation (SMC) assessed frequently.

b. Every hospital/nursing patient should be assessed for the risk of deep vein thrombosis (DVT), especially if they are immobile or bed ridden. If you are not familiar with the DVT assessment, you need to review the scale, how to complete the assessment and what you need to do with your findings.

c. Common nursing diagnoses associated with the musculoskeletal system include, but are not limited to, **Activity Intolerance; Impaired physical mobility; Mobility, Impaired bed; Mobility, Impaired wheelchair; transfer ability, impaired; Walking impaired.**

27. Neuro

a. One of the first signs of decreased oxygenation to the brain is a change in your patient's level of

consciousness. It is important to assess your patient's level of consciousness on your first assessment of the day and thereafter if your patient's diagnoses and your assessment findings indicate it. Neuro assessment includes level of consciousness: AVPU—awake, responsive to verbal stimuli, responsive to pain, or unresponsive; alert, orientation to person, place, time and situation (A&O x4); speech, motor status, pupil: PERRLA: pupils equal, round, reactive to light and accommodation; hearing, vision, taste, smell assessment and swallowing abilities. Your patient's medical/surgical diagnoses and your initial assessment will dictate what and how frequent these assessments must be made. You will record the obtained information in your nursing notes and/or a flow sheet.

b. Common nursing diagnoses associated with the neurological system include, but are not limited to, **Self-care deficit; Disturbed sensory perception; Impaired verbal communication; Acute or Chronic confusion and Impaired memory.**

28. Activity

a. This will be found in the physician's orders and/or the Physical Therapy notes. You will also find information about past activity in the initial nurse's notes upon admission.
b. Be sure to note if your patient needs assistive devices, his/her gait, activity restrictions, and need for restraints.
c. If your patient is an orthopedic patient, be sure to note the amount of weight bearing on the injured bone is allowed. If no weight bearing, you will usually see NWB as the abbreviation.
d. Completing a fall risk assessment will help to ensure that your patient is safe and no further harm will occur. It is based on history of recent falls, medications, and psychological and cognitive status. You will record your findings on the nurse's notes and make sure that the chart reflects that your patient is/isn't at fall risk. To complete the form, circle the appropriate number, add the scores, and then outline the measures you plan to take to prevent falls.
e. Common nursing diagnoses associated with activity are: **Activity Intolerance, Fatigue, Impaired mobility, Self-care deficit, Risk for falls.**

29. ADL's

a. Review the admission nurse's notes for information concerning your patient's ability to care for himself/herself. Does your patient need complete assistance—is unable to do own self-care; partial assistance—can do part of own self-care; or can your patient complete own self-care without assistance: Allowing your patient to do as much for himself/herself, helps to foster independence and increases likelihood of going home sooner and a higher rate of successful recovery.
b. Record your information in the nurse's notes.
c. Common nursing diagnosis for ADL's is **Self-care deficit.**

30. Nutrition

a. The patient's chart will indicate the patient's nutritional status through a consult by the hospital's nutritionist or dietitian. Physician's order the diet and this is found in the physician's initial admission orders, or in subsequent orders as the patient's condition changes. Knowing your

patient's diet ensures that the patient does not receive more than or less than what is needed; that your patient does not receive restricted foods; that he/she does not receive food when the patient has been restricted to nothing by mouth (NPO). If you are not familiar with the different type of diets that are ordered in the hospital/nursing home setting, please review these: liquid diet, soft diet, low fat diet, low sodium diet, low protein diet, low sugar diet, weight reduction diet, high fiber diet, low residue diet, bland diet, and tube feeding formulas. This is a good time to remember you nutrition course information.

b. Completing a nutritional assessment involves need for assistance in eating, ability to swallow effectively, ability to chew, presence of dentures/teeth, presence of a gag reflex, ability to cough, sneeze, presence of a feeding tube, PEG tube, appetite, amount consumed, likes and dislikes, I & O.

c. Fluids are sometimes ordered for patients for numerous reasons: fluid replacement, medication administration, replacement of electrolytes, total parental nutrition (TPN). In your initial assessment of your patient you need to know the type of IV fluid, the flow rate, IV site appearance, and the amount administered. This information is usually on the nurse's notes, I & O sheet, Physician orders, or the MAR sheet. It is important to relate the information about the IV being administered to the medical and nursing diagnoses.

d. Some patients may be diabetic. If this applies to your patient, you will need to perform Accu-checks, usually before meals and sometimes on a routine of every 2-4 hours. Your patient may be on a sliding scale of insulin. You must know when insulin is given and how much if your patient is on a sliding scale. You must know the Accu-check results ***before*** you give any insulin or oral anti-diabetic medication. The sliding scale information will be located on the physician's orders, standing orders, and the MAR. Recording the information will depend on hospital policy.

e. Common nursing diagnoses associated with nutrition include, but are not limited to: Imbalanced nutrition; Fluid volume deficit/excess, Self-care deficit, feeding.

31. Pain

a. Assessment of pain is always a skill that must be approached from a subjective and objective approach. There are many methods available. PQRST is a very popular one and easy to remember: **P**rovocation/palliation; **Q**uality of pain; **R**adiation/region; **S**everity, and **T**iming. Pain scales are available to assist in the severity of the pain: Numeric/Wong/ FLACC. Familiarize yourself with these scales and the one the institution uses where you are doing your clinical experience.

b. Any time your patient complains of pain, not only is it important to assess the pain, but you must intervene. Charting what you did and the patient's response to that intervention is required. You need to know when the last dose of pain medication was administered, how much the patient received, and what other measures helped to reduce your patient's discomfort. You will also need to know the onset, duration and peak of the medication you administer, along with possible side effects in order to know if your intervention is affective. If not, know what you will do next. Remember the mnemonic ***AIR***: Assess, Intervene, Reassess. All this information should be documented in your nursing notes.

c. A common nursing diagnosis associated with pain is **Pain.**

32. Cognitive-Perceptual/Sleep

a. In this assessment, you should review the nursing admission form to obtain a baseline with which you can compare your assessment. This provides an opportunity to witness progress or decline. You will be assessing the patient's senses of sight, hearing, taste, smell and touch.

b. Sleep has been shown to have a devastating effect on recovery and on cognition. Assessing your patient's sleep habits/problems can cue you to needs and possible causes of some of your patient's problems that may or may not have influenced his/her admission.

33. Diagnostic tests

a. Your patient may have diagnostic tests that must be completed on the day of your clinical experience. It is imperative that you understand the test and be able to explain to your patient or family, what to expect before, during, and after the test. You also will need to know what your actions will be before, during, and after the test so that you feel more confident in caring for your patient and you can prevent harm or provide comfort as needed.

b. Tests that are being ordered will be found in the physician's order sheet.

c. You should record your patient's response and the teaching that you have down in the nurse's notes.

d. Look at the results of these tests in relation to your patient's baseline and overall health. Compare the results with previous results.

34. Medications

a. Medications are ordered by the physician and filled by the pharmacy. Pharmacy will have a form called the Medication Administration Record (MAR) that will reflect all meds that have been ordered and are being given, the time of administration and the dose. These MAR's SHOULD BE VERIFIED BY REVIEWING THE PHYSICIAN'S ORDER SHEET TO CONFIRM THE CORRECT INFORMATION.

b. Administration of medication is a nursing task and can be a legal, ethical and moral issue when not done correctly. You must know about your medication, dose, time of administration, how administered, what the mechanism of action is why it is being given, what the normal dose is, peak and duration time, nursing implications, side effects, and what you need to know to educate your patient about the medication, to name just a few.

c. If you are unable to find medication information, the hospital pharmacy may be of help. Never give a medication without knowing about it first. Also, remember that your faculty member is a good resource.

d. Know the trade and generic name. Physicians may write one name, and the pharmacy may substitute generic drugs as a way to decrease costs and this will be reflected in a different name for the drug on the MAAR.

e. Knowing the general classification of a drug helps you to identify general information about the drug. Antibiotics are associated with the nursing diagnosis of risk **for infection.** Antidysrhythmics and antihypertensive meds are usually associated with the nursing diagnosis of **Decreased cardiac output.** Anticoagulants and diuretics are associated with the nursing diagnosis of **Deficient fluid volume.** Corticosteroids are associated with **Ineffective protection.** Anticonvulsants are associated

with **Ineffective tissue perfusion (cerebral).** Insulin and oral antidiabetic agents are associated with **Imbalanced nutrition: less than body requirements.** Medications used for pain are usually associated with the nursing diagnosis of **Pain.**

35. Lab

a. Lab tests are ordered by the physician and will be found in the physician's orders. Results of the tests will be found under the tab marked as "Lab". If using a computer-charting program, you will need to discover where diagnostic labs and other test results are located.

b. Make sure you know what tests are ordered and information about each test. As discussed under diagnostic tests, the same information is expected for lab tests. Many treatments are based on lab results. Medications such as insulin are determined based on blood glucose finger sticks and/or blood glucose results. You need to know the normal and what abnormal results mean for your patient. You also need to know what the implications of abnormal mean for you as the patient's nurse and how your plan of care needs to be modified or changed.

c. Evaluate the results of these tests based on factors that influence the results, the trend, patient's baseline and the patients overall health. ***Do not copy every diagnosis listed from your drug resource.*** **This is specific to your patient**.

d. Compare and contrast the results with other/past tests of this hospitalization and what is considered to be the norm for your patient.

36. Potential Nursing Diagnoses

a. This is determined by the data that you have collected. Review your prep sheet, your assessment sheet notes and data, and your day with the patient.

b. Start out by listing all the diagnoses that you think fit your patient. Then determine if you have data to support the nursing diagnoses. Then select the top two priority nursing diagnoses that pertain to your patient.

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EVIDENCE BASED PROJECT

NCLEX PREP PORTFOLIO

****DETAILS WILL BE ON BLACKBOARD****

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NUR 3404 – Practicum in Nursing I
Clinical Performance Evaluation Tool Guidelines/Grading

Student: _____ Clinical Area: _____

Tool Guidelines
✓ **Each student will self-evaluate at the end of each rotation by completing a CPET.** ✓ **Each faculty member will complete a CPET for each student at the end of each clinical rotation.** ✓ **Each row item must be evaluated by the final evaluation.** ✓ **The clinical score will be determined by clinical faculty placing an "S, NI, N/A, N/O, or U."** ✓ **The score for clinical evaluation will be either "passing" or "failing."** ✓ **A passing grade will only be assigned IF all items are checked "S" at the end of the final evaluation.**
Core Competencies Key: Each core competency has a template or key, which specifies individual guidelines and examples for each. ✓ **The keys are based on level of matriculation in each clinical course.**
Grading Guidelines, Entire Course ✓ **The score for each student in the course will be the numeric grade received for the course based on all of the didactic work required in the clinical syllabus.** ✓ **Clinical performance will be evaluated with the Clinical Performance Evaluation Tool (CPET), and will be scored either "pass" or "fail."** ✓ **Every student must receive a score of "pass" on the CPET to pass the course.** ✓ **If a student receives a "fail" on the CPET, the student will receive an "F" for the course.**

Grade calculation:	**Clinical Coursework**	**Student grade for each area.**
15%	Math Calculation Test	Math Calculation Test #1_____ #2_____
70%	Weekly Practicum Grade	CPET evaluation _____ Weekly practicum grade average_____
15%	NCLEX Prep Portfolio	Project _____
Pass/Fail	Simulation (2 Days)	Day #1_____ Day #2_____

Final course grade _____

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Student: _____ Clinical Area: _____

Wk	Grade	Comment (if applicable)
1		
2		
3		
4		
5		
6		
7		
8		
9		

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Student:_____ Clinical Area:_____

Clinical Performance Evaluation Tool (CPET)

S = Satisfactory NI = Needs Improvement U = Unsatisfactory N/A = Not Applicable N/O = No Opportunity	1	2	3	4	5	6	7	8	9	FINAL EVAL
Provides Patient Centered Care (Values, Caring, Human Dignity Ethics)	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O
Exhibits Teamwork & Collaboration - **Communication: Personnel (faculty, staff, patients, peers, family)** - **Oral: nonverbal** - **Written: documentation**	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O
Incorporates evidence-based practice - **Critical Thinking**	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O
Understands & applies quality improvement methods - **Leadership** - **Assessment** - **Promote healing**	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O
Promotes Safety - **Technical Skills**	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O
Understands & Utilizes Informatics - **Appropriate decision making based on the core competencies above & implemented with informatics support.**	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O	S NI U N/A N/O

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Department of Nursing

Student:_____ Clinical Area: _____ Date: _____

Signature: _____

NUR 3404 - Clinical Performance Evaluation Tool (CPET) Explanation

1. Provides Patient Centered Care

a. **Understands the patient values, preferences, and their expressed needs as part of clinical interview. Implements the plan of care as incorporated in the nursing process, including the evaluation of care.**
b. **Understand ethics and communicates the patient values, preferences, and their expressed needs to other members of the health care team.**
c. **Uses the situational context, with background, assessment, and recommendations (SBAR) to structure care for the patients with other members of the health care team.**
d. **Assesses the presence and extent of pain and suffering and makes recommendations to help improve such.**
e. **Assesses levels of physical and emotional comfort and makes recommendations to help improve such to maintain human dignity.**

2. Exhibits Teamwork & Collaboration

a. **Communicates effectively utilizing SBAR with nurses and other health care members.**
b. **Demonstrates awareness of own strengths and limitations as a team member.**
c. **Functions competently within own scope of practice as a member of the health care team.**
d. **Initiates requests for help when appropriate to the situation.**
e. **Communicates with team members, adapting own style of communicating to needs of the team and situation.**

3. Incorporates Evidence Based Practice

a. **Demonstrates knowledge of basic scientific methods and processes, and correctly interprets findings.**
b. **Differentiates clinical opinion from research and evidence summaries and draws logical reasoned conclusions with rationales.**
c. **Bases individualized care plan on patient values, clinical expertise, and evidence.**
d. **Reads original research and evidence based reports related to area of practice.**

4. Understands and Applies Quality Improvement Methods/Evaluation

a. **Utilizes time management skills to maximize performance.**
b. **Describes strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice.**
c. **Recognizes that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patients and families.**
d. **Gives examples of the tension between professional autonomy and system functioning.**
e. **Explains the importance of variation and measurement in assessing quality of care.**
f. **Describes approaches for changing processes of care.**
g. **Focused on patient needs.**
h. **Modifies plan of care based on patient acuity/changes.**

5. Promotes Safety

a. **Performs an accurate and safe assessment.**
b. **Demonstrates effective use of technology and standardized practices that support safety and quality (medication administration).**
c. **Demonstrates effective use of strategies to reduce risk of harm to self or others.**
d. **Uses appropriate strategies to reduce reliance on memory (e.g., forcing functions, checklists).**
e. **Communicates observations or concerns related to hazards and errors to patients, families, and health care team.**
f. **Performs standard procedures accurately and safely.**

6. Understands and Utilizes Informatics

a. **Explains why information and technology skills are essential for safe patient care.**
b. **Navigates the electronic health record.**
c. **Documents correct and precise plans patient care in an electronic health record.**
d. **Recognizes the time, effort, and skill required for computers, databases, and other technologies to become reliable and effective tools for patient care.**

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Student Name: _____ Week: _____ Date: _____ Score: _____

	5 points	4 points	3 points	2 points	1 point
Pre-clinical diagnostic information and medications.	1. Specific 2. Patient focused with anticipated care 3. Accurate 4. Compared to textbook norms with rationale 5. Referenced	Lacks 1 criteria.	Lacks 2 criteria.	Lacks 3 criteria.	Lacks 4 criteria.
Diagnostic test information, and labs with rationale specific to patient.	1. Contains specific rationales 2. Patient specific interpretation. 3. Accurate 4. Compared to textbook norms with rationale 5. Referenced	Lacks 1 criteria	Lacks 2 criteria	Lacks 3 criteria.	Lacks 4 criteria.
Head to toe assessment, and opening note.	1. Patient Specific 2. Complete 3. Accurate terminology 4. Adequately demonstrates actual student assessment. 5. Spelling and punctuation correct.	Lacks 1 criteria	Lacks 2 criteria	Lacks 3 criteria.	Lacks 4 criteria.
Diagnosis, and outcomes	1. 3 NANDA relevant diagnoses, 3-part diagnoses 2. Nursing Diagnosis is patient specific and Linked to assessment 3. Nursing outcomes 1 short and 1 long term outcome. 4. Outcomes are measurable and attainable 5. Patient focused	Lacks 1 criteria	Lacks 2 criteria	Lacks 3 criteria.	Lacks 4 criteria.
Interventions for priority nursing diagnoses and Evaluation/format	1. Patient focused, Intervention clearly related to nursing diagnosis and outcomes 2. 5 patient specific interventions per outcome with rationale to each intervention 3. Includes collaborative care Patient focused 4. Evaluation addresses outcomes, includes patient specific continued plan of care 5. Evaluates plan of care appropriately by modifying plan of care if outcome not met	Lacks 1 criteria	Lacks 2 criteria	Lacks 3 criteria.	Lacks 4 criteria.

ARKANSAS TECH UNIVERSITY
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Student Name: _____ Week: _____ Date: _____ Score:_____

	50 points	40 points	30 points	20 points	10 points
Application	Arrives to clinical with knowledge of patient diagnoses, pathophysiology, medications, diagnostic tests, including labs. Correctly interprets findings, draws logical reasoned conclusion, and supports interpretation with rationale. Identifies changes in patient status and modifies care accordingly. Able to perform standardized procedures accurately and safely without supervision.	Lacks 2 of the 50-point category.	Lacks 4 of the 50-point category.	Lacks 6 of the 50-point category.	Lacks 8 or more of the 50-point category.
	25 points	20 points	15 points	10 points	5 points
Professionalism	Arrives to clinical site on time. Dresses according to dress code. Brings all required materials and equipment to clinical site. Is respectful to faculty, staff, patient, family and visitors. Is truthful about clinical performance. Follows all other professionalism guidelines set forth in the syllabus or handbook. Paper work is turned in on time. Actively seeks learning opportunities	Lacks 1 of the elements in the 25-point category. Paperwork is less than 1 hour late.	Lacks 2 of the elements in the 25-point category. Paper work is 2-3 hours late.	Lacks 3 of the elements in the 25-point category. Paper work is 4-5 hours late.	Lacks 4 of the elements in the 25-point category. Paper work is no more than 1 day late. (Paperwork that is more than 1 day late will receive a "0" for this element.)
Score	/100				